

Challenges to Independent Living for the Urban Elderly Population By Sabrina Keck

America is facing an increase in its elderly population because people are living longer and because Baby Boomers are reaching retirement age. The research addressing the elderly population and the challenges it faces leaves many questions unanswered and potential connections between various fields unexplored. The elderly population often is neglected in society and academic research, as it is viewed through stereotypes or a patronizing "sense of duty." Although much research has been conducted relevant to race- and gender-based inequalities, especially in urban settings, not nearly as much research has been done on the elderly, to include older citizens who live in our cities. Many people do not associate the elderly with the city, or they wonder why one would choose to live in the city in his or her old age. For some elderly people, this is a choice they make, but for most who live in an urban environment, they are simply continuing on with their lives (Smith 2003). When considering the situation of the elderly in urban America, several issues deserve special attention, including health status and the neighborhood dynamics in which older people live. More than that, connections between these areas must be drawn to discover challenges this population faces and indicators that determine its independence. This paper examines ageism, health concerns, neighborhood dynamics, and how these impact one another, as well as available healthcare services, governmental support, and even racial discrepancies, to address what it takes for the elderly population to remain in its homes.

In a number of studies, almost all elderly individuals state that their independence and especially their ability to remain in their own homes are important to them (Kramarow 1995; Balfour 2002; Mack 1997). Historically, extended-family households have not been the norm in the United States, but today more elderly people live alone than ever before (Kamo 1994). Yoshinori Kamo argues that the cultural values of individualism and personal freedom continue on into the later years of Americans' lives, and people's preferences for independence often represent an attempt to avoid being a burden to one's family. Over the years, the ways in which housing arrangements of the elderly have changed provide some insight into what factors play into this desire. Ellen A. Kramarow argues that several factors may explain an increasing shift in elderly people living alone, including declining fertility rates, rising income levels, and cultural changes. However, no single explanation fully explains this dynamic, as it is the combination of the forces described above that start to account for the change.

It may not be known with certainty why there has been an increase in the number of elderly people living alone; nonetheless, this shift has occurred, bringing with it several consequences. One consequence is that it is now common to think of the elderly as living in separate environments from the rest of society – as they are already living in separate homes – even though that is not the case for the majority of older people. This thinking, in turn, has led to an increasing pathologization of the elderly (Estes 2001). Todd D. Nelson discusses the phenomenon of ageism, arguing that it is manifested in several ways in daily life. Some of these manifestations include patronizing language as both over-accommodation and baby-talk, as well as pseudo-positive attitudes that create a self-fulfilling prophecy whereby older people are encouraged to take on passive, dependent roles (Nelson 2005). The field of biomedicine also has influenced the way people view old age and the elderly (Estes 2001). As Carroll L. Estes writes, "The equation of old age with illness has encouraged society to think about old age as a

pathological, abnormal, and undesirable state, which in turn shapes the attitudes of members of society toward the elderly and of the elderly toward themselves” (Estes 2001). The phenomenon of “ageism” helps explain how society’s attitudes and the attitudes of the elderly can shape the environments in which older citizens live. These views can result in decreased activity among the elderly, as well as expectations that older people necessarily are to be sick and lonely and unhappy, which can cause decreases in independent thinking and living (Estes 2001). On the other hand, many healthcare professionals have dedicated time and research to discovering the best ways to treat elderly patients and believe it is important for all Americans to achieve a healthy lifespan, knowing that they too will one day get older (Koplan 2000). Both the positive, but especially the negative, attitudes expressed toward the elderly play a significant role in the way this population approaches life.

One aspect of an older person’s life that can affect his or her ability to remain independent is physical health. A large corpus of research has been produced relating the health of an individual to his or her functionality. A system of determining functional ability has been created by the healthcare community; it outlines Activities of Daily Living (ADLs), as well as Instrumental Activities of Daily Living (IADLs). ADLs include independence in feeding, continence, transferring between bed and chair, going to the toilet, dressing, and full personal hygiene (Svensson et al 1996). IADLs include using the telephone, controlling medications, and preparing meals; in short, IADLs connote higher levels of functioning (Mack 1997). However, Ruthana Mack argues that ADLs and IADLs are inadequate measures of independent functioning because they fail to account for input from elders themselves. In her study, resources as well as skills were found to be important in determining the independence of an individual, and if there is outside help, many physical limitations can be assuaged (Mack 1997). In fact, Rhonda Montgomery shows the important role that family, friends, and home healthcare professionals play in the well-being of elderly patients who desire to remain at home (IN-TEXT CITATION?).

Besides physical functioning, other areas of a person’s health can determine the likelihood that he or she will be able to maintain independence. Comorbidity refers to multiple medical conditions that interact and sometimes aggravate one another. Olle Svensson’s study of elderly patients suffering from hip fractures found that individuals were able to better cope with other diagnoses, regardless of age, if they came from independent living situations. He also found that in addition to physical conditions, cognitive impairment proved to inhibit a person’s capacity to remain independent, often acting as a compounding factor. People with dementia, for example, are more likely to have other health challenges, including congestive heart failure, anemia, and cerebrovascular disease (Callahan 1995). When it comes to preventative health, patients with cognitive impairment were less likely to receive important screening tests and influenza vaccines (Callahan 1995). It is unclear whether this discrepancy appears because of decreased attentiveness among doctors, or if patients suffering from cognitive impairment would be less likely to pursue follow-up appointments; it is clear, though, that the health of an individual, both physical and mental, helps to determine the likelihood that he or she will be able to remain in his or her home.

After addressing the personal limitations for the elderly that arise from poor health, it is important to consider environmental factors, such as housing, that affect independence. An area that greatly influences an elderly person’s ability to remain in his or her home is a neighborhood dynamic.

The neighborhood in which one lives determines the population demographics of the area, what services are available, the condition of streets and sidewalks, and one's access to transportation. Jennifer L. Balfour argues that "at older age, comorbidity, perceived health, and disability status may be particularly sensitive to neighborhood socioeconomic level independent of individual socioeconomic status" (IN-TEXT CITATION?). Certain problems reported by elderly people in Balfour's study indicated an increased risk of functional loss related to challenges that center on four issues: noise, lighting, traffic, and public transportation. Although these issues are important in determining the overall environment that surround an elderly person, more individuated considerations also must come into play. For example, are there stairs the individual has to climb to get into the home? And once he or she is inside, what kind of upkeep is required to keep the home livable? It is feasible, then, to expect that not only will a neighborhood environment effect a person's health, but other challenges may cause an individual to be more susceptible to neighborhood conditions (Yao 2008). Balfour reports findings that suggest just this and states that "a neighborhood that presents more barriers and fewer resources might trigger a pattern of disuse and subsequent decrements in functional health, in essence speeding up the aging process" (IN-TEXT CITATION?).

This leads me to consider the healthcare options available to the elderly population and how needed services are provided through informal care, such as unpaid labor from family and friends, and formal care, which includes paid healthcare professionals, social workers, Medicare and Medicaid services, and so forth. Various studies find that elderly individuals prefer their primary source of care to come from family and friends (Barker 1998; Penning 2002; Fiscella 2004; Montgomery 1999). Judith C. Barker suggests that one reason for this preference arises from the nature of the care received. In the context of informal care, one's family and friends "care for" the individual—an emotional activity—while formal care provides people who "take care of" an individual, a work role. A concern that has major implications for care services is that with increased formal support, informal support will be undermined and discouraged, resulting in a decreased tendency toward self-care among older people (Penning 2002). While this may seem a valid concern, it offers an excuse to reduce funds and programs for the elderly, and to increase the burden placed on family members to provide care. Barker concludes that "formal services may temporarily augment informal support networks, but do not substitute for informal support" (IN-TEXT CITATION). Margaret J. Penning states that the belief that increased formal support will lead to decreased informal support is empirically false, although it remains widespread, and as a result care that once was provided by paid professionals has shifted to unpaid lay providers, typically women, disproportionately effecting low-income and minority groups (IN-TEXT CITATION?).

When one considers the relationship between race and availability of care, it becomes clear that black elderly individuals tend to have better informal support networks that not only are more extensive, but also longer lasting (Barker 1998). By contrast, research on formal healthcare for various racial groups finds that non-white groups not only perceive a decreased quality of care on average, but are unable to pay for better services available to wealthier, and often white, populations (Barker 1998; Campbell 2001; Fiscella 2004; Jones 1999; Kamo 1994; Torres 1999; Weech-Maldonado 2003). It would then make sense that such minority groups have established more comprehensive and complex systems in order to deal with this discrepancy, especially in urban settings.

It is not feasible to address all the issues discussed above without considering the larger context of societal and governmental regulations that either can deter or exacerbate problems elderly people face. There are conflicting views about what the roles of society and government should be in assisting the elderly. On one hand, Americans value independence as vitally important to our country's character; this suggests that individuals are independent from society and the quality of an older individual's life is based on the choices he or she made in preceding years (Estes 2001). Estes undermines this line of reasoning, claiming that society has a moral obligation to compensate those individuals who have borne the brunt of progress in the past. In this case, caring for the elderly is considered as paying back a debt owed to those who raised us, put us through school, provided instruction and support, and paved the way for our future successes. Further undermining the notion of radical individualism is evidence which supports the idea that disparities that existed during preretirement continue into postretirement (Yao 2008). This extends to Social Security and other welfare systems that distribute assistance based on what the individual did prior to retirement, rather than accounting for individuals' needs.

There is some evidence that health disparities among the elderly related to socioeconomic status begin to narrow slightly, and this might relate to healthy-survivor effects, an explanation which assumes that those who have lived long enough have learned how to cope and survive despite disparities that exist (Fiscella 2004). Kevin Fiscella argues that "having achieved higher educational levels tends to be associated with the prevention of functional limitations, while a higher income level tends to be associated with both prevention and delayed progression of functional decline." Because of a decreased or even lack of income altogether, some elderly persons become dependent on community organizations that can provide formal and informal care at low or no cost. Fiscella mentions the presence of safety-net providers in urban settings that can provide additional support for the elderly poor and other low-income groups. However, half of all these safety-net providers are suffering from financial crises and struggle to retain their physicians. Part of why non-profit organizations are facing crises is because the non-profit sector is being forced to compete with for-profit organizations for limited state resources (Estes 2001). Estes outlines three major functions of U.S. society that are leading to a downward spiral in the non-profit healthcare sector: the state encourages economic growth and private profit; the state provides publically subsidized benefits to alleviate problems that come out of the free-enterprise system, thus legitimizing the process; and the state's purpose is to protect the democratic process. The problems that arise from the state's favorable treatment of business stem from the fact that the first two functions mentioned above require the expenditure of public resources without as large a return in free or subsidized services to the needy population; instead, an increased need for welfare support is created (Estes 2001). Thus, the state is spending itself into fiscal crises and is causing the non-profit healthcare sector to shift to for-profit models because it no longer receives adequate state support (Estes 2001).

Without future changes, younger Americans will face an even more desperate future than does the current elderly population. It is commonly believed that Social Security no longer will be able to support the population paying into it now, leaving postretirement status completely in the hands of one's ability to budget, find non-profit-sector support, and create support structures among family

members, friends, and neighbors. There are programs that exist to assist the elderly in their homes, including Meals on Wheels, which delivers food to individuals unable to produce their own meals, and home healthcare professionals, who visit people in their homes to provide medical support like nursing, physical therapy, and dietary education (Smith 2003; Jones 1999). These alone are insufficient to meet the current and future needs of the elderly, however.

A case study conducted in New York City assessed current conditions and needs, as well as how these needs are being met, for various groups of elderly people. Many Naturally Occurring Retirement Communities (NORCs) have developed over time in almost all socioeconomic neighborhood levels in New York, and services are being provided to the elderly populations living in these areas. In some low-income housing, senior resident advisors have been hired to live among the community so they can arrange services for residents and be on-call twenty-four hours a day; in return, RAs receive free housing and a modest salary (Smith 2003). This goes along with David Barton Smith's suggestion for a future course of action that calls for an increase in allowing elderly residents to continue to age in place. He provides five rules that can be used as tactics for future change: use the forces already transforming care, nurture complex systems, address social and economical disparities, move upstream to address the issue rather than the symptoms, and encourage consumer ownership (Smith 2003). The implementation of such recommendations would allow people to live where they are, negating the need for so many large medical complexes dedicated to elderly care and allowing healthcare providers and elderly individuals to continue to take advantage of the social support that already exists within current neighborhood settings. As Smith writes, "Just as with other forms of deinstitutionalization, a good deal of cross-cultural and epidemiological evidence shows that it [aging in place] enhances the length and quality of lives" (Smith 2003).

Despite all of the research presented above on the elderly and the challenges they face in remaining independent, it is clear that this area of study remains neglected and that this population needs more support. It is important to consider the context of a situation and to understand the neighborhood and home dynamics that affect a person's health status. In addition, macro, or societal, views must be developed to account for historical changes, current cultural norms and beliefs, and technological shifts that impact the elderly. One must remember that the majority of elderly people age in place, not so much as conscious decision, but rather as an attempt to continue living their lives, and this means that the elderly have been and will continue to be active members of our communities. The health risks and neighborhood conditions that can make it more difficult to remain at home, as well as services available that allow for home care, play a big role in the lives of the elderly. This is not a group that is socially isolated and completely independent, but rather one that is complexly connected to every aspect of our society. It is a group that has provided for America and now needs provisions of its own. Moreover, as the population of the United States ages, it is clear that the issues discussed above will continue to grow in importance. One always must keep in mind that one day, everyone will face these problems.

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