JUSTICE FOR GERONTOLOGICAL POPULATIONS: A META-ANALYSIS OF SOCIAL WELFARE

By: Linda Openshaw, Elizabeth McLane, and Andrew McLane

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Linda Openshaw, Elizabeth McLane, & Andrew McLane

Texas A&M University – Commerce

Abstract

Recent trends in the growing gerontological population make the expansions of social welfare and safety net programs ever more pressing. Budget cuts and political clamoring to end, or severely cut entitlement programs, once meant for the poorest of our society, puts millions of older adults in jeopardy. The present meta-analysis examines the trends in social welfare and the need for promoting social justice for gerontological populations.

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In the year 2011, many in the Baby Boomer generation became ages 65 and older. As this population of the U.S. ages, the number of people relying on entitlement/welfare programs will continue to grow rapidly (U.S. Census Bureau, 2014). Generally, when people discuss Welfare programs, it conjures images of so-called "Welfare Queens" with many dependents, unwilling to work and costing additional expenses for tax-payers. Consider the following: "In 2010, there were 40.3 million people aged 65 and older, 12 times the number in 1900" (U.S. Census Bureau, 2014, p. 3). This population is expected to reach 20.9% of the total population in 2050. This translates into greater numbers of people needing long term care, assistance with medications, food supplement programs, and overall increases in medical expenses and other programs. Because of the common misconception of entitlement program abuse, many representatives face pressure from their respective constituents to decrease spending in social services. However, according to the United States Government Accountability Office, millions of senior citizens who depend on social service funding through programs like the Oder Americans Act, are not receiving adequate resources (Jeszeck, 2015). These resources, which include access to nutrition, home health services, and transportation are supposed to be funded by Title III grants under the Older Americans Act. However, despite the elderly, specifically those aged 65 or older, becoming the fastest growing demographic in the United States, the Older Americans Act and other senior care entitlements, starting with the financial crisis in 2008, have been casualties of budget cuts in, recent years (Levine, 2013; Jeszeck, 2015).

According to Richtman (2016), the chair for Leadership Council of Aging Organizations, due to a decrease in employer-sponsored retirement benefits and pensions, one in six of those

aged 65 and older, are forced to cope with hunger, do not receive proper preventative medical care, and do not have access to transportation. Because of the growing number of elderly requiring services and the budget cuts to the programs that provide them, the Government Accountability Office conducted a study concluding that "more should be done in order to meet the needs" of our country's senior citizens (Jeszeck, 2015). However, the ever increasing national income and the uncertainty in social, political, and economic systems have augmented the demands of social welfare today (Suh Chen, & Hsiao, 2015). Making social welfare a top priory in government and the social environment.

A Brief Historical Overview of Social Welfare

Social Welfare, a system whereby the most vulnerable in our society receive assistance, has been shaped by changing economic trends, traditions, and changes in values over time. From America's inception, there has been concern with the general well being and prosperity of its people. However, the role and size of government has evolved with the nation; changing from a rural society with a simple economy, to bustling cities, well connected with the rest of the world. Industrialization created a need for a continual flow of income in order to provide for a family (Historical Development, n.d.). Thus, changing what social welfare looks like, today.

Social welfare dates back to 1785 with the federal government setting aside land for public education (Merriam, 1953). As early as 1798, Congress established a system of health insurance, taking compulsory payments from merchant seamen wages (Merriam, 1953). In 1935, the United States implemented the following programs: "Social Security Old-Age Insurance; Unemployment Insurance; and Public Assistance programs for needy aged, and blind (replaced by the SSI program in 1972); and Aid to Families with Dependent Children (replaced with block

grants for Temporary Assistance for Needy Families in 1996)" (Historical Development, n.d.). In 1934 the first retirement system was developed under the Railroad Retirement Act. In 1937, the United States implemented the Housing Act, creating a system of government subsidies for families living in poverty. Several years later the Social Security Old-Age and Survivors Insurance program was implemented. Aid to the totally disabled, later rolled into the Supplemental Security Insurance program in 1972 wasn't developed until 1950 (Historical Development, n.d.). In 1956, President Dwight D. Eisenhower developed amendments to the Social Security Act, creating Social Security Disability Insurance. The predecessor to Medicaid was signed into law on 1960 and coined the Medical Assistance for the Aged (Historical Development, n.d.). Food stamps was then established in 1964 and Medicare and Medicaid were signed into law in 1965.

In the 19th century, the responsibility for many programs of social welfare would transition to the individual states and later back to the federal government due to the growing complexity of our society and interdependence on a global economic system. However, despite this, many of the social welfare programs (e.g. food stamps or TANF) are still managed by state and local municipalities.

The Great Depression

One of the most influential events in our history that has altered social welfare, is the Great Depression of 1929. Prior to the Great Depression, millions of elderly, people with disabilities, and single women with children, were already living in poverty. These numbers would later grow exponentially, leaving many without food, water, or shelter. In fact, the Great Depression left a significant impact on nearly every American and industry, creating the

foundation of modern social welfare. Similar to the depressions of 1873 and 1892, the Great Depression depleted the nation's first line of defenses (e.g. modest savings, insurance funds, and building and loan assets) within six months and notably strained the safety nets provided by religious, familial, and cultural institutions that had previously made America resilient to economic collapse (Ronald Paul, Elizabeth, & John, 1996). Many charities and state programs were quickly depleted, shifting the role of social welfare from local municipalities, to the states, and then back to the federal government (Merriam, 1953). According to Merriam, (1953):

> By March 1933, it had become generally recognized that the Federal Government must take direct responsibility for relief. The Civilian Conservation Corps was created on March 31 to provide useful work for young people. In May the Federal Emergency Relief Administration was established and given authority to make grants to the States for both work relief and direct relief. The FERA exerted a lasting influence on the administration of relief in the States through its requirement that Federal funds must be publicly administered and its encouragement of relief payments in cash rather than in kind (p. 5).

In 1934, President Roosevelt addressed congress and stressed the general welfare of every man, woman, and child in their efforts of recovery. This led to the formation of the Committee of Economic Security. The recommendations from this special committee would later lead to the formation of the Social Security Act and related programs in 1935 (Merriam, 1953).

Social Security Act

The Social Security Act was signed into law August 14, 1935. This act was a first step in solidifying the federal government’s role in social welfare policy (Merriam, 1953). "The Social Security Act was enacted, in part, to help ensure that older Americans would have adequate

retirement incomes and would not have to depend on welfare" (Dodaro, 2015, p. 3).This law also established insurance programs at the national level in order to meet the threats of old age and unemployment in America. This development was essential since many in the Great Depression had lost their lifetime savings and employment. The Social Security Act provided federal grants to states supplementing the income of citizens who were either ineligible for Social Security or who were impoverished below a basic standard of living. The aim of the federal government was to empower the states to adopt the programs created, giving the governance of social welfare back to the states. However, today, this is shared by federal, state, and local municipalities.

Social Security in today's world, continues to be the foundation for retirement security despite threats of implosion (Dodaro, 2015). The program provides American workers and their families with insurance benefits for retirement, disability, and survivor's insurance. Americans earn these benefits by working and paying into the system. "Over the program's 82-year history, it has collected roughly $19.9 trillion and paid out $17.1 trillion, leaving asset reserves of more than $2.8 trillion at the end of 2016 in its two trust funds" (Mnuchin, Acosta, Price, & Berryhill, 2017).

Social Security benefits continue to alleviate poverty rates among the elderly, and provide financial security to survivors, workers with disabilities, and their families. However, shifts in demographics associated with age, and the effects of the 2007 to 2009 recession, have stifled Social Security (Dodaro, 2015). More precisely, the costs associated with the Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) programs have eroded trust funds and exceeded tax revenues (Dodaro, 2015). Once these funds are depleted, many who rely on these programs will no longer receive benefits in full or on a timely basis; creating greater financial

burden on a population relying on fixed incomes. Lawmakers must act soon in order to minimize the adverse impacts that running out of funding would have on vulnerable populations; including lower wage earners and those who rely on program benefits (Mnuchin et al., 2017). However, a significant challenge with Social Security program is that its yearly budget continues to outpaced by its total cost, which it has done since the year 1982 (Mnuchin et al., 2017). The programs continual struggles appear to be due to the growing number of beneficiaries outweighing those workers paying into the program (Mnuchin et al., 2017).

Supplemental Security Income

In the 1970's the Social Security Act implemented a new program called Supplemental Security Income. Provisions in the 1935 Social Security Act that were intended for the blind and the elderly in need, were later expanded in 1950 to include more people with disabilities (Social Security Administration, n.d.). These three populations were refereed to as "Adult Categories" and were managed by the states. However, by 1969, this system was reorganized due to variability and inconsistency between states. President Nixon sought to "bring reason, order, and purpose into a tangle of overlapping programs" and combined them into the Social Security Act. Adult Categories were later federalized and turned into what we now call Supplement Security Income (Social Security Administration, n.d.). These benefits are paid to those who are blind, disabled, or at least 65 years of age and have limited incomes/resources (Social Security Administration, 2017). Social Security Income differs from Social Security benefits by the following:

- Social Security benefits are payed to those who are "insured" or paid into the program through their wages. Supplement Security Income is not based on prior work (Social Security Administration, 2017).
- Supplement Security income is financed through the U.S. Treasury's general fund and not through the taxes paid while working (Social Security Administration, 2017).
- Many states allow those who receive Supplemental Security income to obtain Medicaid, receive food assistance, and provide a supplemental payment to certain beneficiaries (Social Security Administration, 2017).

The program is only similar to Social Security benefits in that it is paid monthly, managed by the Social Security Act, and has similar medical standards for a disability. However, these standards are separate for children ages from birth to the age of 18 (Social Security Administration, 2017).

The Older Americans Act

The Older Americans Act established in 1965, was designed to administer services to the elders of the United States population in order to provide them with the ability to stay at home and within their respective neighborhoods. Most of the services for the Older Americans Act are provided in the Title III section which consists of at least six additional relevant subcategories outlining what older Americans are entitled to receive (Richtman, 2016). Title III section B allows grant funding to be allocated toward “supportive services and centers,” such as “transportation,” “in-home chore services,” and “adult day care.” Section C1 provides funding for meals in places such as “senior centers.” Section C2 allocates grant money to programs that provide food and “nutritional services” to the elderly that are unable to leave their homes. Section D provides preventative medical care such as vaccines and general healthcare

maintenance. Finally, section E allots grant funds to care-givers of those that struggle with chronic ailments or are disabled (Richtman, 2016). Further Titles under the Older Americans Act, provide additional funding for Native Americans, senior abuse awareness, and technological advances and research for senior care. In addition to the Older Americans Act, the elderly rely heavily on Medicare, Medicaid, and Supplemental Nutrition Assistance Program as well as services for transportation; all of which have received budget cuts or have only slightly increased despite the growing demographic of elderly citizens (Older Americans Act, 2011). For example, from 2009 to 2013 the Older Americans Act suffered a five million dollar budget decrease despite facing an increase of more than seven million people in need of services (Jeszeck, 2015). Furthermore, the United States census expects an increase in elderly from today's 46 million people to 70 million by 2030, as the "Baby Boomers" get older, ninety percent of which will suffer from a "chronic disease" which may prevent them from being self-reliant (Richtman, 2015). Because of the growth in population of the elderly and a decreased budget or insufficient budget increases, the potential for a humanitarian crisis is increasing, prompting the Government Accountability Office to organize a study in 2015 that was then issued to Senator Sanders (Jeszeck, 2015). Jezseck (2015), the author of the Government Accountability Office report over the Older Americans Act, used the report to insist that further action must be taken in order to prevent the disenfranchisement of some of the United States' most vulnerable citizens. Though according to Richtman (2016), the chair of the Leadership Council of Aging Organizations, the 2017 budget signed by President Obama in April of 2016 allows for more Older Americans Act funding, it still does not provide adequate resources for the elderly, especially those in the low-income or disabled bracket. Likewise, funding for programs like Medicaid and Social Security

have only increased by roughly nine percent, which is further limited depending on the state (Secretary). In addition, this is worrisome because it illustrates the continuing trend of underfunded necessary programs with little prospect for change.

Medicare

Medicare was passed into law on July 30, 1965, but beneficiaries would have to wait one year before they were able to sign up. Today, Medicare and Social Security alone make up 42% of federal program expenditures in 2016 (Mnuchin et al., 2017). Currently, Medicare is made up of two trusts. The first, is the Hospital Insurance (HI) Trust Fund or Medicare Part A (Mnuchin et al., 2017). This helps pay for hospital stays, home health, skilled nursing, and hospice care. The Second trust, is the Supplementary Medical Insurance (SMI) Trust Fund and consists of Medicare Part B and Part D. Part B of this program, pays for services such as physician visits, outpatient hospitals, home health, and other services. Part D of this program, provides subsidized access to drug insurance coverage. According to Mnuchin et al. (2017), the HI trust will deplete in 2029 . The SMI is not expected to run out of funding due to adequate financing from general revenues and beneficiary premiums (Mnuchin et al., 2017).

Medicaid

In 1965, President Johnson would sign a bill establishing Medicare and Medicaid under Title XVIII and Title XIX of the Social Security Act (Department of Health and Human Services, 2015). At this time in history, older Americans were those most likely to be impoverished and about half of adults older than 65 had no health insurance at all (Department of Health and Human Services, 2015). The program was later expanded to include: families living in poverty,

women who are pregnant, people with disabilities, and those needing long-term care. Each state controls their own Medicaid, resulting in variability in the services offered.

Many older Americans who have few options other than to move into a skilled nursing facility, will rely heavily on Medicaid. “The number of elderly individuals in the United States who use long-term care services in both institutional and community settings is projected to increase from eight million in the year 2000 to 19 million by 2050” (Gardner & Gilleskie, (2012, p. 1082). The average annual costs of long term care in 2017 is approximately $85,775 for a semi-private room and $97,455 for a private room (Genworth, 2017). There are many variables that impact the rising cost of long term care. Several that contribute to the rising costs include: increasing costs of medical care, increases in minimum wage requirements, a shortage of qualified caregivers, and changes in employment requirements regarding insurance and overtime. The growing need for long term care solutions in the future will only lead to more restrictive criteria, making some ineligible for this program. This is especially true in the face of looming budget cuts and increasing costs of healthcare.

Qualifying: The Basics

There are several approaches in order to qualify for Medicaid. In many states, participants who receive Supplemental Security Income also qualify for Medicaid (General Medicaid Requirements, 2017). Citizens 100% under the poverty threshold are eligible for Medicaid in some states as well. However, in general, a person must be 65 years of age and older, have a permanent disability meeting the Social Security Administration's guidelines, be legally blind, pregnant, child or be the parent or guardian of a child (General Medicaid Requirements, 2017). In addition to meeting these requirements, a person must also be a citizen

or qualified non-resident, reside in the state that the application for benefits was made, and have a social security number (General Medicaid Requirements, 2017).

Another important consideration in qualifying for Medicaid, are the income guidelines. Medicaid eligibility is reserved for the medically needy and those who fit into a special income level. Income qualifications differ from state to state however, the following requirements are generally universal: “stock and bond dividends, pensions, salaries, wages, interest from bank accounts and certificates of deposit, veteran's benefits,” and other benefits, such as social security and disability payments, must not exceed $710, monthly (Financial Requirement, 2017). Other sources of income such as additional governmental assistance (e.g. SNAP, or food stamps and housing and energy assistance), are not considered for Medicaid-eligibility (Financial Requirement, 2017). Additionally, those in need of long-term care, have a higher income threshold for Medicaid-eligibility, at $2,310 per month, as they also usually receive SSI benefits. However, only 40 of the 50 states make this differentiation, capping eligibility at $710 a month (Financial Requirement, 2017).

Current Changes in Healthcare

The current outlook in today's world concerning healthcare reform appears rather bleak. With the looming threat of the Affordable Care Act being dismantled, the ongoing threat of program failure, and budget cuts, the future for many Americans is uncertain. Although there have been many attempts to “repeal and replace” the Affordable Care Act, no alternative healthcare bill has passed. One of those that was proposed in the Senate Senate on June 22, 2017 and revised on July 13, 2017, was called H.R. 1628: Better Care Reconciliation Act (BCRA). BCRA sought to repeal and replace the Affordable Care Act. This act creates substantial

alterations to how Medicaid is financed through the 2017 fiscal year. This budget reconciliation, was projected by the Congressional Budget Office (CBO), to leave 22 million Americans by the year 2026 without healthcare coverage (Bump, 2017). However, it failed to pass into law.

The healthcare debates have exposed several rifts within the Republican party, however, reforming Medicaid has widespread appeal among many in the Republican Party (Singer, Nelson, & Tipirneni, 2017). A popular proposal from President Trump's cabinet is to cap the amount of federal support for Medicaid. This would lead to each state to find "creative solutions" in order to cut costs (Singer et al., 2017). Reform of this kind will likely lead to consumer directed principles within Medicaid, in order to encourage responsibility of healthcare choices for patients and reliance on the free market (Singer et al., 2017). This translates into higher financial burden, but greater decision making in available treatments.

Under the ACA, states were given the flexibility to expand coverage under optional Medicaid expansion. This allowed coverage to be offered individuals living 138% below the poverty guidelines (Singer et al., 2017). "Of the 31 states that have expanded Medicaid under the ACA, six (Arkansas, Iowa, Michigan, Indiana, New Hampshire, and Montana) have used Section 1115 waivers to modify their Medicaid programs, allowing them to design programs that do not meet all federal regulations and permitting experimentation with Medicaid structure and administration" (Singer et al., 2017 P. 1593). Many of these states use the following consumer directed principles: Premiums, cost sharing, health savings accounts, and healthy behavior incentives. Singer et al. (2017), suggests that despite the popularity of consumer directed principles, higher costs for doctor appointments, medications, and treatments can discourage the most vulnerable from attaining preventative care. Placing caps on Medicaid funding will likely

lead to more states opting to use consumer directed principles. Although this would create greater stability for the federal budget, it would place the states at a greater risk if the costs increase swiftly (Singer et al., 2017). Currently, the federal government pays approximately 55% - 100% of the total costs of care for beneficiaries on Medicaid (Goodman-Bacon & Nikpay, 2017). "Under a per capita cap, it would reimburse states at a similar rate, but only for a portion of total expenditures equal to the number of recipient's times the federally defined per capita cap. States would pay for all costs over the cap" (Goodman-Bacon & Nikpay, 2017, p. 1005). In order to balance an annual state budget, resources and services to beneficiaries would be cut, additional resources would have to allocated, or criteria to qualify for Medicaid would become more stringent (Singer et al., 2017).

Implications for Social Work Practice

The ever changing landscape of healthcare and welfare programs on the social environment and the impact on patients, creates a need for social justice at all levels of practice. Changes to insurance and welfare benefits impact those patients who are most vulnerable. According to the National Association of Social Workers (NASW) (2008) preamble, a fundamental mission for social workers is to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (p. 1). It is essential that social workers look at the social environment and the variables that create or contribute to challenges living (NASW, 2008). Assisting the elderly live a life with dignity and self-determination envelopes every value and ethical principal at some level (NASW, 2008). An important consideration for

practice is to examine how we first can honor the patient's wishes, promote quality of life, prevent abuse, and endure safety.

Justice

The social work profession has had a dual purpose which has been "to promote both human well-being and social justice" (Keenan, Limone, & Sandoval 2017, p. 19). This dual purpose sometimes interferes with "our ability to influence societal expectations" (Ginsberg, 1999, p. x) and to use the full range of possibilities for well-being and social justice across practice settings" (Keenan, Limone & Sandoval, 2017, p. 19). Social justice is identified as a core value of the social work profession according to the National Association of Social Workers (NASW) Code of Ethics. "Social workers should challenge social injustice, pursue social change to change forms of social injustice; promote sensitivity to and knowledge about diversity; and ensure access to resources, equality of opportunity, and meaningful participation in decision making for all people". (NASW *Code of Ethics*, 2015).

Social justice advocacy is usually completed on a macro level of practice. However, in applying social justice to work with elderly and disabled clients it is necessary to look at it from an individual perspective. "It may be an individual or family that' having psychosocial challenges, they get depressed or become very anxious, so it's difficult for them to function at their very best" …."on a micro level you have someone in need of an intervention to feel better, but it's difficult for them to find the time to access because they have had all these competing demands. Macro is one's inability to seek services? (Coyle, 2017, p. 12).

In a study conducted by Keenan, Limone and Sandoval (2017) social workers were asked to identify how the dual purposes of the profession are carried out with the following findings

which are very significant for the gerontological population. 1) “Social work occurs through interactive practice activities which includes organizing relationships and resources everywhere, and by creating supportive space for clients in organizations and communities; 2) creating supportive networks, seeing relationships as conduits for resources; 3) navigating systems and politics; 4) and creating an environment in which people can behave differently as they change; 5) changing mindsets; using new thinking and experiences and healing, and 6) challenging injustices everywhere and on every level”(Keenan, Limone, & Sandoval, 2017, p. 22-25).

Social workers are committed to ensuring opportunity and justice for clients and often this involves becoming involved in political processes. Political social work “alters the power dynamics in policy making through strategies such as staffing campaigns, registering and empower voters, serving in political appointees, and running for and holding elected office” (Pritzker & Lane, 2017, p. 80). Political social work is important to help ensure that social work values are carried into society. “All social workers should work together to ensure that the true experiences of those served by social work are represented within the political process” (Pritzker & Lane, 2017, p. 82).

Safety Net: The Role of Religious Institutions

Throughout American history, local groups and religious institutions have provided support in terms of services, or “safety net” resources for the less fortunate in their communities. Although this aid was not effective during the Great Depression, it is still an invaluable resource for many of the elderly who live independently or in assisted living facilities. Of these institutions of community support, none is more pervasive in American society than religion. Not only do churches provide material and financial support through donations, but they extend their

services to emotional support, as well. Even as younger generations tend to adopt a more secular system of beliefs, religion, particularly Christianity remains a foundation of American culture with about 3 in 4 people identifying as Christian (Gollnick & Chinn, 2017). As senior citizens, many of which have grown up with a religious background, fall through the bureaucratic cracks, preventing them from obtaining government assistance, the church is often their only line of defense against hunger. In addition to meals, many churches also conduct clothing drives which they use to help clothe children and the elderly.

Unfortunately, as many people come to terms with their own mortality, they sometimes face regret, depression, and anxiety. These challenges become more apparent when senior citizens lack familial support or are placed in skilled-nursing facilities. Consequently, suicide rates among the elderly, are high in American society (Rushing, Corsentino, Hames, Sachs-Ericsson,& Steffens, 2013). For instance, for every 4 seniors who attempt suicide, one dies (AFSP, 2017). The highest suicide rates are in males aged 45 to 65. The second highest demographic, is those that are aged 85 and older (AFSP, 2017). "Religious involvement, in particular attendance of religious functions, has been shown to be beneficially related to a number of physical and mental health outcomes, with some evidence that involvement reduces risk for mortality and protects against suicide" (Rushing, et al., 2013, p. 366). Religious institutions can offer assistance with food, transportation, clothing, and financial assistance, alleviating financial and material stressors. Religious institutions can also offer the foundations for building a strong support system and offer activities that are altruistic and rewarding.

Case Examples

One of the most rewarding aspects of long-term care and hospice work is reliving some of the patient's most precious memories with them. However, there are times the opposite is true; a focus of regret and anger. Jack, an 85 year old male with blindness and general weakness often recounted the times he went out dancing with Loraine. However, one day when asking about his overall wellbeing, led to him reviewing some of his regrets. The patient had a private room in a lavish nursing facility. However, he was angry. "I was told I could live in this nice place. They said all I had to do was spend down, but I didn't realize that it would mean that they would take everything I worked hard for. I have nothing for my children." In this case, healthcare professionals focused on the end goal of getting a patient placed without explaining the implications of meeting income guidelines and the overall cost of long term care.

Jackie was admitted into the hospital after being found confused and disoriented on a state highway. She was later transferred to a skilled nursing facility on Medicare after her hospital stay. The patient could not recall where she lived, where her children lived, or if she had any siblings. Going through her medical records there was a brief mentioning of a son in Wisconsin and a phone number was listed. Once the family was contacted, they discussed a significant history of urinary tract infections and symptoms of mania. The son provided Power of Attorney paperwork and asked that she be moved into a long term room "If she will stay." The patient had voluntarily left a skilled nursing facility approximately one year ago, rented an apartment, and bought a car. It would be 5 months before she attempted to reconcile her affairs with the nursing facility and her previous apartment. Similarly to previous case example, Jackie was very upset with the prospect of spending her money down in order to qualify for nursing

care. At this time she also realized that she was still paying for her apartment and private paying for a semi-private room (around $230 a day).

Eddie, a 67 year old male living in rural Texas, has several serious medical conditions including diabetes and cirrhosis of the liver. Eddie relies on his social security income and retirement in order make ends meet. His mother, who is 98, lives in the nursing home several miles away and he resides in her home. He has little family support and often times he complains that he does not have enough food. Meals on Wheels and his church are several resources available, but he is too ashamed to ask for help.

Conclusion

Although many in the voting population think harshly of welfare recipients, often criticizing them for scheming or taking advantage of "the system," a large, and growing welfare demographic is the elderly especially, as the "baby boomer" generation continues to age. However, most likely due to the general public's belief that those receiving social services are "Welfare Queens," leeching government support at the cost of tax-payers, representatives face pressure from constituents to cut funding for programs like the Older Americans Act. In addition, with the 2008 financial crisis, many employers made significant cuts to retirement packages and pension plans, leaving many senior citizens in need of food and care without resources. Likewise, Medicare has a limited dollar amount per individual despite requiring monthly premiums. Once those funds evaporate, so too does the care it provides. As the population continues to grow, and funding increases continue to be inadequate, more and more of some of the nation's elderly citizens will be left without proper medical treatment and food. In order to

warn congress of the potential humanitarian issue that future senior citizens could face, the Government Accountability Office conducted a report, requesting action.

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