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Aging in America: Now and When

Laura Ihrig

Abstract: *The following paper is a study of aging in two societies, the United States and the traditional culture of the !Kung of western Botswana, Africa. The material reviewed includes current and projected population trends, cultural norms with regard to the elderly, and potential future implications of the gathered information. Resources consisted of journal articles, books, and government agency reports.*

Introduction

We are getting old. Despite the legend, there is no fountain of youth. Time passes, and as individuals we move a little slower, our joints protest, we forget things—but we, as a society, are also getting old—fast and in large numbers, and therein lies the dilemma. The aging of and in our society is an issue addressed by scholars, politicians, community leaders, health-care professionals and the courts (Brooks and Draper 2004). In fact, the Center for Strategic and International Studies' (CSIS) Commission on Global Aging found that "over the coming half century population trends in the developed world will pose a significant challenge to the sustainability of current social security and health guarantees in the developed countries" (Hewitt 2002:71). Other findings included the same trends posing challenges to the ability to sustain defense, infrastructure, and education, as well as relations between developed and developing worlds (Hewitt 2002).

Exactly what population trends are being referred to? The current population count of the United States stands at approximately 280 million with 35 million of that age 65 and over, or 12.6 percent of the total (US Census Bureau (USCB) 2000). The 65+ group are those considered "old" and are further classified as "young-old', "middle-old", and "old-old". The average life expectancy of the "middle-old" category is 72 (USCB 2000). However, this is actually a recent phenomenon in terms of human evolution. Historically, the human lifespan did not reach far beyond reproductive years. From the late Bronze Age through the Medieval Era and in Europe until about 1750, the average age at death ranged from 31.1 to 40.2 years. It was in the late nineteenth century that life expectancy started to show any significant increase, along with the numbers and proportion of the

elderly. Sewage systems, vaccines, improved nutrition, protected drinking water, and other public health measures in stable societies account for the rise (Shield and Aronson 2003).

Thus we arrive at the twentieth century. In just over the first half of the century the "young" section (under 65) of the U.S. population doubled in size while the elderly population grew by a factor of 5-10 (USCB 2000). At the mid-point of this time period, 1930, just before the Great Depression and a period of low birth rate, life expectancy still stood at 59.7 years.

The following table (table 1) demonstrates some differences between 1930 and 2000 in four areas: total population, life expectancy in given year, the population in that year of 65+, and the percent of the population in the 65+ group (USCB 2000).

	1930	2000
Total US Population in Millions	122.80	281.4
Life Expectancy (in years)	59.7	77.1
Population 65+ in Millions	6.6	35.0
Percentage 65+ of Total Population	5.4	12.4

Table 1: Statistical Population Comparison between 1930 and 2000 in the United States (USCB 2000)

The second half of the twentieth century saw the most substantial increase in life expectancy for Americans as a result of improved medical care (Shield and Aronson 2003). The elderly population continued to rise during this period, albeit slightly slower at the tail end of the century (1990-2010) due to the low birth rates of the 1930s (USCB 2000). So now we have come full circle to the question of future trends in population. The numbers and proportion of elderly are expected to go nowhere but up (USCB 2000). The following two graphs (Figures 1 and 2) illustrate this point.

As one can see the old-old (85+) are estimated by the U. S. Census Bureau to number 18.2 million in 2050. This is actually on the low end of several projections by different experts. Kenneth Manton, Director of the Center for Demographic Studies at Drake University, has estimated the 85+ population in the U.S. in 2050 to be as high as 48.7 million (Hewitt 2002). Lest we begin to think that we are special, alone, or unique, the expanding aging population is a global issue. According to a 2001 bulletin issued by the National Institute of Aging of the National Institutes of Health, the number of people worldwide

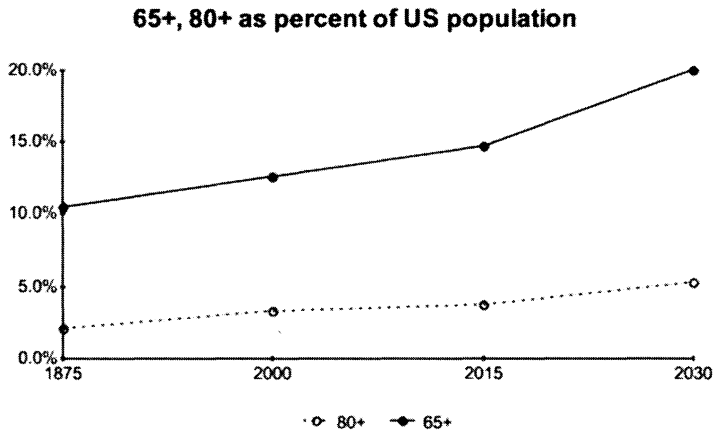

Figure 1

aged 65+ increases by 800,000 every month (Shield and Aronson 2003) or close to 10 million in a year. The two maps in Appendix A reveal a picture of projected global aging between 2000 and 2030, from a report by the U.S. Department of Health and Human Services in conjunction with the U. S. Department of Commerce. The authors of the report state that the number and proportion of elderly in both developed and developing parts of the world are expected to increase dramatically. They go on to note that the rise in developing nations is often overlooked, even though 59 percent (249 million people) of the world's elderly live in developing countries, and this is expected to reach 71 percent (686 million people) by 2030 (Kinsella and Velkoff 2001).

The following two graphs (Figures 3 and 4) provide information about a particular developing part of the world, Sub Saharan Africa. This information was chosen because the !Kung culture is in Sub Saharan Africa and is the culture chosen for discussion of the care of the elderly in a traditional culture. The first graph depicts one time period, the past, and the second looks into the future.

The graph above (figure 3) shows there were nine million people in the 65+ age group in 1950 and 32 million in that age group in 2000 (Shield and Aronson 2003).

The graph below (figure 4) shows projected numbers of 65+ people in Sub Saharan Africa. In 2000 2.9 percent of the total populations were 65+; in 2015 the percentage will be 3.2 percent; and in 2030 the percentage will be 3.7 percent.

All this raises some interesting questions. How do people in developing countries care for their elderly? How do people in developed countries care for their elderly? What are some of the

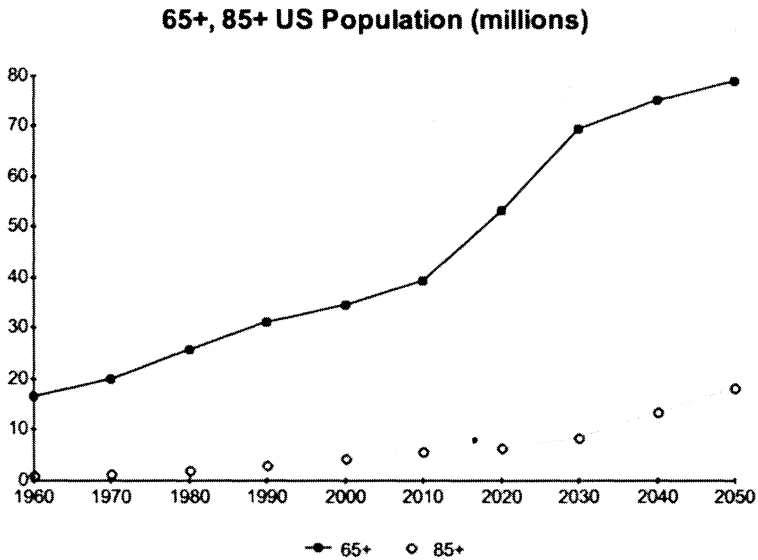

Figure 2

differences? To explore these and other questions two societies will be reviewed. The first people to be considered are people in a developing country. For this, the !Kung people of Botswana, Africa, will be the focus of the review. The second to be reviewed will be the people of the United States. The two cultures chosen will provide insight into the contrast and potential similarities between a traditional and modern society.

Aging in Two Societies

The !Kung are a people in western Botswana, Africa. In the past, they were a hunting/gathering society but have, for the most part become sedentary (Draper and Keith 1992). Today they utilize a combination of food-gathering/hunting and food-producing techniques. They tend gardens, and some own small livestock or even a few cattle (Draper and Harpending 1994).

The !Kung people live in small villages consisting of approximately 20-30 people each, located near a permanent source of water. The physical environment is sparse; consisting of small, round, thatched-roof huts with little to no furniture. The huts are built close together, with no walls or fences between them. This spatial orientation is important to the intimacy and cooperation of day-to-day life among the !Kung (Draper and Keith 1992). They live very poorly and

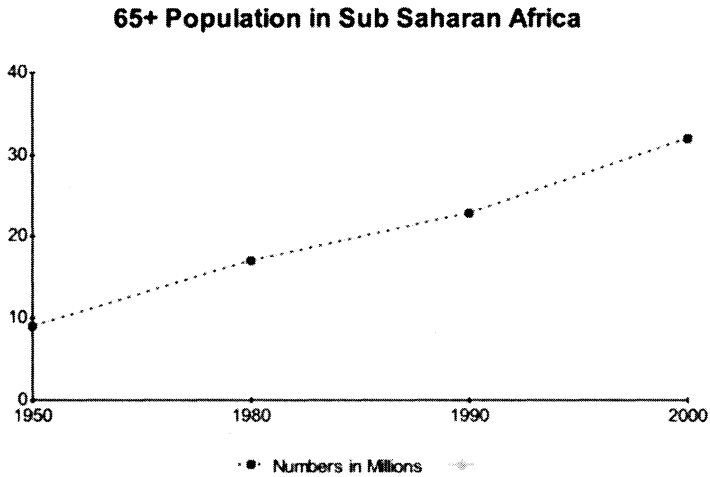

Figure 3

everyday activities, which consist primarily of work to obtain food, are physically taxing (Draper and Harpending 1994).

Villagers are usually related, either by kinship or marriage, and several generations may reside in the same village (Draper and Keith 1992). Marriage among the !Kung is common; as a source of economic support and companionship, and is typically monogamous and durable (Draper and Harpending 1994). The value placed on the companionship of marriage is such that they are likely to remarry if widowed, whether male or female (Biesele and Howell 1981).

As previously mentioned, daily life for the !Kung is harsh. Everyday chores include hauling water, gathering firewood, and tending livestock and gardens (Draper and Keith 1992). At times they may need to carry water as far as three kilometers, clear land for gardens, or build fences (Draper and Harpending 1994). The majority of these activities are done outdoors with a great deal of cooperation and interaction between households and generations. Even food is shared, with a constant flow of people giving or taking food from one hearth to another. Social gatherings are also a shared experience, based on kinship with all ages present. Rarely does a group of common age get together for a particular purpose (Draper and Keith 1992).

The elderly (age 60+) among the !Kung comprise approximately 14 percent of the total population, as opposed to the rest of Botswana in which the 60+ population stands at 6 percent (Draper and Harpending 1994). This is a result of low fertility among the !Kung, therefore the young do not heavily outnumber the old (Draper and Keith 1992).

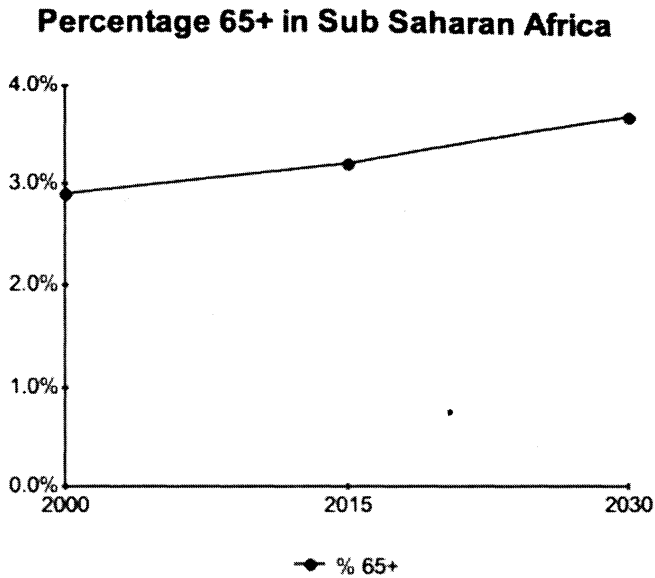

Figure 4

In reality, the !Kung themselves do not consider age, as a specific number, to be important. In fact, they have no native formal counting system aside from that used for purposes of keeping track of livestock. This illustrates their practical mindedness, which applies to how they judge people as well. People are described in terms of personality (e.g. she is lazy), residence, gender, and health (Biesele and Howell 1981).

Although the !Kung do not value specific numbers with regard to age, their language is illuminating in terms of how they view aging. They have a suffix in their language, n!a, which can be translated as "big" or old", and refers to people likely in their forties or fifties; past reproductive years, but still very physically able. They also have a word for the very old, /da!i, which may be translated as "nearly dead" (Biesele and Howell 1981).

As far at the !Kung are concerned, aging has no redeeming value. During an interview, a !Kung member was asked this question: "What is it like to be old?", to which he replied, "All you can do is sit and think about death" (Draper and Harpending 1994:24). What they do value is physical strength, ability, and independence. To the !Kung way of thinking, people who have strength are "whole". As people age and their strength diminishes, they remain members of the group by virtue of the strength of their younger kin (Draper and Keith 1992).

With physical ability paramount, elderly !Kung are liked and respected as senior kin but hold no special status that would entitle them to any particular authority or privilege (Draper and Keith 1992). Their own self-esteem is derived from doing as much for themselves as they can for as long as they can (Draper and Harpending 1994) Despite the negativity toward aging in general, the elderly do not suffer from social or economic stigma; the physical hardships and ailments of aging are more daunting (Draper and Keith 1992). No amenities are available to ease these ailments; such as electricity, running water, pain medication, eyeglasses, false teeth, soft beds or even warm blankets (Draper and Harpending 1994).

Even without such "luxuries" the elderly !Kung retain their own huts in the village, with a spouse, if living. Some will be the simpler, more traditional grass huts that are easier to build and maintain. However, when the rain or cold sets in the old will go to their children's homes for the night, or if there are no living children, in-laws or grandchildren with which the elder has established ties (Draper and Harpending 1994). Children's huts are normally no more than a few meters away. As long as the elder's hut is in the same or nearby village as their younger kin, they are considered by anthropologists to be "living with" them; and 80 percent of !Kung elderly "live with" their younger relations (Draper and Keith 1992). It is these younger relatives, likely adult children, who are expected to assist with daily tasks (Biesele and Howell 1981). Pursuant to village life, however, this is not a sole responsibility. The elderly are out and about the village all day with everyone else and visible to all (Draper and Keith 1992). Everyone can see if they are in need and they continue to be as active in the village as they are able - preparing food, telling stories, or at times more vigorous pursuits. It was reported that when one of the authors arrived at a village one day he encountered an ongoing game of jump rope. The females playing were ages 8, 11, 15, and 66 (Biesele and Howell 1981).

As discussed, the elderly do not relocate or enter institutions. In point of fact, there is nowhere for them to go (Draper and Keith 1992). They do not retire as we know it. In the entire !Kung lifestyle there are no distinct life stages or transitions (such as graduation) from one to another (Draper and Harpending 1994). Transitions are gradual and subtle for all !Kung, including the aging. As stamina and strength gradually decrease, the logistics of needed care are simple. It is provided by those the elder has been living with his/her entire life (Draper and Keith 1992). They "age in place", so to speak.

The concept of aging in place is not unique to traditional societies, at least in intention, if not practice. As a prior Nursing Home Administrator, I have watched as America, in recent years, has seen the advent of Continuing Care Retirement Communities (CCRC). These

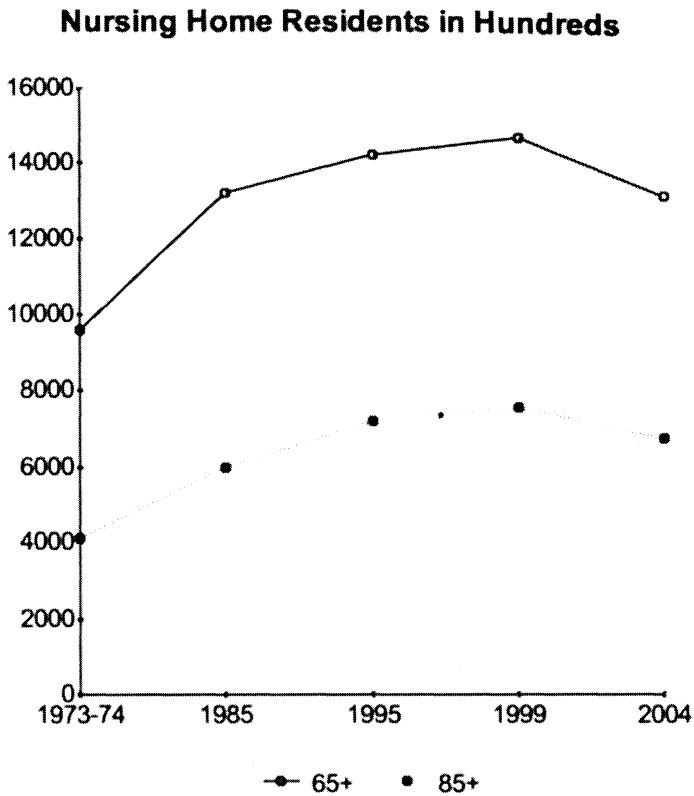

Figure 5

are facilities that offer several levels of care, from independent living to skilled nursing care, all within the same landscape, though not necessarily under the same roof. Despite CCRC's attempt to provide the opportunity to age in place, America's elderly, as a rule, do not age in place. American life in general is a pattern of life stages with marked transitions, such as graduation or marriage ceremonies. Some of the more abrupt transitions may occur when a person is older such as retirement or relocation, which removes them from their familiar patterns of work, residence, or social interaction (Brooks and Draper 2004).

Independence in America is a valuable ideal. The elderly and their younger relatives take great pains to arrange and/or maintain the older person's social and residential independence from the younger (Brooks and Draper 2004). On the whole, the elderly in America and other developed nations rarely live with their children, while in developing

parts of the world the opposite is true (Albert and Cattell 1994). This fact, together with a highly mobile, youth-oriented culture, leaves many elderly socially and residentially segregated from mainstream society (Selby and Schechter 1982).

The older Americans become, the more likely they are to live alone or in a group setting that is not a family household. According to a 2000 Census report, those people living alone or in group quarters included 12.5 percent of the total population, 33.9 percent of the 65+ group, and 60.8 percent of the 85+ population (USCB 2000). "Group quarters" as defined by the U.S. Census Bureau, includes institutions of varying types, one of them nursing homes (USCB 2000). While the number of people residing in nursing homes increased in the last quarter of the twentieth century, it has taken a slight dip since, as the following graph (Figure 5) depicts (National Center for Health Statistics 2007).

Nursing homes are only one form of long term care. A US Senate Special Committee on Aging defined long term care as " a wide array of medical, social, personal, and supportive and specialized housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or disabling condition " (Family Caregiver Alliance (FCA) 2001:1). In 2000, approximately 10 million Americans required some type of long-term care, with well over half (6.3 million) over 65 years of age (FCA 2001). This coincides with a US Census Bureau 2000 report stating that the 65 and over population had a disability rate 3 times that of the general population (USCB 2000).

The general population spends two-thirds of each healthcare dollar on chronic illness. Among the older population, 95 percent of each dollar spent on healthcare is attributed to some type of chronic condition. In 2002, estimated public and private long-term care expenditures were $180 billion and are projected to almost double by 2040 to $346 billion (FCA 2001).

Long-term care costs together with increasing numbers in the elderly population hold serious implications for the future. The proportion of elderly living alone will likely rise due to higher divorce rates, changing gender roles, and greater mobility. There will also likely be more elderly living longer with multiple chronic conditions, stressing the resources of both the healthcare system and families (Shield and Aronson 2003). If the elderly remain segregated from mainstream society, they could be an easy target of blame for heavy public cost burdens (Selby and Schechter 1982).

Perhaps the most severe consequence for the future lies not only in expanding number of the elderly, but the proportion of that number to that of younger people (Shield and Aronson 2003). This proportion is called a "support ratio", which the U.S. Census Bureau describes as

population distribution that affects certain product, service, and housing needs (USCB 2000). The support ratio is measured in terms of how many elderly and youth (under 18) there are per 100 working age adults. Today, the measurement stands at 70 percent (70 elderly/youth per 100 working age adults) with 20 of those 70 being elderly. By 2050 the ratio is projected to change to 90 percent (90 elderly/youth per 100 working-age adults) with 40 of those 90 per 100 being elderly (USCB 2000). To interpret, when the ratio is close to a one-to-one level such as projected for 2050, there will be one person of non working age living for every person of working age. Close to one-half of these non-working persons will be elderly as opposed to children living in a family household.

Conclusion

It is my point of view that economic and demographic forces will leave us in America little option but to change how we care for our elderly. It is estimated that the global aging population expands by nearly ten million people per year. Here in the United States, by 2050, projections of the elderly population are double from where they are today. Population estimates for 2050 for the oldest-old (85+) range from 18 to 48 million. These are significant increases between today and 2050, not only in real numbers of elderly but also in the proportion of the US population who will be in the 65+ group.

The old-old suffer a high rate of chronic conditions to which 95% of their health care costs are attributed. Chronic illness quite often requires long-term care which encompasses many types of services, one of them being residential care. Considering the costs it seems apparent that maintaining residential segregation of the elderly in the future may become more than our resources will support. This is compounded by the numbers of elderly referenced above, and further by the fact that medical expenses are significant among the elderly.

All this comes together when one considers the future of U.S. society and changes that are projected to take place relative to those working and those being supported. The support ratio shows that in 2050 there will be only one working-age person living for every elder/ youth, with one-half of the elder/youth group being elderly. So, one of every two working-age people will be supporting an elderly person in some fashion.

There are alternatives when considering the future care of our elderly population. One group has argued that support by biological kin will decrease. The authors of a 2001 U. S. Census Bureau report wrote the following: "The consensus to date foresees a declining biological kinship support network for elderly people in developed and many developing countries" (Kinsella and Velkoff 2001:81). Others might

disagree with this, suggesting as I do that both increasing elderly population numbers and the affiliated costs of residential care will make support by biological kin increasingly important; because resources for the segregated support of the elderly will not be available, and we will need to explore alternatives perhaps not imagined today.

One example of an alternative has been provided, that of the !Kung culture. Traditional cultures such as the !Kung have traditionally relied on kinship support in caring for their elderly. While they place a high value on physical independence, the !Kung do not particularly think being socially or residentially independent of others is important (Draper and Keith 1992). Therefore, the elderly are not segregated and aging is a gradual, subtle, transition. They age in place, whereas the elderly in the United States do not. Our aging transitions are more distinct, but we may be forced to adopt a more aging-in-place philosophy, and to rely on kinship support networks. Some of these networks could take the form of community and volunteer efforts, especially those aimed at keeping the elderly societally integrated, and inter-generational programs.

While the lifestyles of traditional cultures may not be directly applicable, practical, or even desirable, perhaps we can derive lessons from traditional cultures such as the !Kung. Respect, openness, and involvement in everyday society may be idealistic and abstract, but are small piece of a complex maze as our society grapples with getting older on its way to improving services to America's elderly.

These material points out some of the important issues related to the future of elder care. The issues are complex and simple answers are not available. Many people - social scientists, medical professionals, demographic specialists, and politicians, among others - will need to be involved in developing programs that will meet the needs of a changing society. Even then, the personal needs and desires of the elderly and their families may not be satisfied. This study could not explore all of the issues related to this topic.

In keeping with these thoughts, further cross-cultural research that focuses on community based and inter-generational support systems would be most helpful. Further efforts to examine ways to reduce resources needed to provide residential care for those for whom there will be no other option would also be informative.

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