# Cross-National Studies

### Senior Advocacy Groups in International Perspective

American political scientist *Henry J. Pratt* has examined the political goals of senior advocacy groups in Europe and North America to determine "the possible effect on group behavior of national political culture and forms of government." He finds, not surprisingly, that "groups generally must accommodate to their political settings."

According to Pratt, the early manifestations of mass-based senior citizen mobilization occurred in Canada, Great Britain, Sweden, and the United States in the 1930's. "In contrast, the European continent did not see a politically-oriented senior movement until after the end of World War II."

A more significant differentiation made by Pratt is between countries having "a pragmatic, non-doctrinaire approach to politics that owes something to their common grounding in the English constitutional and common law tradition" (group 1 countries) and those which take a more ideological approach in their national policies.

Pratt places Canada, Britain and the U.S. in group 1 and most continental European countries in group 2.

Senior advocacy organizations in group 1 countries have typically taken "pragmatic, non-ideological, fairly even-tempered approaches to the system of government" and have inclined toward a "strongly non-partisan style of political advocacy." They have also adopted an "extremely broad range of . . . legislative and political concerns." "No . . . limiting definition of self-interest is evident in their officially-adopted goals . . . In avoiding commitment to any particular social or economic ideology, and also by avoiding alliance with a national political party, the leading age-advocacy groups in these countries find themselves relatively unencumbered in seeking to define, and at times also to redefine, their political goals."

In the continental European countries, on the other hand, a variety of ideologically-oriented retiree movements began to emerge mainly following World War II. They are generally more partisan than their counterparts in group 1 countries and "those active in Austria, Italy and France appear to function as a wing of those countries' political parties." A few have even tried unsuccessfully to form their own political parties. Pratt also conjectures that the range of goals adopted by these senior advocacy groups "is more narrowly circumscribed" than for their counterparts in group 1 countries.

Why the difference between group 1 and group 2 movements? To some extent Pratt explains it by historical experience. In many group 2 countries leaders from the leftist-oriented anti-Nazi movements came to power following the war and helped create small voluntary organizations of various kinds, including pensioners' organizations. A more general explanation, however, links senior advocacy groups to the political structure of their countries. Thus, in group 2 countries where multi-party systems predominate as a result of proportional representation in the legislatures, "parties must differentiate themselves one from another or else risk losing voter support, and ideology becomes an important means for accomplishing this end." It is in the interest of senior advocacy groups to help shape the content of a party's ideology and build "support for senior citizen issues among party activists at all levels." In multi-party systems their points of view then stand a good chance of receiving some representation in the legislature. On the other hand, in group 1 countries single member districts are the pattern where no more than one person can be elected at a time. Two party systems will then predominate, and it becomes dysfunctional for senior advocacy groups to "place all their eggs in one basket" by strongly supporting one group over another.

Thus, senior advocacy groups have generally adapted well to the political environment in which they find themselves. Both advocacy styles carry with them some disadvantages, however. In group 2 countries, for example, "a political party alliance can prove seriously disruptive if the needs of the party are allowed to take precedence over the objectives of rank and file members" (of senior advocacy groups). In group 1 countries, the broad range of goals pursued may dissipate energies, weakening the political influence of senior advocacy groups. (Henry J. Pratt, "Political Aging Advocacy Groups: An International Perspective," [Detroit: Wayne State University], paper presented at the International Congress of Gerontology, New York, July 1985).

### Long-Term Care Facilities in France and U.S. Serving Increasingly Dependent Populations

Because of important differences in the types of institutional care facilities available in various developed nations, as well as in the terminology used to define them, systematic cross-national comparisons of the characteristics of long-term care residents are very rare. Now, however, *Pamela Doty* of the U.S. Health Care Financing Administration has been able to systematically compare the characteristics of the clientele served in American nursing homes with those in French institutions. She concludes that the development of the modern nursing home as a medically oriented long-term care facility is an appropriate response to the increasing functional dependencies of those it serves.

Doty's analysis revealed, not surprisingly, that residents of U.S. nursing homes in 1977 were significantly more functionally dependent than were residents in non-medical French retirement homes and "hospices" that year. A full 58% of French residents of retirement homes and hospices in 1977 had no personal care dependencies, compared to only 9.6% of U.S. nursing home residents.

However, when comparing residents in French medically oriented facilities in 1982 with those in American "skilled nursing facilities" in 1984, Doty found roughly comparable—and very high—levels of dependency. For example, 73% of the residents in French facilities, and specifically 84% of those in long-stay (long sejour) facilities, required assistance with mobility, as did 82% of those in U.S. skilled nursing facilities, *i.e.*, only 18% of the latter could walk independently. Similarly, 57% of residents in French facilities required care for incontinence, compared with 48% of those in the U.S. And 56% of the residents in American skilled nursing facilities were mentally confused, as were 45% of those in French institutions. These data indicate that the level of care provided in medicalized facilities in France is equivalent to that offered in skilled nursing facilities in the U.S.

These data also suggest that the populations served in both the U.S. and France long-term care facilities have become increasingly dependent since 1977. Between 1977 and 1982 in France, due to the increasing frailty of their clientele, many non-medical retirement homes and "hospices" were converted into medically oriented long-stay facilities or partially medicalized through the addition of "medical cure sections" within residential facilities. In the U.S., a small scale survey carried out by the Government Accounting Office has also found increasing dependency levels among nursing home residents.

Overall, these studies suggest that the medical orientation of today's nursing homes is a result of increasing dependency, the prevalence of dementia, and the need for nursing and personal care services by the elderly who enter these facilities. *Doty* concludes that those who have been critical of the use of the "medical model" in institutional care ought to look closely at changing characteristics and needs of nursing home residents.

Doty used several sources of national data in making her comparisons—all either full censuses or statistically representative samples of elderly institutional residents. For the U.S., these were: (1) the U.S. 1977 National Nursing Home Survey, which covered both the "skilled nursing" level of care and the less medically intensive "intermediate care level;" and (2) 1984 data from the Medicare/Medicaid Automated Certification System covering residents in "skilled nursing facilities." For France, these were: (1) a 1977 survey by CREDOC focusing on the elderly in what were primarily non-medical residential facilities," and (2) a 1982 survey by CNAMTS covering almost 100,000 persons in 1,658 medical institutions or newly "medicalized" beds in residential facilities. (Pamela Doty, "Comparative Characteristics of the Institutionalized Elderly Cross-Nationally U.S. vs. France," paper prepared as part of the forthcoming Comparative Study of Long-Term Care Policies conducted for the International Society Security Association).

**Long Life** Continued from Page 11

### Aging as Progress

As *Dr. Leonard Hayflick* (U.S.) concluded in his presentation, our present concern with the growing number of elderly people and the impact that this will have on many of our health, economic and other institutions risks obscuring at least one major fact—that many older persons alive today are testimony to the success of the medical, public health, economic, social and educational advances that have been made in the last 100 years.

However, just as the conference participants were agreed that no single variable can be a predictor of longevity, so was there a consensus that no single intervention strategy can be developed to offset the host of needs future groups of the aged will present. Complex strategies are called for.

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