Community Centers and the Elderly: an American and Israeli Comparison[1]

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Despite the various differences between community center programs for the aged in Israel and a sample of programs in America, the two groups share a dominant programmatic focus. Both reflect the centrality of social and cultural activity as a means of meeting the recreational and interactional needs of older adults.

Introduction

Despite their distinctive national contexts and varied traditions of community center work, programs for the aged in Israeli and American community centers are quite similar. A comparison of the results of a national study of programs for the elderly in Israeli *matnassim* (community centers) with the findings of a pilot study of seven American Jewish community centers hosting special activities for the elderly revealed basic programmatic similarities. Nevertheless, a number of differences between the programs also emerged. This article presents selected findings from the two studies and considers their implications for service programming for the aged in community centers.

Inquiry into the structure and character of programs for the elderly raises a number of theoretical questions, the resolution of which helps to shape the menu of program offerings:

—Should activities and services for the elderly be seen as an integral part of overall community center programming, that is, as one additional group served in an age-integrated structure? Alternatively, should programs for older adults be viewed as a separate service which specializes in meeting needs unique to the elderly?

—Are these programs to be considered a universal community service for all older people, or principally a specialized social service for aged persons with special needs?

—Should program services focus upon wellness or upon disability among their consumers?[2]

—What do the elderly themselves seek from communal service? Is their involvement generally social and recreational, with the aim of enhancing their life satisfaction, as activity theory would posit?[3] Or rather, do they seek a comprehensive service agency that gradually meets their needs as they are progressively disengaging from their previous social responsibilities?[4]

In short, should a community center program for the elderly be primarily an arena for social participation, a social agency aimed at meeting the needs of the frail, the impaired and the disen-

[1] Funding for this study was provided by a grant from the Brookdale Institute, Jerusalem.

[2] L. Lowy, "The Senior Center: A Major Community Today and Tomorrow", *Perspectives on Aging* (National Council on Aging) March–April, 1974, pp. 5–9.

[3] S. Cath, "The Orchestration of Disengagement", *International Journal of Aging and Human Development*, Vol. 6, No. 3 (1975), pp. 199–213.

[4] E. Cumming, "Engagement with an Old Theory", *International Journal of Aging and Human Development*, Vol. 6, No. 3 (1975), pp. 187–191.

gaged, or some combination of the two?[5]

Methodology

The study of Israeli programs for the aged took place in 1983–1984. Data were collected by means of a standardized survey questionnaire and field observation. Executive directors and senior staff of community centers and coordinators of programs for the elderly were queried on a range of items, including an inventory of activities offered, demographic data on participants, characteristics of the program staff and evaluation of program emphasis and function.

The study encompassed all Centers with direct administrative responsibility for hosting programs for the elderly, sixty in number, or about half of all local units associated with the Israel Association of Community Centers. The Israeli sample was thus universal. The study was sponsored by the Israel Association of Community Centers, the Brookdale Institute of Gerontology and Adult Human Development in Israel, and the Joint Distribution Committee-Israel. A full report of the findings was recently published by the Brookdale Institute.[6]

An English translation of the Israeli questionnaires was administered to a sample of American Jewish community centers in the summer of 1984. Six centers in Florida, New York, and New Jersey, and a seventh, a French-speaking program in Montreal, were contacted. The site selection was based primarily on a pre-determined travel schedule, and while the sample does not fully represent all American Jewish community centers, it nevertheless reflects a range of program types, functional levels, and communities. This pilot study is instructive, therefore, insofar as it identifies areas for further investigation of program services on behalf of the Jewish elderly in America.

A Comparison of Program Context

A glance at selected aspects of programs for the aged in Israeli and American community centers (Table 1)

[5] P. Taeitz. "Two Conceptual Models of the Senior Center". *Journal of Gerontology* Vol. 3, No. 2 (1976), pp. 219–222.

[6] H. Litwin, *Community Centers and the Aged in Israel.* Brookdale Institute of Gerontology and Adult Human Development in Israel, Jerusalem, 1985.

Table 1.
Longevity, Participation Rates, and Age Integration of Israeli and American Community Center Programs for the Aged

	Israel (N = 60)		U.S.-Canada (N = 7)	
	Average	Median	Average	Median
Years program has functioned	5.4	5	8.1	10
Total annual participation	280	150	1785	1500
Percentage of participants who:				
attend regularly	50	47	42	25
are men	33	31	22	20
are age 75 and over	23	20	28	20
Degree of program age segregation/integration[a]	7.0	—	8.4	—
Desired degree of program age segregation/integration[a]	5.4	—	5.8	—

[a] Rated by directors and senior staff on a scale of 1 to 10, where a score of one reflected age-integration in all activities and services, a score of five reflected an equal balance between age-integrated and age-specific services for the elderly, and a score of ten reflected complete age-segregation for all activities and programs for the aged.

reveals that the latter group has a longer tradition and operates with a considerably larger absolute membership base. The American Centers reported a median annual participation rate ten times larger than that of their Israeli counterparts, partially reflecting the larger catchment areas in the U.S. Proportionately, however, twice as many of the Israeli participants attend programs on a regular basis. Israeli Centers report a slightly higher proportion of men among their participants. Similar rates are reported for participation of the old-old; about a fifth of the participants in both countries are age 75 or older.

Center directors and senior staff were asked to rank the degree of age segregation of their programs for the elderly on a scale of one to ten, where a low score indicated a great degree of age integration and a high score reflected a greater degree of separation between facilities and activities for the aged and those for participants of other ages. Both the Israelis and the Americans reported a considerable degree of separation, the latter to a somewhat higher degree. When asked to prescribe the desired degree of age-integration for their Centers, the two groups of respondents yielded almost identical ratings which reflected a nearly equal balance between multi-generational activities and age-specific services for the elderly.

The strongest influence on programs in both countries was reported to be the coordinator of the program or department for the elderly (Table 2). Both groups also indicated that the executive director of the Center and the elderly participants of the program had considerable influence in shaping the direction of the program. In Israel, the executive director was seen to be slightly more influential than the participants, while in America the reverse view was expressed.

The relatively greater influence of elderly participants in the American sample is further reflected in the fact that a council of the elderly operates in almost three-quarters of the Centers (71.3 percent). The Israeli sample reported a council of the elderly in less than half the Centers (43.3 percent). Assuming that influence is best expressed through organized action, the predominance of such self-governing groups of elderly in American Jewish community centers allows for greater influence in shaping program content.

An important difference arising from national context is evident in the reported degree of influence by the local welfare department and the municipalities in shaping program context. In Israel, these governmental bodies were judged to have moderate influence; in America, these same bodies were considered to be the least influential. The findings reflect the

Table 2.
Factors that Influence the Structure and Content of Programs for the Aged[a]

Factors	Israel		U.S.-Canada	
	Average	Rank	Average	Rank
Program Coordinator	4.3	1	4.6	1
Community Center Director	3.9	2	3.3	3
Aged participants	3.6	3	4.0	2
Welfare Department	3.1	4	1.3	7
Municipality	2.9	5	1.3	7
Community Center Executive Board	2.3	6	2.3	4
Coordinators of other programs	2.2	7	1.4	6
Health services	1.7	8	1.5	5

[a] Influence was rated on a scale of one to five, where one represented no influence, three a moderate degree of influence, and five a great deal of influence.

close interaction between community centers and statutory social services in Israel; in America, the community centers operate independently of government services.

Coordinators of programs for the elderly, cited in both countries as the most influential factor in shaping programs, were similar across the samples in their age and length of employment in the job, but quite dissimilar in their educational background and conditions of employment. The median age of coordinators in Israel was 41 and 50 in America, although in both cases the ages ranged from mid-twenties to late fifties. The median length of employment in the job was four years for American coordinators and three years for the Israelis. A quarter of the latter group, however, had been employed for less than a year at the time of the survey.

The American coordinators reported a significantly higher level of educational training, with a median attainment level of a masters degree in social work and some gerontological training. Only a third of the coordinators of programs for the aged in Israeli community centers had academic degrees of any kind, the median being some amount of post-secondary schooling, usually in a teachers' training seminary. Moreover, two-thirds of the Israeli group were employed in half-time positions or less, while 85 per cent of the American coordinators were employed full-time. All of the Americans (except for one, who was salaried by the area Federation) were salaried by the community center. Half the Israeli group, on the other hand, traced their salary source to agencies or funding schemes other than the community center: the welfare office, the municipality, the public housing company (AMIDAR) or Project Renewal.

The status of programs for the aged, relative to that of other age-based programs, was also rated by senior staff. The Americans viewed their programs to be of a lower status compared with other age-based programs in the community center than did Israeli respondents (Table 3). Although this finding holds true for most of the specific areas considered (i.e. space allocated, budget, and hours of operation), it is most pronounced in the general evaluation. Eighty-three per cent of the American programs for the elderly were considered by their coordinators, in general, to be of lower status than other age-based programs, while less than a third of the Israeli staff surveyed judged their programs to have lower status.

This subjective measure may suggest something about the overall resources that are available to community center programming. While it would seem that Centers in the United States and Canada have greater resources than their Israeli counterparts, there is greater perceived imbalance in distribution of these resources to the aged. The Israeli community centers, on the other hand, with more limited resources, are perceived to distribute them more equitably among all participants.

A final point of comparison between the contexts of programs in Israel and America are the perceptions by community center staff of obstacles to the future development of programs and

Table 3.
Percentage of Community Centers in Which Staff Perceived Programs for the Aged to be of Lower Status than Other Age-Based Programs, by Program Aspect

	Percentage of Staff	
Program Aspects	Israel	U.S.-Canada
Space allotted	15.0	33.3
Budget allocated	33.3	50.0
Hours of operation	28.3	33.3
Staffing	35.6	33.3
General evaluation	30.0	83.3

services for the elderly. Both the absolute scores and relative rankings of the obstacles mentioned indicate that lack of adequate financial resources was considered the most difficult problem in both countries (Table 4). Lack of response to the program by the elderly in the community was ranked second in difficulty in both study samples, although the Israeli respondents seemed to perceive this as somewhat more serious a problem. A major difference emerged regarding the question of trained staff. The Americans viewed the lack of trained staff to be among the least of their difficulties, as may be expected from the high level of training reported among coordinators. The Israelis identified the lack of appropriately trained staff as an obstacle of moderate difficulty, third in their ranking of obstacles to the future development of their programs for the aged.

In sum, programs for the aged in community centers in Israel differ from their American counterparts principally in that they serve smaller populations, employ workers with less gerontological training, and are more dependent upon other community services to maintain their programs. Similarities emerge, nevertheless, in terms of participant characteristics, in factors which shape program content, and in perceived obstacles to program expansion. Given these similarities and differences in context, what are the points of comparison and contrast between the programs themselves?

A Comparison of Program Context

Two methods of enquiry enabled us to trace the prime patterns of community center programming for the elderly. The first was to request directors and senior personnel to list the areas of need to which they think the programs best contribute. The second was to analyze program scope, based on an inventory of activities and services actually offered in each Center. Together, these two areas of enquiry point to the dominant line of program development in community center programs for the aged.

When asked to list the specific areas (from a list of nine categories of need) in which their programs respond to the

Table 4.
Obstacles to Future Program Development, According to Community Center Staff

	Israel		U.S.-Canada	
	Average Score[a]	Rank	Average Score	Rank
Lack of adequate financial resources	3.8	1	4.1	1
Lack of response to program among the aged	3.2	2	2.4	2
Lack of trained staff to work with the aged	3.0	3	1.6	5
Lack of information concerning needs of the local elderly	2.8	4	1.6	5
Lack of coordination betweeen services at the local level	2.7	5	2.3	3
Lack of cooperation among community center staff	2.3	6	1.6	5
Lack of fit between existing program activity and social policy	2.1	7	2.0	4

[a] Rated on a scale of one to five, where a score of one indicated no difficulty, a score of three a moderate degree of difficulty, and a score of five a great deal of difficulty.

Table 5.
Perceived Contribution of Programs for the Aged to Meeting the Needs of the Elderly

Program Aspects	Israel		U.S.-Canada	
	Average Score[a]	Rank	Average Score	Rank
Providing cultural and social programs	4.3	1	3.9	1
Responding to loneliness among the elderly	3.8	2	3.9	1
Organizing elderly on behalf of themselves	3.1	3	3.3	5
Organizing community to work for the elderly	3.1	3	2.4	7
Counseling on rights of elderly	3.0	5	2.7	6
Maintaining physical health of elderly	2.6	6	3.4	4
Organizing elderly to work in community	2.4	7	2.4	7
Improving mental health among elderly	2.1	8	3.7	3
Supplying paid employment opportunities	2.0	9	2.3	9

[a] Rated on a scale of one to five, where a score of one represented no contribution, three a moderate contribution, and five a great contribution.

needs of the elderly, both American and Israeli community center personnel gave top ranking, on both absolute and relative scales, to providing cultural and social programs and responding to feelings of loneliness (Table 5). The other areas mentioned were somewhat similar in their absolute scores, but varied in their relative rankings. The second-ranked grouping of contributions by the Israelis was volunteering and community care activities; the Americans ranked their second greatest contribution as meeting health needs, both mental and physical. The greatest distinction between the two study samples with respect to specific need areas was, in fact, in the area of mental health; the Americans perceived their programs to have made a great contribution in improving the mental health of the elderly and the Israelis, a slight contribution only.

These differing contributions reflect, to some degree, the dissimilar views of the national samples with regard to health programming. The Israel Association of Community Centers has recently formulated guidelines that recommend limited involvement by community center programs for the aged in provision of health-related services, unless local health authorities (such as Kupat Holim clinics or family health stations) suggest such involvement, which they seldom do. The American Jewish community centers, with more inter-organizational autonomy, have chosen to become involved to a greater degree in health-related program services.

By dividing the list of nine need categories into three broad areas—social and recreational activity, community action and specialized services—we see that both sets of respondents considered their greatest contribution to be in the area of social and recreational programming. The Israelis ranked next their contribution in community action and, thirdly, in specialized services. The American respondents viewed these second and third rankings in reverse order.

A profile of programming was constructed on the basis of an overall inventory of activities.[7] The profile was derived from three sources of information: the number of program participants, a rate of relative participation in each program or service area (which

[7] The author thanks Danny Budowski for his assistance in developing the program profile.

took into account the population of the catchment area), and the diversity of program content, as measured by differing activities or services. The three major groupings of programs—social and recreational activity, community action, and specialized services—were scaled as either limited or comprehensive in scope. A more detailed discussion of this profile construction appears in the report of the Israeli study.[8]

The program areas of both countries that were judged to have reached comprehensive scope were compared (Table 6), and surprisingly, the distribution was almost identical. Half of each sample achieved comprehensive score in one of the three areas: in all but one of the community centers in Israel, and in all the American Centers, this area was social and recreational activity. About 28 percent in each sample achieved comprehensive scope in two program areas. In Israel, these were, for the majority of Centers, social and recreational activity and community action; the two American Centers attaining wide scope in two areas were split, one reflecting the Israeli majority pattern and the other listing social and recreational activity and specialized services. A minority of programs in both samples achieved comprehensive scope in all three areas, and slightly fewer failed to achieve comprehensive scope in any of the programming areas (the detailed list of programming areas is presented in Table 6).

Table 6.
Number of Areas in Which Community Center Programs for the Aged have Achieved Comprehensive Scope[a]

	Israel		U.S.-Canada	
Areas	N	%	N	%
None	7	11.7	1	14.3
One	27	45.0	3	42.9
Two	17	28.3	2	28.6
Three	9	15.0	1	14.3
TOTAL	60	100.0	7	100.0

[a] The three areas measured were:

1. *Social and Cultural Programming*
   - Open Recreational Activities: reading periodicals, listening to music, table games, birthday parties, other parties, Kahalat Shabbat, ethnic programs, film club.
   - Structured Courses: arts and crafts, religion and tradition, education and knowledge, creativity, physical exercise.
   - Special Activities: recreation camps, other camping, picnics, conventions, bazaars.
2. *Community Action*
   - Elderly Working for Community: remedial teaching, road safety, grandparent in kindergarten, visits to other elderly, visits to the sick, assisting with army equipment, council of elderly, helping to run center programs.
   - Community Volunteers for the Elderly: home repairs, visiting the sick, social house calls, aiding home-bound elderly, personal escorting, visiting elderly in old age institutions, distributing heating oil, helping elderly, club staff.
3. *Specialized Services*
   - Medical Programs: preventive check-ups, psychogeriatrics, dental diagnosis and treatment, hearing diagnosis and treatment, physiotherapy, speech therapy, occupational therapy, chiropody.
   - Sheltered Employment: in home, at community center, workshops, and other employment.
   - Direct Aid: hot meals, laundry services, hairdresser, bussing, sheltered housing, housework.
   - Counseling Aid: personal social services, group work, information and referral, police safety counseling.

Conclusions

Despite the various differences between community center programs for the aged in Israel and a sample of programs in America, the two groups share a dominant programmatic focus. Both reflect the centrality of social and cultural activity as a means of meeting the recreational and interactional needs of older adults. Community centers seem to have opted primarily for the model of social participation, as noted in the Introduction, in an effort to enhance the

[8] Litwin, *op. cit.*

quality of life of their aging members. Other programmatic models, reflecting remedial or maintenance aims and objectives on behalf of the impaired elderly (as befit the alternative social agency approach), are less dominant.

A look at the programs in both samples reveals that models other than the recreation model, that is, a community care program of mutual voluntary aid or a program of specialized services, have been incorporated in less than half of the Centers sponsoring programs for the elderly. Where these additional models have been instituted, furthermore, they tend to function alongside a social and cultural program base.

Given the dominant recreational emphasis of Israeli and American community center programs for the aged, it is worth considering whether or not the capacity for age-integrated activity may be increased. Since the programs have a stronger focus on ability than upon disability, there seems to be a potential for a higher degree of multi-generational contact than that which currently exists.

At the same time, thought must be given to meeting the needs of the frail and impaired. Can more Centers incorporate such specialized services while maintaining programs geared to the well elderly? Only 15 percent attempted to do so today. Indeed, can we envision a genuine continuum of care as a dominant programming mode within the community center framework? These questions need to be addressed by further development and study of various modes of programming.

As the number and proportion of elderly grow, the community center will be increasingly called upon to meet this population's expanding and changing needs. The resolution of such program dilemmas now will increase the future capacity of community centers to relate in an effective manner to all the age groups it serves, including the very old.

References

Knapp, M., "The Activity Theory of Aging: An Examination in the English Context," *The Gerontologist,* Vol. 17, No. 6, pp. 553–559.

Salamon, M. and P. Trubin, "Difficulties in Senior Center Life: Group Behaviors," *Clinical Gerontologist,* Vol. 2, No. 2, pp. 23–37.