MEDICALIZATION OF THE PROBLEMS OF THE ELDERLY

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Faced with the limitations of present public policy, many health care professionals are being forced to define the social needs of their elderly clients in medical terms in order for these needs to be addressed. The policy analysis presented here attempts to explain this phenomenon and argues on behalf of a more rational and comprehensive approach to policy and services for the elderly in this country.

At morning rounds in a community hospital, the following case was presented by a physician to teach residents about the management of diabetes:

Mrs. B is a 72-year-old widow admitted to the hospital for uncontrolled diabetes. This is her second admission in six months. Today is her twelfth day of hospitalization. After a regimen of monitored diet and insulin regulation, her diabetes is under control. Medicare will reimburse Visiting Nurse Association services for a few weeks so that Mrs. B's condition can be watched.

However, the following notes summarize the patient's actual situation:

Widowed five years ago, Mrs. B has become depressed recently and has neglected her diet. She lives alone on a fixed income. A cataract problem has limited her mobility, curtailed her once active involvement in church and community affairs, and made it difficult for her to administer insulin to herself. Several months ago, her only child, a son, moved to another state with his family. This was a blow to Mrs. B, who spent several afternoons a week with her grandchildren. It appears that Mrs. B's social support system is extremely limited and that her motivation to care for herself has declined. She was recently admitted to the hospital for uncontrolled diabetes, and staff are reluctant to discharge her under the present circumstances.

Faced with the prospect of sending Mrs. B home only to have her return to the emergency room when her home nursing care was terminated, her young physician extended her stay. Concerned about his patient and frustrated with the system, he decides to take his chances with the hospital's utilization review committee and to press the social service department to come up with a better discharge plan. In doing so, he will waste hundreds of health care dollars a day. This case has helped him learn how to "medicalize" the problems of his elderly patient—how to reframe her social needs in medical terms so that they will be addressed by present health care policy rather than be shunted aside. If programs could provide Mrs. B with continuing care from home health aides, travel assistance, counseling services, and day care with an adopt-a-grandparent program, this
A young physician could concentrate on managing her diabetes and cataracts, secure in the knowledge that her psychosocial needs were being satisfied. In addition, the hospital would not be responsible for the costs of Mrs. B's inappropriate care. And, of course, Mrs. B would be happier and probably healthier. Instead, recent Medicare regulations will soon limit Mrs. B's hospital admissions for diabetes, and her plight and that of other patients will intensify.

The case of Mrs. B is symptomatic of a phenomenon in the United States—the "medicalization" of the problems of the elderly—that is related to inadequate policies, deep-seated attitudes and patterns of thought, and fiscal constraints. This article will define medicalization by placing it in the social context in which it takes place, provide some evidence of how it occurs, and offer some possible explanations of why it happens.

Social Context and Influences

Comfort, a distinguished geriatrician, describes aging as a sociogenic process, a process by which society strips older citizens of their socially sanctioned kinship and work roles. What replaces these is a negative role of being old, of being "unintelligent, unemployable, crazy and asexual." Comfort accuses America's youth-oriented culture of treating the old like an underprivileged minority and acknowledges that while "physical losses are serious and will ultimately kill us...most older people do tackle disability with as much or more courage than at any other age." The elderly, he contends, are suffering more from boredom and grief than from illness.

That the problems of older people are largely social in nature is also the major conclusion of Riley, a sociologist. Riley's concepts of age stratification, age inequalities, and age segregation point to social isolation, the loss of status and roles, and the negative stereotypes that accompany these factors as major causes of the problems of the elderly.

The negative stereotypes attached to old age may also result in diverging perceptions on the part of the general public and the elderly concerning the nature of older people's problems. In a Harris poll sponsored by the National Council on Aging, poor health was identified as a problem of the elderly by 51 percent of the respondents in the 18-to-64 age bracket, and inadequate medical care was identified by 44 percent. In contrast, only 21 percent of the respondents aged 65 or over mentioned poor health as a problem, and inadequate medical care was noted by only 10 percent. It is interesting that 23 percent of the respondents in the 65-and-over age group listed fear of crime, a social problem, as their major concern. In discussing the results of the poll, Abrams reached a notable conclusion concerning those older respondents who said that poor health was their reason for not working. He suggested that this was a learned excuse used to cover up other reasons, such as the feeling of not being wanted, a less acceptable and more embarrassing response.

Politicians as well as the general public have been greatly influenced by negative stereotypes of the elderly, and until recent years they have not recognized the ability and willingness of senior citizens to take part in the political process. In 1976 Abrams appealed to state legislators to understand that "a new breed of elderly is developing" that must be considered a viable political force. In fact, Hudson and Binstock maintain that interest in politics increases with age, and Kutza reports that the percentage of older people who vote is higher than the percentage of voters in any other age group. Although the elderly may have physical limitations, these conditions do not diminish their suitability for public involvement. On the contrary, the life experiences that senior citizens have undergone give them a more comprehensive perspective on public issues.

Given the pervasiveness in society of stereotypic attitudes toward the elderly, it is not surprising that these attitudes are re-
flected in various aspects and sectors of American life. Physicians are investigating causal relationships among social problems, negative roles, and poor health. In regard to this topic, Shanas concluded the following:

There is ample clinical evidence that physical and emotional problems can be precipitated or exacerbated by denial of employment opportunities. Few physicians deny that a direct relationship exists between enforced idleness and poor health. The practitioner with a patient load comprised largely of older persons is convinced that physical and emotional ailments of many... are a result of inactivity imposed by denial of work.

Thus it appears that individuals such as sociologists, politicians, and physicians have been questioning the stereotype of older people as weak, infirm, and unable to contribute to society. A logical question, then, is why medical requirements are the needs of the elderly most consistently acknowledged by the makers of public policy. One need only look at Medicare, which will pay for skilled nursing but not for custodial care, to realize that concerns about illness overshadow those related to quality of life in the eyes of policymakers. It is reasonable to ask why policymakers are reluctant to follow the challenge posed by Butler to formulate a national policy on aging that would include in its goals older people's achievement of the right to work and the right to social roles as well as the protection of their freedom of mobility and the creation of comprehensive health and social care. However, asking this question implies an ignorance of incremental policy change, which is the method of change that prevails in the United States because of this country's political process. With incrementation, changes are small and effected cautiously because politicians do not want to upset the electorate. However, because the more efficient use of health care dollars is becoming a national imperative, a more rational approach to policy must be conceived and implemented.

Neglect of Social Needs

How does medicalization of the needs of the elderly take place? The tendency to define and respond to social problems in medical terms can be seen in a variety of areas. For example, federal expenditures for health care reflect a narrow view of the problems of the elderly, and it is clear that specific social needs are not given appropriate attention. In a detailed examination of federal spending on programs for the elderly, Kutza found that Medicare, the most medically oriented of these programs, received the largest share of federal funds. The least medically oriented programs, those related to housing, received the smallest share. In fact, Kutza estimated that Medicare received 12 times the funding received by housing programs.

One might argue that since the elderly receive social security benefits, they could spend some of their allotments on social services. But as Moroney has pointed out, such services are available only to those who meet certain income eligibility criteria. Many middle-class families providing care for elderly relatives are excluded from receiving these services because they are not poor enough. These families may go without day care, homemaker services, counseling, transportation services, and other assistance, or they may struggle with limited budgets to purchase these services in the marketplace.

Not only are the social needs of the elderly often neglected in policy planning, but existing policies sometimes also pursue social goals that conflict. For example, social services that are available for the elderly who are poor are funded through Title XX of the Social Security Act, which distributes block grants to the states. A goal of Title XX is the reduction or prevention of institutionalization through community-based care, a goal that implies a concern for the social needs of individuals. However, the policy governing Supplemental Security Income, the result of other federal legislation that is also in place, seems to
penalize benefit recipients for staying at home: benefits are increased by 50 percent if an individual lives in a foster home but are reduced by 33.3 percent if he or she lives at home and receives care from family and friends. Furthermore, despite the fact that Title XX addresses social needs, an astonishingly low 0.001 percent of Title XX funds are spent on programs specifically designed to provide services to the aged. In 1977 these services reached only 100,000 out of 25 million citizens over the age of 65.11

If federal spending on social services for the elderly is low compared to spending allocated to medical services, some states, according to Abrams, are guilty of "failure ... to put their pocketbooks where their mouths are by neglecting state matching."12 The variability in this area from state to state has been dramatic. In 1975, for example, California spent $88 million on in-home services, compared to New York, which spent $22 million. Some states have only a few social service programs. In 1980 only 36 states had adult day care programs, and only 32 provided home-delivered or congregate meals.13 Given present budget cutbacks, even these programs may become extinct.

The same variability exists in public housing programs. In 1973, 1,500 elderly people were waiting for placement in publicly subsidized housing in Washington, D.C., but in New York City those waiting numbered 32,000.14 In addition, certain expenditures reflect a social welfare policy for the elderly that separates the better off from the poor. For example, elderly people in the middle and upper class receive Old-Age and Survivors Insurance. The elderly who are poor receive Supplemental Security Income and housing subsidies. Furthermore, even when the need for social services is acknowledged, fragmentation of policy leads to gaps in service: depending on their state or community, the poor may or may not have access to public programs. And, ultimately, whether older people are poor or better off, their medical needs receive much more attention than their social needs.

Another area in which the neglect of the social needs of senior citizens is seen is in that of retirement. The criterion for receipt of social security payments is typically retirement at age 65. A change in this arbitrary age is currently being examined by social security officials, and the 1983 amendments to the Social Security Act already call for a change in the primary retirement age to 67 by the year 2027. However, the motivation for extending the retirement age was not to satisfy the elderly's need to work; the extension was a response to the impending threat of bankruptcy of the social security system.

The Harris poll commissioned in 1976 by the National Council on Aging revealed that senior citizens are not alone in objecting to mandatory retirement. The poll found that "86 percent of the American public, young and old, have serious reservations about current [retirement] practices."15 The majority of the public believe that most older people can continue to perform as well on the job as they did when they were younger. But despite public opinion, the practice of mandatory retirement continues, which may well lead to idleness, somatization, and poor health among those forced to stop working. Thus, the secondary im-
pact of forced retirement is felt when the older person arrives at the doctor’s office. And it is ironic that although the provision of social services prior to this point might have obviated the person’s need for more expensive medical services, government payment for medical care is more easy for him or her to obtain.

Explanatory Factors

Policy Perspectives. A number of factors contribute to the pervasive emphasis on the elderly’s medical problems to the detriment of their social needs. For example, the fact that Medicare is linked to the social insurance concept of social policy has been significant in the development of this society’s tendency to respond to social needs in medical terms. Medicare is viewed as medical insurance for the elderly and provides universal coverage after age 65 with no stigma or means tests attached. Derthick’s analysis of policymaking for social security explains that since its inception in the United States in 1935, social insurance has been a politically and ideologically appealing concept. Thus, Medicare was legitimated without much difficulty in 1966 and until just recently reaped the benefits of institutional protection, that is, protection by program executives, legislators, and representatives of labor, big business, and the professions. In contrast, Medicaid and social service programs require means tests, and their public image is one of administrative inefficiency and cost ineffectiveness. The resulting negative stereotype reflects the notion that programs for the poor are poor programs.

More fundamental than the negative stereotypes attached to means-tested programs are the stereotypes attached to social problems. Poverty, homelessness, and a wide variety of social ills all resound with negative connotations. The tendency to perceive the condition of the elderly in medical terms may stem from an attempt to enhance the acceptability of the social problems that old people experience. This attempt is not unique. Alcoholism, drug abuse, mental illness, and child abuse have all at some point been explained in biological rather than social terms. Given biological explanations, society can respond with medical technology, expertise that is readily available.

Medical science has always been more impressive than social science in regard to technology. In the United States, medical specialization was held in high esteem during the early 1960s, the precise time that social security policymakers were formulating new definitions of the problems of the elderly. Not only was the medical model chosen for implementation, but the medical specialist model was chosen as well. This resulted in many of the abuses—unnecessary testing, procedures, and hospitalizations—that policymakers are today attempting to reform by initiating the diagnostic related group (DRG) system. The issues surrounding the exaltation of technology in this country raise the question of why health care professionals have reinforced society’s tendency to put forward medical responses to the problems of the elderly.

Dominance of Medicine. Since the time of the ancient Greeks, physicians have been viewed as scholars and scientists (despite their use of such rudimentary “scientific” methods as holding urine specimens up to the light to study them). In colonial times physicians had little to offer their patients who had smallpox, diphtheria, measles, and other diseases, but they were nevertheless highly regarded by society. According to Grob, As more Americans survived the dangers of infancy and childhood in ever-growing numbers, they began to identify the decline in infectious diseases with measures introduced by modern medicine. At the same time, the character of the medical profession was transformed by science and technology.

Medicine had the answers to modern problems, and the physician was the scientific leader. Nurses, the other major group of health care professionals familiar to the
public, were viewed as physicians' handmaidens, and nursing was condescendingly identified as women's work. Social work, another profession for women, was similarly accorded low status.

In addition to witnessing the growing presence of nurses and social workers on the health care scene, the twentieth century saw the birth and development of many allied health professions, whose members include physical and occupational therapists, dietitians, physician assistants, and speech pathologists. Today, physicians constitute one of 16 categories of health care providers that have been identified, but they are the group residing at the top of a large and complex health care hierarchy. What keeps them in this position in the United States is not only their scientific knowledge and skills but also their political power base and entrepreneurial role and style. In countries such as England and Israel, where physicians make less money than in this country, there is less of a discrepancy between the role and status of physicians and those of other health care professionals.

There are many differences between the health care system in America and those in other nations. In Israel, for example, teams consisting of a family physician, a nurse, and a social worker are responsible for a designated nurse territory. Members of a given team may work in different settings, but they meet weekly to discuss the problems of the families living within their territory. These problems are social as well as medical. This system contrasts sharply with the one used here, in which such coordination is rare. In addition, the health insurance system in this country differs from those used elsewhere. By often reimbursing only the physician, the American insurance system may encourage the overdiagnosis of medical problems.

Reliance on the medical system is reinforced in the United States in a variety of ways, such as when it becomes legitimate for physicians to determine patients' non-medical needs like needs for job training and disability status. It is further reinforced by such practices as waiting for a physician to pronounce someone officially dead when the person died several hours earlier and the physician has been detained. This sanctioning of the medical profession's exclusive right to handle all issues related to life and death has become burdensome to many modern physicians. In the author's experience, many young physicians like the one in the case study described earlier would willingly share their responsibilities with other health professionals. If public policy reinforced the sharing of responsibility, patients such as Mrs. B would be reimbursed for securing social services, and her physician would be reimbursed for providing her with medical care.

Related to the issue of shared responsibility is that of the credentialing of health care providers and how it indirectly contributes to medicalization. As many states continue to deny licensure to social workers, third-party payments from insurance companies are withheld for social work services. This can discourage potential clients from using these services and perpetuate the entrenched position of other health care professionals. Also, restricting the practice of social workers may affect the way in which patients' problems and needs are defined. Provided that social workers remain committed to the philosophy of their profession and its focus on psychosocial needs (rather than a narrower concern with mental health), the profession must be committed to credentialism.

Recommendations

Medicalization, then, takes place on two levels in our society in regard to the needs of elderly citizens. The medical needs of the elderly are sanctioned and are addressed by public policy in a way detrimental to their social needs. At the same time, present policy forces professionals to reframe social problems in medical terms if service is to be provided to their elderly patients.

With Reaganomics as our present reality,
the time is right for a comprehensive cost-benefit analysis of existing policy. Relevant questions require answers. Would not the frail elderly and their families benefit more from the provision of support services and respite care than from an emphasis on institutionalization? Would not senior citizens who are ambulatory be better off maintaining their independence in their own homes with the aid of travel and cleaning services, day care programs, and Meals on Wheels? And would this independence not help keep them out of their doctors' offices? Finally, should they not be allowed to work and contribute to society as long as they feel able? Research data are needed to answer these questions so that social workers can defend the benefits of social programs that foster independence and prove that program costs are appropriate for the achievement of long-term goals.

Happier endings are needed for the story of Mrs. B and for patients like her. Society must acknowledge both her need to contribute and her lack of social support; federal and state policy must provide her with programs that address all her needs; and professionals must work as a team to keep her out of the hospital. Only then will society have met its challenge and fulfilled its responsibility.

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Notes and References
2. Ibid., p. 31.
5. Ibid.
11. Ibid.
21. Interview with Dr. Marcel Monnecken-dam, professor of family medicine at Tel Aviv University, in Summit, N.J., in 1984.