Does Disparity in the Way Disabled Older Adults Are Treated Imply Ageism?

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Although the nearly one in seven Americans who have disabilities share many characteristics, the attitudes toward and the programs, care models, expenditures, and goals for people with disabilities differ substantially across age groups in ways that suggest ageism. Expenditures per recipient are substantially higher for younger individuals with disabilities, largely as a result of more effective advocacy. Programs that are rejected by younger people with disabilities are considered mainstream for older adults. As demographic, social, and economic circumstances change, preserving the programmatic separation will become more problematic. Increased competition for finite resources may motivate a closer examination of commonalities across disabilities in an effort to achieve greater equity.

Key Words: Disability, Long-term care, Medicaid

Disability is common across the age spectrum, but society's response differs substantially by age. Older people are disadvantaged in terms of both the options offered them and the funds spent on them. Expenditures per recipient are substantially higher for younger individuals with disabilities, largely as a result of more effective advocacy. This disparity reflects a long history of viewing disability among older adults as an expected concomitant of the aging process. Older adults are seen as frail and vulnerable people who need to be protected, whereas younger individuals with disabilities accept risk as the price of full social participation. Care options rejected by younger people with disability (including both institutional and home care) are considered mainstream for older adults. We suggest that these disparities in spending and options represent a form of ageism.

What is ageism? Robert Butler, who coined the term, defines ageism as "a process of systematic stereotyping of and discrimination against people because they are old" (Butler, 1975, p. 12). This definition implies both an attitudinal component (stereotyping and prejudicial attitudes, beliefs, and conceptions of the nature and characteristics of older adults) and a behavioral component (discrimination against or inappropriate negative treatment of older adults; Palmore, 1999). Throughout the long-term-care and social support systems, individuals with similar levels of disability are treated differently because of their age. But not all forms of differential treatment based on age are inappropriate, and the distinction between an age-differentiated behavior or policy and discrimination can be subtle (Pasupathi & Lockenhoff, 2004). Typically, age differentiation is justified if it is based on physiological parameters (e.g., expected survival or risk of adverse events), whereas discrimination implies a deliberate effort to exclude or to favor one group over another. Structured forms of power, organization, and regulation in society may also inadvertently discriminate against people in certain age groups (McMullin & Marshall, 2001). We contend that the systematic difference in the way older adults with disabilities are treated relative to younger individuals with disabilities constitutes ageism.
Ageism may also be viewed in terms of relative power. Frail older adults are less likely to act on their own behalf. Age-based organizations like AARP have agendas that focus on more general goals that affect a larger swath of the elderly population, including retirement issues and medication coverage. Studies sponsored by such groups that show large majorities of older adults (89% in 2000) strongly or somewhat agree that they would like to remain in their current home for as long as possible (Bayer & Harper, 2000) seem to be ignored when actions are taken upon members of the frail subgroup, who are labeled as vulnerable adults and reduced to a dependent status. In the most extreme cases, the older person is ruled incompetent, denied rights, and assigned a legal guardian.

Nearly one American in seven has a disability (U.S. Census Bureau, 2004). Disability occurs across all ages, and many etiological and societal commonalities are shared among disabled individuals. People with all types of disabilities face similar access, health, economic, and social consequences. In all age groups, individuals with disabilities are more likely, relative to the overall population, to be poor (Waldrop & Stern, 2003), to use more health care services (Hanson, Neuman, Dutwin, & Kasper, 2003), to be without work (Stoddard, Jans, Ripple, & Kraus, 1998; Waldrop & Stern, 2003), and to receive governmental financial assistance. Regardless of the specific impairment or its cause, people with disabilities typically need one or more of a broad range of health care, supportive services, or accommodations to address the myriad ways in which disabilities impact their lives.

Cast in a civil rights framework, people with disabilities are “a discrete and insular minority” who, as a group, “occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally” (ADA Findings and Purpose, 42 USC 12101(a), p. 8). Viewing differential treatment of individuals with disabilities as a civil rights issue (i.e., as discrimination) gathered steam throughout the 1970s and 1980s and culminated in 1990 with the passage of the Americans with Disabilities Act, which draws heavily from previous civil rights legislation and has been hailed by supporters as a minority group approach to disability policy issues (Francis & Silvers, 2000).

A disparate set of federal, state, and local disability programs addresses the needs of individuals with disabilities. The federal government alone has more than 200 programs, spread across 20 different agencies, designed specifically to provide financial assistance or supportive services to various subsets of individuals with disabilities (National Council on Disability, 2005). Programs for individuals with disabilities are distributed across three broad age groups—children, younger adults, and adults aged 65 and older. There are important differences in programs, care models, expenditures, goals, and attitudes toward people with disabilities across these groups. People with similar types and extent of disability may be treated differently and may be entitled to different benefits depending on their age. Uneven support reflects, in part, advocacy efforts and the underlying attitudes about the subpopulations. Ongoing demographic, social, and economic changes may prompt a reexamination of these differences.

The Impact of Disability

Estimates of the size of the U.S. disabled population have relied on self-reports of disability status, variously defined in terms of functional impairments, restrictions on activities of daily living, or the presence of other selected criteria (e.g., receipt of federal benefits due to an inability to work; Haveman & Wolfe, 2000). There is no consistent definition of disability. The term is defined differently by a variety of private and public agencies and organizations concerned with health and disability issues. It is also defined in at least 67 places in the United States Code (though many of the statutes refer to definitions in other sections of the Code) (Cherry Engineering Support Services, Inc., 2003).

Estimates of the number of individuals with disabilities vary depending on the stringency of the criteria used (i.e., the definition of disability) and the nature of the survey questions. Each of the widely cited national surveys of disability data, including the American Community Survey, the Survey of Income and Program Participation, the National Health Interview Survey, the Current Population Survey, the Decennial Census of the Population, and the Medical Expenditure Panel Survey, defines disability differently. Diverse survey methodologies further contribute to dissimilar estimates (Gregory, 2004). The U.S. Census Bureau’s American Community Survey is among the most recent efforts to provide accurate data on people with disabilities, designed in part to correct flaws in Census 2000 estimates (Stern, 2004). According to the 2003 American Community Survey, 37.4 million civilian noninstitutionalized Americans 5 years of age and older (14% of that population) had one or more disabilities (U.S. Census Bureau, 2004).

Elderly adults (aged 65 and older) experience higher rates of disability than younger adults and children. However, of all Americans who reported any disability in 2000, nearly 56% were aged 16 to 64; elderly adults composed 36% (U.S. Census Bureau, 2004).

The prevalence of disability in the population as a whole is expected to grow. Some researchers suggest that the rate of disability is declining somewhat (Cutler, 2001; Spillman, 2004); however, the rapid rise in obesity and associated health problems has raised questions about this optimistic
versions assert that disability begins with a medical cause. More nuanced perspectives argue that disability is a social construction. One version of the social model views disability as resulting from a disabling environment. Disability, 1986, p. 587), the social model posits that disability is “the lack of some mental, physical, or emotional ‘tool’ which most other people can call upon in addressing life’s tasks” (National Council on Disability, 1986, p. 587), the social model posits that disability is a problem of the individual, maintaining instead that public attitudes, stigma, stereotypes, and how society deals with and responds to a person’s impairment are fundamental to the problem. According to this model, the appropriate response includes eliminating “the attitudinal and institutional barriers that preclude persons with disabilities from fully participating in society’s mainstream” (Silverstein, 2000, p. 1695). The Americans With Disabilities Act was specifically designed to address those barriers.

By focusing on the interaction between the environment and a health condition, not just the health condition itself, the social model rejects the notion that disability is fundamentally an attribute of the individual, maintaining instead that public attitudes, stigma, stereotypes, and how society deals with and responds to a person’s impairment are fundamental to the problem. According to this model, the appropriate response includes eliminating “the attitudinal and institutional barriers that preclude persons with disabilities from fully participating in society’s mainstream” (Silverstein, 2000, p. 1695). The Americans With Disabilities Act was specifically designed to address those barriers.

The social model of disability reinforces the notion that individuals with disabilities share important commonalities. Disabled people of all ages need, for instance, access to information to support choice and control; accommodations to access work, leisure, and family; financial assistance; affordable housing; and preventive, diagnostic, and therapeutic health care services to ensure a basic level of health and safety. Similar types of disabilities occur across all age groups; people of any age can have physical disabilities, cognitive deficits, or mental illness. Regardless of a person’s age, the need for accommodation, access, care, or services can be temporary, long term, or lifelong. The common denominator is the effect of the impairment or disabling condition on the individual’s participation in normal daily activities. All individuals with disabilities require, albeit to varying degrees, assistance, accommodations, or compensatory services.

Differences in Responses to Disabilities

Despite the commonalities shared by individuals with disabilities, the responses to disabilities in diverse populations vary widely in legislation, funding, administration, and services (Burkhauser & Daly, 2002). Similar levels and types of disability are dealt with very differently across different age groups. Whereas cognitively impaired younger people, for instance, are encouraged to live independently and to assume as much responsibility as possible, older adults with dementing illnesses are viewed as needing regular supervision, often in institutions. Yet cognitive disability among the young and the old
is not the same. Although some individuals with cognitive impairment may be educated and improve their function over time, dementia’s clinical course features continual decline. Nonetheless, cognitive impairment in older adults is often the basis for institutionalization, whereas younger individuals are mainly managed in the community. A substantial part of older adults’ heavy use of nursing homes has been traced to active reliance on the medically needy category of the Medicaid program, whereby the predictable costs on a nursing home stay make determining eligibility easier (R. A. Kane, Kane, & Ladd, 1988).

The dominant model of disability that is adopted by a given population with disabilities largely determines the rationale for demanding services available to that population. If disability is viewed as the result of illness, the primary goal is cure or amelioration (e.g., through rehabilitation); care is a secondary target, mainly in a compensatory model where services are designed to compensate for identified dysfunction. Peoples’ entitlements to care are based on the extent of their impairment. Framing the problem of disablement instead as a product not of the physical or mental impairment per se, but of the social and environmental barriers faced by individuals with impairments, transforms the basis of viewing the different treatment of those with disabilities in employment, access to public services, and other aspects of daily life into a form of discrimination and, in consequence, within the realm of civil rights protections. Viewing disability discrimination as a civil rights problem requires a model of disability that identifies the barriers to disabled individuals’ integration into the community as due, at least in part, to social practice and policies. In contrast, identifying disability solely as impairment-related dysfunction, as the medical model does, “undercuts the propriety of construing access for the disabled as equal protection for civil rights” (Francis & Silvers, 2000, p. xvi).

Younger adults with disabilities (including some who are in their 40s and 50s) maintain that disabled individuals have been unfairly denied access to many of life’s activities by virtue of their disabilities (Harris Interactive, 2004). They view disabled individuals as a segregated minority who deserve equal protection under the law. They reject traditional agency-based and medically oriented home care and insist instead on personal care attendants who can provide a broader range of services and thus facilitate their full participation in social commerce (Simon-Rusinowitz & Hofland, 1993). Conversely, older adults with disabilities remain staunchly in the medical model (Oldman, 2002). They and their caregivers share the belief that disability results from underlying disease that is a natural consequence of aging. When care decisions need to be made, family members, health professionals, and sometimes even older adults themselves still consider responses such as institutionalization, which have been rejected by young disabled individuals, as appropriate for older individuals. This discrepancy likely reflects a difference in underlying expectations for these populations.

Some argue that a disparity is not a prejudice if the group affected endorses the choice as a preference. Younger people with disabilities would counter that older people have simply been brainwashed into accepting the inevitability of institutional care. Ironically, when surveyed, older people living in the community express a strong aversion to nursing homes (Bayer & Harper, 2000), but when they become frail these negative feelings are overridden.

Disability is partly a social construct, shaped by the beliefs of individuals with disabilities and their advocates as well as society at large. Advocates of children with disabilities actively pursue an agenda of inclusion (mainstreaming), insisting that disabled children need, and deserve, to be a part of normal childhood activities. Younger adults with disabilities likewise demand accommodations and compensatory assistance that permit them full participation in social and economic activities and the same choices and control in their everyday lives that others in their age group aspire to have. They reject care or services that, if accepted, would keep them apart from the rest of society (R. A. Kane, 2006). Nonetheless, some adults with disabilities, including many in the deaf community, value their separateness from society. As one example, Laurent, South Dakota, is a town expressly created for people who sign: Its developers envision it as “a place where our nation’s signing community can gather together to live, work, play, and worship in comfort and beauty” (Davey, 2005, p. A1). Older adults, in contrast, appear to be more accepting of activity limitations due to disability (R. L. Kane & Kane, 2001).

Therapeutic providers have created their own belief systems, sometimes in concert with consumers and sometimes at odds with them. Those who work with disabled children actively support a variety of supportive and rehabilitative services that are expected to allow these children to assume more independent roles as they mature. Younger adults with disability often find themselves at odds with medical providers who seem fixated on addressing the underlying disease process instead of simply allowing the disabled individuals to get on with their lives.

In contrast to the two younger age groups, both providers and older consumers have accepted a much more limited, pessimistic view of disability in older adults (Adams et al., 2002). Older adults are seen as vulnerable and hence unable to achieve any meaningful measure of independence. They are expected to make do with care that maintains them in a dependent, subordinate role. Old age is assumed to imply inevitable decline (Lynne, 2004). Successful aging is associated with coping through reduced expectations and greater focus (Baltes & Baltes, 1990; Lang, Rieckmann, & Baltes, 2002).
Disability programs, particularly publicly funded programs, reflect these differences in attitudes and expectations across the age groups. In many programs, care approaches that have been rejected by younger individuals with disabilities are still promoted for older adults. State Medicaid programs, for example, historically supported the segregation of individuals with disabilities into institutions, including nursing homes and intermediate care facilities for people with mental retardation. Political activism (particularly on behalf of children and young adults with disabilities), the legally recognized “right to treatment” of institutionalized individuals, expanded use of antipsychotic drugs, and other developments spurred the deinstitutionalization movement in the 1960s and 1970s. Since the early 1980s, states have taken advantage of amendments to the Medicaid statute to develop and fund a variety of alternatives to institutional care that enable beneficiaries with disabilities to live in, and thus remain integrated with, their communities. Most notably, Medicaid’s Home and Community-Based Services (HCBS) Waivers (commonly referred to as Section 1915(c) waivers, after the section of the Social Security Act under which they are authorized) allow states to develop programs for targeted populations to decrease their reliance on institutional care and shift to community-based services.

The waivers both encourage innovative approaches and limit states’ financial risk. Unlike the Medicaid program itself, which requires states to provide uniform benefits to all enrollees, HCBS waivers allow states to vary the types of services and individuals served. Waivers can be designed for separate groups of people (e.g., individuals with a traumatic brain injury) and provide services not offered under the state’s regular Medicaid plan (U.S. General Accounting Office, 2003). The popular HCBS waivers have dramatically reallocated Medicaid long-term-care expenditures. Although the distribution of these expenditures varies widely across states—reflecting differences in the type, number, and amount of services provided under waivers in different states—the clear trend is toward more HCBS spending. Between fiscal year (FY) 1991 and FY 2004, the share of Medicaid long-term-care spending for institutional care declined from 86% to 64%, whereas the share spent for home- and community-based care grew correspondingly (Burwell, Sredl, & Eiken, 2004).

This shift in expenditures was spurred by the Supreme Court’s 1999 Olmstead decision, under which states are required to place persons with mental disabilities in community settings rather than in institutions when the State’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated. Olmstead v. L.C. (1999) 527 U.S. 581 (p. 583).

The federal New Freedom Initiative, begun in 2001, further supported this trend with Real Choice System Change Grants aimed at helping states “develop enduring infrastructures that support people of any age who have a disability to live and participate in their communities” (Medicaid Program, 2001, p. 28,183).

The Olmstead decision and the New Freedom Initiative apply to disabled individuals of all ages and with all types of disabilities, and there are some indications of convergence across disability populations. Consumer direction, for example, is explicitly incorporated into service programs in many states or is included in distinct demonstration projects such as Cash and Counseling (Mahoney, Simon-Rusinowitz, Loughlin, Desmond, & Squillace, 2004). The Deficit Reduction Act of 2005 will permit states to offer (beginning in January 2007) self-direction for personal assistance services without needing to get a waiver. Spearheaded by the disability community, the consumer-directed approach was initially targeted more often at younger individuals with disabilities than at older adults (DeJong, Batavia, & McKnew, 1992). More recently, however, consumer-direction programs have been used with older beneficiaries as well (Benjamin, 2001; Foster, Brown, Phillips, & Carlson, 2005). Thus, for instance, as of 2002, nearly three fourths of the enrollees in the Cash and Counseling demonstration project in Arkansas (one of the demonstration’s initial three states) were aged 65 or older (Medstat, 2002).

But the overall trend toward home- and community-based care has been much more pronounced for some populations with disabilities than for others. By FY 2005, about 58% of national Medicaid long-term-care expenditures for enrollees with mental retardation or developmental disabilities (MR/DD), nearly all of whom were under age 65, went to home-and community-based services and the remaining 42% to institutional-based care (Eiken, Burwell, & Selig, 2006). For older adults and people with physical disabilities, the division in Medicaid long-term-care expenditures was 27% for home- and community-based care and about 73% for institutional (i.e., primarily nursing home) care (Figure 1). An analysis of Medicaid’s HCBS waiver programs found that MR/DD beneficiaries represented 39% of participants nationwide in 2001 and consumed nearly 75% of total waiver spending, whereas older adults and people with physical disabilities, who represented 58% of all waiver enrollees, received only 24% of total expenditures (Kitchener, Ng, Miller, & Harrington, 2005). This expenditure ratio has remained stable: In FY 2005, 75.3% of HCBS waiver expenditures were for long-term-care supports for individuals with MR/DD, and 23% were for older adults and individuals with physical disabilities (the remainder...
was for other populations, such as people with HIV or AIDS and individuals with traumatic brain injury) (Eiken et al., 2006).

Similar disparities are evident in the 13 states that have separate HCBS waivers serving only people aged 65 and older. Total expenditures in FY 2004 for Minnesota's Elderly Waiver (eligibility restricted to ages 65 and older), for example, were $116.6 million, or less than 11% of the state's total HCBS waiver expenditures of $1,097 million. Likewise, of Connecticut's $576 million HCBS waiver expenditures in FY 2004, only $90 million, or 15.6%, was for its aged waiver (Eiken, Burwell, & Walker, 2005).

The disparity across disability groups can be seen vividly using state-level analyses that permit comparisons in terms of expenditure by recipient. Figure 2 presents the data for eight states for which we have tracked the Medicaid-expenditure patterns for various programs. The data are presented as the ratio of MR/DD spending to that on aging and disabled adults in 2004. The first two sets of columns address overall and per-recipient spending for institutional care; the latter two present overall and per-recipient spending for home- and community-based care. With the exception of Arkansas, the ratio of total spending on institutions was less than 1. In contrast, the spending per recipient for institutional care was much greater for MR/DD clients. This difference likely reflects the small numbers of institutionalized MR/DD clients, for whom the cost per case is high. For HCBS, overall spending (a function of per-client costs and numbers of clients) was higher for MR/DD clients in six states, and spending per client was 2 to 5 times higher for MR/DD than for older clients.

Social Security income mitigates the discrepancy in Medicaid payments between older adults and younger individuals with disabilities. Older adults are more likely to receive Social Security and become eligible for Medicaid under the Medically Needy provision, whereas younger people are generally categorically eligible by virtue of their disabilities. As a result, Medicaid expenditures for older adults may not commence until their Social Security income has been spent. The net Medicaid expenditure may thus be less. In 2005, the average annual Social Security payment was about $10,800. Across our eight states the average annual waiver payment for elderly and disabled adults was $12,229, whereas the payment for MR/DD was $36,046. Social Security might explain only a part of that difference.

The pattern of disparity in disability expenditures changes substantially if Medicare is added into the equation. But this computation has not been, and with current data limitations perhaps cannot be, accurately performed. Medicare includes three groups of enrollees: (a) adults aged 65 and older, (b) individuals younger than age 65 who are permanently disabled and have received Social Security disability payments for at least 2 years, and (c) individuals with end-stage renal disease. Although enrollees in the latter two groups, by definition, have a disability, not all of their Medicare expenditures are spent on account of their disability. Some Medicare expenditures may instead go for acute care or other health conditions that have nothing to do with the enrollee's disability, and it is not clear if these should count as disability expenditures. Estimating disability expenditures for Medicare enrollees aged 65 and older with a disability raises different concerns. No Medicare database uses disability as an identifying marker; thus, a proxy measure (e.g., two or more activity of daily living dependencies) would be needed to identify elderly Medicare enrollees who have a disability. Once this cohort of enrollees is identified, the question arises whether all of their Medicare expenditures should be counted or only those expenditures that can be attributed or linked directly to their disability.

The Role of Advocacy

In a democracy, advocacy plays an important role in galvanizing support for a program or a group. Much of current disability policy has been shaped by the actions of advocates. Most disability advocacy is linked to a single, specific disease or syndrome. Only a few cross-disability and broad-based advocacy
organizations, such as the American Association of Persons With Disabilities, the National Organization on Disability (NOD), and AARP, represent more heterogeneous groups. Although most advocacy is diagnosis and population specific, ad hoc coalitions of disability organizations periodically form at the state and federal government levels, but they are rarely inclusive and usually disband once their limited purpose has been achieved.

The advocacy situation differs for young and old. For children with disabilities, the primary advocates are their parents, who have a long-standing interest in the outcome, because the child will be around for a considerable period of time. Young adults advocate for their cause throughout their lifetimes. The situation for older adults is different. Their period of disability is typically much shorter. Their natural advocates are their children. Although children of older adults with disabilities may become actively involved in advocacy activities during the period of active care, they are less likely to sustain this involvement upon the death of the parent. Moreover, personal histories may play a strong role.

Confronting Ageism

The combination of an aging population and a growing unwillingness to spend money on social programs seems inevitably to lead to a competition between younger and older individuals for a constrained resource pool. Such a conflict will raise questions about the fair distribution of finite resources, including concerns about efficiency and attention to current anomalies. For example, Medicare represents positive ageism (Palmore, 1999); it provides near universal coverage for elderly adults with disabilities, whereas more than 5% of younger adults (aged 18–64) with disabilities are without public or private health coverage (Hanson et al., 2003). There is some potential for efficiencies by emphasizing commonalities in needs and interests across age groups and by reducing programmatic fragmentation. From a social justice perspective, it is not immediately apparent why different groups of people with basically similar disabilities should be treated differently. All age groups should be offered comparable services; institutions considered inappropriate for some should not be thrust on others. A more equal distribution of resources may be more appropriate, in light of the commonalities shared by individuals with disabilities across all ages.

Different scenarios for the future are possible. In one scenario sufficient social resources are available to provide adequately for all who need care. But another, currently prevalent scenario looks toward restricted resources and the competition for them (President’s Council on Bioethics, 2005). Some
anticipate that calls for more efficiency in long-term care will lead to greater use of community care, thus changing the current press for institutional care, but it is not yet clear that community care will really save money (increased demand may offset any per-person savings) or dramatically cut back on institutional care. If the competition for Medicaid and other public resources becomes more intense, more attention will inevitably be devoted to the current disparities in funding and program design.

Having different programs and age-differentiated policies does not necessarily imply ageism (discrimination). Neither does putting everyone into the same program necessarily imply equality. One way to reduce ageism in long-term-care policy and programs would be to promote individual resource management for disability program enrollees, usually referred to as consumer-directed care. If everyone could agree that people can have different values, needs, and goals at various stages of their lives, giving money directly to the disabled individuals would allow them to spend it how they want. Presumably, preferences would not be used to set payment rates. Rather, consumers would determine how funds allocated on the basis of consistently assessed needs could be spent.

Another strategy would be to consolidate all programs for individuals with disabilities, regardless of age or etiology, into a single state agency. Several states have pursued such a strategy, including Vermont, Washington, and Wisconsin. Washington’s Aging and Disabilities Services Administration, for example, was formed in 2003 with responsibility for (a) long-term services and supports for elders, adults with physical disabilities, and people with developmental disabilities; as well as (b) Medicaid financial eligibility functions. Consolidating formerly separate agencies into a single governmental unit was meant to promote a unified mission, shared values, and common strategies (such as eligibility assessments and quality improvement initiatives) across all disability programs. An implicit goal was to more closely align disability policy and programs that serve populations of all ages and with all types of disability. Although the approaches across groups would not necessarily be identical, the contrasts would become more evident.

Although disability policy should encourage independence for all people with disabilities, it should not abandon social responsibility or force the same solutions on individuals with varying needs and desires. Differences across disability programs and services reflect not only historical and perhaps theoretical differences, but they may also respond to important distinctions in needs, values, and priorities of different groups of individuals with disabilities. Thus, different groups may not warrant strictly equal responses. Advocates of younger people with disabilities argue that the fact that one group of citizens with shared interests and common needs has successfully engaged the political process to acquire economic and other benefits specific to those on whose behalf they advocate does not by itself mean that the spoils of their labor should be seen as a disproportionate or unfair share. Competing (fairly) in a world of finite resources is not only inevitable; it reflects a basic democratic principle. Other groups should be free to do the same and some do, with varying degrees of success.

Conclusion

There is substantial evidence that older and younger adults with similar degrees and types of disability are treated differently in terms of the options for service they have available and the amount of money spent on them. The question is whether these differences in treatment represent ageism, even if they reflect beliefs held by both professionals and clients who view different expectations as a concomitant of different life stages. This distinction is more complicated when the party potentially being discriminated against shares the dominant values. Acquiescence does not imply fairness. One of the lessons of the civil rights movement was that ingrained social ideas are not necessarily correct. Once the underlying premises were challenged, discrimination was recognized as invalid.

However, fairness need not mean one size fits all. Such an approach could inhibit the development of more appropriate strategies for redressing the impact of disabilities in these different groups. There is insufficient evidence about the effectiveness of various strategies to address cost-effectiveness among different target groups, and some of the outcomes are themselves amorphous. Satisfaction and even quality of life can be influenced by expectations, which, in turn, are shaped by social beliefs (Rust & Oliver, 1994).

Emphasizing commonalities is not a new idea. Three decades ago, R. Morris (1980) proposed reorganizing welfare programs along functional lines across constituencies. He proposed large organizations that could handle a variety of different types of clients who required similar services. Neugarten (1982) argued against older people’s entitlement to special benefits solely because they were old. She too favored a common set of eligibility criteria based on need.

Now the shoe is on the other foot; older adults are receiving disproportionately less. Older individuals should be able to get a full range of services and adequate support. Whether or not it is called ageism, the gap persists.

References
