GERIATRIC BLINDNESS: A NEGLECTED PUBLIC HEALTH PROBLEM

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Because loss of sight among the elderly often accompanies other more noticeable afflictions, geriatric blindness is a neglected yet serious problem for many older people. As the nation’s population grows older, it will be imperative that heretofore separate systems coordinate their efforts to address what the author predicts will be a concomitant increase in geriatric blindness.

Geriatric blindness has been a neglected topic in the health, social work, and gerontological literature. Even though every prediction about the plight of the elderly during the eighties and beyond notes that the size of this group is rapidly expanding and will continue to do so, little is mentioned about the effects of sight loss, an affliction more and more associated with age. There is good reason to believe that loss of sight among the elderly will increase correspondingly to the growth in the aged population if new services are not developed and existing services are not coordinated to head off this potential public health problem.

The task at hand is difficult primarily because blindness, the constraints facing the service system for the blind, and the existing statutes to aid the blind are mysterious to many professionals outside the present service network for the blind. Therefore, this article attempts to shed light on the topic of geriatric blindness, paying particular attention to the web of factors that have contributed to the general minimization of the problems confronting the recognized elderly blind and in store for those who will become blind in old age.

Past and Present Services

No campaign for the prevention of blindness among the elderly can be successfully mounted without an appraisal of the present problem, its genesis, and its implications. To understand the difficulties facing the elderly blind, it is important to examine the development of the service system for the blind in the contexts of the changing demographics of the elderly, the principles on and purposes for which the service system was built, and the constraints under which the system now operates.

The service system for the blind developed in the 1930s to meet the needs of young, potentially employable adults. The federal and state aid programs instituted during the Great Depression needed an objective scheme to authenticate the claims
of those who maintained they could not work because of loss of sight. From this administrative necessity came the use of a numerical standard by which to measure an individual's ability to see (specifically, vision of 20/200 in the best eye with correction) and the term "legal blindness." Although based on a numerical classification, the term actually encompasses a wide range of visual capacities and performances—a confusing point in trying to understand blindness and a given individual's ability to see enough to function.\(^1\)

It was fitting that the policies shaping aid to the blind during the thirties should have focused on the young and on rehabilitative, work-related services: youth made up the bulk of the population. Now, however, the U.S. population has grown older and, concomitantly, there has been an overwhelming growth in the elderly blind population. According to the American Foundation for the Blind, in 1978, about 65 percent of the 1.7 million people who were registered as legally blind in the United States were over age 60.\(^2\) A needs assessment study of the registered legally blind in Massachusetts revealed that of the 13,564 registered blind clients, 2,125 (15.7 percent) were ages 65 to 74 and 5,859 (43.2 percent) were 75 or older. The total percentage of registered blind clients ranging in age from 65 to 75 or older was therefore 59.9 percent. Also worth noting is that 2,750 (20.3 percent) of the registrants were ages 45 to 64.\(^3\)

Over the years, the service system for the blind, aided by important legislation such as Medicare, Medicaid, the Older Americans Act, and Title XX, has expanded to incorporate the growing needs of the elderly blind.\(^4\) However, a substantial portion of the efforts of state and private service agencies for the blind still emphasizes training for the young and employable adult who is visually impaired.\(^5\)

There are other constraints on providing adequate, coordinated services to the elderly who are blind. Although Medicare and Medicaid supply payment for some medical services, reimbursement is limited to specific treatments for serious eye conditions and does not provide for eye examinations, services for those with poor vision, or rehabilitative services that would help in the social and psychological adjustment of people who have severe visual limitations or are blind.\(^6\) In concept, the Older Americans Act, as it pertains to blindness, is important. It provides for the development of an organizational framework (area agencies on aging) to coordinate services for the elderly, which would include services for the blind. But, given the scant emphasis on blindness and on other visual impairments accompanying aging, paraprofessionals and professionals in geriatrics are often unattuned and ineffective in working with blind individuals.\(^7\) On the other hand, service agencies for the blind lack sufficient resources and are limited by their own set of constraints in educating the entire service network for the aging about the problems of the elderly blind.

Just when systemwide efforts were under way to expand services for the growing population of elderly blind—services that would have included transportation, recreation, community education, intensive case finding, and community training for nursing home and agency staffs—the federal budget cuts imposed by the Reagan Administration went into effect. The service system for the blind, like other systems nationwide, was hit by the cutbacks. Title XX funds were reduced for in-home services, and training efforts such as in-service programs for nursing home staff were eliminated. For example, North Carolina Services to the Blind and Visually Impaired cut back on preventive services, and losses of personnel created a delay in services for many of the elderly scheduled for immediate attention.\(^8\) Similarly, the Pittsburgh Blind Association had to reduce its transportation services for a number of elderly clients.\(^9\)

Responding to a 1982 survey examining the effects of budget cuts on state services...
for the blind, officials in Kansas indicated they were about to reduce preventive services by 50 percent. Delaware officials said they were going to reduce services to the elderly by 6 percent, and Ohio planned to impose a 40 percent reduction in services to the elderly.

Problems of the Elderly Blind

Given that the service system for the blind evolved to meet the needs of young and employable adults, that the term “blindness” covers a confusingly wide range of visual capacities, that the service system is grounded in legislation that helps the elderly but not enough, and that the Reagan budget cuts partially immobilized the service system’s attempt to meet the needs of the elderly, it becomes more understandable why there is concern about the visual problems among the elderly and misgiving about the well-being of the future elderly. For example, it is sobering to consider McPherson’s claim that of the 2 million people afflicted with glaucoma, half are over 40; moreover, half the 2 million do not know they have the disease. Considering the limitations of the service system for the blind, the myths and fears surrounding the loss of sight, and the progressive nature of many eye disorders, there is ample reason to predict that a substantial portion of those people cited by McPherson as afflicted with glaucoma will grow blind in old age.

The unfortunate irony here is that with early detection, diagnosis, and treatment, blindness caused by glaucoma can be prevented. Furthermore, sight can be restored in cases of senile cataract. And although blindness from diabetic retinopathy—one of the leading causes of blindness—or retinal degeneration cannot be prevented, the maintenance of good health and control of diabetes and vascular problems can limit further loss of vision.

Most newly blind elderly are poor women over age 70; suffer from more than one other more noticeable ailment; and are not usually recognized as blind because they have some remaining vision. Thus, they are faced with a host of burdens, the least understood but most treatable being blindness. The demographic characteristics of this population are at least superficially similar to those of the nursing home population, the average representative of which is a poor woman who is over age 70 and who suffers from more than one ailment. In light of the general misunderstanding of blindness, it is plausible that a visual loss may have indirectly caused the admission of many nursing home residents whose presenting problem was, for example, a fracture. Visual loss may have contributed to other problems leading to nursing home placement, such as arthritis exacerbated by a visually impaired person’s fear of exercise.

Those newly blind elderly who enter the service system for the blind will probably receive enough social, rehabilitative, mobility, and low-vision services to keep them at home, functioning marginally. But they probably will stay on the periphery of substantial participation in the community. Even if they are able to become involved outside the service system for the blind, those with whom they come in contact are usually unable to work with them effectively. Thus, the elderly blind confront difficulties at every turn—individuals who enter the service system for the blind are partially rehabilitated, but their communities are still unprepared to adjust to their limitations, and the service system is not prepared to educate or train those who may come in contact with the elderly who are blind. The net result for the recognized elderly blind is that they usually cope the best they can and receive the limited services available to the blind.

However, an even larger issue looms. What happens to the unrecognized elderly blind? This is a troublesome and complex question facing the health, social work, and rehabilitation community, especially those professionals concerned with the problems of the elderly.
There are about 9 million people in the United States whose vision cannot appreciably be helped by eyeglasses. That is, even if their sight improves with eyeglasses past the 20/200 definition of legal blindness, they are not able to function better to any substantial degree. Low-vision specialists who provide services to the blind are trained to help people like these learn to use their remaining vision most effectively, often by relying on special aids. If one uses this figure of 9 million in conjunction with the finding of the American Foundation for the Blind, mentioned earlier, that in 1978, 65 percent of the 1.7 million registered legally blind in this country were over age 60, an extrapolation can be made. Applying the rate of 65 percent to this population, one might make a rough and perhaps overstated estimate: the number of elderly, and those nearing old age, who have severe problems and are not classified as legally blind may be as high as 5.8 million. (Again, this is based on the assumption that 65 percent of the 9 million people not helped by eyeglasses are over 60 years old.) Given the dilemmas facing the service system for the blind, it is unthinkable that this system could accommodate even a fraction of that many people. It already has difficulty serving the 1.7 million individuals who are recognized as blind.

**Integrated Efforts**

McPherson is on the right track in arguing that glaucoma can be controlled through a community health approach. Matteson is also correct in noting that the prevention of blindness could be more successful if those who work with the elderly had specific training in making baseline visual assessments. The self-help support groups that have begun to flourish within the service system for the blind are also important. These three approaches would be important elements of a comprehensive community assault on the problem of blindness.

The social work profession could also play a significant role in such an effort. Social workers are an important part of the service network for the blind, the service system for the elderly, and the overall health care system. Thus, social work has the opportunity to provide essential elements needed to attack the problems of the elderly blind. The profession can help connect the three service systems to mount a national campaign aimed at educating the public at large about the scope of this public health problem. However, educational efforts need to be aimed at legislators as well. Legislation is required to provide funds for community education, screening for a host of visual ailments, and training in how to work with the recognized elderly blind. Social workers, being involved in the aforementioned three service systems of potential assistance to the elderly who are blind, could conceivably aid in bringing much-needed national attention to the problems of the elderly blind, which are currently being attacked incrementally. Their efforts could focus on two basic points: not only is legislation needed to restore the services eliminated by funding cutbacks affecting the blind service system, but legislation must also be drafted to provide funds to research and demonstrate the most effective ways of preventing vision loss or further vision deterioration among the elderly.

Even if the success of efforts to draw public attention to the problems of the elderly blind comes slowly, some small, locally initiated demonstration projects, possibly funded privately, could take place in the meantime and provide models for larger national efforts. Social workers’ role in such projects would be essential.

At the local level, social workers from the blind, aging, and health care service systems could take steps to develop a coordinated effort for solving some of the problems outlined. Workers could develop grant proposals to fund a conference or workshop designed to bring those involved in the three systems together to study the
situation in light of the availability of local services. As a result of this effort, personnel outside the blind service system could learn about the services offered within the system and consider whether some of the service techniques might be adaptable to their own work. For example, community health nurses might be trained to make baseline visual assessments, and public health social workers could learn how to probe for visual problems during intake. Other individuals who work with older people could also apply in their settings the information they received. Nursing home staff, for instance, could learn how to teach visually impaired residents to be more mobile, and the facility's accountant could be trained to teach residents how to handle finances even as their sight dwindled. The list of ways to compensate for sensory deprivation and prevent further loss is endless, yet little of this helpful information has gone beyond the service system for the blind thus far.

If local efforts were to follow the suggestions just outlined, a second, program-oriented stage could be initiated, in which the roles of specific services would be more clearly defined. Community health nurses could be trained to screen for glaucoma and perhaps for other vision problems as well. Their heightened awareness that diabetics run a high risk of sight loss could prevent some future problems. On a community level, social service personnel could coordinate a glaucoma program or a complete screening program for vision loss with business, industry, government, and local civic groups. Although such community glaucoma programs already exist, they could be enhanced by instituting follow-up correspondence, developing information and referral, and providing intervention services for high-risk cases.

Furthermore, there are more than five thousand nutrition sites across the country, as well as numerous Meals-on-Wheels programs serving the elderly. The professionals involved in these programs, and even the volunteers who contribute countless hours, could be trained to be on the lookout for the more obvious signs of progressive sight loss and could make referrals to community health nurses trained in visual assessment. On the basis of judgments by medical personnel and workers trained in service to the blind, these referrals could be put on a modified program until expert help is available. In emergency situations, people with visual problems could be referred directly to an agency that serves the blind. In contrast, as the service network stands presently, a person suspected of having a visual problem is referred to the system providing services to the blind and often has to wait for even minimal service. With proper training, local personnel in the health and social work fields and volunteers could do much to shore up the gaps in this service network and perhaps to reduce further vision loss among those referred. In short, a second component of a coordinated approach to helping the elderly blind would be training in assessment for the many people who work with the elderly in various capacities, the development of modified services, and the provision of follow-up.

Another facet of a local attack on the problem would be to develop a network of support for the recognized elderly blind, to help them overcome feelings of loneliness and isolation. The service system serving the blind has already developed a national network of programs to enable the elderly who are blind to develop skills and participate in volunteer and community services. Thus, an elderly person facing progressive sight loss could still be part of an active community group, rather than bear his or her burden alone.

Finally, coordinated local efforts should include a monitoring component designed to examine each element of the program. Social workers in administration or program development could help ensure the success of any overall effort by developing a system to evaluate the program and modify it where this was found to be necessary.
Beyond This Decade

As this nation moves through the 1980s and beyond, the many problems facing an increasingly elderly population will become more obvious. In a youth-oriented society, difficulties that detract from the appearance of youth tend to be suppressed. But neglected problems do not go away; they fester and eventually surface. One problem currently being suppressed but certain to come to the fore is the potential for sight loss among the elderly. However, with the coordinated and concentrated efforts of social workers and others in the helping professions, geriatric blindness can be treated and, in many cases, prevented. A heightened awareness offers hope for the future.

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Notes and References

7. Ibid.
8. Personal communication with Michael Pedeneau, assistant director of North Carolina Services to the Blind and Visually Impaired, September 1982.
9. Personal communication with Dennis Apter, director of rehabilitation services, and Harold Dom, director of social services, Pittsburgh Blind Association, Pittsburgh, Pa., May 1982.
11. Organization for Social and Technical Innovation, Blindness and Services to the Blind in the United States; and ibid.