Aging: How We Got Here and The Way Forward*

Summary

America is entering an accelerated aging crisis that has been largely ignored in policy and planning. Today's inadequate response is rooted in a half-century shift that followed the creation of Medicare and Medicaid in 1965: government funding and regulation gradually displaced local leadership, while the healthcare system evolved around institutional, standardized "factory" models (hospitals, nursing homes, and later assisted living). Those models were built on optimistic assumptions—that chronic disease would be cured, morbidity would be delayed, and institutional settings would efficiently deliver cures—that proved incorrect. Instead, chronic diseases are largely managed, not cured; older adults accumulate multiple interacting conditions that do not fit onto one-size-fits-all assembly-line care. The result is that older adults remain in the community with insufficient supports. The way forward is to rebuild aging care in the community using modern digital networks for communication, coordination, and health monitoring. Community Aging Circles has partnered with Carers UK to make the Carers UK's Jointly app available to families of trusted community organizations to implement technology-enabled, neighborhood-scale support.

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American aging has been swept along as an afterthought, when it is thought of at all, among our larger political, economic and social issues. As a result, the extreme inadequacy of our present response to aging will be a shock when it bursts into public awareness. And that reckoning is coming soon.

Families taking care of frail older members today already know that things are not okay. But with 10,000 baby boomers a day turning 80, starting from the beginning of 2026 and continuing for the next 16 years, everyone is about to know. Aging in America is about to explode into crisis. That we haven't seen it coming is the consequence of a transformation in health care over the past half-century, a transformation so incremental and so large that it has been essentially imperceptible.

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Here's what happened.

In 1965, Medicare and Medicaid—universal health insurance for people over 65 and universal health insurance for the poor—were created. In order to regulate and manage the funding streams created by these programs, government (both federal and state) gradually supplanted established local leadership in the realm of aging and aging care until that local leadership was entirely gone.

The government relief of local responsibility was well-intentioned. The nation's older citizens tended to be poor and there were not so many of them. The expectation at the time was that modern medicine would cure chronic disease in the second half of the 20th century just as we had largely conquered infectious diseases in the first half, that chronic disease would then not be a major expense, that modern health care factories (hospitals and nursing homes) would provide the setting for cures as they had with TB, and that old people would live longer and better, with delayed morbidity, until everything fell apart all at once at the end of life.

These premises turned out to be wrong. We didn't know much about aging.

Sixty years later, none of those early assumptions about the future of aging have been realized. But the vestigial understandings from those optimistic times continue to blind us to a true way forward. Today's aging generation is both our wealthiest and the costliest population cohort, and one of the largest. We don't cure chronic diseases, after all—we mitigate them. The facilities we relied on for aging care are clearly inappropriate for aging's accumulating chronic conditions.

But now, at least, we now know a lot more about aging.

The modern nursing home movement, spawned by the passage of Medicaid, congregated older people and provided funding to develop health care interventions that were disseminated through best practices. But new interventions that could be tailored to each individual did not fit onto the standardized nursing home platform that was set up to batch-process residents.

The dramatically increased number of frail older people arriving in nursing homes with their associated costs forced government to triage, selecting the frailest for care. Nursing home lengths-of-stay shortened dramatically until what had been "old folks' homes" became short-term-stay mini-hospitals, abandoning long-term care. Costs rose precipitously.

Private equity bought up nursing homes, focusing on maximizing financial returns from government reimbursement streams. Historic management by clergy and social workers was replaced by MBAs and accountants. The next generation of care workers did not want to work in these assembly-line facilities. Government reimbursements remained locked into these industrial-era institutions that had abandoned long term care. The same thing is happening with assisted living. Hospitals are extremely specialized, inappropriate settings for the complex, cumulative challenges of chronic care. Lengths of stay have shortened dramatically and today we have but 25% of the hospital beds per 100,000 as compared to 1960.

The existing system provides minimal ongoing support and guidance for chronic disease. For example, 50% of prescribed medications are taken inappropriately or not at all. Our present health care model is like a car rental business with a large fleet that the owners never maintain, but only repair. They never change the oil in the cars and only open the hood when the engine overheats and stops. The result is a very big repair shop (or hospital system). Frail older people remain in the community with inadequate supports, until they arrive at the emergency room. A week or two, and tens of thousands of dollars later, they are discharged back to a home environment unable to support them. The cycle repeats. 17% of Americans are 65+, while constitute 40% of hospital stays. As a result, we are producing frailty at a rate that the society has insufficient dollars to address. Medicare expenditures represent 45% of the projected national deficit. Both the challenge and the way forward are in the community.

The end result of this evolution is that there will soon be few acceptable long-term care options outside the home to meet the needs of 72 million aging baby boomers.

Consequently, older people will remain in the community, with their families assuming a greater role in their care. Already, one in four American adults (63 million) are family caregivers. As such, they experience stress, health risks and financial strain. In 2025, the National Council on Aging found that 80% of older households don’t have the resources to weather major financial shock such as a widowhood, serious illness or the need for long-term care.
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While this set of circumstances is starting to create alarm among some policy makers, the search for remedies has been misplaced because it has been based on the assumption that we need to do more—more medicine, more institutional care, more funding. But this is a fundamental misunderstanding about how we are achieving this longevity revolution: that medicine has been the driving force for life extension. The

actual reason for extended life in the second half of the 20th century was that modern society limited risk across all the dimensions of modern life, for example:

- The 1948 Framingham Heart study initiated the concept of lifestyle risk factors
- Chlorination made drinking water uniformly safe
- The FDA and food delivery systems made safe, nutritious food universally available
- We increasingly designed our transportation and physical environments to avoid injury
- Tort reform financially penalizes any actor (corporate or individual) who negligently causes harm

These interventions, and thousands of other small and large ones from all the domains of modern living, were combining, enabling people to live longer, while accumulating multiple, interactive, complex chronic health conditions associated with older age.

From hindsight, it becomes apparent that aging has actually been passing through an intermediate institutional developmental phase and is returning (actually being returned) to the environment that enabled it to develop, the community. And the nature of the actual aging experience in the community is very different from how it had been shaped in specialized institutional long-term care regimes. In the home environment, the challenge with long-term care is the sheer volume of entangled, common issues and responsibilities for which the household has not been equipped to manage and orchestrate. Now it can be.

The modern digital world, with its ability to provide networks for information sharing, communication, health surveillance and other necessities that in the past required the co-location of frail older persons for efficiency, can now allow older persons to remain safely in their homes. We are able to access and orchestrate a wide range of interventions and tailor them to the changing needs of each older person. The older people, the interventions, and the human, equipment and financial resources necessary for care now all reside in the community. Even some medical procedures and prescriptions can be administered at home. After a long journey through a twentieth century dominated by institutions, we are returning to a greatly changed version of where we started.

The promise of founding aging care in the community on this new network technology is not a futuristic fantasy. It exists. Carers UK, a national charity in the United Kingdom, has developed programs over the past decade to support caregivers in the UK. Their Jointly app, currently in use by 30,000 people, creates circles of care that connect those aging in their communities with their families, other caregivers and neighbors. The

nonprofit Community Aging Circles (CAC), has partnered with Carers UK, to bring this technology to the U.S. Our mission and role is to help community organizations set up and operate community-based program using digital network technology for coordinating people and monitoring health and services to meet the unique needs of their frail aging community members who can no longer safely live at home without assistance. The technology makes it possible to capture and organize the details of the frail aging person's life and needs online in order to meet their needs safely and inexpensively. CAC can also supply technology-based equipment to monitor health and well-being actions and benchmarks in real time. We provide community education and support, as well as the technology for block-level community engagement with frail neighbors.

Lack of long-term care leadership is the primary roadblock to the development of this next era of aging in America. Aging has remained molded and (mis)shaped by old frameworks whose underlying assumptions are no longer valid. Healthcare is one of the few remaining analog-based sectors in America. While 90% of our healthcare expenditures are for chronic conditions, care is delivered in a system organized to treat acute disease by curing it. Chronic conditions are by their nature not curable.

There are three fundamental reasons why these new technologies that will allow people to age in the community have not been recognized or acted upon:

1.The existing healthcare framework, leadership. buildings, workforce, financial underpinnings, and venues are not designed to see that these healthcare presentations are actually expressions and exacerbations of conditions that have been accumulating throughout peoples' lives. Consequently, healthcare is applied only when a condition "ripens" to one that the existing system is equipped and funded to address. Because the healthcare industry is designed and organized to recognize aging only this way, it cannot reform itself.

2. Government, locked into an antiquated industrial era legislative and administrative straitjacket, is overwhelmed by chronic disease and unable to fund or manage the existing delivery system. Bounded by the historic Medicare/Medicaid framework, government is not tasked to create a new one. Having previously replaced local community partners with acute care insurers and health professionals to whom they delegated operational responsibility, now government has no partners with whom to share the burden of addressing the long-term care challenge and to identify the appropriate interventions.

3. Community organizations, now three generations removed from involvement in aging, may not be aware that the current facility-based system is collapsing. Nor are they aware of what is entailed in a network era model of long-term care that enables them to organize and address the frailty in their midst with little cost or risk, and that there is no one else to address the challenge appropriately and responsibly. Having been cut out of their role and responsibility for older age, and having witnessed the regulatory, labor, and financial risks of the existing industrial era, community organizational leaders may not be aware of the opportunities to address the needs of the aging members of their community. They may have their own initial resistance. The unfortunately common frailty experience with aging parents and friends has been off-putting, traumatic, with lingering sights, sounds and smells. Consequently, community organizations may resist even considering the possibility of involvement.

The Community Aging Circle's program can address both the needs both of a community organization and its families. Trusted community organizations can safely and inexpensively enable families to coordinate and connect, helping their members access the resources that can dramatically reset their long-term care experience. The chaos and isolation can be reduced dramatically. Community leadership can reach out to existing community programs so that they can be connected to a person's circle of care with the *Jointly* app. This strengthens the community's aging network and the older person's connections to resources that support them living in the community.

The CAC program can also reset the importance of the community organization for dealing with the needs of aging in the community. Community will again have central place in the lives of its members as the role of government and industry has been retreating in America. Network technology can now enable community to step back into a critical role.

As communities move toward integrating older people's interests into mainstream community life, their civic organizations will evolve. Leadership will come to understand the threat of chronic conditions and the advantages of digital programs and will facilitate community support networks. The kind of community that will be most relevant to aging from now on will be the community created by people who live within sight and reach of each other. The neighborhood, with the comfort of proximity and the strength of shared interest, is the bedrock on which the future of aging care in the U.S. rests.