This article hypothesizes that public policy targets benefits to three classes of elderly: (a) the poor or marginal elderly, (b) the middle- and lower-middle-class downwardly mobile elderly, and (c) the middle- and upper-middle-class high-income elderly. It is suggested that public policy for the elderly serves as an intervening variable or mechanism which helps to ensure status maintenance in old age. It is argued, in conclusion, that public policy for the elderly must be redirected to emphasize a redistribution of benefits from an elite of high-income elderly to the poor and near-poor elderly.

The modernization and industrialization of society has resulted in a rapidly aging society. The growth of the elderly segment of society has produced demands for extensive social welfare measures to protect the well-being of the elderly. The government has increasingly assumed the role of protecting people against many of the risks incurred with old age. Correspondingly, government expenditures for the elderly have resulted in a "graying of the budget." The mounting costs of programs for the elderly are beginning to draw attention, in part a reflection of a mounting resistance to social welfare expenditures in general. As expenditures to the elderly are the major component of overall social welfare expenditures, this resistance reflects a growing criticism of funds directed to the elderly.

These developments raise important questions. Two such questions are as follows: (a) Who among the elderly receive the benefits of government intervention? (b) Are these benefits based on need? This article
hypothesizes that public policy targets benefits to three classes of elderly.3 These beneficiary classes include: (a) the poor or marginal elderly; (b) the middle- and lower-middle-class downwardly mobile elderly; and (c) the middle- and upper-middle-class high-income integrated elderly. It it theorized here that public policy for the elderly operates to maintain in old age status and social class differences experienced prior to old age. It is suggested that public policy for the elderly serves as an intervening variable or mechanism which helps to ensure status maintenance in old age. The conclusion of this article argues that public policy for the elderly must be redirected to emphasize a redistribution of benefits from an elite of high-income elderly to the poor and near-poor elderly.

Social Class and Public Policy for the Elderly

There is a pervasive feeling on the part of both the public and many planners and policy analysts in gerontology that the hardships associated with old age fall evenly on the elderly. There is a sense that old age is the great leveler of social class and status distinctions. Correspondingly, much of the work done on status attainment ignores that segment of the life cycle that extends beyond sixty-five years of age. The status-attainment literature focuses on explaining the impact of family origin and education on occupational attainment and income position in the years immediately following schooling.4 It is assumed that an individual’s maximum socioeconomic position is achieved prior to leaving the labor force. Subsequently, little attention is paid to social status and stratification issues for individuals over sixty-five years of age, despite the fact that life expectancy at age sixty-five is fourteen years for men and eighteen years for women.5 The elderly in effect are treated as a social class; issues of social and economic inequality are obscured. Yet, considerable income variation does continue into old age. In 1977, 21 percent of the elderly couples in this country had incomes of $15,000 or greater, whereas 27 percent had incomes of less than $6,000.6 A segment of the elderly population, primarily high-income elderly, also possesses significant asset holdings.7 Henretta and Campbell examined income variations among the elderly on the basis of status attainment prior to retirement. Their findings held that the factors which determine income differences prior to retirement are the same ones that determine income in retirement.8 “While everyone may ‘take a cut in pay,’ old age does not reduce the effect of attainment variables on income.”9

Prior to retirement, earnings constitute about 87 percent of the aggregate money income for the entire population.10 Income studies for
individuals and families over the age of sixty-five in contrast identify earnings as constituting 23 percent of aggregate money income. Another 39 percent is derived from social security, 7 percent from private pensions, 6 percent from government employee pensions, and 18 percent from assets. Given the persistence of social class differences into old age, that persistence must be in part induced through the operation of such intervening variables as the accumulation of assets over a lifetime, tax policy toward the elderly, health insurance measures, pension policy, and other government measures.

Given the existence of socioeconomic differences prior to old age, why might we presume that they would persist in old age with the active assistance of public policy measures? In analyzing the differences in the quality of life circumstances among individuals and classes of individuals, David Gil identifies three universal processes or societal mechanisms which shape those circumstances. Those interrelated processes include resource development, division of labor and task for status allocation, and rights of distribution. Individuals and classes of individuals either have or do not have the right to certain resources and benefits based on their status. It is argued here that the public assumption of risks for the elderly is based in large part on status patterns established prior to old age, and that the rights to publicly supported benefits in old age stem from one's preretirement status. The erroneous view that the elderly constitute a universal social class identifies the "status" of old age as being the determining characteristic which entitles the elderly to publicly supported benefits. While there is an element of truth in this notion, it obscures the impact of primary socioeconomic status characteristics on entitlements in old age.

How might the interplay between socioeconomic status and public policy benefits for the elderly be conceptualized? The work of Richard Titmuss illustrates the connection. In public welfare measures for the elderly, as in nonelderly welfare measures, there are different classes of "approved" and "disapproved" public dependency. Accordingly, those elderly who receive approved public dependency measures do so on the basis of possessing certain status, achievement, and need characteristics. These elderly expect and receive their entitlements as a matter of right. They receive what Titmuss calls occupational and fiscal welfare. Occupational welfare benefits result from one's occupational status, that is, health insurance, contributory social security, and private pension benefits. Fiscal welfare measures are primarily tax-based income transfers facilitated by such things as double income tax exemptions for the elderly, property tax relief, and tax-protected retirement savings plans. Disapproved social welfare measures are based strictly on the criteria of need. Benefits for the poor elderly are given as a measure of paternalism and not as a matter of right. Means-tested benefits such as Supplemental Security Income for the elderly are de-
signed to provide a minimal level of care and sustenance. The public assumption of risks to the elderly is based on the distributive principle of equity. Accordingly, those who possess certain valued status characteristics are seen as having earned and deserved greater benefits.

Classes of Elderly Entitlement

In social policy for the elderly there is a tendency to label the elderly as a problem group. Efforts to discriminate need within the elderly population are limited, and yet the needs of the various segments of the population are quite different and access to resources to meet those needs is very disparate. As a means of categorizing both need and elderly public policy measures, three classes of elderly beneficiaries can be identified: (a) the marginal elderly, (b) the downwardly mobile elderly, and (c) the integrated elderly. The nature of social provisions, in-kind versus cash, and the level of benefits for each class of elderly individuals are determined by the elderly individual’s socioeconomic status. Consequently, each class of elderly is entitled to different government-sanctioned and defined levels of support—levels of support which serve to sustain in retirement those socioeconomic inequalities experienced prior to retirement.

Marginal Elderly
The marginal elderly are those individuals who are characterized by absolute need and poverty. The official federal government poverty statistics in 1978 identified 14 percent, or 3.3 million, elderly persons as poor. These are individuals who remain poor despite the receipt of public income transfers. For many of these individuals poverty in old age is simply a continuation of a life of poverty. The marginal elderly, as indicated by data on elderly Supplemental Security Income recipients, are more likely to be individuals living alone, female, minority, and of advanced years. They are individuals who worked as unskilled or semiskilled laborers, domestic workers, or worked in jobs not covered until recently by Social Security. Their needs in old age are clear-cut and absolute.

Downwardly Mobile Elderly
The downwardly mobile elderly, on the other hand, are assumed to closely correspond to individuals who were previously middle or lower middle class prior to old age. With the onset of old age, they find themselves threatened with poverty or near poverty. The downwardly mobile elderly experience need on the basis of a sense of relative depri-
vation. They attempt to maintain a life-style based largely on their past experiences. They seek to accomplish this with limited success through the marshaling of public sources of support. Their own private resources are limited.

**Integrated Elderly**
The integrated elderly are assumed to be previously middle- and upper-middle-class individuals. They represent a class of individuals who in old age are able to hold onto some of the key determinants of status maintenance, such as property ownership, essential knowledge and skills, and positions of community influence. Due to their higher economic status prior to old age, they are able to marshal both the private and public resources necessary for the maintenance of their socioeconomic position. It is hypothesized that due to their maintenance of socioeconomic status, this class of individuals is more likely to maintain those social values, roles, and group memberships, both formal and informal, which constitute the ties necessary for social integration.

A Three-Tiered System of Benefits to the Elderly

Since earnings from work constitute the primary source of income for most individuals, the cessation of these earnings upon retirement imposes an economic hardship for most elderly which society has sought to ameliorate through a variety of public and private programs. This network of programs is comprised primarily of income-maintenance measures supplemented by health insurance and social service programs. This network is comprised of three tiers, or levels, of support. The first tier consists of means-tested welfare programs such as Supplemental Security Income, Medicaid, and Title XX services for the marginal elderly. The second tier involves the compulsory, earnings-related Social Security program; the Medicare health insurance program for Social Security recipients; and the universal Older Americans Act social service programs for the largest group of elderly, the downwardly mobile. The third tier involves publicly supported benefits for the integrated elderly. The benefits for this group come in the form of both straight public transfers, publicly supported and regulated “private” provisions to the elderly such as private pension plans, and various tax exclusions and benefits which serve to supplement and fill the gaps left by Social Security and Medicare. By combining publicly supported “private” benefit schemes with Social Security and Medicare, the integrated elderly are able to resolve most, if not all, the economic hardships associated with old age.
Each tier reflects a separate set of policy objectives, which are in turn reflective of different policy constituencies or classes of elderly beneficiaries. Each tier, through the use of public policy as an intervening variable, seeks to maintain a certain level or “minimum” of government support consonant with the elderly individual’s prior socioeconomic status. The policy objective for the marginal elderly is to ensure subsistence. The policy objective for the downwardly mobile elderly is to provide a cushion of benefits to prevent a slide into poverty and to maintain some comparability between pre- and postretirement lifestyles and socioeconomic status. Such policies seek to ensure a measure of social adequacy in benefit levels. The policy objective sought for the integrated elderly is the maintenance of preretirement lifestyles and socioeconomic position. It should be understood that most of these policies cut across at least one or all classes of elderly. The point of suggesting three distinct classes of beneficiaries is to identify the “primary” target population for each policy measure.

Income-Transfer Programs
In further developing this notion of elderly policy measures and corresponding classes of elderly beneficiaries, the three major areas of government support for the elderly which are examined include the following: (a) income-transfer programs, (b) health care, and (c) personal social services. The concept of three tiers of government intervention and of classes of elderly beneficiaries is applied to each policy area. Accordingly, income-transfer programs to the elderly are seen as being composed of three tiers of support: (a) means-tested programs for the marginal elderly; (b) compulsory earnings-related Social Security for the largest segment of the elderly population, the downwardly mobile elderly; and (c) public and private pensions, savings plans, and tax benefits for the integrated or high-income elderly.

The central income-transfer measure for the marginal elderly is Supplemental Security Income (SSI); SSI is a means-tested measure, and as such, beneficiaries must meet certain income and asset standards. The enactment of the SSI program in 1972 replaced a previously state-directed public assistance income-transfer program with a single federally financed and operated one administered by the Social Security Administration. The SSI established a common minimum income benefit for the marginal or poor elderly. As of July 1981, the guaranteed monthly income was $265 for an individual and $397 for a couple. States have the option of supplementing the federal benefit and must do so where recipients would receive less under SSI than the previous federal, state, and local system. While establishing a minimum floor of benefits for the poor elderly, the “welfare” of the SSI recipients in the states is still highly uneven. For example, after the implementation of the SSI program in 1974, 7.8 percent and 36.3 percent, respectively, of
the SSI adult assistance population remained in poverty in California and New York. This compared to an 85.5 percent and 87.5 percent poverty rate for the SSI adult assistance population living, respectively, in Mississippi and Texas.\textsuperscript{20} The majority of the elderly public assistance population remains in poverty despite the implementation of the SSI program: "... aged persons living in nuclear families with income at or above the poverty line increased only from 30 percent in 1973 to 34 percent in 1974."\textsuperscript{21} The marginal elderly are guaranteed the most meager subsistence under the SSI welfare income-transfer program.

The second tier of income support for the elderly is Social Security. Presently 90 percent of the work force is covered by old age, survivors, and disability insurance, or what is known as Social Security. In 1981, the Social Security program collected contributions from 100 million workers and their employers and paid approximately $120 billion in benefits to 36 million people, the majority of whom were elderly. The average monthly Social Security benefit amounts for an individual and couple in July 1981 were $374 and $640, respectively.\textsuperscript{22} The term "downwardly mobile elderly" includes the majority of Social Security recipients who earn the average wage. This group relies on the Social Security check and whatever private savings they have accumulated for their economic support in old age. For the downwardly mobile elderly Social Security is a guarantee against falling into absolute poverty in old age. Robert Ball, former Social Security Commissioner, estimates that without Social Security some 60 percent of the elderly would fall into poverty.\textsuperscript{23}

The third tier of income-transfer programs for the elderly involves the integrated elderly. They are elderly individuals who receive a combination of governmentally supported public and/or private pensions in addition to their Social Security check. They also receive cash benefits from government-supported private savings plans and favorable tax policies. Coverage of private retirement plans doubled between 1950 and 1974 from 22 percent to 44 percent of the private labor force.\textsuperscript{24} By 1974, of 19.7 million old age and survivor recipients, 6.4 million were receiving benefits from private pension plans. Private pension plans tend to go to average and above-average wage earners.\textsuperscript{25} One of the obvious results of private pensions is that they serve to supplement the Social Security benefits of middle- and high-income workers. Munnell notes that "a man retiring in June 1976 who had earned in all years the maximum earnings taxable for Social Security received a Social Security benefit equivalent to 31 percent of preretirement (1975) earnings. According to a study by the Bankers Trust Company, a male worker received an additional 37 percent of previous earnings in private pension plans."\textsuperscript{26} In 1976 the estimated income of dual pensions was $10,050, compared to $6,400 for elderly families with only Social Security.\textsuperscript{27} The high-income worker with Social Security, a private pension
plan, and asset income from a lifetime of investment was protected against a serious loss of income in old age. Robert Ball estimates that in 1978 approved private pension plans were subsidized by about $10 billion a year. This figure is for the amount of taxes that would have been paid if the tax exemptions had not been provided. In contrast, the federal share of the expenditures for all elderly on SSI amounted to approximately 2.5 billion in 1979.

This third tier of income support for the integrated or high-income elderly also involves the supplementing of Social Security benefits with other public pension benefits. It is estimated that 40 percent of all civil service pensioners receive cash benefits from Social Security. In 1976 some 60 percent of state and local retirement system beneficiaries were also covered by Social Security. Skolnick estimated that 40 percent of all railroad retirement beneficiaries were receiving Social Security. The high incidence of multiple public pension benefits also applies to many federal government employees and veterans. Public employee, railroad, and military pensions accounted for an estimated $34 billion in federal expenditures in 1978.

Another form of income transfer that applies primarily to the integrated elderly are the voluntary savings and insurance plans authorized by the 1974 pension legislation. The Individual Retirement Accounts (IRAs) and Keogh plans are subsidized by the government through foregone taxes, adding about 20–30 percent of the value of the individual contributions. Tax policy benefits the high-income elderly in other ways also. The elderly, while they share the tax advantages of the general population, have special tax preferences. Tax advantages, such as the nontaxation of Social Security benefits, double income tax exemptions for individuals sixty-five and over, property tax reductions, and preferential treatment on the sale of a home ($100,000 tax free), yield economic benefits that go primarily to high-income elderly. Tax preferences amount to subsidies to an affected group, in this case to the high-income elderly. In 1974 the three major tax preferences for the elderly, the additional exemption, the retirement income credit, and the exclusion of Social Security from taxable income, amounted to an excess of $4 billion in revenues foregone to the federal government. These tax preferences, in conjunction with private and public pension supplements to Social Security, serve to ensure the economic position of the higher-income elderly, or what are referred to here as the integrated elderly.

**Health Care Programs**

Health care programs for the elderly are also comprised of three tiers of support. On the bottom tier we have the welfare Medicaid program, in the middle the Medicare program, and on the top tier a combination of Medicare and private health insurance measures designed to provide
comprehensive coverage. Each tier of benefits corresponds to the three classes of elderly beneficiaries—the marginal, downwardly mobile, and integrated elderly.

The Medicaid program is a means-tested program. Eligibility is linked to public assistance and shares the shortcomings and complexities of that system. Currently an estimated 30 percent of Medicaid expenditures are directed to the marginal elderly primarily in the form of institutional care, both nursing homes and hospitals. Medicaid paid for 39 percent of nursing-home costs for persons sixty-five and over in 1978. Some 13.4 percent of the total personal health care expenditures financed by public programs for individuals sixty-five and over comes from Medicaid.37 The central issues pertaining to Medicaid coverage for the marginal or poor elderly are issues of eligibility for Medicaid coverage and type and availability of various types of health care provisions.

The problems associated with eligibility for Medicaid coverage are multiple. First of all, while states cover all Aid to Families with Dependent Children (AFDC), not all SSI recipients are eligible. Some fifteen states opted to use the more restrictive state Medicaid eligibility requirements of 1972.38 This provision was allowed to offset the anticipated influx of the SSI recipients resulting from the passage of the SSI program in 1974. Second, it must be remembered that not all elderly who are eligible for SSI, and thus for Medicaid, participate in the SSI program. The participation rate of elderly eligibles in the SSI program is believed to be approximately 55 percent.39 In addition to public assistance recipients, states may extend coverage to the medically needy—individuals whose incomes after medical expenses are less than 133 1/3 percent of the AFDC eligibility level. Only twenty-eight states provide coverage to the medically needy.40 Davidson and Marmor found that in a majority of the states claiming to serve the medically needy, the income test was as severe or more severe than the SSI income test for the poor elderly.41

What is the outcome of this maze of Medicaid eligibility guidelines? First, Medicaid does provide substantial and important assistance to the marginal elderly. However, the provision of this assistance is highly incomplete and uneven. Medicaid expenditures are concentrated in the wealthier states. In 1973, New York, Michigan, California, Illinois, and Pennsylvania accounted for 50 percent of all Medicaid expenditures in the country.42 The unevenness is further depicted in an examination of Medicaid participation rates among the poor. Using a ratio based on Medicaid recipients to the aged poor, one found in 1974 that the ratio varies from .24 in West Virginia to 2.82 in California.43 Finally, despite Medicaid, the elderly poor still spend more out-of-pocket than do the nonpoor elderly. Feder and Holahan note that "... families with incomes above 'near poverty' ($2,600 for an individual in
1970) spent 5.9 percent of their incomes on medical care and insurance, families with lower incomes averaged 12.3 percent.\textsuperscript{44}

A second major shortcoming of Medicaid is its preoccupation with funding institutional care. The result is poor care and high costs. It has been estimated that between 10 and 25 percent of the institutionalized elderly population could live in the community if appropriate services were available.\textsuperscript{45} In 1969, 13 percent of the nursing home residents used Medicaid funds as their primary source of payment. By 1977 this had increased to 48 percent. These costs consume 41 percent of every Medicaid dollar and 74 percent of the elderly Medicaid dollar.\textsuperscript{46} Medicare by comparison accounted for only 2 percent of the residents in nursing homes. In contrast to the focus on institutional care, only 1 percent of Medicaid expenditures went to home health services in 1978, and 80 percent of these expenditures went to the state of New York.\textsuperscript{47} This bias toward institutional care is in part also reflected in the finding by Davis and Schoen that “aged Medicaid recipients averaged 4.6 visits in ambulatory settings, considerably less than the 5.8 average of the entire elderly population.”\textsuperscript{48} The result of Medicaid’s stance toward the health care needs of the marginal elderly is both inadequate coverage of necessary health care expenditures and an unwarranted bias toward the provision of institutional as opposed to home-based care.

The Medicare program is directed primarily to the nonpoor elderly. Within that group the largest class of beneficiaries consists of the downwardly mobile elderly—the middle and lower middle class. Medicare constitutes a second tier of support in policies addressing health care needs of the elderly.

Medicare eligibility is nearly universal. Individuals are eligible to receive benefits if they are sixty-five or over and receiving or entitled to receive Social Security or railroad retirement benefits. In order to receive Part A benefits, the elderly must pay $160 deductible for the first sixty days of hospital care and $40 per day for the sixty-first through the ninetieth day in the hospital. Under Part B, Supplemental Medicare Insurance (SMI), enrollees pay a monthly premium which was $8.70 as of July 1979.\textsuperscript{49} The SMI portion covers physician services, and all SMI services are subject to an annual deductible and co-insurance.

The distribution of Medicare benefits demonstrates persistent variation based on income. The distribution closely reflects the class patterns of elderly beneficiaries suggested in this article. The National Opinion Research Center’s 1970 survey of the distribution of Medicare expenditures reported data in three broad classes of elderly recipients. The survey suggested that per capita Medicare expenditures are about 70 percent higher for elderly with family incomes above $11,000 than for the elderly with incomes below $6,000. Per capita hospital expenditures are twice as high for the highest income class as for the lowest
income class. The distribution of benefits is the inverse of what would be expected based on the probable incidence of need for health care resources. Medical survey data from 1968 found that Medicare SMI reimbursements for families with incomes above $15,000 were $160 per person, compared to $79 per person for families with incomes below $5,000. In addition, physician visits have been found to increase uniformly with income. Davis and Schoen note that "among the elderly with an average number of days of disability, the lowest users of physicians' services were those with incomes below $5,000, who averaged 6.6 visits annually; the highest were people with incomes above $15,000, who visited physicians 9.5 times a year, or 44 percent more frequently.

There are a number of factors that no doubt help account for this development in the distribution of Medicare benefits. The greatest single one is the reliance on a uniform cost-sharing provision, co-insurance and deductibles, irrespective of ability to pay. This serves to curtail the participation rates of those who lack either the private resources or private insurance plans to pick up the costs not covered. A recent estimate of Medicare coverage of health-related costs to the elderly reveals that it covers only 30 percent of such costs. This is down from an estimate of 38 percent in 1977. Congress enacted Medicare to reduce the financial burden of medical care to the elderly. It was not intended to cover all health care costs but rather to relieve the elderly of a significant portion of their health care costs associated with hospitalization, surgery, and recovery. The difference was to be made up by private funds, a situation which prohibits many poor and near poor from full participation in the program. Increasingly, however, only those elderly individuals with private insurance policies can meet the gaps incurred by Medicare. Therefore, this is the only group which can assure itself of comprehensive health care coverage in old age.

The integrated or high-income elderly are able to ensure complete, comprehensive health care coverage through a combination of Medicare, private health insurance, and private financial resources. This combination of policy measures constitutes a third tier in health-care policies for the elderly. In many situations individuals purchase private insurance to pay some or all of the Medicare deductibles and co-insurance. In other situations unions and management may continue individual or group coverage into retirement. A conservative estimate identifies 37 percent of the personal health care costs for the elderly as coming from the private sector through a combination of private insurance and individual private outlays. Private health insurance and private financial resources are essential to ensure comprehensive health coverage in old age. The integrated or high-income elderly are the only class of elderly that can "afford" comprehensive health care through combining private resources with the public Medi-
care program. The proportion of the elderly in 1974 whose bills were paid by private insurance, along with payments by the individual, increases with income—10 percent with incomes below $2,000, 34–36 percent with incomes from $4,000 to $14,999, and 39 percent with incomes above $15,000 were served by private insurance.\textsuperscript{56} Those with the most comprehensive private insurance in old age are more likely to be white, better educated, and unionized.

What kind of private health insurance coverage do the elderly have? In 1977 an estimated 9 million, or 38.2 percent, of the elderly had no private hospital insurance. Some 13 million, or 52.9 percent, had no private surgical insurance. Additionally, only 25.3 percent of the elderly had private health insurance for office and home visits, 19.2 percent for prescribed out-of-hospital drugs, 16.9 percent for private-duty nursing, 19.9 percent for visiting nurse services, 20.4 percent for nursing home care, and only 5 percent for dental care.\textsuperscript{57} Increasingly, private insurance group coverage is being extended into retirement, with premiums often being picked up by the employer.\textsuperscript{58} Only a minority of the elderly, although a significant one, had sufficient private health insurance to complement their Medicare coverage.

In the discussion of the Medicare program, it was reported that benefits and utilization increased with income. In the discussion of the role of private insurance, the possession of comprehensive private health insurance has been seen as essential to guarantee comprehensive health coverage. A related finding to the above points concerns the general issue of access to health care coverage. For the poor or marginal elderly receiving Medicaid, access to health care providers is a central problem. Access for what we have termed the downwardly mobile elderly Medicare recipients, while less of a problem, is still a concern. It has been found that when Medicaid and Medicare fee levels are lower than those of private insurers, doctors limit the number of Medicaid patients and Medicare assignments and see private insurance patients instead.\textsuperscript{59} Not only do private health insurance patients have easier access to health care, thereby affecting who receives care generally; they also have considerable influence on the cost of care. Greenspan and Vogel argue that the private health care insurance sector, partially as a function of the tax subsidies given to it, serves to raise prices in the medical sector, thereby constraining the Medicare and Medicaid programs’ abilities to provide access to care for their beneficiaries.\textsuperscript{60} In turn, the discrepancy between private-sector costs of health care and government reimbursement levels creates a demand for private health insurance on the part of those elderly who need it to fill the Medicare coverage gaps and who can afford to purchase it. The decline in the coverage of health care costs by Medicare has been accompanied by a growing number of complementary contracts.\textsuperscript{61} The argument is that private insurance policies serve to increase overall health care costs, diminish the coverage of
Medicare and Medicaid, and, as a partial result, create a demand for private insurance policies to cover the subsequent gaps.

**Social Services**

The elderly experience a range of needs for personal social services, needs which are met either by the elderly individual, family, friends, or services from the public sector. Again it is argued that personal social services to the elderly are grouped into three tiers. On the bottom tier means-tested social services are provided to the poor or marginal elderly. Such services to the elderly are provided primarily through Title XX of the Social Security Act. The middle tier of service provision for the elderly is marked by the services provided under the universal entitlement Older Americans Act program. While the poor are a priority service population under the Older Americans Act, the primary beneficiaries of the program are nonpoor, middle- and lower-middle-class elderly. The third tier of service provision, which is directed at the higher-income integrated elderly, is comprised primarily of privately secured services. It is argued that the publicly supported income transfers of social security, public pensions, publicly supported private pensions, and tax-exclusion benefits provide the integrated or high-income elderly with sufficient income to purchase a majority of their personal social services in the private market.

Public in-kind social services to the elderly are comprised primarily of those services developed under the Older Americans Act and Title XX of the Social Security Act. These programs differ from each other on three dimensions: (a) elderly service constituency, (b) means of entitlement, and (c) nature of the social service provision.

Title XX is a program providing social services to all age groups. A priority service constituency is the poor elderly. Entitlements to services are means tested. The vast majority of Title XX services to the elderly go to the elderly receiving SSI. Title XX services provided to the marginal elderly have been called basic life-sustaining services. Gil argues that, based on status attributes, social policies involve the individual’s right of access to an array of life-sustaining and enhancing resources generated by society. In analyzing the Title XX service provisions to the SSI elderly, I found that 86 percent of those services could be grouped into what I call life-sustaining, self-care services. Self-care services seek to compensate for losses in health and the capacity for complete self-maintenance. They include services such as homemaker and chore services, home management, home-delivered meals, and adult protective services. They also include out-of-home services such as adult day care, foster care, health-related services, and institutional or residential care services. Together these services are directed at assuring a basic minimum of support for the marginal elderly but do not
which elderly assure publicly majority vices where cans as patterns seek employment of assumption request such XX backed integrative, interventions integrate and services services elderly wardly minorities. Having toward tained criterion contrast public services.66 The assumption of the program is that middle- and lower-middle-class elderly have most of their basic needs taken care of and often are seeking services to improve or maintain their past quality of life. Integrative services seek to compensate for loss of roles and positions of influence and involvement in the community. The losses might include the loss of a job, spouse, income, or community ties and roles which serve to integrate the person and give him or her a sense of belonging. Service interventions which seek to reintegrate the individual include employment and education services and new institutional outlets for socialization, such as senior centers and organizations. Access services seek to compensate for losses in ties and linkages to community institutions and resources. Service interventions include transportation, information and referral, and legal services. An analysis of the service patterns of 139 Older Americans Act Area Agencies on Aging identified the primary service provisions of agencies without Title XX resources as falling into the category of what we have called life-enhancement, integrative, and access services. For those area agencies which had obtained Title XX resources for the elderly, there was a significant shift toward the provision of basic life-maintenance services.67 Older Americans Act services have sought to provide some measure of quality of life and not mere subsistence for the downwardly mobile elderly.

The third tier of personal social services is marked by a situation where the integrated, high-income elderly secure personal social services with their own financial resources. These resources in turn are obtained through a combination of private investment and publicly backed private and public retirement income and tax-benefit programs. Having sufficient income, the integrated elderly are able to secure a majority of needed services in the private market and need not resort to publicly provided in-kind services such as those provided under Title XX or the Older Americans Act. Private health insurance policies also assure access to many health-related services for high-income elderly such as private duty nursing and visiting nurse services. This class of elderly is also more likely to be situated in an intact family system which has access itself to a broader array of financial and social resources.68

In contrast to Title XX service for the marginal elderly, Older Americans Act programs serve a largely nonpoor constituency, the downwardly mobile elderly. Entitlements to services are universal, and the only criterion necessary to prove eligibility is that one be elderly. The Older Americans Act identifies a priority for serving the poor and minorities but sees its larger mission as serving all elderly who might request its services. Until recently, service provisions for the downwardly mobile elderly have focused on life-enhancing services. The assumption of the program is that middle- and lower-middle-class elderly have most of their basic needs taken care of and often are seeking services to improve or maintain their past quality of life. Integrative services seek to compensate for loss of roles and positions of influence and involvement in the community. The losses might include the loss of a job, spouse, income, or community ties and roles which serve to integrate the person and give him or her a sense of belonging. Service interventions which seek to reintegrate the individual include employment and education services and new institutional outlets for socialization, such as senior centers and organizations. Access services seek to compensate for losses in ties and linkages to community institutions and resources. Service interventions include transportation, information and referral, and legal services. An analysis of the service patterns of 139 Older Americans Act Area Agencies on Aging identified the primary service provisions of agencies without Title XX resources as falling into the category of what we have called life-enhancement, integrative, and access services. For those area agencies which had obtained Title XX resources for the elderly, there was a significant shift toward the provision of basic life-maintenance services. Older Americans Act services have sought to provide some measure of quality of life and not mere subsistence for the downwardly mobile elderly.

The third tier of personal social services is marked by a situation where the integrated, high-income elderly secure personal social services with their own financial resources. These resources in turn are obtained through a combination of private investment and publicly backed private and public retirement income and tax-benefit programs. Having sufficient income, the integrated elderly are able to secure a majority of needed services in the private market and need not resort to publicly provided in-kind services such as those provided under Title XX or the Older Americans Act. Private health insurance policies also assure access to many health-related services for high-income elderly such as private duty nursing and visiting nurse services. This class of elderly is also more likely to be situated in an intact family system which has access itself to a broader array of financial and social resources.
Social Policy and Social Integration of the Elderly

As the term “integrated elderly” implies, the high-income elderly are more likely to be socially integrated than other classes of elderly. The combination of public policy benefits and private resources for the high-income elderly helps to assure the maintenance of their prior socioeconomic status in retirement. Socioeconomic status, as Cutler has noted, is one of the most consistent correlates of social participation. The research of Rose, Tissue, and Hyman and Wright links socioeconomic status with frequency of participation in formal organizations. Lower-class individuals are more often outside the reach of formal social networks. Liang notes that since socioeconomic status is also correlated with health status and satisfaction with financial standing, “it could be assumed those individuals with lower incomes would have less access to activities which require money and transportation and, obviously, those individuals who believe they are too sick to participate in activities will not likely be active.” Rose, in examining class differences among the elderly, found that in relation to the lower class, the middle class is: “a) less likely to have a problem of interpersonal relationships, and less likely to have relationships disrupted by old age; b) more likely to have a subjective sense that old age has not brought them ill health or unhappiness; and c) less likely to have problems, of course, connected with adequate income.” The Rose sample of middle-class elderly included individuals who identified themselves as upper middle class and above. As such, they correspond with what we have termed the high-income or integrated elderly. The integrated elderly assisted by public policy interventions and private resources are likely to experience the least disruption in their transition into old age.

Social Class and Social Need among the Elderly

The development of this three-tier benefit approach to the elderly is in part a function of how need is defined. How one defines entitlements to meet those needs is, in turn, related to political considerations. Townsend identifies perceptions of need based on: (a) objective deprivation, (b) subjective or relative deprivation, and (c) conventionally acknowledged deprivation. To this list a fourth view of deprivation or need can be added: universal deprivation.

Objective Deprivation
Objective deprivation is based on actual objective losses and absolute
need. The most obvious measure of objective need is income, that is, sufficient income to raise oneself above poverty and assure a basic standard of well-being. Another measure is access to comprehensive health care and social services. The poor or marginal elderly have the greatest absolute need for income, health care, and social services. However, they lack, as a class, the status, political resources, and organizational capacity necessary to obtain adequate benefits.

**Subjective-Relative Deprivation**
Subjective deprivation is the counterpart of the concept of relative deprivation. The term “relative deprivation” was used by Stouffer and his associates and elaborated on by Merton to denote “feelings” of deprivation relative to others and not “conditions” of deprivation relative to others. It is argued that the downwardly mobile elderly experience the greatest sense of relative deprivation. This sense of deprivation leads to political ferment, which demands public welfare measures to maintain some continuity between pre- and postretirement life-styles.

The concept of relative deprivation is central to understanding the development of present-day policy measures for the elderly. It is argued that the primary target population of public policy measures for the elderly is the downwardly mobile middle- and lower-middle-class elderly. Prior to the development of the modern “welfare state,” public and private measures for the elderly were directed largely to the poor. When the middle- and lower-middle-class older worker was detached from the work force by the depression and the continuing advance of industrialization, social welfare measures focused on this extensive class of displaced elderly. A secondary and indirect beneficiary of the new policy measures for the middle-class elderly are the high-income elderly, who now reap the public benefits initially targeted to the middle- and lower-middle-class elderly, as well as other increasingly substantial tax-exclusion and income-transfer benefits.

**Conventionally Acknowledged Deprivation**
How does the concept of conventionally acknowledged deprivation fit into this analysis? Conventionally acknowledged deprivation results from a merging of individuals and societal perceptions of deprivation. Both perceptions are influenced by the status attributes of the client population. Status locates a person in the social structure and denotes “a collection of rights and duties.” Gil goes more directly to the point by saying that the effect of status is the development of an institutionalized inequality of rewards for classes of individuals with different statuses. The criteria underlying the distribution of benefits to the elderly are multiple. As mentioned earlier in this article, those criteria include status, achievement, and “need.” Government entitlements to the elderly are distributed primarily on the basis of achievement and
status and only secondarily on a criterion of objective need. Middle-class individuals who experience a sense of relative deprivation in old age are more likely to have their claims for assistance approved because of their status characteristics. The downwardly mobile elderly are seen as having earned their benefits, in contrast to those individuals who have always been poor.

**Universal Deprivation**

A fourth perception of need envisions the elderly as a class of individuals who are universally deprived. Here the elderly are seen as constituting a separate social class based on age. Consequently, elderly individuals who feel deprived are inclined to fight any attempt to distinguish degrees of deprivation within the class, that is, priorities for minorities and poor elderly. This notion of universal deprivation additionally serves to produce other effects: (a) it obscures the real objective differences in need among the elderly, (b) it obscures the persistent effects of social class on rights and entitlements to public resources in old age, and (c) it uniformly labels the elderly as a problem population and as a separate entitlement class based on age alone.

**The Need to Redistribute Public Benefits to the Elderly**

Currently there is growing concern among policy analysts and politicians about the “graying” of the federal budget. In fiscal year 1981 more than $150 billion in direct cash and in-kind benefits was provided to the elderly by the federal government. Tens of billions in tax exclusions will, in addition, be paid out to the elderly.79 In 1980 an estimated 25 percent of the federal budget went to the elderly, and based on demographic trends and current benefit structures, this is expected to reach 40 percent early in the next century80 and 63 percent by the year 2025.81 These figures and much of the discussion about the graying of the federal budget would have us believe that the elderly as a class are benefiting equally from these measures, and that, in fact, poverty in old age has disappeared.82 For example, a caption to a recent article in *Forbes Magazine* reads as follows: “The myth is that they’re sunk in poverty. The reality is that they’re living well. The trouble is there are too many of them—God Bless ’em.”83

**Reagan Administration Initiatives**

The Reagan Administration argues that government assistance to people must be reserved for those who are truly needy. However, using this
article’s conceptualization of old-age policy, Reagan Administration initiatives would seem to most severely affect the poor aged while benefiting the high-income elderly. While this analysis is tentative and cursory at this early stage of the Reagan Administration, the policy initiatives on both the budget and tax side of his overall economic plan point in that direction.

Social welfare measures to the marginal aged are being drastically cut. An expenditure cap has been placed on Medicaid. The cap calls for a 3 percent cut in expenditures for fiscal year 1982, 4 percent for 1983, and 4.5 percent for 1984. Title XX service expenditures have been cut from $2.99 billion in fiscal year 1981 to $2.4 billion in 1982. Title XX expenditures will gradually grow to $2.7 billion in fiscal year 1986. The federal matching requirement for Title XX services is being eliminated along with the specific requirements of services for welfare recipients. Enrollment for the Supplemental Security Income (SSI) program is expected to increase with the possible elimination of the Social Security minimum payment. Thousands of elderly individuals will fall between the cracks and receive coverage from neither program. Other programs benefiting the poor elderly, such as legal services, housing, and food stamps, have also been drastically cut.

The effects of Reagan Administration policy initiatives for the middle- and lower-middle-income elderly are less certain. Two characteristics of the administration’s policy toward this group of elderly which do stand out are: (a) the weakening of policy elements which target benefits to the poor elderly, and (b) evidence of a certain “political respect” for the potential clout of the middle-income elderly. The weakening of policy elements which target benefits to the poor elderly can be seen in the possible elimination of the minimum Social Security benefit, the increase in co-insurance and deductible payments associated with Medicare, and the dropping of the Older Americans Act service provision calling for the targeting of services to elderly individuals with incomes of less than 125 percent of the poverty level. Each measure may be seen as an attempt to eliminate the “welfare aspect” of programs which serve primarily lower-middle and middle-income individuals. The administration is very cautious about cutting benefits to the middle-income elderly. David Winston, writing for the Heritage Foundation in the book Mandate for Leadership, regards the elderly as a conservative constituency. Winston in all likelihood is not referring to the poor elderly, who seldom vote in large numbers. Reagan Administration trial balloons concerning cuts in Medicare, Social Security, and the Older Americans Act which would most affect middle-income elderly have met with a great deal of resistance and have to date been largely unsuccessful. Budget cuts have been made which affect the group least able to resist them politically—the poor elderly.
What about policy measures for the high-income elderly? As policy benefits to the high-income elderly come most often in the form of cash transfers or fiscal welfare, as opposed to in-kind benefits, one needs to look to the Reagan Administration tax legislation for its implications for the high-income elderly. As the overall administration tax bill resulted in a transfer of wealth to high-income individuals, it also results in tax expenditures for future high-income elderly individuals. The primary vehicle for this tax subsidy to the wealthy elderly comes in the form of the expanded-use Individual Retirement Accounts (IRAs) and retirement subsidies for the self-employed. The legislation liberalizes the class of individuals and the amount of income these individuals can put aside free from taxation for future retirement benefits.87 Designed as a savings incentive, the tax transfer amounts to an increased subsidy of the wealthy elderly. James Schulz reported on 1976 data which showed that “the only income group that has a high IRA utilization rate is the one for people with incomes over $50,000. Less than one percent of the eligible wage earners with incomes under $15,000 took advantage of the IRA opportunity in 1976.”88 Under the Reagan Administration, tax legislation—increased tax expenditures for the IRAs over the period 1982–86 will amount to $8.3 billion, with another $770 million for self-employed plans. Another area of support for the high-income elderly comes with the increased tax expenditures on the elderly person’s sale of his or her residence. The amount to be excluded for capital gains taxes has been increased under the Reagan Administration tax legislation to $125,000. Tax expenditures here amount to an estimated $301 million for fiscal years 1982–86. When these three tax measures are combined for fiscal years 1982–86, we have an estimated increased tax expenditure which benefits primarily the wealthy elderly of some $9.395 billion.89

Need to Redirect Benefits
What we have in public policy measures for the elderly, then, is a three-tiered benefit structure which employs highly political and subjective standards of entitlement: (a) a standard for the poor, (b) a standard for the middle- and lower-middle-class elderly, and (c) a standard for the high-income integrated elderly. The standard for the marginal elderly, based on maintaining a subsistence level of support, sentences several million individuals to destitution for the rest of their lives. The vast majority of public benefits are expended for the lower-middle and middle-class downwardly mobile elderly. The standard here is directed at achieving a basic level of “adequacy” and decency in old age. Public expenditures for the high-income integrated elderly are significant and growing. The standard for the high-income elderly is based on the goal of maintaining continuity between pre- and postretirement life-styles.
Such a standard for the high-income elderly raises the issue of whether or not it is in the public's interest to use billions of tax dollars to bolster high-income life-styles of an elite of American elderly when millions of others have incomes which are inadequate to the task of meeting the most basic of needs such as food, shelter, and health care.

In an effort to ensure a basic standard of adequacy for all elderly, policymakers need to critically examine the impacts of public programs for the elderly and judge the desirability of their distribution.\(^\text{90}\) We need to ask who should benefit and who is actually benefiting from the vast array of programs for the elderly. To do this, we must collect information on income and asset distribution. Policymakers must examine Medicaid and Medicare programs for barriers to comprehensive health coverage for the poor and middle-class elderly. Co-insurance and deductibles, for example, could be made sensitive to the elderly individual's ability to pay. Ways of making social service programs more efficient in targeting to the poor and near-poor elderly under Title XX and the Older Americans Act must be developed. The situation must be changed where multiple pensions and tax-free pension benefits go to an elite of high-income elderly, and tax policy as it benefits the high-income elderly must be revised. These benefits should be redistributed to the poor and near-poor elderly. A guaranteed annual income for the elderly should be developed to assure that all elderly have an adequate standard of living. Poverty and other associated socio-economic inequalities will continue to persist in old age until we commit ourselves to redistribute policy benefits to those who are truly in need.

Notes


3. I discuss a two-tier conceptualization of social services in analyzing Title XX and Older Americans Act services to the elderly (see Gary Nelson, “Contrasting Services to the Aged,” Social Service Review 54 [September 1980]: 376–89). The third tier of aged beneficiaries is conceptualized in the present article as being able, due to fiscal welfare measures, to purchase their own services on the private market.


6. Ibid.

8. Ibid., p. 990.
10. Schulz; p. 18.
14. Ibid., p. 16.
15. Ibid., p. 18.
25. Munnell, p. 22.
27. Ball, p. 395.
30. Munnell, p. 16.
31. Skolnik.
32. McMillan and Bixby, p. 5.
33. Ball, p. 392.
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42. Davis and Schoen, p. 52.
44. Ibid., p. 49.
45. Ibid.
47. Ibid., p. 19.
48. Davis and Schoen, p. 65.
50. Davis and Schoen, p. 107.
51. Ibid., p. 108.
52. Ibid., p. 111.
54. Davis and Schoen, p. 93.
55. Fischer, p. 78.
56. Feder and Holahan, p. 44.
61. Carroll and Arnett, p. 4.
64. Gil (n. 13 above), p. 16.
65. Nelson, “A Role for Title XX in the Aging Network.”
66. Nelson, “Contrasting Services to the Aged.”
67. Ibid. .

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78. Titmuss (n. 14 above).
82. Binstock.
85. Ibid.
88. Schulz (n. 7 above), pp. 130-31.