Matching Services and Activities To Meet the Varied Needs of Older People*

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Clearly, the development of an intelligent scheme of comprehensive, articulated services to provide a continuum of care for the elderly requires the cooperative efforts of the larger community, the government authorities, and voluntary agencies. Within each Jewish community, a coordinated effort must be taken to assess the problems of the aged, determine priorities, the strategy for mobilizing resources, the allocation of responsibility for leadership, authority and the development of needed services, and assurance that the Jewish elderly have access to, and secure, needed benefits and entitlements.

Introduction

Imre Kaslovsky celebrated his second year at Scheuer House of Jewish Association for Services for the Aged; the House is located in Coney Island, overlooking New York's inner harbor. At 92, Mr. Kaslovsky strolled cheerfully three miles down the boardwalk to Brighton Beach. He had been burned out of his apartment house in Hunts Point, the Bronx, and after a long stay in an old welfare department hotel, was resettled by the Agency. An active participant in the Hirschman "Y" program at Scheuer House, Mr. Kaslovsky is optimistic, and has made a new life.

A decade of sustained effort lies behind this account. Recognition of the problems of the Jewish aged, planning, organization, advocacy, fund-raising, housing development with the assistance of an array of municipal, state and federal housing and finance agencies, community work to secure local support ultimately made possible the building of Scheuer House and the provision of a complex array of services for three hundred residents by JASA and the Associated YM-YWHA's of Greater New York.

On May 16, 1976, Brookdale Village, a housing development for elderly people in the Rockaways was dedicated by JASA. The second stage of the building program was completed: 547 apartments, and a 27,000 square foot multi-purpose community service facility. The cost of this stage was $18,000,000, funded by the State of New York, the Federal government by mortgage interest and rent subsidies, through Municipal tax exemptions, and a philanthropic gift of the Brookdale Foundation. The first two buildings with 512 apartments were completed in 1969 at a cost of $7,000,000. More than 3,000 applications were received with little publicity. Brookdale Village is fully rented.

Planning of this facility and its supportive services began six years ago. Long Island Jewish-Hillside Medical Center agreed to establish a primary health care service at Brookdale. Education, recreation, group services and services for individuals are now being developed by JASA with the assistance of the New York City Department for the Aging. The planning and funding arrangements to produce the services needed by the elderly residents of Brookdale and all of the Far Rockaways are complex. Grants under Title III and Title VII of the Older Americans Act, and the Employment and Manpower Program of the U.S. Department of Labor have been secured. The parameters of services will further evolve with the participation of older adults of the community in the governance of the program. A time-limited one year "start-up" grant from Federation was a useful increment to available program resources but has created a longer term planning problem. Planning for Brookdale Village six years ago was based upon extensive demographic, social and health data about the elderly of the Rockaways and in similar residential facilities in New York and throughout the country. A plan for a comprehensive continuum of service reflecting the "state of the art" was developed. The community facilities were designed to fulfill the required functions. There was no way in 1970 to ascertain the source of the resources needed in 1976-1977 to conduct the health, welfare and educational programs needed by the Jewish elderly of this planned community. Membership dues and fees for older adult programs at best cover only a modest portion of the costs of service. During an era when services for the elderly are so heavily funded by government, the Agency had to assume the risks of the uncertainties of funding and do forward planning and organization, based upon a judgment of need, with faith in the power of advocacy in the cause of the Jewish elderly to persuade government and voluntary philanthropic circles to provide the means to develop the needed programs.

The overwhelming response of the Jewish elderly of New York to these housing opportunities reflects the harsh realities of life and the poignancy of the fate of tens of thousands of poor Jews who survive in the inner city of this and many other metropolitan areas throughout the country.

The Heterogeneity of the Jewish Aged

On any given workday, the experiences of the elderly encountered by JASA's professional staff give cause for great optimism, and despair. The capacity of older people to work, to create, to contribute their leadership and experience to the community, to enjoy leisure time, their families, friends and neighbors is encouraging. Others live in fear and despair, in anguish and isolation, sometimes disabled, mentally impaired, poverty stricken. There are great contrasts in the lot of Jewish elderly people, and in the circumstances of large numbers of different communities. The elderly are a very heterogeneous population.

Any discussion of the constellation of services which have been found useful to serve so varied a population as the aged and the Jewish aged must assume knowledge of salient facts. A wealth of data is at last available to describe the circumstances of the aged and to enrich our understanding of their problems and prospects. An overwhelming collection of books, magazines, statistical reports, surveys, research findings, articles in the press and journals has accumulated, far beyond the capacity of the social work practitioner or executive to absorb.

A number of excellent articles and documents summarize the array of information needed by the engaged older adult program developer.[1]

All of the relevant data and as much as can be gathered about the specific group of elderly to be served are useful. Indeed, the first canon for mobilization of resources, fund gathering, in this age of management by objectives is the requirement for a clear exposition of needs to be served, objectives to be achieved, and methods to be used, as well as

*Read to the Consultation by the National Jewish Welfare Board for Jewish Community Centers on Serving the Jewish Older Adult, New York, Oct. 19, 1976.

[1] Elaine M. Brody, "Aging," *Encyclopedia of Social Work,* XVI. National Association of Social Workers, New York, 1971.

Elaine M. Brody and Stanley J. Brody, "Decade of Decision for the Elderly," *Social Work,* Vol. 19, No. 5 (September, 1974).

Morris Zelditch, "Trends in the Care of the Aged," this *Journal,* Vol. XXXIV, No. 1 (Fall, 1957), pp. 126-140.

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The Epidemiology of Aging, U.S. Department of Health, Education and Welfare, P.H.S.-W.I.H., DEHEW, Pub. No. (NIH) 75-71.

Dr. Celia Weisman, *The Future Is Now,* National Jewish Welfare Board and the Brookdale Foundation, 1976.

Demographic Highlights, Facts for Planning, National Jewish Population Study, Council of Jewish Federations and Welfare Funds, New York.

Ethel Shanas, *Measuring the Home Health Needs of the Aged in Five Counties, Journal of Gerontology,* Vol. 16, NI-37-40.

costs for the specific program to be developed.

The plight of the Jewish aged, which looms so large a problem for the Jewish community, is a consequence of some very complex phenomena of American life in the urban areas, and indeed of Jewish history. So successful was this generation of aged Jews that their children, better educated and far more affluent, were able to leave the old neighborhoods of settlement and their parents far behind. Everywhere the in-migration of peoples of other colors and ethnic groups succeeded the departing younger family. The elderly Jews find themselves in changed, deteriorating neighborhoods, ill-housed, wanting in the ordinary amenities—the butcher, the baker, the physician and dentist, the synagogue or community center. They live in fear, and the fear is real because the aged of every color are victims of the aggressions and delinquencies of the impoverished.

The ecology of the Jewish elderly, their geographic location is one of the major elements in determining their needs and assessing their problems. Chenkin[2] estimated that more than half the Jews, 3,155,000 people, lived in fifteen urban areas, which include New York, Philadelphia, Chicago, Los Angeles and Boston. Here the phenomenon of the isolated, remnant, poverty-stricken Jewish population in old neighborhoods is observed. But the elderly themselves do move, to the outer rim of the city, to suburban areas, and from the north to the warmer, sunnier climates of California, Arizona and Florida. There are signs of the relocation of mature suburbanites of means back to the city or to apartment houses or town houses in satellite cities. But the main body of the Jewish elderly will remain in older communities for this next decade. The character of the Jewish elderly varies from neighborhood to neighborhood, from "inner city area" to suburb. The needs and interests of the Yiddish foreign-born retired furrier and the middle-class former school teacher vary enormously, however similar their relative age and physical condition.

An Overview of Services for the Elderly

The sense of crisis in care of the Jewish aged moved a number of Jewish communities to assess their existing services and to establish new organizations and new structures to respond to the emerging problems of the greatly increased population. The National Jewish Population Study of 1971, completed by the Council of Jewish Federations and Welfare Funds, estimated the Jewish aged over 65 to number 710,768 in 1976, some 12.4 per cent of the total Jewish population. By the year 2000, when 29 million older Americans over 65 might be anticipated, elderly Jews would number 900,000, no less than 15 per cent of the Jewish population. In 1976, moreover, one-third of the aged was over 75, and 6 per cent over 85.

In New York City, the Jewish Association for Services for the Aged was established by the Federation of Jewish Philanthropies of New York in 1968. Its functions were to plan, mobilize the resources, develop and operate a comprehensive array of health and welfare services to meet the needs of the Jewish elderly person, well or feeble, alert or senile, poor or affluent, in New York City and Nassau County, all within an already existing structure of Federation agencies in each of the functional fields. During the past eight years, JASA has developed 21 neighborhood-based community service centers, serving 26,000 people a year, and 30 senior citizen associations and day centers, serving 4,000 members. A great variety of demonstration programs have been conducted and evaluated.

In other communities, other organizational patterns of response resulted. In Chicago, in 1972, the Council for the Jewish Elderly, a committee of its Federation, was established to coordinate the functions of existing agencies and to develop new services in designated geographic areas. The committee ultimately became an operating agency, equipped to enter into "purchase of service" arrangements with other agencies. The Federation in Baltimore established an operating committee to coordinate the work of its agencies. All of these approaches recognized the need to bring new and vigorous lay and professional leadership to resolve the complex problems of the elderly. These instrumentalities soon recognized that the overwhelming needs of the Jewish elderly could not be met by voluntary resources, and required large-scale government funding to provide required services.

Government Funding of Social Insurance and Services

American society has not yet responded adequately to meet the needs of its burgeoning population of the aged. Their problems are manifold, and remain unresolved, despite the substantial progress which has been made in development of programs to meet their needs. The aged are still poor and need adequate income, health care, home care services, adequate housing, social services, legal assistance, opportunities for employment, good food, opportunities for socialization and constructive use of leisure time, and, at the least, decent institutional care. During the last forty years, a major shift has occurred by assumption of government responsibility for funding and provision of these services. Program planning for the elderly can only be considered as a function of the provision of government resources and statutory and administratively mandated programs and services.

During the depression years of the 1930's, the financial responsibility for public assistance was assumed by the government. In the face of the equally overwhelming problems of the aged now completely beyond the financial capacity of voluntary philanthropy, or of the aged themselves to meet, the government has at last stepped into the breech.

The passage of the Social Security Act in 1935 was a landmark in establishing the rights of older Americans. But not until the forties was significant interest in the aged aroused. The aged have at last become a major policy concern of the Federal government. The basis for provision of adequate income maintenance was assured with successive amendments to the Social Security Act, which greatly increased benefits and provided for "indexing," tying payments to the cost of living. The transformation of Old Age Assistance to Supplementary Security Income was a major gain for the poorest elderly. The passage of Medicare, as Title XVIII and Medicaid under Title XIX of the Social Security Act transformed the economy of the care of the aged under voluntary auspices. Homes for the aged became substantially or almost wholly funded by the government, and hospitals whose care of the aged equalled one-third of their bed days, were beneficiaries. In the calendar year, 1975, expenditures under Title XIX (Medicaid) were $13,524,560,000, a substantial portion of which was for the elderly. Medicare reimbursements were $4,109,848,000, 92 per cent of expenditures were for people over 65.[3] During this same period, significant social service programs for the aged were established through a series of legislative acts. As early as 1935, Title I of the Social Security Act, providing for Old Age Assistance, paid for the cost of social service workers employed by the states and local government to assist Old Age Assistance beneficiaries. In 1967, for the first time, Federal purchase of services for the beneficiaries of Aid to Dependent Children and the Disabled Aged and Blind from voluntary agencies was authorized under Title XVI of the Social Security Act, in open-ended funding. By fiscal year 1972, a maximum of 2.5 billion dollars was allowed. Federal regulations established by the Department of Health, Education and Welfare spelled out in detail, objectives and modalities of program services.

The Older Americans Act of 1965, another landmark, for the first time established legislation to meet the needs of the aging expressly. Functions of advocacy, planning,

2 Alvin Chenkin, "Jewish Population in the U.S. 1974" *American Jewish Yearbook,* 1976, pp. 229-248.

3 "Developments in Homemaker—Home Health Aid Services," *Washington Legislative Bulletin,* Vol. 24, Issue 41, Social Legislation Information Service, Washington, D.C., September 13, 1976.

assessment of needs, inventory of resources, and the joint planning of solutions were established. It was hoped that by advocacy efforts the public could be persuaded to devote resources under their control to the provision of new additional or better services for older persons. The Act also provided for payment for direct provision of demonstration services.

Title III in 1976 provides for continued payment for provision of services, area planning, shared federal-state funding, purchase of service from voluntary agencies. Low income, minority aged are a priority, as is engagement of older people in program governance.

Title VII established the nutrition program, and, in essence, the organization of senior centers for hot lunches, the provision of nutrition education, transportation, recreation opportunities, counseling and linkage and social contact opportunities.

Despite the constraints on greatly increased Federal funding of social services, continued pressure to expand these programs exists. They are popular, and at last the cause of the aged has acquired considerable political merit.[4]

A Compendium of Services to Meet the Requirements of Older People

Dr. Celia Weisman has suggested a useful set of categories for defining large groups of the elderly and the broad classifications of programs to serve these groups: Type I, the "Intact Elderly," Type II, the "Moderately Impaired Aged," and Type III, the "Vulnerable Aged."[5] From an operational viewpoint, these broad categories are useful, but experience in the operation of health and welfare service makes somewhat sharper distinctions of functional disability and hence, of categories of the elderly. A fourth category, the "Physically Disabled and/or Mentally Impaired" should be added.

There is no community which has developed a comprehensive network of integrated services to meet the needs of a heterogeneous aged population over the full span of later years. There are now many more services and entitlements for the elderly than ever before. These are very unevenly distributed over the United States, with enormous variation in scope, quality and quantity of services throughout the country. There is great variation in state and local contributions to federal programs. In recent years, a great deal of experience has been gained in the conduct of service and demonstration projects. The "state of the art" has been improved.

The World Health Organization has formulated the objectives of health and welfare care for the aged as follows:

1. To sustain their independence, comfort and contentment in their own homes, and when independence begins to wane, by all necessary means for as long as possible.
2. To offer alternative residential accommodations to those who by reason of age, infirmity, lack of a proper home, or other circumstance are in need of care and attention.
3. To provide hospital accommodations for those who by reason of physical or mental health are in need of a full medical assessment, therapy, rehabilitation or long-term skilled medical and/or nursing care.[6]

Clearly, the development of an intelligent scheme of comprehensive, articulated services to provide a continuum of care for the elderly requires the cooperative efforts of the larger community, the government authorities, and voluntary agencies. Within each Jewish community, a coordinated effort must be made to assess the problems of the aged; to determine priorities, the strategy for mobilizing resources and the allocation of responsibility for leadership and authority; to develop needed services; and to assure that the Jewish elderly have access to and secure needed benefits and entitlements.

Program development for the aged has reached new levels of sophistication, particularly where sources of funding, government agencies, foundations, and a new generation of Federation planners require planning by objectives. Exacting standards of service and care have been established for health and welfare service, particularly for the disabled and impaired elderly, and in health related programs. Data gathering, preliminary surveys, research on current experience, a definition of objectives, methodology and costs, time estimates for development and operation, establishment of levels of service and outcome are now expectations. The complexity of needs of the elderly has stimulated institutions in all the traditional fields to employ the methodology and therapies of other fields and to become "multifunctional." Thus, homes for the aged and casework agencies have been operating day centers for the elderly; community centers have provided mental health and casework services, therapeutic day centers for the impaired, and housing facilities.[7] Multifunctional agencies such as JASA have utilized methods of all of the functional fields. For the future, it is likely that the constellation of functions needed by the elderly will cross traditional lines of institutional functions. This will increase opportunities for institutional cooperation and may create problems of rivalry and competition among institutions and professional fields. The YM-YWHA in over a century of development has become a comprehensive communal service center.[8] Each community will ultimately determine the outer limits of that functional service expansion. Theoretically, as in the Catholic community, it would be possible for one community corporation to operate directly all of its health and welfare services. Whatever the ultimate arrangements in each community, as the development of services for the elderly becomes more health-related for the physically disabled and mentally impaired elderly, the standards and practices of these fields become operative, whether the source of funding is philanthropic, governmental or the consumer's payments. Professionals in the health field: doctors, nurses, therapists, must be employed. Costs mount, and risks increase.

At the other end of the spectrum, the provision of degree-granting educational programs may require operation of such services by accredited educational institutions. These requirements become the functional discipline in rational planning and organization of comprehensive services for the elderly.

The proliferation of government programs for the aged, each defining a category of beneficiary, program objectives, required services and practices, and program locale, challenges the Jewish communal agency with another set of problems and opportunities.

Because of the magnitude of government funds of services for the aged, the expectations of the varied systems and regulations of government become a major consideration in program development. The health systems of nursing homes, hospital administration and medical care under Titles XVIII and XIX of the Social Security Act become program entities. So too, the administration of programs under the Older Americans Act, the Higher Education Act, Public Works and Employment, etc.

A priori, the Jewish community center and other agencies serving the elderly need to clearly define their goals and objectives, as criteria for selection of programs and services in which they wish to participate. An understanding of government programs and a capacity to adapt to the mandates to fulfillment of the agency's own function are essential. If the government programs are not compatible with agency's objectives, then government funding must be eschewed.

Undue emphasis on government funding and programs does not accord proper recognition to the continued growth of services for the

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[4] Ethel Shanas, *op. cit.*

[5] Dr. Celia Weisman, *op. cit.*

[6] *Planning and Organization of Geriatric Services,* Technical Report Service, World Health Organization, Geneva, 1974.

[7] Irving Brodsky, "Serving the Jewish Aged, the Center's Changing Role," *The JWB Circle,* 1976.

[8] Bernard Warach, "The Comprehensive Community Center: A Prospectus for the Provision of Integrated Jewish Communal Services," this *Journal*, Vol. XVII, No. 2 (1965).

elderly established by the Jewish community center, the casework agencies, the synagogues and other Jewish organizations under voluntary funding.

In 1974, 257 Jewish community centers and YM-YWHA's in the United States and Canada, affiliated with the National Jewish Welfare Board, estimated a membership of 850,000, of whom 9.7 per cent or 82,450 were over 65 years of age. The number of elderly served by the centers is growing. Indeed, the Jewish community center on a national basis is not serving the elderly in fair proportion to their incidence in the Jewish population, which is estimated to be 12.4 per cent. In some communities, the character of neighborhoods has changed so rapidly that more than half the membership is elderly.

There is evidence of a growing interest in the role of the synagogue with the aging. The Synagogue Council of America has initiated a program, funded by a government grant, to promote the participation of the elderly in social and educational programs and religious services of the synagogue. Commissions on Aging have been established in each of the major Jewish denominational bodies. Agudath Israel of America has undertaken sponsorship of senior citizen center services.

Adult Jewish organizations, such as the Council of Jewish Women, American Jewish Committee, American Jewish Congress, and B'nai B'rith have all initiated programs for the elderly. There is great need for consideration of these efforts, in each community and facilitating the availability of the professional competence and resources of the Jewish social work agencies to stimulate and strengthen the development and provision of these services for the elderly. The needs of the elderly are so great that every institution in Jewish life should be enlisted in this effort.

Guidelines to Program Planning to Meet the Needs of the Elderly

A brief set of guidelines to program planning development to meet the needs of the elderly is suggested:[9]

1. A planning mechanism is required in each community. This body could engage the representatives of the constellation of health, welfare, education, employment, religion, and adult organizations, including older adults, needed to plan, mobilize resources and develop coordinated programs for the aged.
2. Service planning to meet the needs of the elderly should be comprehensive and provide a continuity of levels of care, service program and opportunity.
3. Services should reflect the needs of all of the elderly within a defined geographic area of service.
4. Services should be community-based and available on a local, decentralized basis, as close to clusters of the elderly as possible.
5. Services should be planned for a heterogeneous aged population: the disabled, mentally impaired, the ill, the well, the poor and well-to-do, the least and best educated.
6. In each community and at each agency, a set of priorities of service should be established to guide the program development efforts. Priority of service should be given to individuals of greatest risk, and at time of crisis.
7. Responsibility for the development of services should be allocated and provision made for coordination and integration of efforts.
8. Procedures for effective inter-agency referrals should be established.
9. An evaluative mechanism should be established to permit policy-makers to assess the quantity and quality of services rendered, and their effectiveness.

A sufficient body of experience is now available to suggest the comprehensive range of services and programs which can be developed to meet the varied needs of so heterogeneous a group as the elderly. The resources to establish all of these programs are not yet available on any rational basis for every older American. All of the services have been established and demonstrated their value somewhere within the Jewish community in the United States and have been reported. Not all are or will be provided by the Jewish community, although all are needed by some elderly people.

The social insurance entitlements of the government are cited. These are the underpinnings of support needed by the elderly, for which elderly people may be eligible. Jewish communal organizations have an important role in ensuring access of the elderly to these benefits.

The following compendium has been drawn to reflect that range of services and entitlements and the four categories of the elderly most appropriately served by each, to modify Dr. Celia Weisman's classifications a little. The four categories are:

Category I — The Intact Aging
Category II — Moderately Impaired Aging
Category III — Vulnerable Aging
Category IV — The Physically Disabled and Mentally Impaired Aging

The programs and services are given in order, from those for the most disabled and impaired to the least. They are the building blocks for program development.

A Compendium of Comprehensive Services and Entitlements for the Elderly

Program or Service	*Entitlement*	*Category of Aged*
Institutional Care		
Skilled Nursing Home	Medicare, Medicaid	IV
Health Related Facility	Medicare, Medicaid	IV
Adult Residence	Supplementary Security Income	IV
Foster Home	Supplementary Security Income	IV
Hostel	Supplementary Security Income	IV
Health Care		
Mental Hospital	Medicare, Medicaid	I-IV
Hospital	Medicare, Medicaid	I-IV
Outpatient Department	Medicare, Medicaid	I-IV
Emergency Care	Medicare, Medicaid	III-IV
Health Maintenance Organization	Medicare, Medicaid	I-IV
District Health Center	Medicare, Medicaid	I-IV
Physician	Medicare, Medicaid	I-IV
Dentist	Medicare, Medicaid	I-IV
Day Hospital	Medicare, Medicaid	III-IV
Day Centers	Medicare, Medicaid	III-IV
Night Hospital	Medicare, Medicaid	III-IV
Health Education	Social Security-Title XX	
	Older Americans Act-Title III, IV, VII	I-IV
Housing for the Elderly		
Concierge		
Security Guards		
Meal(s)	Federal/State/Local	
Housekeeping	Housing Program and	I-III
Social Services	Supplementary Security Income	
Group Services		
Emergency Response		
Core Health Services		
Home Environment Evaluation and and Correction	Medicare-Medicaid	III-IV

[9] *Ibid.*

Program or Service	*Entitlement*	*Category of Aged*
Core Health Services		
Homemaker-Home Health Aide Services (including light housekeeping)	Medicare-Medicaid	III-IV
Medical Services	Medicare-Medicaid	III-IV
Medical Supplies & Equipment	Medicare-Medicaid	III-IV
Nursing Services	Medicare-Medicaid	III-IV
Nutrition Services (including home-delivered meals, nutrition information or counseling, etc.)	Medicare-Medicaid	III-IV
Patient Transportation Services	Medicare-Medicaid	III-IV
Pharmaceutical Services	Medicare-Medicaid	III-IV
Physical Therapy	Medicare-Medicaid	III-IV
Social Services	Medicare-Medicaid	III-IV
Technical Diagnostic Services (including lab, x-ray, cardiogram, etc.)	Medicare-Medicaid	III-IV
Specialized Health Services		
Occupational Therapy	Medicare, Medicaid	III-IV
Podiatry	Medicare, Medicaid	III-IV
Respiration Therapy	Medicare, Medicaid	III-IV
Speech Therapy	Medicare, Medicaid	III-IV
Other Specialized Services, which includes:		
Audiological Services	Medicare, Medicaid	III-IV
Dental Services	Medicare, Medicaid	III-IV
Mental Health Services	Medicare, Medicaid	III-IV
Peripatology Services	Medicare, Medicaid	III-IV
Prosthetic/Orthotic Services	Medicare, Medicaid	III-IV
Optometric Services	Medicare, Medicaid	III-IV
General Health Services		
Handyman Services	Medicare, Medicaid	III-IV
Heavy Cleaning Services	Medicare, Medicaid	III-IV
Housekeeping Services	Medicare, Medicaid	III-IV
Personal Contact Services (including telephone reassurance, friendly visiting, etc.)	Medicare, Medicaid	III-IV
Translation Services	Medicare, Medicaid	III-IV
Other General Services, which includes:		
Barber/Cosmetology Service	Medicare, Medicaid	III-IV
Legal and Protective Services	Medicare, Medicaid	III-IV
Pastoral Services	Medicare, Medicaid	III-IV
Recreational Services	Medicare, Medicaid	III-IV
Telephone Reassurance	Medicare, Medicaid	III-IV
Meals on Wheels	Medicare, Medicaid	III-IV

Program or Service	*Entitlement*	*Category of Aged*
Community Center and Senior Center Services		
Social Activity	Social Security Act-XX Older Americans Act-III, VII Information & Communication	I-III
Lounge		
Informal Education		
Educational Programs		
Concerts		
Lectures		
Physical Fitness		
Health Education		
Arts and Crafts		
Music		
Dance		
Choir		
Jewish Experience		
Food Cooperative		
Nutrition-Meals		
Social Action		
Travel		
Vacation Services		
Employment & Volunteer Service		
Employment	Social Security Act-XX Older Americans Act-III, VII Information & Communication	I-III
Employment Agency		
Workshop (co-op)		
Workshop Protected		
Volunteer Service		
Volunteer Service Referral Agency		
Concrete Services-Supportive	Social Security Act-XX Older Americans Act-III, VII Information & Communication	I-III
Health Check-Ups		
Transportation		
Nutrition Counseling		
Legal Services		
Services for Individuals and Their Families		
Outreach	Social Security Act-XX Older Americans Act-III, VII	I-III
Information & Referral		
Counseling		
Case Management		
Emergency Relief Grant		
Loan		
Purchase of Services		
Purchase of Equipment		
Supervision of Supportive Services		
Advocacy		
Friendly Visiting		
Telephone Reassurance		
Meals on Wheels		
Legal Counsel		

Program or Service	*Entitlement*	*Category of Aged*
Entitlements		
Federal Old Age and Survivor's Grant	Social Security Act	I-IV
Supplementary Security Income	Social Security Act	I-IV
Emergency Relief Grants	State/Local	I-IV
Food Stamps	Federal/U.S. Dept. of Agriculture	I-IV
Medicare (Part A & B)	Social Security Act	I-IV
Medicaid	Social Security Act	I-IV
Medical Assistance	State/Local	I-IV
Transportation Subsidy	Federal/State/Local Programs	I-IV
Rent Subsidy	Federal/State/Local Programs	I-IV
Rent Control	State/Local	I-IV
Social Services	Federal/State/Local	I-IV

Geriatric services have grown more complex and more extensive. There has been an acceleration of their growth and development, stimulated by a great reform of government funding. The voluntary agency has been a significant instrumentality in provision of services for the aged. The Jewish community made a major contribution to development of these services. Reciprocally, in recent times, government resources have enabled Jewish communal agencies to serve the Jewish aged more effectively.

The World Health Organization reports upon the world-wide tendency to regard geriatric institutions as components of a wider constellation of collaborative health and welfare systems, rather than as self-contained entities. Geriatric services are becoming more functional and more complex, and will require more careful planning and management.

Certain major trends in service development are apparent. During the next decade, the major emphasis in care of the disabled and mentally impaired aged, some ten to fifteen per cent of the elderly, will be on strengthening community-based home care services. In response to the changing character of the well elderly, the second major trend will be toward strengthening and increasing their opportunities for employment, continuing education, new roles in the community, greater intergenerational relationships, and political leadership.

The aged population explosion is a triumph of human progress. To achieve the restructuring of American society, the re-adjustment of our institutions, services and programs will require a monumental effort, already underway. Within the Jewish community and in concert with all Americans of good will, a coalition of laymen and professionals must be created in every community on behalf of the elderly. The Jewish community center, its laymen, professionals and members, have much to contribute as advocates on behalf of the elderly, and in the conduct of services on their behalf. I am optimistic about the prospects of the older American and, indeed, of all of us.

Financing Services to the Aged: Approaches and Dilemmas

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I believe that two such (emerging) needs and trends to which Centers can contribute more significantly in the future are continuing education for the aged, and pre-retirement preparation and counselling for those in the middle years. These two programs should increasingly become major elements in the adult activities of Centers.

Some Characteristics of the Aged Population

The funding of service—whether by governmental or voluntary sources—is related, among other factors, to identifiable needs that arouse social concern, and to the numbers of people who are experiencing significant and wide-spread unmet needs.

The population over 65 comprises over 21 million people or 15 per cent of the total adult population.[1] These figures reflect an increase of 28 per cent since 1965. The U.S. Census Bureau anticipates a further growth to 31 million over 65 in the year 2000—an increase of over one-third the present figure. As regards the Jewish population, the National Jewish Population Study of the CJWF estimated the aged as 12.4 per cent of the Jewish population in 1976—increasing to 15 per cent by 1991.

By contrast, birth and fertility rates have dropped, with the number of youth 14 to 24 estimated to peak at 45 million in 1980 and decreasing to 42 million in 1985.

Translated into service statistics of the past ten years, many of our Jewish community centers have found themselves serving larger numbers of the aged and decreasing numbers of children and youth. This is, in part, a gross reflection of population trends. Both funding and service patterns bear an important relationship to population trends.

The passage of the Older Americans Act in 1965, and subsequent amendments to the Act reflect the government's response to the widespread needs of the aged. The voluntary sector has also responded, of course, in a more modest fashion related in part to more limited resources.

The most recent census data tells us that females constitute 59 per cent of those over 65, that the median income of the aged is $4,800, and two thirds of the aged have incomes under $7,000 a year. Ninety per cent of the aged are white. Sixty-three per cent have less than a high school education, although by 1990 over 50 per cent will be high school graduates.

In New York City, a study conducted for Federation[2] found 272,000 Jewish individuals to be poor or near poor, of whom half were the aged. The study recommended an expansion of services for the needy aged. Similar studies and recommendations have been made by Jewish Federations and welfare funds in other large cities—notably in the states that have the largest aged populations such as California, Pennsylvania, Florida, Illinois, and Ohio.

Funding from Local Central Fund-Raising Bodies

Since Jewish community centers rely primarily on allocations from central fund-raising bodies, supplemented by activity fees, what are the expectations for increased grant allocations in behalf of the aged?

The possibility of increased allocations is influenced by a number of variables—some of which are indicated below.

The first variable has to do with the overall fund-raising achievement of local Jewish Federations and welfare funds. The peak year of such fund-raising was 1974—the year of the

[1] *Myth and Reality of Aging in America*, National Council on Aging, April, 1975.

[2] *New York's Jewish Poor and Jewish Working Class*, Center for New York City Affairs, New School for Social Research, November, 1972.