

Social Structures

Demographic Changes and the Well-Being of Older Persons

K. Warner Schaie, PhD
Peter Uhlenberg, PhD
Editors



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Preface

This is the 19th volume in a series on the broad topic of “Societal Impact on Aging.” Lawrence Erlbaum Associates published the first five volumes of this series under the series title of “Social Structure and Aging.” The present volume is the 14th published under the Springer Publishing Company imprint. It is the edited proceedings of a conference held at the Pennsylvania State University, October 10–11, 2005.

The series of Penn State Gerontology Center conferences originated from the deliberations of a subcommittee of the Committee on Life Course Perspectives of the Social Science Research Council chaired by Matilda White Riley in the early 1980s. That subcommittee was charged with developing an agenda and mechanisms that would serve to encourage communication between scientists who study societal structures that might affect the aging of individuals and those scientists who are concerned with the possible effects of contextual influences on individual aging. The committee proposed a series of conferences that would systematically explore the interfaces between social structures and behavior, and in particular to identify mechanisms through which society influences adult development. When the first editor was named director of the Penn State Gerontology Center in 1985, he was able to implement this conference program as one of the center’s major activities.

The previous 18 volumes in this series have dealt with the societal impact on aging in psychological processes (Schaie & Schooler, 1989); age structuring in comparative perspective (Kertzer & Schaie, 1989); self-directedness and efficacy over the life span (Rodin, Schooler, & Schaie, 1990); aging, health behaviors, and health outcomes (Schaie, Blazer, & House, 1992); caregiving in families (Zarit, Pearlin, & Schaie, 1993); aging in historical perspective (Schaie & Achenbaum, 1993); adult intergenerational relations (Bengtson, Schaie, & Burton, 1995); older adults’ decision making and the law (Smyer, Schaie, & Kapp, 1996); the impact of social structures on decision making in the elderly (Willis, Schaie, & Hayward, 1997); the impact of the workplace on aging (Schaie & Schooler, 1998); mobility and transportation in the

elderly (Schaie & Pietrucha, 2000); the evolution of the aging self (Schaie & Hendricks, 2000); societal impact on health behavior in the elderly (Schaie, Leventhal, & Willis, 2002); mastery and control in the elderly (Zarit, Pearlin, & Schaie, 2002); impact of technology on the elderly (Charness & Schaie, 2003); religious influences on health and well-being in the elderly (Schaie, Krause, & Booth, 2004); historical influences on lives and aging (Schaie & Elder, 2005); and the impact of social structures on self-regulation in the elderly (Schaie & Carstensen, 2006).

The strategy for each of these volumes has been to commission reviews on three major topics by established subject-matter specialists who have credibility in aging research. We then invited two formal discussants for each chapter—usually one drawn from the writer's discipline and one from a neighboring discipline. This format has provided a suitable antidote against the perpetuation of parochial orthodoxies and made certain that questions are raised in regard to the validity of iconoclastic departures in new directions.

To focus each conference, the organizers have chosen three aspects of the conference topic that are of broad interest to gerontologists. Social and behavioral scientists with a demonstrated track record are then selected and asked to interact with those interested in theory building within a multidisciplinary context.

The present volume focuses on the impact of demographic changes on the well-being of older persons. Significant demographic changes are altering the structure of the American population. As in most other countries, there will be a rapid increase in the number and proportion of older individuals in the U.S. population. Large-scale immigration is changing the ethnic composition of cohorts as they age. Changes in marriage, cohabitation, divorce, and childbearing are altering family experiences and kinship networks over the life course. These changes also affect the size and composition of the population of working age that provides the base for economic support of the elderly and that provides most of the care for older persons who are suffering from disabilities and disabling chronic diseases and who consequently become functionally dependent.

In this volume, we examine the implications of changes in the American population structure for the role and support of older people. These influences include the roles of changing age distribution, immigration, increasing longevity, and family change. Massive immigration in recent years is of interest because immigrants are taking on a major role in the care of frail elderly and because it will lead to an increasing number of immigrant elderly in the future. Changes in family patterns and age

distribution are examined from the point of view of changes in kinship networks and intergenerational support. Because of the obvious public policy considerations, we also examine the consequences of the aging of the baby boomers and their increasing longevity, and the concomitant reduction in the relative size of the cohorts that would be expected to support the aging baby boomers.

The reader will find here reviews of recent literature on demographic changes that are likely to affect the elderly, but more importantly, integrative discussions and opinion papers that address the specific consequences of demographic changes for today's elderly and the elderly in the proximal future. Addressed also are possible mechanisms that can explain how demographic change can modify individual aging processes.

The first topic in this volume was designed to examine the manifold implications of the aging of immigrants. How will current immigration patterns affect the composition and size of cohorts entering old age in the future? What are the welfare implications of a growing number of elderly immigrants? What special issues arise for persons that age in immigrant communities? An attempt is then made to forecast these effects for both the immigrant population and the larger North American society. We deal with the effects of immigration on health care for older people. The latter discussion involves both the health status of immigrants as they age, and the role of immigrants as major care providers for the elderly in many parts of the United States.

The second topic is concerned with shedding more light on the societal and individual consequences of the aging of the baby boomers. The focus is both on the economic consequences of population aging for U.S. society and the older people in it, as well as the impact of population aging on the health care and long-term care systems. Consideration is given to the broad range of economic impacts, as well as the differential impact for various segments of the baby boom. We then turn to the effect of the aging baby boomers on the health care system. The contrary trends discussed here involve reduction in morbidity and disability in the baby boomers compared with cohorts who entered old age before them and the greater demand on the health care system that will occur not only because of increased numbers but also because higher average levels of education and information access will make baby boomers more demanding consumers of health care.

The third topic involves the implications of the changing composition of the older population created by sociodemographic changes occurring over the past half century. Over time, there is a continual replacement of the members of the older population as some die and

new cohorts cross the threshold of old age. This process of cohort replacement can produce significant changes in the older population and raises questions regarding how the well-being of those in later life might be affected. This is an important topic because of the salient roles of kinship networks in the support of frail and dependent elderly as well as the intergenerational transmission of economic resources and provision of physical and emotional support. This topic includes discussions of the effects of increasing education, decreasing fertility, and longer lives for kinship and support networks of the elderly. But consideration is also given to the effects of changes in marriage and divorce patterns as they influence the well-being of older individuals. Examined here are the consequences in old age of the dissolution of families (of both older people and their children) as well as the possible consequences of reconstituted families. Of importance, also, is the expected increase in the proportion of the cohort who never married and never had children, and attention is called to gender as a central issue in considering future changes.

We are grateful for the financial support of the conference that led to this volume that was provided by conference grant R13 AG 09787 from the National Institute on Aging and by additional support from the College of Health and Human Development of the Pennsylvania State University. We are also grateful to Chriss Schultz for handling the conference logistics and to Jenifer Hoffman for coordinating the manuscript preparation and for preparing the indexes.

K. WARNER SCHAIE
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CHAPTER 1

Older Immigrants*

Judith Treas and Jeanne Batalova

Your mommy was very . . . what do you call it? “Persistent?” suggested the granddaughter. Yeah, to come, to come here. Yeah (laughing), but I don’t like to come here. I was crying and crying. Aba, she . . . she is always mad at me at the telephone and crying (laughing). . . . Then, you know, I don’t want to come here because I cannot eat. I cannot sleep. I do not want to leave my children and I think that the Philippines is too far from the United States to travel. That is the first time that I will travel by air. I am nervous all the time when I think of it. I become thinner, thinner, thinner (laughing). And all of a sudden, all my children there in the Philippines, they say to me, “Why don’t you come to the United States? You will be legal. Some of the people want to go there, but they cannot go there. But you, you will go there, and it’s legal.”

—71-year-old Filipina immigrant speaking with granddaughter

In discussions of health care, income transfers, and a host of other matters, the future needs and resources of older adults take center stage. In contrast, in the immigration arena, older adults are relegated to a footnote because the socioeconomic incorporation of children and young adults are dominant concerns. The majority of older foreign-born persons, those who immigrated decades ago, are themselves the product of the processes of incorporation into American

*Chapter prepared for the Conference on Social Structures: The Impact of Demographic Changes on the Well-Being of Older Persons, Pennsylvania State University, October 10–11, 2005. Partial support for this chapter comes from a grant to the first author from the Russell Sage Foundation.

society. A smaller segment of older immigrants are recent arrivals. Typically, members of the “point-five generation” (.5) that follow adult children to the United States come too late in life for the schools and the workplaces by which immigrants have traditionally made their way into American society. Because older immigrants, like their younger counterparts, will play a larger role in the U.S. population in coming decades, we contend that immigrants will be increasingly important to discussions of the well-being of older Americans. Foreign-born seniors, however, are usually overlooked, even by publications that aim to address broad issues in the older population, such as the Urban Institute’s (2005) *Older Americans’ Economic Security*.

Looking to the middle of the 21st century, our chapter begins with a review and evaluation of demographic projections for growth in the number of older immigrants and their share of the older American population. Except as otherwise indicated, statistical information in this chapter is derived from tabulations of the 5% Public Use Microdata Samples (PUMS) of Census 2000. The quotations in this chapter are drawn from intensive interviews with 55 foreign-born persons aged 60 years and older conducted in California under the supervision of the lead author. We use the terms “foreign born” and “immigrants” interchangeably. The chapter also considers the flow of older immigrants to the United States and the implications of population aging and late-life immigration for the diversity of future cohorts of older Americans. We gauge the incorporation of the older foreign-born population, drawing a distinction between long-term residents of the United States and older newcomers. We conclude our chapter with a discussion of implications immigrant incorporation has for economic and social well-being of immigrant elderly.

OLDER IMMIGRANTS AND THE FUTURE

I hope, but I can't predict what is going to happen in the future. I'm not sure where I'm going to live, because the young people have their own lives. After they go married, if they still want my husband and I live with them, then we will.

—61-year-old Taiwanese immigrant

Immigrants’ Increasing Share of the U.S. Older Population

The foreign-born share of the population aged 65 years and older declined throughout most of the 20th century, dropping from 31% in 1900 to 9% in 1990 (Figure 1.1). With a time lag to permit the aging of

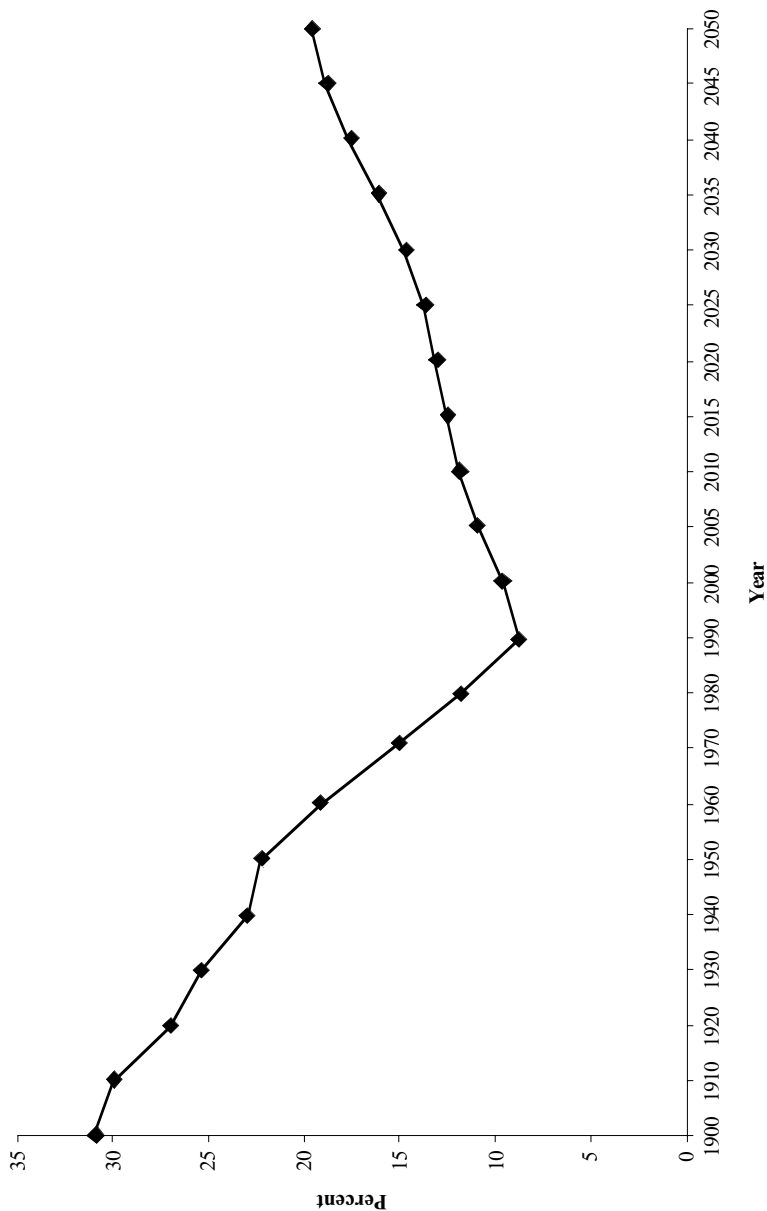


FIGURE 1.1 Foreign-born elderly as percentage of U.S. population aged 65 years and older, 1900–2050. (*Sources:* Data for 2000 to 2050 are from the U.S. Census Bureau, 2003, “Projections of the Foreign-Born Population by Age, Sex, Race, and Hispanic Origin: Lowest, Middle, and Highest Series, 1999 to 2100,” retrieved July 15, 2005, from <http://www.census.gov/population/www/projections/natdet.html>. Data from 1900 to 1990 are from the U.S. Census Bureau, Campbell J. Gibson and Emily Lenmon (1999), Report 29, “Historical Census Statistics on the Foreign-born Population of the US: 1850–1990” Table 7. “Age and Sex of the Foreign-Born Population: 1870 to 1990.” Retrieved July 15, 2005, from <http://www.census.gov/population/www/socdemo/foreign/reports.html>.)

immigrants, these percentages follow the percentage of the total population that is foreign born. The restrictive national origin quotas of the 1920s, followed by the Great Depression and World War II, slowed immigration to a trickle before the volume of immigration increased. The foreign-born share of the older population bottomed out in 1990 and began to climb. By 2000, 9.5% of the population aged 65 years and older was foreign born. By 2050, 19.6%—more than 16 million people aged 65 and older—will be born in another country, according to the most recent projections by the U.S. Census Bureau (2004). Immigrants will figure more and more prominently among older Americans in the future, but this development can be put in historical perspective. Although the percentage of foreign born that is projected for the middle of the 21st century is about twice as large as today, it is only two-thirds of what was seen a century ago in America. In the future, immigrants will figure more prominently among older Americans.

The upward trend indicates that the foreign-born component will be a significant minority of older adults in the middle of the 21st century, but some evidence suggests that these projections are likely to understate the future size of the older immigrant population. Projecting the population is always a risky business. A faulty baseline population estimate or flawed assumptions about trends in the components of population change can lead to predictions that are too high or too low. Even small errors compound over time, making long-run projections prone to bigger errors than short-term projections. Prognosticating on the future levels of fertility and mortality is difficult enough, and demographers have historically underestimated the pace of declines in mortality for the older population (Crimmins, 1981). The future course of immigration is even harder to anticipate. Not only are the size and composition of immigrant streams hostage to the vagaries of geopolitical and economic “push” factors around the globe, but they are also determined by U.S. immigration policy, which is subject to change.

With a baseline from the 1990 Census, the available age-specific projections of the foreign-born population by the U.S. Census Bureau illustrate the difficulties in foretelling immigration trends. These estimates assumed, not unreasonably, that there would be an initial increase in family members immigrating because they would be petitioned by some of the 2.7 million people who, having been legalized under the Immigration Reform and Control Act (IRCA) of 1986, were newly eligible to sponsor kin. After this blip, a steady decline in the arrival of immigrants was expected to follow. Immigration has not declined, and barring unforeseen developments, it is hard to imagine that it will do so in the future. The projections of the foreign-born have underestimated the number

of people immigrating to the United States, compounding an initial underestimate that resulted from the 1990 Census' undercount of the Hispanic and undocumented populations.

The upshot is a 4-million-person shortfall in the foreign-born population as projected for 2000. Although 17 million foreign-born persons were projected, 21 million were counted in Census 2000. Projections for the native-born fell short by 2 million, but this is a relatively trivial error given the much larger size of this population. Clearly, new projections of the foreign-born population are called for, but demographers must first reconcile two thorny technical issues: (1) how to harmonize the Census 2000 racial/ethnic classification (and its new multiracial groupings) with fertility and mortality data reported for different racial and ethnic categories, and (2) what to do about a big processing backlog for immigrant applications, which complicates the count of the immigrants admitted every year. There are individuals already in the country who have applied for an adjustment to their visa status to become lawful permanent residents; because of the backlog in processing their applications (as well as the visa caps for countries and immigration categories that are set by the law), they do not appear in the immigration admission data for a particular year (Jernegan, 2005; Batalova, 2006).

For those interested in older immigrants, the good news about existing projections is that estimates for older people are better than those for younger people. Migration, especially international migration, is a young person's game. Labor migrants who move for better job opportunities tend to be young adults (and so are their spouses and children). Settling in their host countries, they grow old in the communities where they have lived and worked. Thus, immigrants exemplify what gerontologists have called "aging in place."

Of course, the life course investments that bind aging immigrants to the United States also root older adults in other countries to their homeland. Relatively few people immigrate after, say, age 50. In 2004, for instance, less than 15% of immigrants admitted to the United States were aged 50 or older (U.S. Department of Homeland Security, 2005a). At least for the next couple of decades, projecting the numbers of foreign-born persons aged 65 and older is made easier by the fact that most of these immigrants are already middle-aged adults living in the United States and their numbers are known.

The bad news, of course, is that projections for older immigrants are fraught with much more uncertainty as we move into the middle of the 21st century. Seniors in 2050 are today's young adults. Because many of these young people have not yet immigrated to the United States, their numbers are not known. Reliable data on emigrants are hard to find, and

we do not know how many immigrants in coming decades will decide to return to their countries of origin. We do know that some returnees work long enough in the United States to qualify for Social Security, as evidenced by the 431,000 beneficiaries abroad who were retired or disabled workers, their survivors, and dependents (U.S. Census Bureau, 2005). In short, the projections of foreign-born older adults for the next decade or two are apt to be much closer to the mark than long-run estimates. Because assumptions about immigration levels used in available projections of the foreign born are too low, they are apt to markedly underestimate the numbers of immigrant older Americans in the middle of the 21st century. In the 65 years and older population, the projection of 19.6% foreign born is, at best, a lower bound on immigrants' share of the older population of the United States in 2050.

Immigrant Implications for Future Racial/Ethnic Diversity of the Older Population

Immigrants are typically young, and they often start their own families in the United States. Thus, their immediate impact is to make the American population younger. As low-fertility populations confront the daunting prospect of declining numbers of workers supporting growing numbers of retirees, some policy makers have viewed immigration hopefully. Rejuvenating effects on the population age structure are short-lived, however, because young immigrants eventually grow old in their host society. As a way out of the generational imbalance created by the perfect storm of subreplacement fertility and lengthening life expectancies, international migration fails, in part, because it would require much higher levels of immigration than most countries comfortably contemplate (United Nations, 2001).

If immigration is not a long-term fix for population aging, it has proven to be a fast track to population diversity (Bean, Lee, Batalova, & Leach, 2004). Europeans dominated migration streams for most of American history. Changes in U.S. immigration law in 1965, however, removed barriers to Asian, Latin American, and African immigration. The upshot is that immigrants today come mostly from Asia and Latin America, with implications for the racial/ethnic makeup of the U.S. population. By 2000, Hispanics were about as numerous as African Americans (U.S. Census Bureau, 2004). Both Hispanics and Asians are projected to triple their numbers by 2050, when non-Hispanic Whites are expected to make up only half of the American population.

Figure 1.2 illustrates the racial composition by nativity in 2000 for persons younger than age 65 and for those 65 and older. Native-born

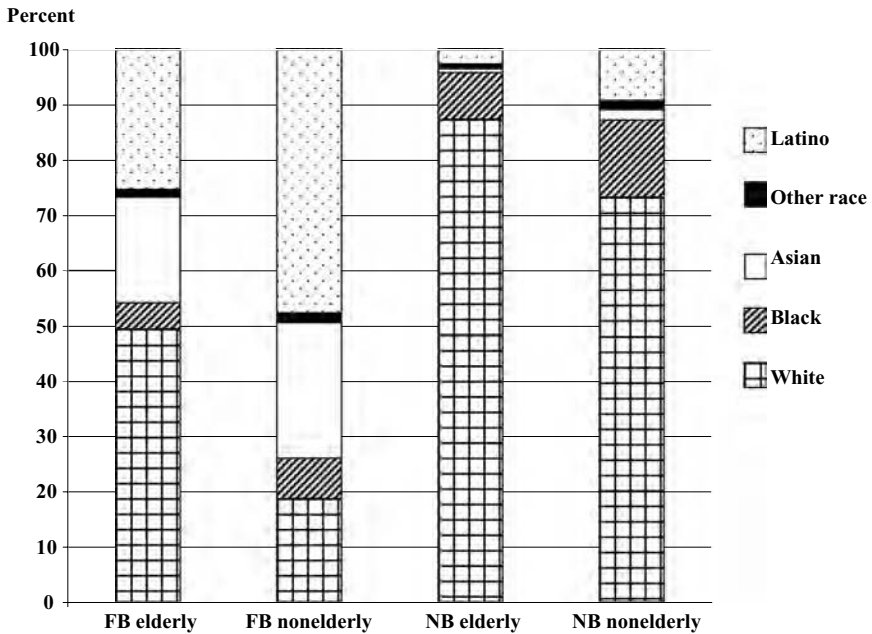


FIGURE 1.2 Foreign (FB) and native-born (NB) elderly (65+ years) and non-elderly (0–64 years) population by race and ethnicity, 2000. (Source: U.S. Census Bureau. 2000 Census of Population and Housing 5% Public Use Microdata Samples [PUMS] data file, retrieved January 30, 2005, from <http://www.census.gov/Press-Release/www/2003/PUMS5.html>)

Americans are overwhelmingly non-Hispanic Whites, with Blacks representing the most numerous racial/ethnic minority. Non-Hispanic Whites, however, do not constitute a majority among the foreign born, especially among the younger segment. Note, in particular, the large shares of Latinos and Asians among foreign-born persons aged 0 to 64. These are the immigrants who will be aging into the population of foreign-born seniors in coming decades. Coupled with new entrants who will join the ranks of immigrant older adults, we can look for much greater diversity among older foreign-born persons and—by extension—among older Americans in general.

To put the racial makeup of contemporary immigration into perspective, Table 1.1 shows the top 10 countries of origin in 2004 for the parents of U.S. citizens, the legal category by which many older adults are admitted to the United States. Mexico is far and away the greatest source, accounting for 29.3% of all parents who were admitted. Three other major Western Hemisphere countries—Dominican Republic, Colombia,

TABLE 1.1 Total and Top 10 Countries of Birth: Parents of U.S. Citizens Admitted in 2004

	Number	Percent
Mexico	22,725	29.3
India	6,599	8.5
China	6,489	8.4
Philippines	6,314	8.1
Dominican Republic	2,473	3.2
Colombia	1,962	2.5
Vietnam	1,635	2.1
Iran	1,627	2.1
Haiti	1,611	2.1
Korea	1,472	1.9
All other countries	24,627	31.8
Total	77,534	100.0

Source: U.S. Department of Homeland Security, *Yearbook of Immigration Statistics, 2004*, Table 8. "Immigrants Admitted by Selected Class of Admission and Region and Country of Birth, Fiscal Year 2004." Washington, D.C., U.S. Government Printing Office.

and Haiti—account for another 7.8% of parents. Most of the remaining countries are in Asia—India, China, the Philippines, Vietnam, and Korea—which together contribute 29% of admitted parents. Persons born in the above nine countries and Iran make up 68.2% of all parents sponsored by U.S. citizens. No European country falls among the 10 leading countries from which parents of U.S. citizens are admitted.

Returning to projections, growing ethnic and racial diversification is indeed projected for foreign-born seniors, as shown in Figure 1.3. In 2000, nearly half (47.6%) of the foreign-born elderly aged 65 and older are non-Hispanic Whites, but their share is projected to fall off dramatically. According to these projections, early in the next decade, Hispanics will supplant non-Hispanic Whites as the largest group of immigrant seniors. Before that decade is over, non-Hispanic Asians are also projected to outnumber non-Hispanic Whites. By 2050, Hispanics will make up 41.5% of foreign-born persons aged 65 and older, whereas non-Hispanic Asian and Pacific Islanders will constitute 29.7%, non-Hispanic Whites 20.2%, and non-Hispanic Blacks 8.4%. Of course, the caveat is that these projections understate current immigration, thus leading to a likely underestimate of Hispanics and non-Whites.

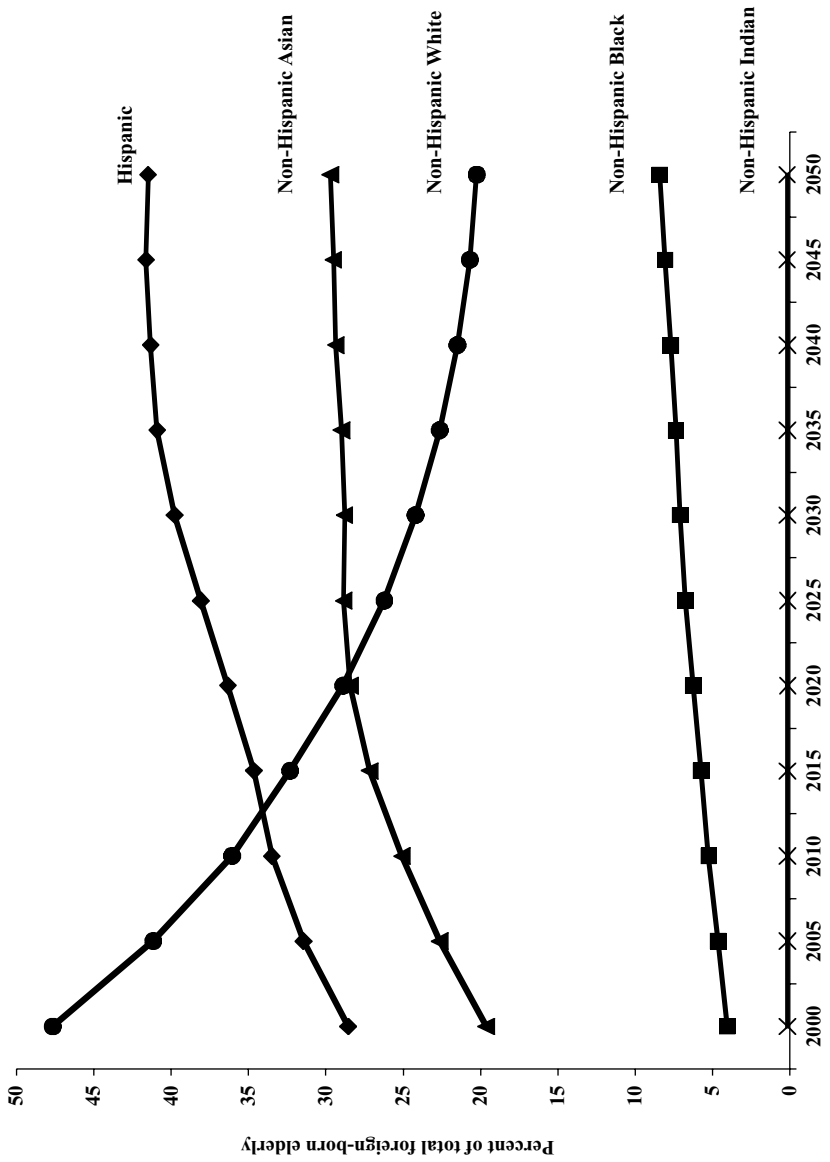


FIGURE 1.3 Racial/ethnic composition of foreign-born elderly aged 65 years and older, 2000–2050. (Source: U.S. Census Bureau, 2003, National Population Projections, “Projections of the Foreign-Born Population by Age, Sex, Race, and Hispanic Origin: Lowest, Middle, and Highest Series, 1999 to 2100.” Retrieved January 30, 2005, from <http://www.census.gov/population/www/projections/natdet.html>.)

OLDER NEWCOMERS

When I arrive here in the U.S., the way of thinking was a little bit of different than ours. But little by little you get used to them, and you start understanding the system. You get to understand certain things, but at the beginning, you would feel, like, [in a different voice pretending to be someone else looking over her shoulder] “What is she talking about?”

—65-year-old Cuban refugee

The older foreign-born population consists largely of persons who have been in the United States for a long time. In 2000, 87% of the 3.3 million foreign-born persons aged 65 and older had arrived before 1990. Although post-1989 arrivals made up only one in eight older immigrants, they are also of interest, in part, because they offer insights into prospects for immigration of older adults in coming decades. Figure 1.4 shows the trends in the admission of permanent residents aged 65 and older over the past half century. The number of all immigrants admitted to the United States reported in the immigration statistics tables consists of two types of flows: (1) newly arrived legal permanent residents—persons who were issued immigrant visas by the Department of State overseas, and (2) status adjusters—persons who enter the United States in one legal status and then adjust or change to permanent residence while in the country.

In 2004, over 40,000 older adults immigrated to the United States. The late 1980s and early 1990s showed the increased numbers anticipated in the wake of the 1986 IRCA legislation, but immigration of persons 65 and older has remained high since then. Not only has the number of older immigrants increased, but their share of all lawful permanent residents also climbed since 1956, reaching as high as 5% in 1999. In addition to permanent immigrants, of course, many older people come as temporary visitors. In 2004, 2.2 million persons 65 and older entered the United States as nonimmigrants (U.S. Department of Homeland Security, 2005a). They made up 7% of all nonimmigrants. Fully 93% of these elderly nonimmigrants were “temporary visitors for pleasure,” that is, tourists and persons visiting family members in the United States.

About two-thirds of all permanent immigrants admitted to the United States each year are family members of U.S. citizens and lawful permanent residents (McKay, 2003). Unlike permanent residents, American citizens aged 21 and older are permitted to petition their

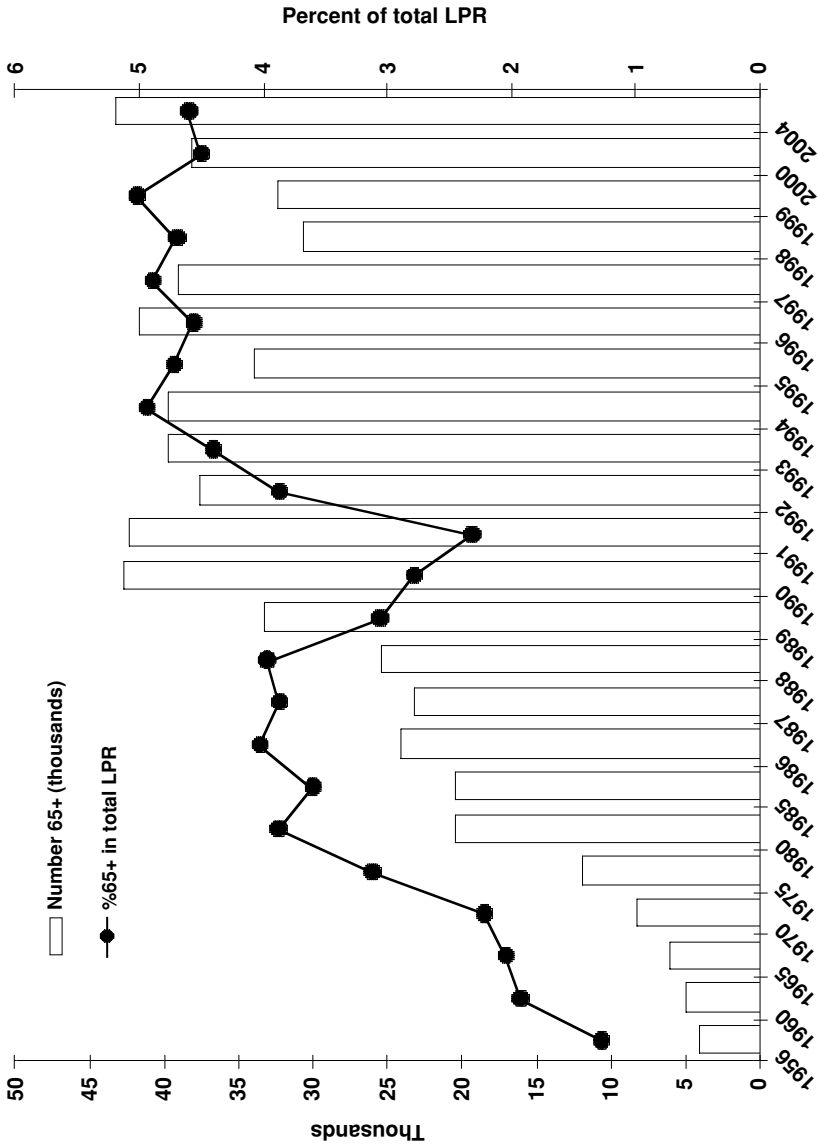


FIGURE 1.4 Number and percent of persons aged 65 and older admitted as lawful permanent residents (LPR), 1956–2004. (Source: Immigration and Naturalization Services, “Statistical Yearbook of the Immigration and Naturalization Service,” selected years 1965, 1970, 1985, retrieved May 6, 2005; U.S. Department of Homeland Security, “Yearbook of Immigration Statistics,” 2000, 2004. Table “Immigrants admitted by sex and age,” retrieved May 6, 2005.)

parents' immigration without annual limitations on family visas. In 2004, among 43,285 immigrants aged 65 and older, an overwhelming majority (84%) were the immediate relatives of U.S. citizens (U.S. Department of Homeland Security, 2005a).

Despite some ups and downs in admission numbers reflecting, among other things, the processing backlogs of applications for visa adjustment by individuals already in the country, the number of persons admitted as parents of U.S. citizens increased. The numbers went from 45,232 (or 7.5% of all immigrants) in 1986 to 77,534 (8.2%) in 2004 (U.S. Department of Homeland Security, 2005a). Because U.S. law permits family-based reunification, current immigrants are likely to become sponsors of new immigrants. Since there are so many young adult immigrants already in the country, the immigration of new waves of aging parents is to be expected as their grown children become more established in the United States.

Sponsoring a relative's immigration involves signing a legally enforceable affidavit of support, and sponsors must generally show that their family income equals or exceeds 125% of the U.S. poverty level for their given family size (U.S. Department of Homeland Security, 2005b). The sponsor's obligation holds until the relative either becomes a naturalized citizen or works for 10 years in the United States. Of course, many older immigrants will never meet these conditions. Many are not employable, particularly in the formal sector of the economy. As a 77-year-old woman from Korea put it, "I'm too old to work. Besides, who would hire me?" Many bemoan the difficulty of learning English—generally required for citizenship (Treas & Mazumdar, 2002). Describing how her inability to master English kept her from becoming an American citizen, a 61-year-old woman from Mexico explained, "At our age . . . it just doesn't stick."

Factoring in the time for a potential immigrant sponsor to get citizenship (residence for at least 5 years usually required), to meet the minimum income requirements, and to have applications processed, sponsored parents are invariably middle-aged or older when they arrive in the United States. The 1996 welfare reform legislation that limited most public benefits to citizens created a stronger incentive for older people to become citizens (Van Hook, 2003). Furthermore, the English language requirement for citizenship is waived for the disabled and for long-term legal residents (e.g., those 55 years old who have been a permanent resident for at least 15 years; U.S. Department of Homeland Security, 2005c). Thus, we can expect some older people will overcome or outlast the hurdles to naturalization and benefits that they face.

Many of the older newcomers—with or without government benefits—will remain financially dependent on their adult children for the rest of their lives. This is not to say that older adults are not important members of America's immigrant families. If they cannot help out financially, they still play invaluable roles in immigrant households. By helping the younger generations with chores and child care, offering emotional support, and affirming family solidarity, they contribute to the successful incorporation of the younger generations in schools and the workplace (Treas & Mazumdar, 2004).

FOREIGN-BORN OLDER ADULTS: DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

*You did not know that, that I am already a citizen? You better apply for one.
The fee is already high. More than two hundred [dollars].*

—66-year-old Filipina naturalized citizen to grandson who is a permanent resident

Immigrants' share of the older population is certain to increase. The implications of this increase depend on whether immigrant selection and incorporation processes give rise to an older immigrant population whose well-being resembles that of native-born seniors or diverges markedly. A comparison of native-born and foreign-born older adults today offers a rough indication of what lies ahead. Of course, tomorrow's older Americans will not necessarily start from the same place nor tread the same pathway to old age that the current generation of older adults has. The foreign-born segment of the older population, for example, will hail largely from Asia and the Western Hemisphere, not Europe. The changing origins of immigrants reflect the broader forces of globalization that are altering the economic life course. Americans, particularly those with less education, face greater economic insecurity from global economic competition at the same time that the public safety net is being cut back. We do not know how successfully Americans, new and old, will be in preparing for old age or what public and private supports for old age will exist when today's workers retire.

On some counts, the foreign born and the native born today are much alike. Commonalities in the life course assure that older people, wherever they were born, confront similar challenges of aging, such as higher rates of disability. Widowhood is another risk of later life for both foreign-born and native-born older adults. With figures that approximate their native-born counterparts, 46% of foreign-born women aged

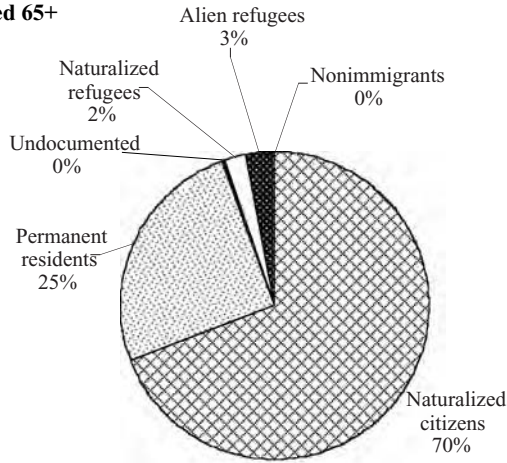
65 and older are widowed, as opposed to 40% who are married. Because the burden of widowhood falls disproportionately on women, only 13% of older, foreign-born men are widowed, whereas 76% remain married—similar to other older men in the United States. On other counts, however, older immigrants are distinctive. Foreign-born seniors are not as well educated as their native-born counterparts. Half of foreign-born persons aged 65 and older versus one-third of their native-born counterparts did not graduate from high school.

Older immigrants also differ from the younger foreign-born population. As noted, older immigrants are more likely than younger ones to be non-Hispanic Whites. In terms of immigration status, too, older foreign-born persons in the United States differ markedly from their younger counterparts, as shown in Figure 1.5. Of course, surveys cannot obtain very reliable data on legal status, so these data come from the 2000 Census data with imputed legal status provided by the Urban Institute (Urban Institute, 2005). The undocumented population was estimated by subtracting an estimate of the legally residing immigrant population from the total number of immigrants. The subtraction result was further adjusted for the undercount of the undocumented population in Census 2000 (Passel, Van Hook, & Bean, 2004).

Consistent with the fact that many older immigrants are long-time residents of the United States, fully 70% of these older adults aged 65 and older are naturalized citizens, as opposed to only 30% of the younger people. Although 28% of younger people are undocumented immigrants, hardly any older foreign-born persons fall into this category. At this particular point in their life course, elderly immigrants are generally more secure than their younger counterparts. Enjoying the full rights and benefits of citizenship, most elderly immigrants have at least some public safety net, whereas many younger people are marginalized by their undocumented immigration status. Whether these young people will be able to attain citizenship before they, too, are old depends on the uncertain course of U.S. immigration policy.

In 2000, older immigrants already constitute more than 20% of the 65+ population in some states, namely, California, Hawaii, and New York. These states, of course, have long been immigrant gateways. The surprising development in recent decades was the movement of immigrants to places where they had not previously had a substantial presence (Durand, Massey, & Charvet, 2000; Singer, 2004). Undoubtedly, immigrants' share of the older population will continue to rise in traditional enclaves. Looking to the future, however, new destinations will also confront challenges of a diverse population of elderly immigrants as the newcomers in these communities grow older.

Persons aged 65+



Persons aged 0-64

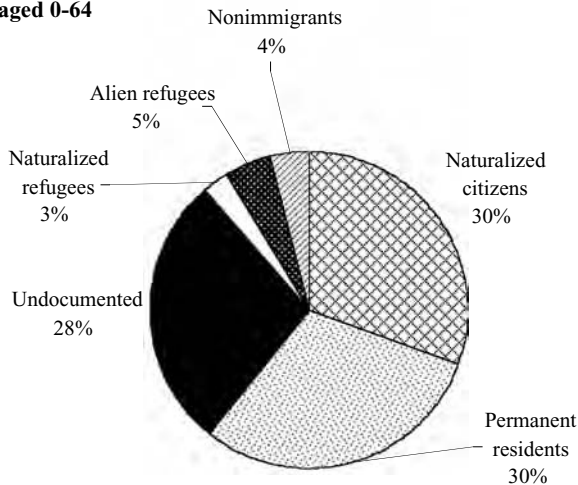


FIGURE 1.5 Legal status of foreign-born persons by age, 2000. (Source: Urban Institute. 2000 Census of Population and Housing 5% Public Use Microdata Samples [PUMS] data file with imputations of legal status. Obtained May 3, 2005.)

**OLDER IMMIGRANTS: LONG-TIME RESIDENTS
AND RECENT IMMIGRANTS**

Well, if he, ah, got his MediCal and his Social Security income, I think he better stay here, because everything is free—the doctors and your medicine. And you could have that Social Security income as your pocket money. While you go to

the Philippines, you will not have that. You have to pay everything. It's better to take the Social Security income, because your children who are earning, they are paying a [payroll] tax.

—83-year-old Filipina on whether an older immigrant should return home

There is a critical distinction to be made among older immigrants. Recent immigrants differ from seniors who came earlier. Marked by the historical characteristics of their immigration epoch, newcomers are more likely, for example, to be of Hispanic or Asian as opposed to European origin. They have spent less time in the United States, meaning they have had less opportunity to become citizens and to incorporate into the society. Their immigration came later in life, so their needs, capacities, and structural opportunities diverge from those who arrived as young adults. It is useful to distinguish “long-term” immigrants who arrived before the 1990s from “recent” immigrants who came later. There is a risk, of course, in generalizing about long-term immigrants. They include people who immigrated long ago as children and who have so thoroughly assimilated to American life that their origins constitute only a minor biographical footnote. Our generous definition of long-term also includes persons who came in late middle age and have not succeeded in learning English or finding an economic toehold in U.S. society. Nonetheless, this contrast points out the distinctions between earlier and later immigrants and native-born seniors.

One obvious difference is that recent immigrants are younger. Older adults who are most likely to immigrate are the younger seniors, rather than their frailer counterparts. As Table 1.2 illustrates for the year 2000, native-born seniors and those who immigrated before the 1990s are very similar in terms of their age distributions: Roughly one-half are aged 65 to 74, one-third are 75 to 84, and one-eighth are 85 and older. Among persons 65+ in 2000 who arrived after 1989, over two-thirds are 65 to 74, one-quarter are 75 to 84, and only 6% are octogenarians or older.

On indicators of incorporation and well-being, however, there is a big distinction, not only between native-born and foreign-born seniors, but also between those who immigrated decades ago and those who are more recent arrivals. Largely excluded from the public safety net by welfare reform legislation of 1996, recent arrivals are also less equipped to make their way independently in the United States. For example, the English-language ability of earlier immigrants is greater. Among persons 65+ who immigrated before the 1990s, 53% were fluent in English in 2000 (reporting that they either spoke only English or spoke English

TABLE 1.2 Age Distribution by Nativity, 2000

	Native Born	Pre-1990 Immigrants	Recent Immigrants
65–74	51.7	54.5	68.2
75–84	35.8	32.5	25.6
85+	12.5	13.1	6.2
Percent of Total	100.0	100.0	100.0
Total Persons (1,000s)	31,651	2,901	429

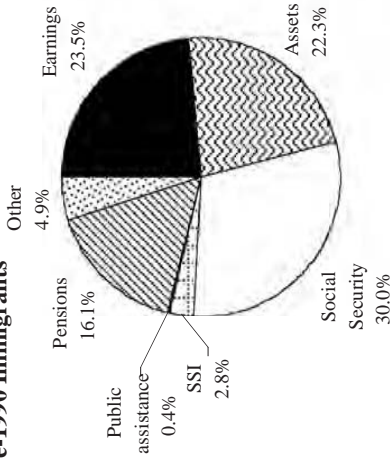
Source: U.S. Census Bureau, 2000 Census of Population and Housing 5% Public Use Microdata Samples [PUMS] data file, retrieved January 30, 2005, from <http://www.census.gov/Press-Release/www/2003/PUMS5.html>.

“very well”). Only 22% of those who arrived more recently spoke English this well.

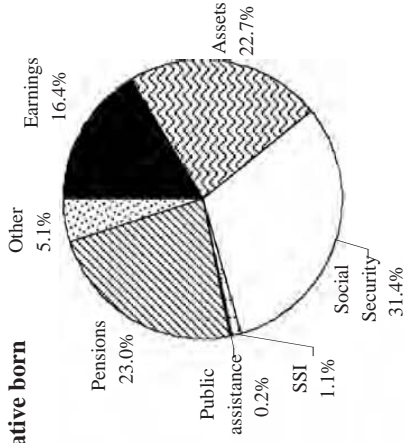
Income is arguably the best indicator of incorporation. In old age, immigrants do not fare as well as the native-born population, but those who have lived longer in the United States are at a considerable advantage compared with newcomers. Among men aged 65 and older, for example, median personal income in 1999 was \$22,500 for the native born, \$15,900 for pre-1990 immigrants, and \$6,000 for arrivals after 1989. For older women, median personal incomes were much lower than for men, but nativity differences remain—\$10,800 for the native born, \$8,300 for pre-1990 immigrants, and \$4,300 for recent arrivals.

In terms of income sources, foreign-born seniors who have spent more time in the United States look very much like native-born older Americans (Figure 1.6). For both native-born and long-term immigrants, Social Security is the linchpin of economic well-being. Nearly one-third of all personal income in 1999 derived from Social Security—a fact that reflects a sustained history of employment in the United States by the older person or spouse. By contrast, Social Security amounted to only 18% of income for older adults arriving in the 1990s. As for other retirement income, the native born were clearly advantaged in terms of private pensions. These pensions made up 23% of their income versus 16% for long-term residents of the United States and only 11% for those immigrating after 1989. Newcomers relied more heavily on employment. Earnings constituted 34% of all personal income for recent arrivals, 24% for earlier arrivals, and only 16% for the native born. Their reliance on earned income is surprising given the limited employability of many elderly newcomers, but their lack of retirement income is a strong incentive to find some work that yields money, even if it

Pre-1990 Immigrants



Native born



Recent Immigrants

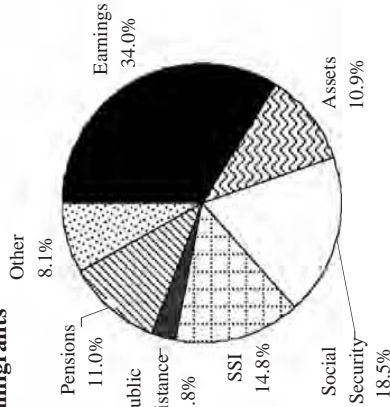


FIGURE 1.6 Sources of personal income by nativity, population 65 and older NPRE, 2000. (Source: U.S. Census Bureau. 2000 Census of Population and Housing 5% Public Use Microdata Samples [PUMS] Data File, retrieved January 30, 2005 from <http://www.census.gov/Press-Release/www/2003/PUMS5.html>)

involves casual employment or menial tasks (e.g., recycling cans, home sewing). “Other” income, a category that includes private transfers from kin, made up 8% of new immigrants’ personal incomes as opposed to 5% for each of the other groups.

Older newcomers’ incomes also stand out because a larger share comes from Supplemental Security Income (SSI) (15%) and other public assistance (3%). Welfare reform legislation made immigrants arriving after August 22, 1996, ineligible for most welfare benefits (Treas, 1997). A sharp decline in welfare participation in immigrant households followed (Borjas, 1999). Older immigrants who were receiving benefits before that date continued to be eligible, as did legal immigrants who were subsequently credited with 10 years of U.S. work history and those who subsequently naturalized. Other qualified exceptions include refugees, asylees, and U.S. military veterans and their families (Northwest Justice Project, 2003). Thus, despite efforts to tighten welfare eligibility, the low incomes and special circumstances of some recent immigrants mean that SSI remains a significant income source for this older population as a whole.

In 2000, income from assets like interest-earning bank accounts constituted 23% of income for the native-born and 22% for long-term immigrants, but only 11% for recent arrivals. Home ownership underscores the differences between the groups in the accumulation of assets. Fully 82% of native-born seniors in 2000 lived in a home that they or someone else in the household owned, as did 72% of long-term immigrants. In most cases, the older person or couple was the homeowner. Among recent immigrant seniors, however, only 48% lived in an owner-occupied home. The older person was the homeowner in only half these cases, consistent with the high likelihood that new immigrants will live as guests in the homes of their grown children.

CONCLUSION AND IMPLICATIONS

Concerns for the well-being of aging Americans and the implications of aging baby boomers for American society have generated considerable academic research and public debate. Similarly, enormous research effort and rapt policy attention have been given to the issues of incorporation of the second generation of immigrants. In contrast, the older immigrant population has yet to claim the spotlight in either the aging or immigration research agenda. In this chapter, we offer a demographic and socioeconomic profile of older long-term immigrants and the more recent point-five generation, and we consider the implications of the

aging of immigrants and late-life immigration for the future of American elderly.

First, we believe that the currently available projections of the foreign-born population underestimate the absolute and relative shares of foreign born among the older population in the United States. Most likely, immigration will continue at a high level, and given the current geographic distribution trends among the immigrant population, the effects of an aging immigrant population will be felt in both traditional immigrant states (California, New York, Florida, Texas, and Hawaii) and new immigrant gateways (South Carolina, Tennessee, Arkansas, Alabama, and others).

Second, immigrants in general and older immigrants in particular contribute to the increasing racial and ethnic diversity in American society. Today's large share of non-Hispanic Whites among foreign-born older adults will be decreasing in the decades to come, whereas the shares of Hispanics and Asians will be increasing. This, coupled with new immigrants from Latin America, Asia, and Africa who will "age in place," will change the racial and ethnic composition of older Americans in general. This changing makeup of the older population has important implications for programs for older adults. Given cultural differences in tastes and preferences, we might look for senior meal programs to offer more rice and fewer potatoes, and more salsa music and less ballroom dancing to the changing populations they serve. Similarly, medical providers will need to adapt to provide culturally appropriate health education and care to growing populations who are at greater risk of certain conditions than native-born non-Hispanic Whites.

Third, socioeconomic and cultural incorporation of older immigrants is a covariant of time spent in the United States, national origin and condition of arrival, and context of reception. Not surprisingly, we find that compared with native and long-term immigrant seniors, older immigrants who arrived between 1990 and 2000 are disadvantaged. They are less fluent in English, are less likely to live in an owner-occupied home, and have much lower levels of personal income.

We find that long-term immigrants are more similar to their native-born counterparts than to more recent immigrant elderly. For example, the former two groups are more likely to rely on income from Social Security, assets, and employer pensions for their economic well-being. In contrast, recent immigrant elderly receive their income disproportionately from employment and private transfers. In the context of minimal public assistance available to immigrant families, the responsibility for financial, physical, and psychological well-being of elderly newcomers falls on the shoulders of their family members.

In short, America can look forward to a growing population of older adults who are not native born and whose racial and ethnic backgrounds differ from historical patterns. Largely barred from the receipt of public benefits and highly dependent on kin support, some of these older adults will be among the most vulnerable seniors in the nation. The point-five generation that immigrates in later life to join grown children confronts many obstacles to full incorporation into American society. The poor employment prospects, lack of English fluency, and limited educations of these late-life immigrants exemplify some of their difficulties. It remains to be seen whether today's younger immigrants, many of whom are undocumented and consigned to poorly paid jobs, will be able to gain a secure toehold in the United States before they grow old. Will they be able to follow the relative success of today's long-term older immigrants? Will they approach the native-born population in asset accumulation and receipt of employer pensions? Will their children attain the economic stability necessary to offer adequate family support to aging relations?

If families fall short of meeting the needs of older immigrants, communities could confront unprecedented challenges. Historically, immigrant populations have been "underserved"—unfamiliar and uncomfortable with programs and professionals looked to by other Americans for help with family problems (Moon, Lubben, & Villa, 1998; Tsai & Lopez, 1997). Furthermore, public programs available to immigrants are being cut back. Accommodating growing diversity in national origins and languages poses a significant dilemma, especially when the target population consists of frail older people who may have few day-to-day contacts outside their own families. One critical site where these issues will play out is the health care system. Woefully inefficient, burdened by staggering costs, and faced with growing demands of aging baby boomers, medical care in the United States is ill-equipped to deal with a growing population of medically indigent older immigrants who are not eligible for Medicare or Medicaid. Of course, the challenges are not merely economic ones because culturally sensitive and linguistically appropriate services will also be a key component in the provision of adequate health care to older immigrants.

The challenges posed by older immigrants, especially older newcomers, have not received enough attention, and neither have the important contributions that they make to America's immigrant families. Faced with an uphill struggle to establish themselves in the new country, immigrant families benefit from older relations who can provide concrete services, offer emotional support, and serve as cultural bridges to a distant homeland (Treas & Mazumdar, 2002). Important functions

performed by older family members involve caring for others, including baby-sitting infants and toddlers, supervising schoolchildren, nursing the sick, and comforting the dispirited. Dual-career couples are especially dependent on older people to manage their households (e.g., cooking, cleaning, doing laundry, gardening, shopping, performing home repairs). Older people's small economies (raising vegetables, scavenging for discarded treasures, transforming leftovers into favorite family meals) also stretch the household budget. Lastly, older people promote transnational ties to a homeland, teach the native tongue, preserve meaningful customs, and encourage mutual support among kin. In households where the generations must rely on one another for success and survival, older adults are an important resource facilitating the socioeconomic incorporation of younger family members, even as they transmit the beneficial legacy of their cultural heritage.

Given the contributions and challenges of older immigrants, their increasing numbers, their impact on the racial and ethnic diversity of the entire older population, and the different socioeconomic paths of incorporation available to newcomers warrant further attention. Convincing answers are needed for policy makers to understand adequately the changing population of foreign-born seniors and to design immigration and aging policies to address the needs, resources, and implications of the graying American society.

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Older Immigrants: Cultural Issues in Access to Health Care (Commentary)*

Charlotte Ikels

Immigration is altering the makeup of the American population. In particular, changes made to U.S. immigration law in 1965 have led to increasing ethnic diversity. Treas and Batalova (chapter 1, this volume) note that Hispanics and Asians (e.g., Chinese, Indians, Vietnamese, Koreans, Cambodians, and Hmong, as well as people from the Philippines) will triple in number by 2050, when Whites (according to current definitions) will constitute only half of the American population. These changes mean that the older population itself will become increasingly diverse as a result of both the aging of younger immigrant cohorts and the continuing immigration of their already middle-aged or older parents.

That life expectancy and disease prevalence rates vary among ethnic and racial groups within the United States has long been noted, and the lower life expectancies and higher disease prevalence rates—“health disparities”—of Hispanics, African Americans, and Native Americans, for example, reflect their disadvantaged circumstances. These circumstances have included a history of group discrimination, low levels of

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literacy, unsafe neighborhoods (both environmentally and socially), and economic barriers to accessing health care, for example, lack of health insurance, low income, and high opportunity costs to waged workers who, unlike salaried workers, may have to choose between earning their daily bread and taking the day off to seek health care. In addition to population-level factors, individual level factors, such as lifestyle and genetic susceptibilities, also play a role in poor health outcomes.

In the case of older immigrants, especially those arriving late in life, the situation is even more complex. As Ikels (1998) points out, place of origin characteristics directly impact health status through exposure to local pathogens, diet, and environmental stressors, for example, fumes from burning fuel indoors, water and air pollution, and unsafe working conditions, as well as through the availability of health care. The later in life an immigrant comes to the United States, the more likely his or her body bears, for better or worse, the long-term consequences of such exposure. Antecol and Bedard (2006) note that immigration itself can have negative consequences in that some immigrant populations arrive in better health than their American-born peers but become less healthy (converging toward American norms) the longer they have lived in the United States.

In general, health care providers have paid little attention to the role of the home community in shaping immigrant experiences of disease and illness. Such factors are largely beyond the control of host country researchers and clinicians and, in any case, have already had an impact on the immigrant's health. Instead, health care providers have focused on the role of language and cultural factors, for example, health beliefs, practices, and therapeutic preferences, in shaping immigrant experiences of health and illness. Culture, whether that of the immigrant or the health care provider, has often been perceived as a barrier to effective communication and positive health outcomes. In 2002, the American Society on Aging devoted an entire issue of its journal, *Generations*, to satisfying the demand for information on how to address the needs of the changing older population (Tursi, 2002).

MEETING THE HEALTH CARE NEEDS OF OLDER IMMIGRANTS

To serve this increasingly diverse immigrant population appropriately and effectively, for example, to prevent or reduce health disparities, health care providers must be sensitive to its diverse needs. Not only must physicians, nurses, and other direct care providers be familiar with the basic epidemiologic profile of each local group—its particular physical

and mental vulnerabilities—but they must also have the skills necessary to elicit patient, family, and community cooperation in the quest for health. Certainly, one way to assure the availability of people with these skills is to recruit members of the immigrant communities directly into the health professions. The Institute of Medicine acknowledges that one of the most serious problems in health care delivery has been the mismatch in terms of ethnicity and racial characteristics between local communities and the people expected to serve them. Smedley, Butler, and Bristow (2004) stated, for example, that Hispanics make up “over 12 percent of the population, but only 2 percent of the registered nurse population, 3.4 percent of psychologists, and 3.5 percent of physicians. Similarly, one in eight individuals in the United States is African American, yet less than one in twenty dentists or physicians is African American” (p. 24). Smedley et al. (2004) noted that when minorities have a choice, they prefer to seek care from people of their own racial or ethnic background and that patients matched with clinicians sharing the same background express greater satisfaction with the care they receive. As the following account illustrates, there are multiple reasons why such matching can make a difference in health outcomes.

In her book, *The Spirit Catches You and You Fall Down*, Fadiman (1997) relates the paradigmatic case of a medical encounter gone wrong because of ethnic/racial differences. Hmong refugee parents (the Lees) from Laos are thrown into disarray when their infant daughter, Lia, is first diagnosed with epilepsy. According to Fadiman, Hmong views of epilepsy are ambivalent; on the one hand, epilepsy is recognized as a burden and as potentially dangerous, but on the other hand, it is regarded as a sign that one can host spirits and thus may be destined to become a shaman, which is a spiritual healer of high status within the Hmong community. Consequently, Lia’s parents weigh the importance of her medications and their side effects differently than the health care providers who view Lia’s seizures solely as a health problem. Further complicating matters is the parents’ illiteracy in both English and Lao, and their inability to handle spoken English well. Even when an interpreter is present during regular appointments, information is lost, as it cannot be written down. During the many emergency room visits, no interpreters are present, leaving the parents to sign many documents that they do not understand.

In the face of the many alterations in Lia’s prescribed regimen and continued seizures, the Lees attempt to gain some control over the disease by cutting back on the medications and by complementing her treatment with traditional therapies, such as the ingestion of herbs and rubbing the skin with a coin. Ultimately, they even call on a shaman to restore Lia’s wandering soul to her body. The perceived “noncompliance”

of the parents eventually leads to the involvement of Child Protective Services and (temporary) loss of custody of Lia. Fadiman notes that the involvement of the legal system casts the conflict in power terms and leaves the Lees with distrust of the health care system. This experience, she argues, resonates with the historical experiences of the Hmong in China, where they were the objects of acculturative pressures by Chinese officials. In China, they resisted this pressure by fleeing to less inhabited areas, including to Laos. Thus, unlike many immigrants who come to the United States intending to change their way of life, the Hmong came to the United States expecting to preserve their way of life. Convinced that they are good parents with the welfare of their child uppermost in their minds, the Lees walk a fine line between following the directives of Lia's health care team and their own sense of effective parenting to regain and then maintain custody of their daughter. Lia goes on to experience major seizures (including "the big one") that, coupled with—and possibly precipitated by—a diagnosis of sepsis, leave her in a persistent vegetative state. Fadiman learns that Lia's parents may have been right when they complained that her treatment was making her ill; suppression of the immune system is sometimes a side effect of her major medication. Lia is discharged from the hospital to the Lees to die, but to the hospital staff's amazement, she does not die. Instead, under the dotting care of her mother, she continues to gain weight and has remained for years the center of family attention, although completely incapable of responding.

Fadiman does not fault the health care providers, none of whom are Hmong; she regards them as caring, if sometimes harried, professionals, but she does note one glaring shortcoming. In going through reams and reams of records and documents, she finds no evidence that anyone ever took the trouble to learn how the Lees saw their daughter's problem. She recalls a set of eight questions developed by Kleinman, Eisenberg, and Good (1978) to ascertain a patient's or, in this case, the caregivers' "explanatory model," that is, their interpretation of what was happening to their daughter. Fadiman believes that had the Lees' view been sought, they would never have been misperceived as neglectful parents, and some kind of compromise might have been possible by working through leaders within the Hmong community.

The strategy of working through community leaders need not be limited to those leaders who are formally recognized, such as clan heads or religious specialists. In Boston's Chinese community, Ikels (1986) notes that certain individuals, although not formally occupying positions of power, are nevertheless very influential in the lives of immigrant elderly. She calls these people "natural helpers" because they readily

assist the recent immigrants who turn to them for advice and found that they shared six characteristics:

1. They had established reputations such that one did not need to know them personally to approach them.
2. They were bilingual and, to a lesser extent, bicultural. Because so many of the Chinese elderly, especially the women, were illiterate, they were totally dependent on the spoken word.
3. They were relatively accessible, living or working in areas with concentrations of Chinese.
4. All had extensive managerial experience, having worked as administrators or having run their own businesses. They were familiar with the ways of bureaucracies and not intimidated by them.
5. All were middle-aged or older people themselves, their age lending credibility to their advice. Many elderly were reluctant to share their problems with younger professionally trained social workers, but were comfortable talking with peers.
6. All highly valued the act of helping. (Ikels, 1986, p. 219)

Yet, these individuals operated under the radar of formal service providers. Given the poor representation of minority groups in the health professions, involving credible nonprofessionals in health care settings as greeters, ombudspersons, or cultural brokers would make patients feel comfortable and more likely to continue their relationships with the facility. A more permanent solution to the problem of underrepresentation would be to recruit more minorities directly into the health professions. Given that recruitment and training of such personnel are likely to be gradual and long-term processes, many health care providers have instead, or in addition, attempted to train their current staff in cultural competence.

CULTURAL COMPETENCE

Clinic, hospital, and nursing home administrators have long been aware of the challenges inherent in meeting the needs of patients or residents who do not speak English and/or whose cultural backgrounds differ from that of the mainstream. For example, the relative scarcity of non-White minority elderly in nursing homes was noted as early as the 1970s and variously attributed to cultural incompatibilities, stronger family ties, racial discrimination, and illegal residence (resulting in fear of detection and possible deportation). On Lok in San Francisco is probably

the earliest and most successful attempt to reach such an underserved population.

On Lok began in 1972 as an adult day care center, catering primarily to residents of Chinese descent in the Chinatown and North Beach areas. Now known as On Lok Senior Health Services, the nonprofit organization provides a full range of comprehensive medical, social, and rehabilitative services to over 1,000 enrollees. Cultural diversity is a feature not only of its clients (of whom 63% are Asian or Pacific Islander, 12% Hispanic, 12% White, 10% African American, and 2% other) but equally so of its staff (of whom 74% are Asian or Pacific Islander, 15% Hispanic, 9% White, 2% African American, and less than 1% other; Kornblatt, Eng, & Hansen, 2002). Because of its long history of serving a diverse population, On Lok has been able to develop expertise in culturally sensitive matters, such as discussing advance directives with clients who think talking about death is sure to result in bad luck. Nevertheless, as it expanded beyond the Chinatown–North Beach area, even On Lok felt the need to offer diversity training to its staff. The training program initiated in mid-2000 had four key objectives: to increase awareness of the role culture plays in daily life, to understand how culture shapes what people bring to the workplace, to promote cultural sensitivity, and to provide a welcoming environment (Kornblatt et al., 2002). These goals were aimed at enhancing interaction among the staff as much as at improving patient care. Other health care providers have also attempted to promote diversity training and cultural competence since the phrases first became widespread in the early 1990s. However, there was little systematic guidance in program design or evaluation, and on a national level, it was difficult to know how well the needs of members of the various racial and ethnic categories were actually being met.

To address these problems, the Office of Minority Health (OMH, 2001) of the U.S. Department of Health and Human Services (HHS) issued a set of 14 national standards for culturally and linguistically appropriate services in health care in March 2001. Before being finalized, a draft of the proposed standards was made available for public commentary, excerpts from which are included in the executive summary. Although supportive of the goals of the standards, many commentators felt that the standards themselves would be unduly burdensome. Service providers with high employee turnover or small numbers of patients or clients from numerous ethnic groups are already stretched thin. Health centers or nursing homes in remote locations are unlikely to have sufficient expertise within their own ranks to be able to develop cultural competence training programs and unlikely to have sufficient funds to bring in outsiders.

To help such disadvantaged facilities improve their capacity to deal with a culturally diverse clientele, three strategies have been developed. All rely heavily on self-motivation, that is, interpreting the research results and publications prepared by others. Most of these publications take one of three approaches, although some combine approaches. They include: (1) providing focused studies of the ethnic minorities a facility is likely to encounter, (2) offering a generalizable set of tools and skills to guide the health care provider in conducting a culturally sensitive patient interview, and (3) presenting detailed case studies or rich ethnographic data on a particular ethnic population. Although books and articles in the first two categories often aim explicitly at the promotion of cultural competence and improvement in utilization rates, those in the last category do not necessarily emphasize these goals.

Typical examples of the first approach are works by Aroian, Khatzky, Tran, and Balsam (2001); Sohn and Harada (2004); and Strumpf, Glicksman, Goldberg-Glen, Fox, and Logue (2001). Each of these studies focuses on one or more ethnic groups in a specific locale: Aroian et al. on elderly immigrants (almost all Jewish) from the former Soviet Union living in the Boston area, Sohn and Harada on Korean Americans in Los Angeles County, and Strumpf et al. on elderly Cambodian, Vietnamese, Soviet Jewish, and Ukrainian refugees living in Philadelphia. By their very nature, focused studies are necessarily narrow, exploring only a few variables, but they can be very useful in identifying features of the local situation that affect access to health care.

Works following the second approach, for example, Stuart (2004) and Purnell and Paulanka (2005), provide more hands-on instruction for cross-cultural or multicultural interviewing. Stuart offers 12 suggestions for psychologists working with immigrants or other people likely to come from cultural backgrounds other than that of the archetypical middle class. He argues that the systematic sketch approach risks promoting stereotypes and ignoring intracultural variation. Even in the case of immigrants, the idea that he or she is a representative member of a bounded and stable culture cannot be sustained in the face of the global spread of mass media and the acculturative pressures that make every immigrant a multicultural person. Rather than simply assume that a person is a representative of a particular ethnic group, Stuart proposes that each client be viewed as an individual whose ethnic background constitutes only one of many variables shaping his or her values and attitudes.

In a similar vein but for a wider range of health care professionals, Purnell and Paulanka (2005) propose the Purnell Model for Cultural Competence as suitable "in all practice settings and by all

health-care providers” (p. 7). The model incorporates 12 cultural domains: “overview/heritage, communications, family roles and organization, workforce issues, biocultural ecology, high-risk health behaviors, nutrition, pregnancy and the childbearing family, death rituals, spirituality, health-care practices, and health-care practitioners” (p. 8). Purnell and Paulanka provide an extensive set of questions to be used to elicit the desired information for each domain. However, they recommend that given the reality of time constraints, the client interview include only those domains directly relevant to the situation at hand. The bulk of the book (27 of 29 chapters) utilizes the 12 domains schema as a framework to describe particular groups (from A for African Americans to V for Vietnamese) in terms of their heritage.

Two problems commonly encountered in broad cultural depictions are lumping together populations that are so diverse that the depiction becomes nearly meaningless and treating cultural values as if they were predictive of actual behavior. Values, however formalized in religious, philosophical, or legal texts, serve as guides for behavior. They should not be understood as predictive of behavior. For example, older people of Chinese heritage are widely thought to be venerated, respected for their wisdom, and cared for by their children. Yet, even in China itself, enormous cohort differences in educational attainment and Mao-era denunciations of authority suggest that these views are not widely held, and according to Miller (2004), Wang (2004), Yan (2003), and Zhang (2004), expectations of care from children often go unrealized.

The third approach, utilizing detailed case studies or works presenting rich ethnographic data on ethnic groups, offers the best sources of information on the actual circumstances of elderly immigrants in concrete communities. Such studies have particular value for programs in cultural competence because they inevitably demonstrate the degree of intracultural diversity in family and household organization as well as invite the reader to observe how health and illness are managed over time and the constraints real people face in choosing their health care providers. Solid ethnographies by Freidenberg (2000) on elderly Puerto Ricans in New York, Guo (2000) on elderly Chinese in New York, Omidian (1996) on elderly Afghan refugees in California, and Pang (2000) on elderly Koreans deal explicitly with health care seeking and/or mental health issues among older immigrant populations. Yet, the features that make these studies valuable are the same features that potentially limit their applicability; that is, they describe a particular population at a particular time in a particular place. Societies, populations, and cohort characteristics can change rapidly, so this type of study must be approached cautiously.

CRITIQUES OF THE CULTURAL COMPETENCE PARADIGM

Not everyone is convinced that training in cultural competence is risk free or that it can carry all the responsibility for reducing health disparities. Even Fadiman's (1997) book on the Lees has come under critical scrutiny. *The Spirit Catches You* has become a major tool in medical and anthropological training to promote cross-cultural sensitivity. Taylor (2003) notes that it is required reading for all first-year medical students at several universities, and in 2001 it was required reading for all incoming freshmen at California State University-Chico. Taylor greatly admires, even "loves," the book, but as an anthropologist, she has reservations about the way Hmong "culture" is portrayed, as a fixed, uniform set of beliefs and practices shared by all Hmong. This stance assumes that individual Hmong, such as the Lees, have no agency; they are hapless followers of the Hmong way, from which any deviations will be stigmatized as "non-Hmong."

In this critique, Taylor's argument is similar to that voiced by Milem, Dey, and White (2004), whose review of the weaknesses of the cultural competence approach reveals two problems: (1) the tendency to essentialize (portraying culture as a specific, unvarying set of characteristics) and, perhaps, to stereotype people—one is no more than one's culture; and (2) the tendency to lump together into a single category ("Latino" or "Asian") populations that do not share the same history or experiences and are in fact quite different culturally. Milem et al. (2004) believe that the most effective diversity training for health care professionals would blend a more nuanced cultural competence approach with a communications skills approach, for example, employment of the same eight questions from Kleinman et al. (1978) that Fadiman admires. The more nuanced approach would acknowledge that culture is contingent, changing, and heterogeneous, and that social and economic differentiation within the ethnic community results in subgroups differently valuing aspects of their shared culture. Culture is not a case of one size fits all.

Another critique of the paradigm is that it is too one-sided, that is, that the problem in communication and/or the delivery of health care is attributed to the mismatch between the patient or client's culture and that of the provider and that the appropriate remedy is for the provider to develop the necessary skills and knowledge to work effectively in a multicultural environment. Little other than lip service, let alone training effort, is directed to the fact that the individual physician, nurse, therapist, or social worker brings his or her own often unconscious biases to the encounter. Dean (2001) argues that attainment of cross-cultural

competence is a “myth” and that the best one can hope for in therapy is mutual understanding and respect that over time can promote trust. She also argues that professional training constitutes as important a part of cultural baggage as one’s ethnic heritage. Fox (2005) extends this critique, pointing out that students enter medical school imbued with optimistic beliefs about the power of medicine and that the medical school experience does little to challenge these beliefs or to attune students to other possible perspectives.

A third critique of the cultural competence paradigm is that, as a concept, it is too nebulous and that it means different things to different people. Consequently, measuring the attainment of cultural competence, evaluating training programs, and determining the impact of these programs on health outcomes can be very problematic (Betancourt, Green, Carrillo, & Ananeh-Firempong II, 2003; Geron, 2002). Betancourt et al. (2003) note that there are at least three types of cultural competence interventions variously aimed at the organizational, structural, and clinical dimensions of the health care system and that all of them are important in reducing disparities. Geron (2002) argues that instruments to assess cultural competence may be biased against the very populations the concept is intended to help, that is, that minority staff may be practically qualified yet be unable to demonstrate their knowledge and skills on tests developed according to mainstream language and cultural norms. He also notes the limited role of the consumer in the evaluation process.

CULTURE—ONLY PART OF THE STORY

The emphasis on developing cultural competence among service providers is intended to improve the health care environment, such that currently disadvantaged populations can receive services appropriate to their needs and delivered in ways respectful of their heritage. But there is a downside to this story—a focus on culture as the primary contributor to health disparities deflects attention from other possibly even more important contributors. As stated at the beginning of this chapter, the health status of minority groups has been shaped by histories of group discrimination, low levels of literacy, unsafe neighborhoods (both environmentally and socially), and economic barriers to accessing health care, for example, lack of health insurance, low income, and high opportunity costs to waged workers. Training in cultural competence does nothing to address these problems. And in some ways, the

situation has become even worse for more recent elderly immigrants, as their eligibility for services has been restricted by Title IV of the *Welfare Reform Act of 1996*.

Treas and Batalova (chapter 1, this volume) note that long-term elderly immigrants (those who immigrated in their youth and aged in the United States) are more like their native-born counterparts than like recent elderly immigrants. “[O]lder immigrants who arrived between 1990 and 2000 are disadvantaged. They are less fluent in English, are less likely to live in an owner-occupied home, and have much lower levels of personal income. . . . Largely barred from the receipt of public benefits and highly dependent on kin support, some of these older adults will be among the most vulnerable seniors in the nation.” Their increased vulnerability is a consequence of policy decisions and the historical timing of their immigration—not of their cultural background.

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Immigration and an Aging America: Downward Spiral or Virtuous Circle? (Commentary)

Charles Hirschman*

Demographic change is often interpreted as an impending crisis. The current headline is the downward slide to a “graying America,” where senior citizens outnumber children and there is an accompanying loss of savings and innovation (Peterson, 1999). Only a few decades ago, the demographic crisis was the “Population Bomb,” which included the high fertility era of the baby boom in the United States. In the early decades of the 20th century, the demographic problem was sinking fertility in Europe and North America that was thought to forecast the demise of Western civilization.

These sensationalist extrapolations and interpretations are rarely promoted by demographers. Students of demography are taught that trends rarely last forever and that all societies have feedback loops—that is, cultural and economic institutions that moderate the impact of demographic pressures. Over history, there are many examples of social change in response to demographic and ecological pressures, including changes in patterns of age at marriage, celibacy, long-distance migration, and patterns of inheritance and intergenerational obligations

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(Davis, 1963; Wilson & Airey, 1999; Wrigley, 1969). Demographic trends do have consequences, and the adjustments are generally unwelcome and sometimes painful. But the claim that “demography is destiny” overstates the relationship and assumes that societies are unable to adapt and change in response to demographic pressures.

The study of societal adjustments to demographic change is complicated because the pressures and strains are often mediated through social and political institutions, as are the responses. For example, an increase in population numbers (in a society or a group) may lead to diminished welfare, but only if resources are fixed and there is no technological change or shift in political power. In an ingenious analysis, Samuel Preston (1984) showed that the “birth dearth” following the end of the baby boom in the 1970s and 1980s was associated with a decline in the welfare of American children, whereas the rising numbers of elderly were able to enhance their status through government redistribution of resources.

The situation in the 21st century is likely to be different. The fraction of the American population aged 65 years and older increased significantly, from 9.3% in 1960 to 12.4% in 2000. This is, however, a very small shift relative to what lies ahead. By 2050, the fraction of the population aged 65 and older is projected to rise to 20% (He, Sengupta, Velkoff, & DeBarros, 2005, p. 13). An even greater change is predicted in Europe, where the elderly will soon be about one-third of most national populations. Changes of this magnitude are certain to create social and economic pressures for the society as a whole, as well as tremendous pressures for changes in the roles of the elderly.

In this chapter, I review the potential relationships between population aging and immigration—the other demographic tidal wave affecting American society. Some observers assume that these demographic waves will be additive and exacerbate the changes that would occur if only aging or only immigration were the major demographic change on the horizon. There is also another possibility, namely, that immigration and population aging may be complementary forces and each will work to offset, at least in part, the pressures created by the other.

This review begins with a short demographic primer on the origins of population aging, followed by a review of the arguments and evidence presented by Treas and Batalova (chapter 1, this volume). Then, I consider the demographic pressures created by population aging on economic transfers and the health care system and how immigration might affect these processes.

THE DEMOGRAPHIC SOURCES OF AGING

Most nondemographers assume that population aging is the result of declines in mortality. The expectation is that the decline of death rates leads to increased longevity, which results in an increasing share of the population at older ages. This seems intuitively plausible; however, the demographic metabolism is complicated by combined processes of fertility and mortality and the age pattern of mortality (Coale, 1964, 1972).

At any point in time, the age structure—the proportions of the population at each age—is the product of fertility and mortality in preceding decades. This discussion assumes a closed population without in- or out-migration. Births enter the population at age 0 and advance up the age structure with the passage of chronological time. The population at any age, say x , at time t is the difference between the number of births x years earlier and the cumulative number of deaths experienced by the cohort from $t - x$ to t .

In most populations, the proportion at the oldest ages—the peak of a population pyramid—is generally the smallest and represents persons who have survived from birth to old age. Because lower mortality rates lead to more persons surviving to older ages, it is tempting to interpret reductions in mortality over time (or differences between two populations, more generally), leading to increases in the fractions at older ages. However, the impact of mortality on the age structure is diffuse because deaths are distributed by age. If mortality is reduced at age x , the result is more persons at each age above x . Reductions in infant mortality and at the youngest ages (which has been the largest component of 20th-century mortality decline) actually lead to a more youthful age structure.

In formal demographic models and simulations, Coale (1972) and other mathematical demographers have shown that variations in age structure (over time and between populations) are dominated by changes in fertility, with only modest effects attributable to mortality change. This is because births are concentrated at age 0, whereas deaths are distributed at all ages. The American baby boom, which lasted from the late 1940s to the mid-1960s, dramatically increased the proportions at younger ages. Over the second half of the 20th century, the arrival and subsequent maturity of the baby boom generation accentuated waves of economic demand, crowded schools and labor markets, women's participation in the labor market, and massive changes in family structure (Easterlin, 1978). Very low levels of fertility are the primary reason for

the much older age structures in Europe relative the United States. The projected aging of China and many other developing countries in the coming decades is primarily a product of their recent declines in fertility.

Because fertility is already at very low levels in the United States and other industrial countries, mortality changes will probably have somewhat greater impact on age structure in the coming years. Mortality rates are already very low at younger ages, and significant further reductions will be more difficult to achieve. There is still considerable room, however, for major reductions in mortality rates at middle and older ages through improvements in treatment, diagnosis, and prevention of chronic conditions and diseases. Reductions in mortality at older ages will gradually increase the proportion of elderly in the population.

THE SITUATION OF OLDER IMMIGRANTS

Judith Treas and Jeanne Batalova (chapter 1, this volume) present a much-needed overview of the situation of older immigrants, with a focus on what is likely to happen in the coming decades. They describe the current and future size and composition of the elderly immigrant population. Treas and Batalova also address some broader issues, including the likely impact of immigration on strains created by population aging. As I read their study, the message is that the effects of population aging and immigration are largely additive, with the immigrant elderly adding to the societal burdens created by population aging. In the final section of this chapter, I attempt to make the alternative case, namely, that immigration and aging are complementary forces, with immigrants helping American society adjust to the costs of population aging.

With an increasing flow of immigrants over the last three decades of the 20th century, immigrants and their children (often referred to as first- and second-generation immigrants) comprised about one in five Americans at the turn of the 21st century. Unless there is some major change in immigration law, the “post-1965 immigration wave” is likely to continue for the foreseeable future (Massey, 1999). Immigration creates its own dynamic of expansion through social networks. Current immigrants can sponsor and assist newcomers who tend to be related to (or from the same communities as) those who are already here. Moreover, immigrant niches in certain industries and occupations generate demand for additional workers.

The Age Composition of Immigrants and the Immigrant Share of the Elderly

Treas and Batalova predict more older immigrants, both in absolute and relative terms. They cite Census Bureau projections, which show the foreign-born elderly rising from about 10% of the total elderly (aged 65 years and above) in 2000 to about 20% in 2050. They conclude that this figure is likely to be even higher because of the undercount of Hispanics (most of whom are foreign born) and the presumption that Census Bureau estimates of future immigration are likely to be too low. Their argument is that increasing numbers of immigrants, most of whom are young, will eventually lead to more elderly immigrants with the passage of time. Treas and Batalova are certainly correct in terms of the absolute number of elderly immigrants. And as the fraction of the total population of immigrants rises, there is likely to be higher fractions of immigrants in all age groups, including the elderly, but the projection of 20% seems too high, in my judgment.

The age structures of the foreign born and the native born have been moving in opposite directions in recent decades (He, 2002). The native-born population has been getting older because of the decline in fertility and the advancement of the large baby boom cohorts into late middle age. On the other hand, the foreign-born population has become increasingly younger with the resumption of large scale immigration in the last few decades of the 20th century. At the onset of the post-1965 wave of immigration, about one-third of the foreign-born population was over age 65—about triple the proportion of elderly among the native-born population. The foreign-born seniors were the survivors of the massive numbers of immigrants who arrived from southern and eastern Europe during the early decades of the 20th century.

From 1970 to 2000, the numbers of immigrants (the foreign born) tripled, from 10 million to over 30 million, and the foreign-born share of the American population more than doubled, from 4.7% to 11.1% (Gibson & Jung, 2006). During this period, the age structure of the foreign born became much more youthful—even younger than the native-born population. The ranks of the foreign-born elderly were depleted by the gradual disappearance (through death) of early 20th-century immigrants and almost all new immigrants were in the working ages. As Treas and Batalova note, “international migration is a young person’s game,” and fewer than 15% of new immigrants are over 50.

The Census Bureau projection that the percentage of foreign-born elderly will rise to 20% by 2050 (cited by Treas & Batalova) can be

questioned on several counts. Even with the high immigration of recent decades, the foreign-born share of the American population in the middle working ages in 2000 is only about 12% to 13% (Gibson & Jung, 2006, p. 39; Hobbs & Stoops, 2002). Simple projections of “aging in place” do not approach the predicted 20% foreign born among the elderly in the coming decades. Moreover, the numbers of native-born elderly will increase dramatically in the coming decades as the large baby boom cohorts will move into the ranks of the elderly.

The assumption of continued high immigration to the United States for the foreseeable future does not necessarily imply an increase in the proportion of foreign-born elderly. The number of elderly immigrants has been fairly modest. Assumptions about the eventual aging of younger immigrants must be adjusted for some level of emigration among older or retired immigrants. The United States does not maintain official records of emigration, but Census Bureau estimates show that anywhere from 10% to 30% of the foreign-born population leave the country every decade (Ahmed & Robinson, 1994). Unless there are dramatic surprises that cannot be foreseen, the foreign-born population will remain a much younger population than the native born. The numbers of the foreign born will definitely increase, and they will increasingly resemble the national origins of the younger foreign born—disproportionately Latino and Asian—but their share of the total elderly seems unlikely to rise much above 15%—which would be about one-half of what it was in 1970.

Might Immigration Offset Population Aging?

Treas and Batalova acknowledge that the combination of young immigrants and higher fertility (relative to the native born) will make the total U.S. population younger, but they caution that “Rejuvenating effects on the population age structure are short-lived, however, because young immigrants eventually grow old in their host society. As a way out of the generational imbalance created by the perfect storm of sub-replacement fertility and lengthening life expectancies, international migration fails, in part because it would require much higher levels of immigration than most countries comfortably contemplate.”

Treas and Batalova underestimate the impact of immigration on slowing population aging. The effects of immigration on the age structure are short lived only if the age composition of immigrants changes or if immigration decreases. Neither seems likely at present. The impact of the baby boom of the 1950s and 1960s on 21st-century aging is only partially due to the size of the baby boom cohorts; primarily, it is because

the baby boom was followed by much smaller birth cohorts in the 1970s and 1980s.

The Census Bureau has estimated the old age dependency ratio (population over age 65 as a percentage of the population aged 15–65) for each decade from 2000 to 2100 under four scenarios: zero, low, middle, and high immigration (Hollmann, Mulder, & Kallan, 2000). The middle series projects immigration to remain at approximately its current absolute level, about 1 million net immigrants. The old age dependency ratio would rise from about 20 in 2000 to 40 in 2050 if immigration were zero, and it would still rise to 36, 34, and 30 if immigration continues at low, middle, or high levels. As other researchers have shown (Coale, 1986; Espenshade, 1994), immigration cannot reverse the impact of population aging, but the projected effects on the future age structure are not trivial.

There is almost always some nativist response to rising levels of immigration, and the discussion of the United Nations report on “replacement level immigration” (the level of immigration necessary to offset population decline) did spark fears of too much immigration (United Nations, 2000; also see Bermingham, 2001). There was a strong backlash against immigrants from Eastern and Southern Europe in the early 20th century that led to immigration restrictions in the 1920s (Higham, 1988). There were continued voices against immigration in the late 20th century, but none reduced the influx of immigrants. As more immigrants and their children become voters and the American economy becomes more dependent on immigrant workers, the prospect of drastic immigration controls seems less likely, although it is possible.

THE DEMOGRAPHIC CHALLENGE OF AGING

Because population aging is a new phenomenon with few historical precedents, anticipating the nature of future social change is necessarily a fairly speculative enterprise. I am fairly skeptical of the prediction of catastrophic outcomes that some have projected, but there will be social adjustments at the family, community, and societal levels. Many of these are already evident. There will be many more three- and four-generation families. Overall, extended families and kinship networks will be smaller than in the past, especially in terms of lateral kin, but children will have more grandparents and great grandparents, as well as great uncles and great aunts, than past generations did. There may be more economic demands to support aging relatives, but each person will have fewer siblings to share any bequests than in earlier times.

Employers and community organizations, including churches and civic clubs, may have fewer younger workers and families with young children, but they will have more persons approaching or above the normal retirement years. With more elderly, there are likely to be more claims on social services, and there may be imbalances between available resources and needs of older populations. Indeed, many small communities that have experienced out-migration have long encountered such problems. On the other hand, the availability of more elderly persons in good health who possess a strong work ethic and civic responsibility may create new opportunities for businesses and voluntary organizations.

Because many families and communities will not be able to cope with the economic and social demands of population aging, the expectation is that government, especially the federal government, will have to assume greater responsibilities to redistribute resources to the dependent elderly. The mechanism for such programs—the intergenerational compact—has been part of all human societies.

The family, in addition to its reproductive and economic roles, is an institution that is well organized for the transfer of food and other resources (including care) from adults in the prime working ages to dependent children and older persons. These transfers are motivated by affection, but also by interdependence and reciprocity. Adults generally feel an obligation to support older family members who cared for them at an earlier stage of life. In most traditional societies, one of the primary motivations to have children is as an “investment” for old age security.

Because the loss of a single working age family member can wipe out the support for children and the elderly, most communities and societies have designed “backup” means to support families in need. The first line of defense is the extended family system, which might include customs for widows and widowers to marry other relatives. Most traditional societies also have programs of social insurance that pay one-time or continuous benefits to families who experience a death. These social cooperatives sometimes collect small regular taxes from all members, whereas others depend on contributions when the need arises.

The “welfare state,” which redistributes funds from taxes to programs for children and the dependent elderly, is very similar to the social insurance customs and practices of traditional communities. In principle, modern programs of intergenerational transfers are more efficient and less costly than community-based programs because the risks are shared by a larger pool of persons. However, large programs may face additional challenges because of the loss of legitimacy and support for intergenerational transfers that are inherent in extended families and

in face-to-face communities. Bureaucratic programs can also be more expensive because of the complexity and infrastructure of welfare organizations.

Population aging creates a challenge to current and future societies because it is likely to raise the costs of the intergenerational compact. Is it possible that some of these costs might be met by immigrants?

Old Age Pensions

Most national systems of old age pensions were designed as extensions of the intergenerational compact. In some ways, old age pensions are similar to public education, except the benefits flow up rather than down the generational ladder. The provision of schooling for an individual child would be beyond the reach of most parents (the costs of private schooling approximates the actual price of education), but a fairly modest tax from all workers (or all property owners) generally covers the cost of public education for all children.

Whereas educational taxes can be considered as an investment for the collective future, or perhaps a repayment for one's own education, old age pensions are a form of social insurance. Insurance covers the uncertainty of death. Because individuals cannot foresee their own longevity, almost everyone benefits from a collective pooling of resources to cover the unknown needs for economic support after retirement. Some individuals may "lose" in the sense that they do not live long enough to collect their share, but they have also gained because they lose only the amount paid in taxes, which is much less than what they would (or should) have saved for their individual retirement.

Because almost all state-sponsored old age pensions are "pay as you go" systems (not individual savings accounts), they have one other major cost-savings, namely youthful age structures. Until recently, all industrial societies had three, four, or more workers paying retirement taxes for each retiree receiving benefits. Under such circumstances, fairly modest per-capita taxes on workers were sufficient to support relatively generous pensions to retirees. With the expected shift of age structure in the United States in the first half of the 21st century, Social Security taxes (or general revenues) will have to be raised considerably to provide for the higher ratio of retirees to workers. The other alternative is to cut benefits directly or indirectly by raising the age of eligibility. Neither of these options are popular ones.

Official projections of the long-term future of Social Security in the United States rely on assumptions that probably underestimate future improvements in longevity and future declines in fertility (Lee, 2000; Lee

& Tuljapurkar, 1997). Fertility is projected to remain at current levels, just below the replacement level, which is far higher than in almost every other industrial country. Mortality projections assume that recent trends in increased longevity will slow down. More realistic assumptions suggest that payroll taxes will have to double from the current level of about 12% of wages (Lee & Tuljapurkar, 1997, p. 77).

Immigration does not solve the Social Security problem, as noted earlier, because population aging cannot be stopped under any reasonable immigration scenario. But immigration does slow population aging, especially if immigration is assumed to continue or even increase. A recent report to the Social Security Advisory Board recommended that assumptions about future immigration be converted from absolute numbers to a rate (based on the U.S. population), which would effectively increase the assumed positive benefit of immigration on the solvency of the Social Security system (Technical Panel on Assumptions and Methods, 2003). With an intergenerational accounting framework, Lee and Miller (1998, 2000) have shown that immigrants (and their descendants) contribute more in taxes than they receive in benefits. Just as the age structure of immigrant households makes them disproportionately the beneficiaries of public education, the relative youth of immigrants also means they are less likely to be beneficiaries of Social Security and Medicare (and Medicaid for the institutionalized elderly). Immigrants also help to relieve the per-capita fiscal burden of native born for the national debt, national security, and public goods, which are major federal expenditures that are only loosely tied to population size.

Health Care

Population aging will also add pressures on the health care system. Recent evidence shows that more recent cohorts of the elderly are healthier than earlier generations and experience lower rates of disability (Crimmins, 2004; Manton & Gu, 2001; Wolf, Hunt, & Knickman, 2005). Nonetheless, older persons have higher rates of chronic conditions than do younger persons. As the fraction of the elderly rises, there will be more funds spent on doctors, nurses, home health aides, and all other medical professionals, as well as on hospitals, nursing homes, and pharmaceuticals. In general, most health care costs are not paid directly by consumers, but by transfer payments from taxes and insurance costs. For the elderly, most health care costs are paid by Medicare and Medicaid. Current tax revenues for health care, similar to those supporting Social Security, will be under strain as population aging increases the number of beneficiaries relative to the working population.

Because most immigrants are more likely to be younger workers (who pay general taxes and payroll Medicare taxes) than older Medicare recipients, immigrants provide some additional resources to support the health care system for the elderly. But there are two additional reasons why more immigrants might lower pressures on the health care system. Immigrants provide a significant share of workers for the health care system, and immigrant families are somewhat less likely to rely on institutional support for elderly family members.

Many immigrants work in the health care system at all levels—as physicians, nurses, lab workers, and biomedical researchers. The increased supply of highly skilled immigrants has eased shortages for health care personnel, especially in areas (inner cities) and institutions that are considered less desirable by native-born workers. Moreover, immigrants often work in many of the less skilled positions in the health care industry as attendants in nursing homes and as home health aides. These positions are generally poorly paid and involve many personal services for elderly patients that family members are reluctant to perform. The health care industry is one of the sectors of the economy that cannot be imported or outsourced. Unless there is some new source of domestic workers, immigrants are likely to be an important resource for an increasingly aging society.

Minorities and immigrants, in general, have a strong sense of obligation to care for their aging parents, and elderly immigrants are more likely to reside with their adult children than the native-born elderly (Ishii-Kuntz, 1997; Kamo & Zhou, 1994). These cultural patterns might reduce, at least to a small extent, the very large economic burden of the institutionalized elderly that are supported by Medicare and Medicaid.

CONCLUSIONS

Almost all 21st-century societies will soon, if they have not already, begin to experience the social and political strains of population aging. There are strong cultural norms of respect and support for the elderly in most societies, and most industrial societies have made political commitments to provide pensions and health care for the elderly. These commitments were easier to invoke in earlier times where there were relatively few elderly. As the elderly double (or even triple) their relative share of the population (from less than 10% to 20% or more), there will be higher per-capita economic and social costs borne by the working population.

At first glance, the burdens of population aging seem to be compounded with the increasing numbers of immigrant elderly.

Immigration does add to the absolute numbers of dependent elderly, and the immigrant elderly are different from the native born. The majority of the immigrant elderly are likely to be considered minorities (Asian, Latino) in the American context. And recent immigrants are less likely to speak English, less well educated, and have lower incomes than the native-born elderly. With less access to public benefits, the immigrant elderly might be considered to be a burden to immigrant families who are struggling to make it in America, as well as to the larger society that must reckon with the costs of an increasing proportion of elderly.

This interpretation—which sees the additive effects of population aging and immigration creating a downward spiral—might be premature. First, the negative expectations of population aging may be exaggerated, and second, immigration may counteract some of the pressures created by population aging. Perhaps the “virtuous circle” interpretation in the title of this chapter may also be an exaggeration, but it calls attention to complementarities that are frequently overlooked.

The transition to an older population may have some positive outcomes. The presence of a relatively well-educated, prosperous, and healthy retired population could be an important societal resource (He et al., 2005). Many elderly, especially the oldest old, may be relatively inactive, whereas other elderly may be more interested in leisure pursuits than volunteer service. However, even if only a relatively small fraction of the active retired persons in their 60s and 70s could be persuaded to help in schools, community organizations, and charitable programs, they could make an important difference. The rising labor force participation of women has depleted the ranks of volunteers in many communities and created a huge demand for after school programs for children. The growing numbers of elderly in society will increase economic pressures on Social Security and medical services, but it has also created a new opportunity and resource for societies with the wisdom to appreciate the potential of “elder power.”

During the transition to an older society, immigration provides some relief that mitigates (although does not eliminate) the pressures of population aging. The majority of immigrants come during their active working years, and they generally have a very strong work ethic and traditional family values. Immigrants help to shore up the ratio of workers to retired persons in the short run. If immigration continues at a constant rate (increasing absolutely) and immigrants have higher fertility than native families, the impact on the age structure will continue. Moreover, a considerable fraction of immigrants will leave the country and may not collect Social Security; this is most likely for undocumented immigrants.

The occupational roles of immigrants are also a resource for an increasingly elderly society. Many immigrants work in health care occupations at all levels, including nurses and health aides that care for the elderly in nursing homes and in private homes. Immigrants often work in sectors that native-born workers shun because of low wages, low status, and few benefits. Caring for the infirm and disabled elderly is not a job that very many Americans desire. Immigrants help to fill this need.

The social and economic implications of demographic projections rely on uncertain assumptions, including that demographic trends will continue and behavioral patterns that characterized the past will not change. My guess is that both population aging and immigration will continue, but that their impact will be both complementary and more benign than currently anticipated.

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Population Aging and Benefit Sustainability: The Impact of Baby Boomer Aging on the Health Care System

Stephen Crystal

The first of the baby boomers—the cohort born in the years following the end of World War II—began reaching age 60 in the year 2006. Thus, the long-awaited aging of the boomers is upon us. Concurrent with this milestone has been increased intensity of public debate concerning the sustainability of basic institutions of care and social protection in old age. In the United States, there have been renewed arguments that with the boomers' aging, the entitlements to a defined set of benefits represented by Medicare and Medicaid are unsustainable; that excessive utilization in an aging population is the villain; and that we face an upcoming choice between major cutbacks in benefits (and/or explicit rationing) on the one hand, or economic meltdown and generational warfare on the other.

For example, former Colorado Governor Richard Lamm has suggested that as this large cohort retires, we must confront such “ethical dilemmas” as whether to give flu or pneumonia immunizations to people with Alzheimer’s disease (Lamm, 2002). Daniel Callahan (1995), similarly, has cited the expanding health care costs resulting from the “increasing weight of an aging society” in claiming that age-based rationing of medical care will become not only ethical, but also an ethical imperative. He suggests that as the health care demands of an aging society

increase, entitlement to life-extending care should only be made available up to an age that corresponds to the end of a “natural life span” (about 80 years, in his judgment). Whereas many factors, including system inefficiencies and the power of special interests, contribute to the high and growing costs of U.S. health care, arguments like those of Callahan and Lamm address the issue of sustainability mainly from the “demand side” and seem to place the whole ethical onus for constraining these costs on elderly consumers.

Of course, the argument that the elderly claim more than their share of societal resources is not a new one. Around 500 BC, Euripides wrote:

I hate the men who would prolong their lives
By foods and drinks and charms of magic art
Perverting nature’s course to keep off death
They ought, when they no longer serve the land
To quit this life, and clear the way for youth.
(Andre & Velasquez, 1990)

Presumably, had he been transported to the modern era, Euripides would have been surprised by modern medicine’s “charms of magic art” and the extension of life expectancy since his era, which have contributed to projected ratios of elderly in the population that are new for our nation, although they will be comparable to what has already been experienced in several other developed countries.

Laurence Kotlikoff and Scott Burns (2004) are among the most recent scholars to predict a “coming generational storm.” And in Congress, there have been renewed efforts to shift the impact of increasing Medicare costs from the government to beneficiaries by converting the program from a “defined-benefit” to a “defined-contribution” plan, in which the government makes a fixed sum of money available toward premiums in a privatized market of competing health plans and the beneficiary pays the remainder (less if a bare-bones policy is selected, and more for a more comprehensive policy). This “choice” approach could cause low-income elderly, who tend to be in worse health status and who are most in need of comprehensive health coverage, to be sorted into the more-limited plans with more restrictions and higher beneficiary cost-sharing.

Arguments for the unsustainability of existing health care entitlements rely heavily on the demographic impact of this large baby boom cohort on health care costs, particularly its effect on the Medicare and Medicaid programs. Because the “baby boom” has been followed by a “baby bust,” it is argued that old-age dependency ratios (the proportion of elderly to nonelderly adults in the population) will threaten the

financial stability of the programs and that the growing appetite of this large elderly population for health services cannot be borne by programs that are supported by the tax contributions of the working-age population.

Proponents of this view often project the impact of changing demographics in a fairly linear fashion. However, the boomers' aging will affect the health care system in many ways other than sheer numbers. In considering the potential effects, we need to consider such questions as the following: How are the boomers likely to differ from their predecessors in terms of their health-related behaviors, their age-specific health and functional status, their social and economic circumstances, and the way in which they interact with the health care system? What can be expected in terms of the *distribution* of health status and economic resources, not just their averages? What will be the impact of increased scope for health care technology? Which interventions will contribute to "compression of morbidity" by reducing disability faster than they extend survival, and which will simply postpone death for chronically ill individuals with severely compromised function and quality of life, expanding morbidity? Which trend will prevail, and what choices between these types of interventions will be faced by boomers and policy makers? How are the boomers likely to impact the health care system as citizens and voters, not just health care consumers?

It should also be noted that in thinking about the growth and sustainability of health care expenditures as the boomer cohort reaches old age, it is important to distinguish two distinct issues that together drive the overall expenditure: the per-person cost of care and the number of individuals in the population needing care. In the United States, a high-end outlier in per-capita spending among nations, this distinction is particularly salient.

THE BOOMERS: QUANTITATIVELY OR QUALITATIVELY DIFFERENT?

The argument that the baby boom cohort, by its sheer size, will unmanageably strain health care and other societal institutions is consistent with the view of demographic change that considers the most important characteristic of a given cohort to be its relative size (cf. Easterlin, 1987). According to this model, the members of large cohorts, as they age, strain societal resources at each point in time. This higher level of competition for limited resources shapes their educational, occupational, and ultimately retirement opportunities at each life stage. This model

would predict that a large cohort such as that of the boomers would be disadvantaged economically and in other respects, relative to earlier and later cohorts. However, the problem with reductionist perspectives of this sort, which concentrate on structural characteristics of cohorts, such as their size, is that each cohort experiences a historically and economically unique set of experiences that also shapes its outcomes. Therefore, a life-course perspective is needed that takes into account the particular circumstances experienced at particular life stages. Indeed, as evidence accumulated during the late 1980s and early 1990s on the economic experience of the boomers in their working years, it increasingly appeared that they were likely to fare better than their parents in old age (Easterlin, Schaffer, and Macunovich, 1993; Johnson and Crystal, 2003).

The postwar baby boom cohort grew up under quite different circumstances than earlier cohorts. Some of these differences will tend to increase demand on the health care system, whereas others may have opposite effects. In terms of potential impact on the health care system, generational differences in gender roles are of particular salience. One of the society-changing impacts of World War II was the entry of women, both unmarried and married, into a much broader range of occupations—a change that continued into the economic boom following the war. Baby boomers thus grew up in a very different era than earlier cohorts with respect to gender roles. Labor force participation by married women with children, as well as single women, became much more widespread. These changes helped to lay the groundwork for the women's movement, which, in turn, further contributed to changes in gender-segregated occupational roles, the entry of many more baby boom women into professional and managerial occupations than in previous cohorts, and other changes in gender roles. Increased dependency of baby boomer households on dual-adult incomes appears to have become a structural feature of family life in this cohort, serving as the principal means by which this cohort prevented declining real wages from translating into declining family income during long stretches of the postwar period (Johnson & Crystal, 2003).

IMPACT OF CHANGING GENDER ROLES

One important effect of changing gender roles in the occupational structure in the postwar period was to reduce the availability of women, particularly married women, as unpaid, informal caregiving labor for elderly and disabled family members, leading to increased demand for formal long-term care programs. This aspect of the boomers' impact on the

health care system has already taken place, to a large extent, as many of them are already in midlife, a life stage traditionally associated with caregiving demands. Related demographic changes, such as lower rates of coresidence between middle-aged boomers and their elderly parents compared with earlier cohorts, have also contributed to increased demand on formal long-term care (Waehrer & Crystal, 1995). Coresidence declined sharply as the baby boomers reached adulthood and midlife compared with the levels experienced by earlier cohorts at similar ages, although it seems lately to have somewhat stabilized at a much lower level than was the case among earlier cohorts. As a result, older persons, especially those not coresiding with a spouse, became less likely to have informal caregiving resources available to them when functional impairment developed. These trends have contributed to the increased demand for alternative forms of long-term care, such as assisted living and home care.

As they reach the years in which their risk of functional limitation and need for long-term care increase, the boomers' own fertility patterns will be among the factors shaping their experience and health care system impact. The baby bust that followed the baby boom reflects the smaller average number of children born to baby boom women and the higher rate of childlessness in this cohort compared with preceding cohorts. This is a factor that will further contribute to long-term care demand in coming years, especially affecting the financial future of the Medicaid program.

IMPACT OF EDUCATIONAL ATTAINMENT

Boomers' interactions with the health care system as they age will also be shaped by the higher levels of formal education that characterize this cohort in contrast to preceding cohorts. Within a cohort, individuals higher on the educational distribution experience higher status in various social hierarchies, conferring benefits that can translate into health advantages. The impact of raising the distribution as a whole in successive cohorts—that is, the replacement of a less well-educated generation of elders with better-educated boomer elderly—is perhaps more complex, involving the effects of education on health-related behavior of individual elderly, as well as “contextual” effects of educational levels on attitudes and culture within a cohort. Education confers a variety of resources that can contribute to self-management of health through multiple pathways, including the ability to assimilate prevention messages, interact effectively with health care professionals and systems, and

manage treatment regimens. Better-educated cohorts may be somewhat more prepared than current ones to negotiate the health care system.

Whereas the boomers' higher level of education may provide health advantages that could improve age-specific health status and the need for acute health care services, it might also contribute to an increased propensity to seek out services to ameliorate the health problems associated with aging. Aided and abetted by the growth of direct-to-consumer advertising for new treatments that emphasize lifestyle and quality-of-life benefits, "consumerist" attitudes among the baby boom cohort may contribute to increased use of health care services as this cohort ages. Boomers' health care behavior in their preretirement years suggests that as they age, they may be less accepting than earlier cohorts of functional decline as a natural part of the aging process and more assertive in seeking technological fixes to the problems of aging. In short, this may be a cohort that is less willing to "go gently into that good night."

Thus, it is likely that the distinctive characteristics of the baby boom cohort will have multiple and sometimes conflicting impacts on future health care utilization per elderly person. Projecting the net balance of effects is further complicated by the fact that effects of cohort differences will be intertwined with those of many other changes in domains such as health care policy, direct-to-consumer marketing of health care services, and, especially, continuing technological intensification of health care, as the scope of what medicine and pharmacology can do—at a price—increases. Thus, the analyst is faced with a classic case of intertwined age, period, and cohort effects. All things considered, however, it seems likely that the better-educated boomer cohort will, on average, possess health advantages resulting from factors such as a higher level of knowledge and access to information about health risks and medical treatments. By the same token, they may seek out services more assertively and it is likely that they will not readily accept efforts to restrict or ration their use of health services. This may presage increased generational conflict over health care financing in coming years.

In the United States, as pressure mounts on Medicare and Medicaid budgets from the combined impact of demographic change, technological intensification, system inefficiencies, high "middleman" costs, direct-to-consumer marketing, and other forces, increased efforts can be anticipated to control these costs by shifting more of the costs to beneficiaries through limitations on covered services, sharply increased cost-sharing, or other means of implicit or explicit rationing. At the same time, it seems unlikely that the aging baby boom cohort will readily accede to such efforts. In this regard, it is relevant to note that the boomer

cohort's size, education, and access to communications technology will also make it an even more powerful electoral force than has been the case for previous generations of elderly. This prospect has been noted by some elected officials as a reason for urgency in implementing Medicare reforms before it becomes, politically, "too late."

Finally, with regard to the impact of cohort differences in education, it is necessary to emphasize the importance of within-cohort differences and heterogeneity, rather than exclusively focusing on comparisons of averages across cohorts. In many respects, within-cohort differences are much more salient than those between cohorts. During the boomers' lifetimes, educational differences in particular have become, in some ways, an even more significant source of stratification for life chances, economic status, health-related behavior, and other respects. Financial returns of education have increased, for example, and health-harmful behaviors like smoking have become increasingly concentrated in the less-educated portion of the population. Thus, disparities in health and health care needs between the educationally advantaged and disadvantaged subgroups of the elderly population will be particularly important. This is even more the case when one looks directly at the differential circumstances that will be faced by boomers in relation to their differing economic resources, as discussed in the next section.

ECONOMIC PROSPECTS

What of the prediction that the baby boom generation, because of its large size and the resulting heightened competition for jobs and other resources at each stage of life, will reach old age as an economically disadvantaged cohort? Such a scenario could constitute a double whammy for the health care system, which would face higher demands for care on the part of a cohort with limited ability to self-finance that care through insurance premiums, taxes, copayments, or other means. In terms of average economic resources, however, this does not appear to be the likely scenario. Within the baby boomer cohort as a whole, there will certainly be substantial economic resources available toward financing health care needs. Indeed, those in the upper 40% of the income distribution have typically benefited substantially from trends such as the growth in home values, increasing stock prices that have swelled retirement accounts (for those who have them), and increasing returns to education in the labor market. Those in the middle and below have typically not done as well. They have faced stagnating wage levels during

much of the cohort's adult years. Typically, married couples have kept stagnating wages from causing stagnating family income by increasingly relying on wives' incomes, with the accompanying impact on informal caregiving noted earlier (Johnson & Crystal, 2003).

On average, the incomes of baby boom families have been at least comparable to those experienced by preceding cohorts at each age (Crystal & Shea, 2003a; Johnson & Crystal, 2003). But one can drown in a lake that is, on average, only 3 feet deep. Although the boomers cannot be characterized as economically disadvantaged as a group, we can expect that this will be a very high-inequality cohort (Crystal, 2006; Johnson & Crystal, 2003). A high level of economic inequality among the boomers in their retirement years would likely mean, in turn, a high level of socioeconomic disparity in access to health care services. This is likely even for services covered by Medicare, given the trend toward increasingly substantial beneficiary cost-sharing, and especially likely for services not covered by Medicare, such as long-term care. In the long-term care arena, economic inequality among boomers is likely to interact with other trends toward disparate long-term care systems for higher-income and lower-income elderly, such as the growth of a private-pay-oriented assisted living industry and of long-term care insurance sold disproportionately to upper-middle-income individuals, in ways that further contribute to socioeconomic disparities in access to long-term care.

During most of the post-World War II period, considerable societal support existed for benefits for the elderly, which could be seen as reflecting a sense of enlightened self-interest as well as altruism; as it has sometimes been put, the elderly are the one minority group that the rest of the population aspires to join. However, as the baby boom cohort ages and its needs challenge public budgets at federal, state, and local levels, increased controversy over the public response is likely. Will a sense of "we are all in this together" prevail, or will support for a common floor of health care adequacy erode in the face of new pressures? In this regard, it should be noted that along with its economic heterogeneity, the baby boom cohort is also likely to be racially, ethnically, and culturally more diverse than preceding cohorts.

Thus, although there is little reason to believe that the baby boomer cohort will be an unusually disadvantaged one *on average*, there is much more reason for concern about the issue of within-cohort economic and health inequality. As we examine the future impact of present health care policy decisions, such as those affecting the future of Medicare, it is particularly important to assess their likely impact on lower-income individuals.

INEQUALITY, HEALTH STATUS, AND CUMULATIVE ADVANTAGE AMONG THE BOOMERS

During their working years, baby boomers have lived through major changes and turbulence in the structure of the U.S. economy that have had particular impact on lower-income and lower-education members of the cohort. Many of the well-paid industrial jobs, with good benefits, that were available to working-class Americans—for example, unionized jobs in steel, auto-making, and the like—have disappeared as manufacturing positions are replaced by service positions. These changes have contributed to increasing income inequality. What are the implications of this experience for health and health care as the cohort reaches its later years? The effects of early advantages and disadvantages can cumulate, particularly in the later years, as health and disability factors become more prominent (Crystal, 2006; Crystal & Shea, 1990, 2003b). Differences in health and functional status also interact with differential demands and supports faced by differently situated individuals to produce substantial cumulative occupational and economic differences. Consider, for example, the much higher reported rates of “inability to work due to disability” among individuals with lower levels of formal education, as shown in Figure 4.1, which displays rates of work disability by exact year of age and education, based on U.S. Census data.

Much gerontological research has documented the strong association between economic and health disadvantage. Such disparities reflect the net result of many factors, including aspects of the economic structure, individual life course events, and public policy choices, such as the structure of retirement income, disability, and health care financing policies. In considering the distribution of late-life economic and health outcomes, health care policy choices can be seen as buffering the impact of life course events and economic forces. In this perspective, inequalities and inequities in late-life outcomes, although shaped by individual life course events, can be viewed not just as inevitable consequences of human differences but also as the result of particular policy choices that vary across nations and time. The pattern of late-life outcomes is best viewed in the context of a life course perspective that takes into account the cumulative impact of events at various stages of life and the extent to which the impact of these events on disparities is buffered by informal and formal institutions of social protection.

A useful framework for thinking about this process of cumulative advantage over the life course, which can be applied to assessing the likely impact of multiple individual and societal factors on outcomes for baby boomers as they age, is shown in Figure 4.2 (Crystal & Shea, 2003b).

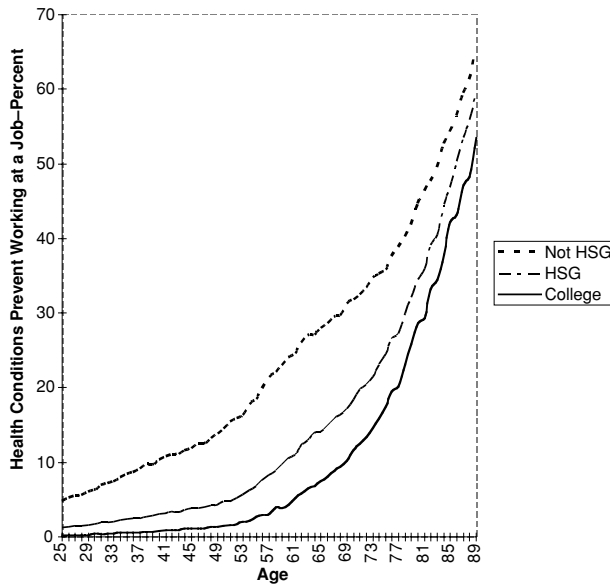


FIGURE 4.1 Rates of work disability by exact year of age and education, based on 1990 U.S. Census data (5% sample).

Drawing from the disablement tradition (Ustun, Chatterji, Bickenbach, Kostanjsek, & Schneider, 2003), this approach considers the impact of health factors on other outcomes in terms of a process that proceeds from physiological dysfunction to performance limitation to disability. Thus, for example, as noted earlier, those with less education will, on average, experience more rapid decline in the ability to perform specific tasks as they age, and these differences may be magnified by differences in occupational demands and access to treatments and services that can ameliorate the impact. A given level of impairment may be less likely to be disabling for a college-educated individual whose occupation draws heavily on knowledge and cognitive skills, and whose value to the employer is such that accommodations to his or her impairments are provided, than for an individual with less than a high school education.

What does this perspective suggest about the future of the boomers? During its life course thus far, economic changes, including globalization, increased income differentials by educational attainment, the decline of well-paid unionized jobs in sectors such as manufacturing, and other forces that act at multiple stages of the process depicted in Figure 4.2, presage high income and health inequality among the boomers as they move through late life. At the same time, in the United States (and in a number of other nations as well), the financial role of government

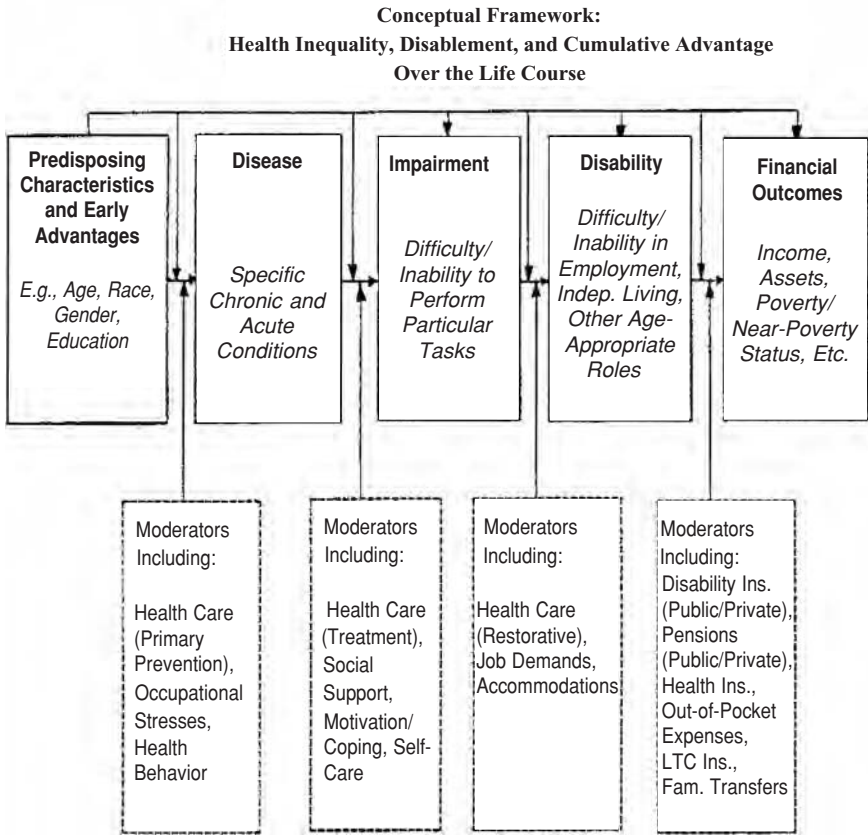


FIGURE 4.2 Health inequality, disablement, and cumulative advantage over the life course.

in supporting increasing costs of traditional social-insurance programs has become increasingly controversial. As these forces collide during the boomers' retirement years, at issue is whether evolving policies on old-age benefits will adequately buffer the impact of economic disparities on health outcomes (and vice versa) or whether, as perhaps an unintended consequence of policy changes aimed at limiting the financial burden of "entitlements," they will become less able to perform this important role.

WILL EXISTING BENEFITS BE SUSTAINABLE AS BOOMERS AGE?

Without question, all else equal, the sheer size of the baby boom cohort will add to the already substantial strains on existing benefit systems, such

as Medicare and Medicaid. But, of course, all else is never equal. Beyond the effects of sheer size, other cohort characteristics will affect health care utilization and cost in diverse and complex ways. As noted, differences in family composition are likely to increase demand for formal long-term care above and beyond cohort size effects, as may attitudinal changes encouraging a “consumerist” orientation to health care. On the other hand, some studies (e.g., Manton & Gu, 2001) suggest there is a trend to reduction in age-specific burden of functional impairment, which may be related to changes in health behaviors, better treatment of risk factors, use of assistive devices, or other factors.

Other studies suggest that many risk factors for chronic diseases show continuing improvements, many linked to education (Singer & Manton, 1998). To the extent that such trends continue or even accelerate as boomers reach old age, they could function as ameliorating factors in the burden on the health care and long-term care systems. It should be noted, though, that the jury is still out on the long-term significance for health care needs of the apparent decline in disability, as the trends are not uniform across disability measures and may reflect, in part, increases in the use of assistive devices or improvements in areas of function that are less closely linked than others to the need for formal long-term care (Freedman et al., 2004). And not all risk factors are trending in a positive direction in the baby boom cohort; for example, the impact of increases in obesity is of particular concern.

Thus, some characteristics of the baby boom cohort may increase health care demand, whereas others may have the opposite effect. However, I would argue that the future sustainability of existing benefit systems is likely to depend less on the characteristics of the baby boom cohort than on other factors. Immigration policy, for example, is one important factor that could help maintain age balance of the population and economic balance of benefit financing systems, or not, depending on the outcome of ongoing political debates over these policies. Prominent among the broader factors will certainly be the pace of technological intensification in health care in general and the way in which this issue is managed in coming years. More generally, policy choices concerning the structure and ground rules of health care financing systems will strongly affect the relative power of payers and sellers of health care services and products, and thus the prices paid for those services. A case in point is the debate over the sustainability of the Medicare prescription drug benefit, given its privatized structure, substantial built-in administrative costs, and fragmentation of drug purchasing among many private entities rather than negotiating drug prices centrally on behalf of all of its enrollees.

Examination of recent trends in U.S. health care expenditures, particularly compared with those of other developed countries, suggests that we do have a serious sustainability issue, but not one that can principally be blamed on population aging. For example, estimated national health expenditures increased from \$1.36 trillion in 2000 to \$1.88 trillion in 2004, a 38% increase, and accounted for 16.0% of gross domestic product (GDP) in 2004, up from 13.8% of GDP in 2000 (Centers for Medicare and Medicaid Services, 2006). These increases, however, can hardly be blamed on baby boomers, as at most only a small part of the change over this relatively short time span can be attributed to population trends. If sustained over the coming decades, these trends would have much more cost impact than would the aging of the boomers. Thus, I would argue that the sustainability issue is not primarily one of aging baby boomers. This phenomenon certainly adds to the importance of structural reforms in health care, but such reforms would be needed in any case, and in cross-national perspective, there is nothing that is so unique about the demographic circumstances projected for the United States as to make current levels of federally financed defined health benefits “unsustainable.”

Indeed, the projected population imbalance in the U.S., by itself, is less severe than will be experienced by most other developed countries. In fact, projected proportions of elderly in the population are similar to levels already reached in some major countries where health care expenditures are lower than those the United States is currently experiencing. European-style social insurance systems have certainly had their economic costs, such as high unemployment rates due to tax burdens on employers. These burdens are, however, due more to pension costs than the cost of health services, which despite universal coverage, are typically lower in European “social welfare states” than in the United States, both in absolute terms and as a percentage of GDP (Anderson, Hussey, Frogner, & Waters, 2005). Under the employment-based system of coverage for working-age adults that exists in the United States, the burden of health care costs on many employers is heavier than is the case for competitors in nations with national health care systems, a situation that encourages export of jobs and threatens the economic growth required to support the needs of an aging population.

The major health care policy problem we face with the aging of the boomers, I would argue, is not so much the ferocity of the storm as the poor quality of the levees. The United States pays a heavy price for its unique approach to health care finance. Among developed countries, we are unique both in the high share of national resources spent on health care (an estimated \$5,267 per capita in 2002, 53% more than

any other country; Anderson et al., 2005) and the high proportion of citizens without coverage. The share of GDP spent on health care in the United States far exceeds the level of expenditure in developed countries that have already experienced the level of population aging that we are projected to experience as the boomers retire. For example, almost 19% of Germany's population was over age 65 in 2002. While among the higher-spending nations in Europe on health care, Germany in that year provided essentially universal health care to its people at a cost of 10.9% of its GDP (Anderson et al., 2005; Central Intelligence Agency, 2005).

It is widely perceived that high health care spending in the United States is the result of high per-person utilization of services, but data on comparative utilization do not support this view. Although we use more of certain high-technology services, on most measures of health care use, the United States is actually below the median for developed countries (Anderson, Reinhardt, Hussey, & Petrosyan, 2003). For example, among Organization for Economic Cooperation and Development (OECD) nations, we are in the lowest quartile of hospital beds per capita and have fewer physicians and nurses per capita than the OECD median. For medical care services such as those covered by Medicare, the main distinguishing characteristics of our system are high prices, high administrative costs incurred by providers and numerous middlemen (31.0% of national health expenditures by one estimate, compared with 16.7% in Canada; Woolhandler, Campbell, & Himmelstein, 2003), and lack of coordination among multiple providers and systems. In the long-term care arena, a similarly high level of dysfunction exists (Kane & West, 2005).

Reform proposals for programs such as Medicare, aimed at reducing the growth of program costs, typically have been structured to shift more of the costs of services back to beneficiaries, through premiums, copayments, and the like, rather than to limit the total bill. But the problem is the overall cost of care to society, not just who is stuck with the tab. Increasingly, the United States appears as an outlier, both with respect to the level and trend of overall health care expenditures and with respect to the structure of the health care system. It is difficult to avoid acknowledging the connection between these two facts. As the baby boomers age, I would argue, it will become increasingly difficult to resolve the problems of financing publicly paid care by shifting costs back to individual beneficiaries; this may prompt increasingly heated debate over fundamental issues of program structure.

Fundamentally, in the struggle over controlling health care costs, which takes place in every country, three issues are key: what volume

and mix of health care services will be utilized, what prices will be paid for those services, and how efficiently will the delivery system coordinate services and channel funds into actual care as opposed to administrative and middleman costs. On the utilization front, we can probably expect renewed efforts to limit care as baby boomers age. However, during the 1990s, there was considerable backlash against efforts to impose the more restrictive versions of managed care models on beneficiaries of employment-based insurance (including many baby boomers), and they are unlikely to be more receptive to such models as they age. On the pricing and administrative costs fronts, the decentralized U.S. system suffers particular disadvantages. Due in large part to well-financed efforts by provider and middleman interests, the role of the public sector in managing the overall system has been limited, and single-payer proposals have been unsuccessful. Even within the Medicare program, there has been much resistance to allowing the program to fully exercise its potential purchasing power. In Medicare's history, opposition to program initiation or expansion was often co-opted by closing the mouths of opposing interests with gold. Thus, a framework for coverage was developed and has been periodically expanded, but at the cost of building substantial costs and price pressures into the system.

The most recent example of this phenomenon is the design of the Medicare prescription drug benefit in a way that divides drug purchasing up across many private drug plans, rather than having Medicare negotiate prices centrally on behalf of its more than 40 million beneficiaries. This approach will assure that U.S. taxpayers continue to pay substantially higher prices for prescription drugs than prevail in other developed countries. The program's design also diverts substantial portions of the health care dollar into marketing and administrative expenditures. In this respect, it aims to mimic a system of employment-based health insurance that itself is hardly economically efficient (Woolhandler et al., 2003). Similarly, the complexities created by multiple payers, plans, and rules impose substantial costs on providers at all levels, from the physician's office to the hospital billing department. As the boomers reach old age, it seems fair, then, to ask: Is it the predictable increase in health care use that is unsustainable or the rickety structure through which it is provided and financed?

CONCLUSION

As the baby boomers move into their 60s and beyond, they will certainly impact the health care system in many ways. In their interactions with

medical care providers, it seems likely that this cohort, with its higher levels of education, high expectations, and greater exposure to the Internet and other new resources of the information age, will bring a more consumerist attitude, as its members have done during their middle years. The rise of health care marketing and direct-to-consumer advertising of pharmaceuticals will also contribute to this development. The size of the baby boom cohort may also have contributed to a sort of cultural centrality that has been noted about this cohort's experience since their youth. In coming years, perhaps the 1960s slogan "never trust anyone under 30" will be replaced for some boomers by "never trust anyone under 60."

Compared with earlier cohorts, baby boom seniors will bring more information to health care encounters (garnered from the Internet and other sources), will ask more questions, and will expect more sharing of information as opposed to simply accepting and following "doctors' orders." They may also be less willing to accept managed care restrictions on services they desire. These trends may collide with increasing pressures for cost containment. Historically, older people have reported relatively high satisfaction with their own physicians (though less satisfaction with the systems in which they operate). In the coming era, however, there may be new sources of strain on physician-patient relationships as physicians struggle to address multiple health issues and requests from their elderly patients in time-constrained visits while they are pressed by payers to adhere to an increasing number of prevention, care management, and quality guidelines. And although the current cohort of elderly are often highly loyal to their primary care physicians, many baby boomers have been conditioned to changes in providers as their employers shift health plans and could respond to stresses by doctor shopping.

As financial pressures on Medicare increase, we are likely to see renewed efforts to shift "financial responsibility" to elderly beneficiaries by increased cost-sharing. Given the likely high level of income inequality within the boomer cohort as it ages, a considerable concern with such proposals is the potential for increased disparity in access to care. One of the great accomplishments of Medicare following its enactment was the narrowing of historical socioeconomic disparities in health care use. Will we see a reversal of this accomplishment as the boomers age and the scope of health care technology increases?

In long-term care, boomers with their smaller families can be projected to demonstrate increasing demand for long-term care services and probably also higher expectations as to choice in the form that these services will take. With the continuation of recent trends away from sole

reliance on the nursing home as the venue for formal long-term care, we can anticipate the increased growth of alternative forms of long-term care, such as variations on the assisted living concept. Again, however, the challenge will be that of socioeconomic equity. The market will provide for an increasing menu of choice for higher-income boomers, but financial pressures on Medicaid and other publicly funded long-term care will increase, colliding with efforts to address well-known quality and staffing problems in settings such as nursing homes and with efforts to increase access to a range of good-quality long-term care choices for lower-income seniors. The growth of private long-term care insurance, while potentially increasing the range of choices for those who can afford it, may also reduce the stake of higher-income people in the adequacy of publicly funded long-term care.

As the boomers age, a critical issue for the sustainability of existing health care programs such as Medicare and Medicaid will be the long-term impact of tax-cut initiatives implemented in recent years. According to Congressional Budget Office estimates (U.S. Senate, 2005), federal revenues declined from 20.9% of GDP in 2000 to 16.3% in 2004, a level not seen since the Eisenhower Administration, when the population structure was far different from today's. It could be argued that we can afford to pay for the baby boomers' health care, but not on an Eisenhower-era level of tax effort.

Finally, at the broader level of national budgetary and legislative debates, we can anticipate increasing strife as the growing electoral power of senior citizens collides with the increasing budgetary pressures experienced by Medicare and Medicaid. We will increasingly hear about the "unsustainability" of current defined-benefit commitments in the face of the demographic force of the retiring baby boom cohort. But is it these commitments that are unsustainable or rather some of the current aspects of "American exceptionalism" in public finance and health policy? Rather than discuss the consequences of an aging population in isolation, we need to consider the choices posed by the combination of an aging population, reduced tax effort (particularly for high-income individuals), and a fragmented health care system that limits government's role, does not effectively aggregate purchasing power to control prices, and will have increasing difficulty dealing with the demands of a mature population structure. Although often framed as a scenario of intergenerational conflict between "greedy geezers" and the young, I would suggest that in the context of increasing income inequality among the elderly, the more salient challenge framed by the boomers' aging will be how we deal with equity between the prosperous and penurious *within* age groups. Thus, I would argue that the challenge posed by the oncoming

aging of the baby boomers is less an issue of the need for health care rationing than it is one of national commitment to social protection and reform of health care systems.

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What Havoc Will the Boomers Wreak? (Commentary)

Robert L. Kane

There is a much exaggerated image of the baby boomers descending on the U.S. health care system like a tsunami. A more appropriate metaphor may be the forecast that the large numbers of older persons will expose the basic fault lines in the American health care system, just as Hurricane Katrina uncovered the many structural and politicoeconomic failures of New Orleans and American emergency response efforts. Ironically, one of the physiological hallmarks of aging is the impaired response to stress. Older people's baseline values are generally close to normal, but their stressed values are generally quite abnormal (Kane, Ouslander, & Abrass, 2003). In the case of the health care system, what is already a faulty system, ill adapted to the realities and needs of chronic disease care (Kane, Priester, & Totten, 2005), will have great difficulty coping with the increased demand, certainly at anything that resembles an affordable or acceptable cost.

The baby boomers will play several different roles in determining health care over the next several decades. Until now, the major driver of health care costs has been technology. It is not the numbers of doctors or nurses or even hospital beds that drives costs; it is the aggressive use of expensive technology. We have long struggled with the realization that the return on investment in terms of improved health is weak, but the question has become more complex as some evidence of real benefit begins to emerge. For example, the reduction in heart disease deaths is attributable to both improvements in preventive behaviors and better care.

The potential effects of the boomers will fall into several categories:

- their present role and their future role,
- the effects of their numbers and their age,
- their effects on acute care and long-term care (LTC), and
- their effects on overall costs or the costs of specific programs.

The boomers may be the users of tomorrow but they are the caregivers of today. Right now, they are the advocates for their parents. The tastes and expectations they have acquired for care and technology are being translated into action in pressing the cause of their parents, who may have much more modest expectations from the health care system.

It is quite possible that boomers may make their greatest contribution in this contemporaneous role as advocates. When they themselves become frail elders, they may be more accepting, if only because of the burden of illness. It is now, when they are healthy, that they can campaign so vociferously.

Some observers argue that technology trumps age in affecting health care costs (Aaron & Schwartz, 2004; Chernew, Hirth, Sonnad, Ermann, & Fendrick, 1998; Cutler, Rosen, & Vijan, 2006). The nature of the care is a major determinant of its cost. We are an especially technophilic society (Callahan, 2002). We look to technology to solve many problems and are willing to spend money on technology, even when the marginal returns are very modest, especially if it is perceived as someone else's money. Hence, we struggle repeatedly with questions about futile care. Our responses have not been especially informed.

Health care is not equally distributed. A small minority account for a very disproportionately large amount of use and cost. Although there are some predictors of who will be in this state, most of it arises unexpectedly. Much has been made of the observation that health care expenditures are dramatically highest in the last year of life (Levinsky et al., 2001; Lubitz & Riley, 1993). This presumably profound observation is about as helpful as saying that most operative deaths occur in the operating room. Nonetheless, much effort has gone into seeking ways to reduce these terminal expenditures. One of the great concerns is so-called futile care, that is, care that is unlikely to yield improvement in health outcomes or quality of life. One effort to address futile care has been the use of advance directives. The well-publicized stories of young people in comas have driven society to press for an agenda that strongly encourages everyone, but especially older people, to file advance directives, specifying just what they would want done were they unable to express their wishes.

These advance directives are symptomatic of our disjointed thinking about the end of life. First of all, most people have no basis on which to judge how they would feel in one of those extreme situations. There is a general tendency for healthy people to fear states of impairment more than people in those states. Hence, under the banner of enhancing our autonomy, we are all too ready to sign away any opportunity to experience such situations before deciding whether they are intolerable. We tend to imagine that certain states will be intolerable, when evidence suggests that those in such states value them more positively than those imagining these states (Sackett & Torrance, 1978).

An even greater irony is that patient-centered decision making is greater in the abstract than in the reality. Although patients are strongly encouraged to issue advance directives, their actual preferences when they are awake and able to express them are largely ignored. Physician-assisted suicide is illegal in all but one state. Refusal of therapy is usually an invitation to a psychiatric evaluation and sometimes even litigation.

Certain basic rules of health care utilization are not likely to change. Health care will continue to be asymmetrically used, with a small subset of eligible persons accounting for the majority of use. The boomers will swell the denominator but not change the distribution. The same challenges to meeting the problems of high-risk persons will prevail. The same failures of the health care system will be exposed, but perhaps their growing numbers will provide more impetus to address them.

The current health care system is poorly situated to provide the kind of care we need today and tomorrow. It has too long ignored the epidemiological reality that we live in a world dominated by chronic illness. The system is still set up to fight the last war. We need a major overhaul to create a chronic disease care system (Kane et al., 2005). The goal of good chronic care is to prevent those exacerbations that are associated with hospitalizations and high cost.

Alas, the heart of good chronic disease care is proactive primary care. But this demand arises just as the interest among physicians in such practice has reached a nadir. One answer may lie in using other types of health professionals. The rise of nurse practitioners comes at an opportune moment. They have been shown to be effective as providers of primary care (Mundinger et al., 2000; Mundinger, 1994). Their values may be more directed to needed active patient involvement in care.

Along with a reallocation of resources to invest in better primary care, the chronic care revolution will require greater use of communications technology. Patients and their clinicians need to be in active communication to monitor the status of health problems, but this monitoring cannot be affordably accomplished through clinic or home visits.

Instead, various means to monitor patients' status, usually with the active involvement of the patient, must be implemented. Early detection and warning systems must be combined with effective first-order interventions to nip problems in the bud before they become severe.

Some critics suggest that a universal health insurance system will solve many of our current and future problems. That outcome is unlikely. The one area in the United States where we now have virtually universal coverage is Medicare, and it is about on a par with the rest of the care system in terms of controlling costs. Universal coverage may well be a laudable goal to make care widely affordable and reduce inequities, but it is not the panacea some see. Much will depend on how such a universal health insurance system would be operated; but it is quite feasible to maintain most of the weaknesses and shortcomings of our present system under a universal payment banner. In fact, broadening the coverage and thus growing the resource pool may exacerbate the very bad behaviors we are seeking to change. Universal coverage could be harnessed as a force to bring about needed change, but only if it was centrally managed and developed appropriate incentives were developed. Such a step seems hard to imagine in a political system where the influence of providers is so strong.

Even with some of the optimistic forecasts about modest declines in age-specific disability rates (Cutler, 2001; Freedman, Martin, & Schoeni, 2002; Manton & Gu, 2001), a growing number of older boomers will eventually become disabled and need care. The vast majority of LTC is now provided by family members (Arno, Levine, & Memmott, 1999; Navaie-Waliser, Spriggs, & Feldman, 2002). However, the baby boom was followed by a baby bust. The boomers have fewer children than their parents. As a result, informal caregiving will be placed under even more stress than has been created by the shifting roles of women in the labor force (Morris, Caro, & Hansan, 1998). At the same time, many of the same factors have led to a shortage of professional nurses (Aiken & Mullenix, 1987) and nurses aides or home care workers (Crown, MacAdam, & Sadowsky, 1992; Crown, Ahlburg, & MacAdam, 1995; Feldman, Sapienza, & Kane, 1990).

WHERE WILL BOOMERS HAVE THEIR GREATEST EFFECTS?

It is easy to see the effect of the baby boomers on Medicare, especially because that program primarily serves older persons. Indeed, it is the only virtually universal health care insurance program in the United States (Hayward, Shapiro, Freeman, & Corey, 1988). The growth in the

numbers of elderly beneficiaries will place heavy demands on Medicare and has already spurred debate on how the program can withstand the onslaught. It is important to bear in mind that the Medicare program was already facing financial problems as a result of the tremendous growth in technology, but now this growth will be multiplied by the larger numbers of eligible users. The question remains: Can the projected demand be harnessed to catalyze a reassessment of what Medicare should cover, or will it simply lead to draconian steps to control costs? The recent experience with the coverage of drugs suggests the greater likelihood of the former.

The growing numbers of boomers will also affect Medicaid. As noted earlier, the pressures on the informal care system will be strong, and more formal care will likely be needed. Given that the boomer generation has a low savings rate, many of these LTC users will be likely candidates for the medically needy component of Medicaid. Concerns about such demand have led states, which already see their Medicaid programs under great strain, to seek ways to prevent such spend-downs to qualify as medically needy. Many states have therefore pursued a variety of strategies, including encouraging private LTC insurance and encouraging reverse mortgages, but neither strategy seems likely to make much of a dent in the problem. Few of the people who can afford private LTC insurance are active candidates for Medicaid and reverse mortgages are proving to be very poor resource management strategies for older people and their families. In an effort to stem the perceived tide of older people divesting themselves of assets to become eligible for Medicaid, some states have enacted harsher penalties for divestiture and have increased the look-back period by which eligibility is determined. A few have placed liens on estates of the deceased to collect their Medicaid payments before any legacy is distributed among the heirs.

Indeed, a persistent question is whether the state should support older persons' strong desires to leave such legacies. Public policy seems to be moving in opposite directions. On the one hand, states are trying hard to discourage Medicaid use as a device to leave legacies. At the same time, the Congress is endorsing legislation that reduces or eliminates inheritance taxes.

The pressures on Medicaid may well lead to some intergenerational confrontations. At present, there is a great disparity in the way Medicaid funds are dispensed to cover persons with disabilities at different ages. On a per recipient basis, younger persons with disabilities receive much more funding than do older persons (Kitchener, Ng, Miller, & Harrington, 2005). Moreover, younger persons have many more options for how they receive care. Alternatives, such as institutional care and

home care, which are eschewed by younger persons with disabilities as far too restrictive, are considered quite appropriate for frail older persons with comparable levels of disability. Younger persons with disabilities want personal care attendants who can assist them in participating in the full range of life activities. This situation has come about as a result of much more effective lobbying by and on behalf of younger persons.

The question will be whether the demographic pressures will stimulate a reconsideration of this two-class care and raise anew specters of intergenerational warfare. Does age-based entitlement still make sense (Neugarten, 1982)?

Pressure may thus arise on both the universal entitlements under Medicare, where some proposals have called for shifting them to means-testing, and already means-tested programs like Medicaid. However, the loss of universal coverage could erode public support for such programs (Hirschman, 1978). Pressures on both of those programs could revive interest in some form of rationing (Blank, 1988; Churchill, 1987), although at least one experiment with such an approach did not fare well (Dixon & Welch, 1991; Kitzhaber, 1993). Similar strategies may be introduced under the guise of evidence-based medicine (Wennberg, 1990).

In many ways, one might argue that the boomers are being scapegoated. Labeled as active consumers, their insatiable appetite is being blamed for the rising costs of health care. Our addiction to technology is not directed specifically at older people. Americans are generally enamored with technology and look to new developments to solve a variety of problems, from communication to new organs. The pressure to apply medical technology creates a continuing pressure to expand applications of new procedures to older people. Ironically, so far, those who have managed to live to become quite old are not the heavy care users many believe (Lubitz, Liming, Kramarow, & Lentzner, 2003).

Nor does it necessarily follow that the baby boomers, who have been marked as a consumer generation, will reach old age as avaricious consumers, seeking to acquire all the medical and supportive care they can. The well-observed differences between longitudinal age-related changes and inter-cohort changes differences is just as likely to apply here (Riley, 1994; Riley & Riley, 2000). The boomers may be much more effective as consumers on behalf of their parents than they will be when they become frail themselves and must rely on the advocacy of others.

Up until now, the health care system has been very slow to adopt changes in its modus operandi that would make it more compatible with the general pattern of illness that prevails today and will likely dominate tomorrow. In truth, we live in a world of chronic disease, but the existing health care system is better situated to address acute events. The

needed changes involve changing the way we pay for care. Fee-for-service payment is not compatible with the investment mentality needed to practice effective chronic care. One must be willing to spend more up front in expectation of subsequent savings by reducing the rate of untoward events that lead to expensive hospitalizations (Kane et al., 2005). Managed care would seem to be an ideal vehicle to achieve this transformation, but the initial results have not lived up to those expectations (Boult, Kane, & Brown, 2000; Kane, 1998; Kane, 2000; Robinson, 2001). Models for chronic care have been promulgated (Wagner, Austin, & Von Korff, 1996). Adoption has been slow. It may not be a coincidence that the National Health Service in the United Kingdom has been much faster to adopt practices that support the needed transition (Department of Health, 2006; Wilson, Buck, & Ham, 2005), perhaps because they have already undergone the demographic transition that lies in America's near future.

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Demographic Reflections on the Aging of the Baby Boom and Its Implications for Health Care (Commentary)*

Vicki A. Freedman

In his chapter, “Population Aging and Benefit Sustainability,” Crystal (chapter 4, this volume) notes that overly simplistic projections often underlie arguments that the baby boom will threaten the financial stability of health care programs, particularly Medicare and Medicaid. He challenges us to consider how the baby boom generation differs from preceding generations in ways that might influence their health care consumption. Crystal effectively argues, for example, that this cohort has substantial (albeit, unevenly distributed) economic resources, smaller family size, and a more consumerist culture, all of which may increase demand for care above and beyond cohort size. On the other hand, he points out that the cohort is better educated and may potentially face lower rates of disability than previous cohorts, which might ameliorate the demand. Ultimately, he concludes that impending increases in

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the population needing care will pale compared with increases in the per-person costs of care because of the inefficiencies of the U.S. health care system. Indeed, he argues, “The future sustainability of existing benefit systems is likely to depend less on the characteristics of the baby boom cohort than on other factors.”

These seemingly straightforward demographic issues have been the subject of much debate and confusion in the literature. Some researchers argue quite strongly that the aging of the baby boom will overwhelm aspects of the health care system. At the same time, there are studies that appear to argue conversely that population aging has little to do with growth in health care expenditures. Other research has suggested that continued declines in disability will help offset the growth in numbers of older adults, whereas still others argue that younger cohorts are likely to enter old age with higher rates of disability than those that prevail today.

Given these apparent contradictions, in this commentary, I invite the reader to linger just a bit longer on these fundamental demographic matters. In doing so, I make three central points. First, the aging of the U.S. population is not likely to be a transient phenomenon; instead, the passage of the cohorts of 1946 to 1964 into late life more likely marks a fundamental shift in the age composition of the United States, to which the health care system must respond. Second, projections of growth in health care costs due to population aging alone do not take into account the full impact of this shift, which will be substantial over the next 25 years. Third, continued declines in disability, although a welcome trend, will be unlikely to buffer the effects of this predicament on the health care system unless these trends result in reductions in long-term and end-of-life care needs. I conclude with some speculation as to the changes the baby boom generation might bring to these often overlooked aspects of the health care system.

A SHIFT, NOT A WAVE

To fully appreciate the implications of the aging baby boom generation, it is useful to review the general principles of population aging. This phenomenon can be measured in various ways, but most commonly, it is indicated by increases in the mean age, median age, or proportion of the population over the age of 65. In their classic chapter on the demographic conditions responsible for population aging, Preston, Himes, and Eggers (1989) demonstrated that increases in the mean age of a population cannot generally be attributed to high or low levels of

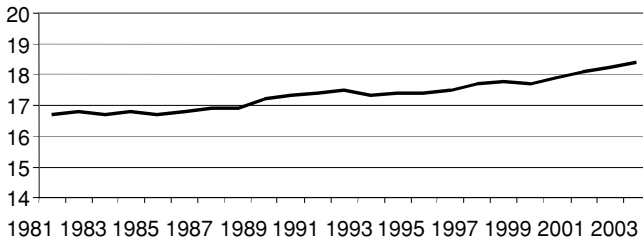


FIGURE 6.1 U.S. life expectancy at age 65: 1981–2003.

fertility or mortality, but instead to *changes* in such rates. Further, the authors established that the decline in mortality at older ages was the dominant factor shaping population aging in the United States during the 1980s.

Why is this important? Demographers have identified two essential stages of population aging. A population's mean age is first driven up by fertility declines, then by declines in mortality. Once the latter stage is reached, population aging will continue as long as mortality rates continue to drop at older ages. Moreover, unless fertility or mortality rates reverse course, the distribution favoring older ages is likely to persist.

In the United States, age-adjusted mortality rates have continued to drop since the 1980s, from 5,700 per 100,000 people aged 65 and older in 1982 to just over 4,900 in 2003 (National Center for Health Statistics, 2006a). Over the same time period, life expectancy at age 65 (a summary measure calculated based on age-specific mortality rates for older adults) has steadily increased from 16.7 years in 1981 to nearly 18.4 years in 2003, and this trend shows no sign of abating (National Center for Health Statistics, 2006b; Figure 6.1).

Census Bureau projections of the age distribution of the population suggest that large cohorts of elderly could remain a fixture in the United States well after the baby boom has passed (U.S. Census Bureau, 2006; Figure 6.2). These projections assume that average life expectancy at birth will continue to increase gradually, from 74 and 80 years in 1999 for males and females, respectively, to 81 and 87 years in 2050. Under these assumptions, in 2010, those at the leading edge of the baby boom (born in 1946) will be 64 years old, and only 13% of the population will be aged 65 or older (with 2% aged 85 or older). By 2030, those at the tail end (born in 1964) will have reached age 66, and those at the leading edge will have reached age 84. Between 2010 and 2030, the 65- to 84-year-old age group will increase from 11% to 17% of the population. Note that by 2050, when the baby boom has reached age 86 and above, the

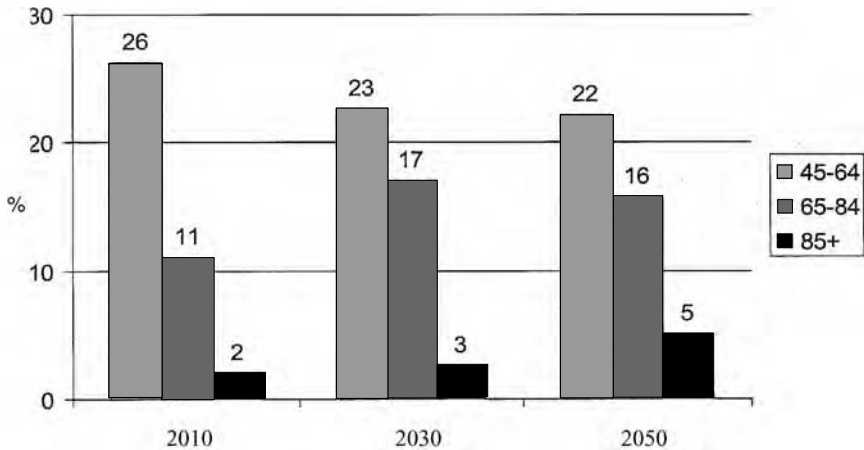


FIGURE 6.2 Projected age distribution of the US population: 2010–2050.
Source: U.S. Census Bureau (2006).

65- to 84-year-old group will remain substantial, at 16% of the population. In sum, these figures suggest that large cohorts of older adults will begin, but will likely not end, with the baby boom generation.

Thought about in these terms, the aging of the baby boom cohorts represents not a wave, but a fundamental shift in population structure. The emergence of this shift in the coming years, in turn, represents an opportunity to change how U.S. society views health in relation to social welfare in late life.

THE BOOM'S EFFECT: NOT JUST AN AGE SHIFT

Older adults use more and fundamentally different types of care than adults in middle age, teens, and children. In any given year, per capita health care expenditures for people aged 65 and older are three to five times that for younger Americans (Reinhardt, 2003). From a life course perspective, about half of the roughly \$300,000 per capita lifetime health care expenditures is spent after age 65 and about \$100,000 is spent after age 85 (Alemayehu & Warner, 2004). Because of this strong age gradient, it makes intuitive sense that shifts toward older ages would therefore contribute to increases in health care expenditures.

Yet, there is considerable agreement that, historically, population aging has accounted for about only a small share of the total rise in health care spending (Reinhardt, 2003). In recent years, growth in national health expenditures has been in the 7%-per-year range (Heffler et al.,

TABLE 6.1 Summary of studies predicting effects of population aging^a on growth in health care spending

Author	Projection Period	Outcome	Percent Per Year
Alemayehu and Warner (2004)	2000–2030	Per capita health care expenditures	.6
Burner et al. (1992)	1990–2030	Total health care spending	.5
Cutler and Sheiner (2001)	1992–2050	Medicare acute care spending per enrollee (excludes long-term care)	.14
Keehan et al. (2004)	1999–2049	Per capita health care expenditures	.5
Martini et al. (2006)	2000–2050	Per capita health care expenditures (excluding nursing home and long-term facility costs)	.3
Reinhardt (2003)	2000–2030	Average number of U.S. hospital discharges per capita	.5
		Total health spending per capita	.4

^a Refers to change in age distribution alone; see text for details.

2005), but population aging has accounted for at most 0.5% per year. A much greater share of increases in health care expenditures has been attributable to increases in the per capita costs of medical care linked to technology and intensity of care (Bodenheimer, 2005). There is also substantial agreement about projections of the effects of population aging on future health expenditures (Table 6.1). Despite variations in modeling assumptions and the way in which results are presented, four of the six estimates in Table 6.1 fall in the 0.4%-to-0.6%-per-year range. In this context, the effects of “population aging” refer to the increased health care expenditures that can be solely attributed to changes in the age distribution of the population. As such, these effects do not reflect impending increases in the size of the older population or differences from earlier cohorts in health and demographic characteristics related to expenditures.

Consequently, the findings highlighted in Table 6.1 provide an incomplete portrait of the likely effects of the baby boom generation on health care expenditures. Most obvious, the cohort born between 1946 and 1964, numbering roughly 76 million births, was considerably larger

than the birth cohorts on either side. Primarily because of projected reductions in mortality, the baby boom is predicted to decline in size in the future at a much slower pace than the preceding generation. Hence, according to Census Bureau projections, 70 million people will be 65 years or older by 2030 (compared with about 35 million today) and 21 million will be 85 years or older by 2050 (compared with about 4 million today). Moreover, there is new evidence emerging that suggests the baby boom cohorts, although on average of higher socioeconomic status than previous generations, may have worse health and functioning relative to previous generations (Lakdawalla, Bhattacharya, & Goldman, 2004; Soldo, Mitchell, Tfaily, & McCabe, 2006).

In the future, the combined effects on total health expenditures of growth, aging, and shifting health and demographic profiles of new cohorts reaching late life are projected to be substantial (Mendelson & Schwartz, 1993; Goldman et al., 2005). Using a microsimulation model, for example, Goldman and colleagues (2005) forecast that total health care expenditures for Medicare beneficiaries will more than double between 2000 and 2030, from \$300 billion to \$621 billion (in 1999 constant dollars). These figures correspond to growth of roughly 3% per year. The authors go on to demonstrate that further technological breakthroughs will greatly increase spending beyond these forecasted levels. But this does not negate their finding that the size and characteristics of the baby boom and following generations will be a central force in health care spending.

An emerging theme in the health economics literature calls for balancing attention to the rise in medical spending with a focus on its value in terms of health and longevity. Cutler, Rosen, and Vijan (2006), for example, have compared increases in life expectancy with lifetime costs of medical care for four age groups for the period 1960 to 2000. Assuming that 50% of longevity gains were due to medical care, they found that the costs per year of life gained were highest for the elderly and that costs for this group have risen more rapidly than life expectancy. Such analyses raise the question of whether there may be diminishing value over time to these expenditures.

DISABILITY DECLINES AND HEALTH CARE EXPENDITURES

Some have suggested that future declines in rates of late-life disability might be able to offset projected increases in health care expenditures due to the aging of the baby boom generation (Singer & Manton, 1998). Indeed, the consensus to date suggests that there has been a decline

in disability prevalence of about 1% to 2% per year in recent decades (Freedman, Martin, & Schoeni, 2002). However, most of the decline thus far has been in the proportion of the older population needing help with what are referred to as instrumental activities of daily living, that is, shopping, managing money, and doing laundry (Freedman et al., 2002; Spillman, 2004). Declines in more severe and more costly activities of daily living disability, that is, getting help with bathing, dressing, and eating, have been much smaller (Freedman et al., 2004).

More importantly, varying assumptions about future declines in the prevalence of late-life disability does not appear to have a large effect on projected health care spending. Goldman and colleagues (2005), for example, projected that per capita health care spending would be 8% lower and total health care spending 6% lower than otherwise forecasted if disability rates continue to decline. A related analysis by Chernew, Goldman, Pan, and Shang (2005) found that differences in late-life per capita spending by disability status have narrowed over time so that further declines in disability rates will not dramatically slow total health care spending on the elderly in the future.

Why is growth in health care spending so robust to assumptions about disability declines? Evidence suggests that cumulative spending for older adults over their remaining lifetimes is largely invariant to health status. More simply put, an individual reaching age 70 is likely to spend about \$140,000 (in 1998 dollars) over his or her remaining lifetime, whether that individual reaches age 70 with functioning intact, with some limitations, or with severe disability (Lubitz, Cai, Kramarow, & Lentzner, 2003, p. 1048). Based on this analysis, Lubitz and colleagues conclude, "Health promotion efforts aimed at persons under age 65 may improve the health and longevity of the elderly without increasing health expenditures." Using the same logic, it follows that disability prevention efforts may improve the health and longevity of the elderly without *decreasing* health expenditures.

What, then, can be done to offset the impending increases due to the baby boom? Two additional facts provide some direction. First, if an individual enters a nursing home, cumulative life expenditures are roughly \$85,000 higher than otherwise (Lubitz et al., 2003). Indeed, as longevity increases, acute care expenditures rise at a reduced rate, whereas long-term care expenditures rise at an accelerated rate (Spillman & Lubitz, 2004). Second, the last year of life, at whatever age it occurs, accounts for roughly one-fourth of Medicare outlays for the elderly (Hogan, Lunney, Gabel, & Lynn, 2001). Indeed, time to death, rather than age per se, has been shown to be a powerful predictor of acute health care costs

(Miller, 2001; Lee & Miller, 2002; Stearns & Norton, 2004; Cutler & Meara, 2001; Yang, Norton, & Stearns, 2003). Decreases in the per capita costs of long-term care and end-of-life care could then, possibly, offer opportunities to offset the impending boom.

TARGETS FOR CHANGE: LONG-TERM AND END-OF-LIFE CARE

Thus far, I have argued that the shift toward a more permanently older society, which begins with the baby boom generation, is likely to double the demand for health care for the elderly over the next 30 years. Although population aging by itself has a small effect on health expenditures, the combined effects of size and characteristics of the baby boom generation suggest at least a 3% growth in health expenditures for the foreseeable future, assuming no technological changes. Further declines in disability, although a welcome trend, will not change this basic tenet, unless per capita long-term or end-of-life care costs are reduced.

The aging of the baby boom also represents an opportunity to reshape long-term and end-of-life care. As they deal with their parents' end-of-life needs, the baby boom generation is acquiring a new vocabulary and set of experiences with home health, adult day, personal, rehabilitation, assisted living, hospice, and palliative care. Taking on the advocacy role for their parents as they navigate this maze, they will undoubtedly learn that there is much to improve about the current nonsystem(s). Not only are services expensive and piecemeal, but finding high-quality services continues to be a challenge, and not just for those with limited resources.

Ethnographers and other qualitative analysts who study the culture of the baby boom generation have pointed out this generation's penchant for living large. But one must wonder whether it will be centenarianism they will seek as they begin to cross what has been traditionally considered the threshold of late life in 2011. Perhaps instead they will aim to live this final stage to its fullest extent, not by demanding life-extending care, but by demanding preventive care, assistive technologies that make their parents' and eventually their own lives easier to navigate, and services that permit them to remain in their homes and out of institutional settings. Perhaps they will then seek to die a "high-quality" death with ample pain and symptom management, involvement in decisions about treatment, and achievement of a sense of completion and peace. Perhaps they will make it acceptable to die at home or in a palliative setting rather than in an acute care hospital.

Crystal suggests that the boomers will ultimately exert their influence through the political system, as a powerful voting bloc. If they have the political will to begin the uncomfortable dialogue that has evaded both politicians and citizens and the stamina to support policies that emphasize quality of life and death over mere life extension, they may indeed have a profound effect on the health care system.

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Perspectives on the Economic Implications of the Aging of Baby Boomers*

Eric R. Kingson

Sober discussion about the economic implications of the aging of baby boomers requires challenging two popular images—that they are homogeneous and that their aging presents a unique economic crisis, best resolved by rolling back social spending directed at older Americans.

This chapter first describes how these images weave their way through past and current discourse about the economic implications, personal and societal, of the aging of baby boomers, the 78 million American residents born from 1946 through 1964. The main body of the chapter discusses the diversity of baby boomers and why their demography, though significant, *is not* destiny. We conclude by suggesting that analysis of the economic implications of the aging of baby boomers should place more emphasis on the concerns of those baby boomers at greatest risk and on making value choices more explicit.

*The author wishes to acknowledge that sections of this chapter draw upon and update a monograph Eric Kingson prepared for the AARP, entitled *The Diversity of the Baby Boom Generation: Implications for Their Retirement Years*, Washington, DC: American Association of Retired Persons, 1992. The author also wishes to thank his wife and colleague, Nancy H. Smith, who provided helpful comments on drafts of this chapter.

POPULAR DISCOURSE

More often than not, boomers have been presented, especially in media accounts, as a homogeneous group with shared history, values, and hopes. Further, the aging of baby boomers has often been discussed, especially by those seeking to advance a conservative political agenda, as potentially causing a major economic crisis best avoided by cutting social spending for the old. Analysts operating from perspectives fundamentally supportive of traditional social insurance and related social welfare approaches, including the author of this chapter, are generally quite critical of the conservative framing of issues related to the aging of baby boomers.

MEDIA ACCOUNTS DISTORT POLICY CHOICES

Baby boomers have often been discussed as a “lucky generation,” the first cohort to be raised in the suburbs, to grow up with television, and to take higher education opportunities for granted. At times, they have been termed “unlucky” with regard to adverse experiences in the housing and employment markets and dire predictions about their retirement. Whether termed “lucky” or “unlucky,” most of the focus has been on college-educated baby boomers, what Landon Jones called the “emerging Superclass” (Jones, 1980).

Today, presentations of boomers as well educated, affluent, consumption-oriented, and self-centered are common (Hughes & O’Rand, 2004). As in the past, the focus is on so-called trendsetters within this generation—almost to the exclusion of other boomers.

Indeed, the temptation to present baby boomers in stereotypical and hyperbolic terms is difficult to resist—especially for print and electronic journalists seeking an exciting lead and for conservative activists and politicians seeking to shrink social welfare commitments. Unfortunately, such presentations paint an inaccurate picture of this cohort and the economic challenges facing baby boomers and the nation as they age.

Declaring that boomers “fundamentally will alter the marketplace,” a *Washington Times* series on their aging notes that “long-term health care facilities expect a surge in demand, and morticians say their field will face a shortage as boomers die.” More optimistically, the series also opens by saying that “boomers will be better off than any other retired generation in history” and by observing that boomers “are far better-educated, more technology-savvy and living healthier into their later years” (Dinan & Fagan, 2005).

In a similar vein, a December 27, 2005, National Public Radio special on baby boomers turning 60 began:

Love them or hate them, the Baby Boomers—all 78 million of them—have had something of a headlock on American culture since Carole King first felt that Earth move under her feet. And the baby boomers haven't released their grip since. On Sunday, the oldest of this massive generation will begin to turn 60, at a rate of almost 8000 a day. And with the boomers commitment to living forever, it's possible Mick Jagger will be playing the Super Bowl half-time show in 2020.

Today we're celebrating the legacy of the boomers who grew up to dominate, not only with numbers, but also with their idealism and sheer chic. There's almost no institution left untouched by the boomers. They're stomping through the halls of Congress as well as up the billboard charts. They've been social idealists, marching against the Vietnam war and rallying against segregation. But as they've aged, they've also been accused of self-importance and arrogance, as they turn to fitness gurus and life coaches to cushion their inevitable march towards the golden years. (Seabrook, 2005)

CONSERVATIVE FRAMING OF POLICY CHOICES

Perhaps more problematic are stereotypes of baby boomers as a large cohesive "generation" with many shared characteristics and as a demographic tidal wave threatening to overwhelm social institutions. Such characteristics have been used as political imagery to serve conservative political goals—to shrink government and public commitments to the old.

Nearly all agree that the "old-aging" of baby boomers will strain public and private disability as well as health and pension systems. Expectations about work and retirement, about the capacity to finance public and private disability and health and retirement systems, are in flux. Appropriate concern exists about whether baby boomers are better prepared for their retirements than their parents' generations; whether they will be able to maintain their living standards in old age. But this is very different from a pattern of policy pronouncements and policy claims that have been used by conservative pundits, activists, and policy makers to advance a political agenda.

Conservative opposition to social insurance and related public interventions date back to before the passage of the Social Security Act in 1935 and continues through the present day (see Altman, 2005). Beginning in the early 1980s, this opposition has been framed in terms of

“generational equity” themes and images of the economy being strained to the breaking point as a result of entitlement spending, especially those directed at older Americans.

The advocates of shrinking government and social welfare spending have made good use of crises, real and constructed, to advance their agenda (Kingson & Williamson, 1993; Quadagno, 1996; Altman, 2005). Writing in 1983 in the journal of the libertarian Cato Institute, Stuart Butler, Vice-President for Domestic and Economic Policies Studies at the Heritage Foundation, and Peter Germanis, then an analyst with the Heritage Foundation, advanced a tongue-in-cheek “Leninist strategy” to deconstruct Social Security (Butler & Germanis, 1983). Calling for “guerilla warfare against the current social security system and the coalition that supports it,” they suggested that advocates of radical conservative change must: (1) assure existing beneficiaries and older workers that proposals such as privatizing Social Security would not harm them; (2) take full advantage of all opportunities to demonstrate flaws in and disadvantages of the current program; (3) develop a credible privatized alternative; (4) sell this alternative as beneficial to the young, most of whom question Social Security’s future; and (5) engage powerful private interest groups (e.g., financial industry) that stand to gain from privatization.

During this same period, conservative activists put forth a new political theme, “Generational Equity.” Emerging as a catch-all slogan, this concept reflected understandings that (1) support of policies for elderly persons was a major cause of growing federal deficits; (2) elderly persons received too large a portion of social welfare spending to the detriment of children and other groups; (3) the projected future growth in the costs of these programs would place an unsustainable burden on future workers; (4) younger people would not receive fair returns on their Social Security and Medicare investments; and (5) all of these factors, if left unchecked, would lead to generational conflict. Former Governor Richard D. Lamm, who continues to be a major proponent of this concept, put it this way in 1985:

Simply put, America’s elderly have become an intolerable burden on the economic system and the younger generation’s future. In the name of compassion for the elderly, we have handcuffed the young, mortgaged their future, and drastically limited their hopes and aspirations.

The policymakers of the 1960s and 1970s... set up unsustainable pension systems... They placed the bill for all these programs on succeeding generations, who consequently inherited the crippling economy their excesses caused. (Lamm, 1985, pp. 52–54)

By the mid-1990s, these themes had been recast as an “entitlement crisis” (Quadagno, 1996) and later as a full-scale assault of the traditional Social Security program. Republican pollster Frank Luntz advised Republican members of the House of Representatives in 1995 to frame the budget debate “in terms of ‘the American dream’ and ‘our children’s future.’” Turn “the issue of ‘fairness’ against the Democrats,” he argued, by asking, “Is it ‘fair’ for Medicare recipients to have an even greater choice of doctors and facilities than the average taxpayers who are funding the system?” (Toner, 1995). The Bipartisan Commission on Entitlement and Tax Reform (1995, p. ii) warned that entitlement spending will “unfairly burden America’s children and [stifle] standards of living for this and future generations.” Launching a national campaign to “help its member companies educate its employees and citizens” about the danger of the federal deficit and the growing costs of entitlements, the Business Roundtable defined “the baby boom bubble” as a major source of the problem and that seniors, as a group, are “not guilty” (as cited in Kingson & Williamson, 1996).

Similarly webbed through today’s “neo-conservative” critiques of Social Security, Medicare, and related policies is the argument that young Americans simply cannot financially support the growing number of baby boomers, reinforced by references to the shrinking number of younger workers relative to retirees. During the past few years, serious consideration has been given to proposals to partially privatize Social Security, and elements of privatization have been introduced into Medicare through new pharmaceutical benefits. Perhaps most striking, the President of the United States, George W. Bush, regularly built on and advanced this image to support his political agenda:

[I]f you’re a younger citizen, you’d better be paying attention to this issue. And . . . here’s the reason why: There’s a lot of people like me—we’re called the baby boomers—who are getting ready to retire. . . . Do you realize that there’s about 40 million Americans retired today; by the time the baby boomer generation fully retires, there will be 72 million Americans, more or less. There is a lot of us. We’re living longer than the previous generation. . . . And a lot of politicians have run prior—in prior years, and said, vote for me, I’ll increase the benefits for a generation coming up. And you know what? They did. And so, therefore, my generation, our generation, which will be living longer—and more of us—have been promised greater benefits, which is okay until you realize this aspect of the problem: fewer people are now paying into the system.

In 1950, there was about 15 workers per every retiree. In other words, the load was pretty well spread across a group of people paying

payroll taxes. Today, there's 3.3 workers per retiree. Soon there's going to be two workers per retiree, trying to take care of a generation which is going to be living longer with greater benefits and a lot of us. So that's the problem. That's the math. That's the beginning of your understanding—or the country's understanding of why we have a problem. (White House, 2005b)

CHALLENGING STEREOTYPES AND HYPERBOLE

Stereotypes and hyperbole about the aging of baby boomers distort policy discussions (Cornman & Kingson, 1996). Hence, as a prerequisite to advancing discussion about the economic implications of their aging, it is important to carefully explore how the discussion is framed and challenge misunderstandings.

The Diversity of Baby Boomers

Although it may be necessary at times to generalize about baby boomers, it is simply inaccurate to characterize 76 million people—born over 19 years, spanning all ethnic, racial, health, and income classifications—as a homogeneous mega-cohort. To do so falsely implies a singular approach to the development of public and private policies addressing their aging. Such stereotypes may encourage policy makers and the public to overlook differences in the retirement risks facing many baby boomers (e.g., younger versus older boomers, homeowners versus renters). Of primary concern, it can displace attention away from those likely to be at greatest risk.

Indeed, it is diversity, not uniformity, that characterized this mega “birth cohort.” Take their age, for example. Some baby boomers were 17 years old when John F. Kennedy was assassinated, others were in playpens, and more than 4 million were yet to be born. When the oldest members reach age 65 in 2011, the youngest—termed “new wave” boomers—will still be in their mid- to late 40s. As others have also pointed out, new wave baby boomers are more likely to be at risk during their retirement years than “old wave” boomers (Bouvier & De Vita, 1991; Hughes & O’Rand, 2004; Kingson, 1992; Light, 1988; Macunovich, 2000). Older boomers (born from 1946–1954) were more likely to have entered the labor force and housing markets during favorable periods and were more likely to be homeowners, build equity, and acquire pension assets. The new wave boomers potentially face greater risk from the shrinkage in public and private retirement income and health systems. Boomers also

differ by race and ethnicity, with roughly 18 million of their members among minorities at risk, groups generally having higher rates of poverty, although there is much variation within these groups.

The impact of analyses that take nativity into account is very interesting. There were 76 million live births over the 19-year period in which baby boomers made their entrance, 17 million more than there would have been if the fertility patterns of the early 1934s continued (Russell, 1987). But in 2004, there were 77.4 million baby boomers. What happened? The influx of 10.4 million immigrants offset the roughly 9 million baby boom deaths, with emigrations playing a very small role. No analysis of the economic impact of baby boomers is complete without recognizing the dramatic effect of immigration on this cohort and its retirement preparedness.

Boomers also differ by family circumstance. The coming of age of baby boomers coincided with numerous changes in the family, with a higher proportion (roughly 10% compared with 5% of their parents' generation) unlikely to marry (Committee on Ways and Means Committee, 1987). Boomers have often postponed having children, had smaller families, divorced more frequently, and raised more children in single-parent households (Hughes & O'Rand, 2004; Saluter, 1989). Among old wave boomer women, nearly 35% had experienced at least one divorce by the age of 40 (see Hughes & O'Rand, 2004). Indeed, two-fifths, possibly more, of first boomer marriages have or are expected to end in divorce, although most have or will remarry (Butria, Iams, & Smith, 2003). Kinship patterns are more complex, and with this complexity come questions of who is responsible for parental and step-parental care (Hagestad, 1986). With fewer children, the increased labor force participation of women means that boomers are likely to have less of a kinship system to rely on for informal support, although this may be partially offset by the presence of more siblings.

Boomers differ by education. The baby boom cohorts have already done considerably better than previous generations, but here, too, there is much diversity. Although nearly one-quarter have completed 4 years of college, over 3 million have not gone beyond eighth grade (Siegel, 1989). Again, minority and younger boomers have generally not done as well. For example, about 15% of African American and U.S.-born Hispanic old wave boomers held college degrees in 2000, compared with nearly 30% of similarly aged White and 45% of U.S.-born Asian old wave boomers (see Hughes & O'Rand, 2004).

The employment and income story of baby boomers is not simple. On the one hand, boomers generally have earnings at least as high as those of other generations at similar points in their life course

and have earned higher real incomes than their parents did at similar points in their life course (Employment Benefits Research Institute [EBRI], 1994; Holtz-Eakin, 2003). Large numbers of new jobs were added as they entered the labor force (Russell, 1982). On the other hand, for many, their early work years have coincided with slowed economic growth, stagnant wages, and the loss of manufacturing jobs, resulting in failed expectations of economic progress (Levy, 1987). The trend in income distribution since the mid-1970s has been toward greater inequality—with certain groups, such as men with less education, being most negatively affected. Although obviously many are doing quite well, about 8.5% of all baby boomers, roughly 6.6 million people, had incomes below the poverty level in 2004 (U.S. Bureau of the Census, 2005a). Of over five million single female baby boomers heading families with children in 1991, about 45% had incomes below the poverty level.

Baby boomers also differ with respect to the equity they are accruing in the housing market (Apgar & Zhu, 2005). Boomers entered the housing market at a period of rapidly increasing costs for purchases and rentals. Even so, some are very well housed, especially among the older ones, who caught the first wave of appreciation (Russell, 1982). On average, the older baby boomers have done better than the younger ones to the extent that they were able to purchase housing at a time when prices and interests were simultaneously low and also catch the wave of appreciation in housing of the late 1970s and 1980s. When it comes time to retire, it seems likely that the older ones will again be at an advantage. At retirement, many will be selling large houses and buying smaller housing units. It is possible that this will drive down the value of larger houses just as the younger boomers sell their units and conceivably drive up the price of the smaller units just as the younger boomers enter that market.

They also differ with respect to the control they are likely to have about deciding where to spend their later years. A sizable portion of boomers will have opportunity for choice and may be more selective in deciding where to live (Frey, 2001; Longino & Bradley, 2003). As is true today, those with limited resources will have a much greater propensity to age in place. These disparities seem likely to intensify. In some cases, affluent, mostly suburban individuals take their tax dollars and purchasing power to warmer climates, potentially leaving a less robust tax base to struggle with intensified costs of schools and services for frail elders.

Private pension coverage also varies considerably among different groups of baby boomers. Only 28% of year-round full-time private-sector

workers, aged 25 to 64 years, with earnings below \$20,000 per year, participated in employer-sponsored plans in 2000 compared with 72% of such workers with earnings between \$40,000 and \$59,999. Part-time workers, disproportionately female, have still lower levels of coverage in firms sponsoring these plans (Purcell, 2001). The proportion of workers participating in employer pensions has declined between 1994 and 2003, from 58.6% to 54.4% (Purcell, 2004). In terms of the baby boom and those who follow, the shift away from defined benefit plans toward defined contribution and cash balance plans places more responsibility for retirement savings on employees (Butria et al., 2003), especially younger ones.

In terms of retirement income prospects, a 2003 Congressional Budget analysis suggests that boomers are accumulating wealth (i.e., pensions and other financial assets, including equity in homes) at a pace at least equal to their parents. As these assets are translated into income flows, as measured in absolute dollars and also in terms of poverty rates, boomers are likely to have higher real (inflation-adjusted) living standards in their retirement. But many—perhaps as much as one-half—will experience declines in the standard of living experienced during their working years (Butria et al., 2003; Butrica, & Uccello, 2005; EBRI, 1994; Holtz-Eakin, 2003). For those who can work longer, the cost of longer lives may be offset by more employment income. The Congressional Budget Office (CBO) also found that lower income boomers will depend more heavily on future governmental benefits, especially Social Security, than recent studies indicate. Indeed, reductions in these benefits will have a particularly detrimental effect on low- and moderate-income boomers (also see Brown & Kingson, in press).

In short, challenging the notion that baby boomers are a homogeneous group leads to a more robust understanding of the personal circumstances of different groups of baby boomers as they near their later years. Whether discussing education, housing assets, race, values, earnings, pension coverage or virtually any descriptor of baby boomers, there is far more variability among 78 million baby boomers than stereotypes of boomers imply. And this variability has important implications for how problems associated with the economic status of the baby boomers are defined and the policy solutions that follow.

Demography Is Not Destiny

Almost from the beginning of the baby boom, very different explanations have been advanced about the causes and implications of this demographic phenomenon, whether institutions could adjust to their

numbers, whether boomers were “lucky” or “unlucky,” and whether their large numbers potentially undermined their economic well-being. As boomers approach their older years, it is useful to reflect on earlier understanding of the baby boom.

The first year of the baby boom, 1946, was a banner year for newborns. Births in the United States spiked to 3.4 million newborns, about 20% more than in 1945. As is well known, high birth rates continued through 1964, a span of 19 years (Jones, 1980). A total of 76 million people were born during this period, some 17 million more than would have been if the birth rates of the early 1940s had continued (Russell, 1987). Today, taking deaths and net immigration into account, some 78 million people are part of this mega-cohort, variously termed “baby boomers,” “baby boom generation,” or “baby boom cohorts.”

The 76 million baby boomers . . . constituted a boisterous, bumptious new nation within the old. Fifty percent larger than the generation before it (and 15 percent larger than the one after it), the baby boomers became the indigestible pig in the python, as demographers describe it, occasioning discomfort and upheaval as they passed through every stage of life. (Jones, 2006, p. 102)

Explanations about what caused the baby boom are cast at two levels: explanations of demographic events associated with the baby boom as well as social and economic theories of why these events occurred. The latter explanations have significant bearing on the extent to which the demography of the baby boom is viewed as driving their and the nation’s economic well-being.

Changes in the fertility rate are primarily responsible for the baby boom, its continuance over 19 years, and the baby bust that followed. The rate at which women of child-bearing ages have children is the key determinant of the age structure of society (Russell, 1982). Prior to the late 1930s, birth rates had declined steadily for over 100 years, “from an estimated 55 births per 1,000 population in 1820 to about 18 or 19 per 1,000 population in the 1930s” (Russell, 1982, p. 11). Following this, the total fertility rate, which is the average number of births over a woman’s life, increased significantly in 1946. It continued to increase through the mid-1950s, and then, beginning in 1965, began declining, reaching historic lows by the mid-1970s.

The demographic factors that explain this rise in fertility rates are fairly straightforward, involving more women marrying and having children; having, on average, slightly larger families; and having children earlier (see Bean, 1983; also Russell, 1982).

The demographics of the baby boom are easy enough to describe and not controversial. In contrast, the social and economic explanations of this phenomenon generate less consensus and sometimes serve to structure policy discussions along diverging paths.

The initial increase in the fertility rates from 1945 through 1947—resulting in the birth of 1 million more babies in 1947 than in 1945—is best explained by the end of war in 1945 and the return to normalcy. But something else is needed to explain its continuation into the 1950s and early 1960s (Light, 1988; Bean, 1983). Landon Jones emphasizes cultural changes, suggesting that “the flush of military victory, the staggering prosperity, the renewed faith in the future”—combined in the postwar years to create a “Procreation Ethic,” encouraging marriage and conventionally sized families of two to four children (1980, p. 22). Child-rearing and full-time homemaking became the socially reinforced feminine role of the 1950s and financial support the prescribed male role (Russell, 1982; Light, 1988; Bean, 1983). The economic growth of this period improved the economic outlook for those contemplating families and children.

Demographer Richard Easterlin’s fertility theory suggests that small birth cohorts, such as those born in the 1930s, usually have relatively larger families than large cohorts. Assuming relatively low levels of immigration, being part of a small birth cohort, he theorizes, increases the likelihood of the individual’s and cohort’s economic success. Such cohorts benefit from less competition for entry-level positions and more opportunity for job advancement and so are more likely to improve their economic status relative to their expectations. If a “couple’s potential earning power is high in relation to aspirations,” Easterlin suggests, “they will have an optimistic outlook and feel freer to marry and have children” (1987, p. 39). In turn, large generations, the theory predicts, give birth to relatively fewer children because of more adverse labor market experiences and less likelihood of achieving their material aspirations.

Easterlin’s carefully developed thesis is consistent with the idea that “demography is destiny.” As Easterlin puts it, “For those fortunate enough to be members of a small generation, life is—as a general matter—disproportionately good; the opposite is true for those who are members of a large generation” (1987, pp. 3–4). This view provides a basis for explaining difficulties that groups of baby boomers have had in such areas as the housing and employment markets and may have regarding retirement security. It also is consistent with generalizations about the difficulties that the aging of baby boomers will pose for the society as a whole and for the baby boom as a group, although Easterlin’s analysis suggests that the standard of living of baby boomers in old age

will, on average, be better than that of their parents (Easterlin, Schaeffer, & Macunovich, 1993).

Neo-conservative critics of federal expenditures on the old rely heavily on the demography as destiny view. Their critiques present the changing age structure—summarized by references made to the increasing ratio of persons aged 65 and over to persons of so-called working ages—as prima facie evidence that society will be unable to sustain institutions such as Social Security and health care services when the baby boom enters old age. Failure to address this problem, they suggest, will generate conflict between generations (see Kotlikoff, 2004; Kotlikoff, 1992; Lamm, 1985; Longman, 1987; Peterson & Howe, 1989, 2004).

Other approaches explain the baby boom and baby bust phenomena, placing greater emphasis on economic and social factors. Butz and Ward (1979) suggest that fertility decisions of married women of the 1950s and 1960s were sensitive to the opportunity costs related to work/fertility trade-offs. A couple will have more children, they suggest, when the husband's income is high, but a wife's earnings potential will also affect decisions about the number and timing of births. If her earnings are high, the cost of dropping out of the labor market to have and raise children is correspondingly high, and the couple is likely to have fewer children. When relatively few women held jobs during the affluent 1950s, the effect of husbands' income dominated, and couples had larger families and had them sooner. As rising real wages drew more women into the labor market, women's earnings became more important and began to outweigh the effect of husbands' incomes, leading to declines in birth rates in the late 1960s and 1970s. Seeking to understand the drop in fertility in developed nations, those with membership in the Organization for Economic Co-operation and Development (OECD), University of Chicago economist Alicia Adsera's research (2004, pp. 23–24) suggests other labor market factors are more powerful. She finds higher fertility in countries such as the United States “with high female participation, and, either flexible employment [or] low joblessness.” Bean, who we previously noted emphasized an ethic of procreation as explanation for the continuation of the baby boom through the mid-1960s, also notes that good economic times made the prospect of marriage and child-rearing easier, but “rising labor force participation among married women of childbearing ages in the absence of changes in traditional sex role attitudes made having large families harder” (1983, p. 364).

Arguably, age structure—although sometimes an important explanation for economic and societal outcomes related to boomers—has not been the dominant factor. For example, baby boomers, as a group, have had more and better educational opportunities and are better

educated than cohorts that preceded them—outcomes that would not be predicted by demographic determinists (see Russell, 1982). Similarly, economist Frank Levy (1987) suggests that the economic stagnation of the period from 1973 through the mid-1980s is principally responsible for undermining the progress of young White male baby boomers first entering the labor markets during this period, not their large numbers.

As mentioned, the old age dependency ratio is projected to increase—under the Census Bureau’s middle series assumptions, from about 21 persons aged 65 and over per 100 persons aged 20 through 64 today to 38 elderly persons in 2030 (He, Sengupta, Velkoff, & DeBarros, 2006). But as economist James Schulz (2001) and others (Committee on Ways and Means, 1987; Crown, 1985) note, the old-age dependency/support ratio tells only one part of the story.

As Schulz explains, “projections indicate that aged dependency will never approach the levels of youth dependency in the 1960s and 1970s and that total dependency will be lower” (2001, p. 289). In other words, compared with 1964, when all baby boomers were under age 20, the so-called nonworking populations, persons aged 0 to 19 plus those 65 and over, shrink relative to persons ages 20 to 64.

Moreover, the heavy reliance on the changing old age dependency ratio as an important basis for the critique of existing entitlements for the aged mistakenly assumes that older people of the future will not participate in the labor market at a greater rate than that of elderly recent cohorts. Yet, there is convincing evidence that this early retirement trend is attenuating. Responding, in part, to declines in health and occupational pension security as well as expectations of longer lives, there seems to be a slight up-tick in the labor force participation of late middle-aged workers (older baby boomers) and new elderly cohorts (see Quinn, 1999).

Hence, for many analysts (Committee on Ways and Means, 1987; Schulz, 2001), the ability of public and private institutions to honor the pension income and health claims of the baby boom will depend far more on the economic capacity of the society during the booms’ retirement years and the willingness to honor the various public and private commitments made to baby boomers.

Further, “retirement,” a relatively new institution, continues to evolve. The idea of retirement as a normative event traces its roots to the emergence of private pensions in the early 1900s and most directly to the implementation of the 1935 Social Security Act, further reinforced by the early retirement opportunities negotiated into many occupational pensions. Besides protecting against loss of income in later years and supporting late life leisure, retirement policies affect labor markets, shift

unemployment from younger to older workers, and sometimes reduce labor costs (Graebner, 1980; Schulz, 2001). The emergence of age 65 as the benchmark for “normal” retirement age was largely an artifact of a decision made by the Social Security planners based simply on what seemed appropriate and affordable at the time (Cohen, 1958). What has been structured in response to social, economic, and political circumstances can be restructured as times change. Indeed, legislative changes in Social Security’s retirement-age policies, financing problems in traditional defined benefit pension plans, the uncertainty of the stock market, increases in longevity, and concern over rising health care costs may all be contributing to a reassessment of what constitutes a “normal” age of retirement.

Increasingly, retirement, if that is a correct term, embraces a wide range of arrangements, activities, and uses (Quinn, Burkhauser, & Myers, 1990). People “retire” for many different reasons: because they can afford to, because they want to do something else, because of health, because they lost their job. In retirement, people work, pursue education or avocations (for some reason called leisure activities), volunteer, provide care to relatives, and focus on families or other leisure activities. In their 1999 report, “New Opportunities for Older Workers,” the Committee for Economic Development stated, “This unprecedented demographic shift, which will begin within a decade, calls for fundamental rethinking about the work force of the future” (1999). As noted, it seems to be happening. We may well be at the beginning of a significant turn-around in labor force participation of retirees that seems to be taking place, with fewer early retirements and more post-retirement employment in new full- and part-time positions (Quinn, 1999, also see Quinn, 2004; Quinn & Burtless, 2001; Steurle & Carassi, 2001). Importantly, as an evolving concept, the definition, meaning, and purposes of retirement will be determined by the public values defining the meaning and purposes of the third and fourth ages (Cornman & Kingson, 1996).

DISCUSSION

In challenging the argument that the aging of baby boomers is creating an economic crisis, I do not wish to imply that no problems or potential crises exist. Indeed, it is clear that a number of systems are facing major problems, and these problems will affect the well-being of baby boomers and other cohorts. Although in some cases (e.g., health care financing), these problems are exacerbated by the aging of baby boomers, for the most part, they are not caused by their aging.

Economic Threats: Real, Not Imagined

The relatively slow growth in wages of the past 30 years combines with large federal deficits, international trade deficits, consumer debt, and rising energy prices to fuel anxiety over the future of the economy. Net national savings—the sum of government and private savings—declined substantially during the 1980s, from an average of about 8% per year during the 1950s, 1960s, and 1970s (Schultze, 1990) to an average of 3.3% from 1983 to 1992 and increasing to about 6% from 1996 to 2000, only to drop precipitously to less than 2% a year since 2002—0.1% in 2005 (Department of Commerce, 2007)!

Health care coverage is declining while costs rise; defined benefit pension plan protections have become less pervasive and far less secure. Tax cuts and the war in Iraq have swollen the federal deficit, further constraining future growth of the economy. Shrinking oil supplies have combined with the nation's dependency on oil to further swell American trade deficits. Taken together, these pose huge challenges to the well-being of future cohorts of retired and working persons.

Projected deficits in Social Security—the Old-Age, Survivor, and Disability Insurance program (OASDI)—also add to the economic uncertainty. Although projected under the intermediate assumptions as being able to meet benefit commitments through 2040 (Board of Trustees, 2006a), clearly Social Security's long-term financing needs to be shored up through some combination of benefit reductions and tax increases. Further, as the Social Security and Medicare trustees report, "Medicare's financial difficulties come sooner—and are much more severe—than those confronting Social Security," in large part because "underlying health care costs per enrollee are projected to rise faster than the wages per worker on which the payroll tax is paid and on which Social Security benefits are based" (Board of Trustees, 2006b).

Given uncertainty and potential volatility, how heavily can such forecasts be relied on when making decisions about the future of Social Security, Medicare, and related programs? Henry Aaron suggests it is important to understand that addressing many of the most important retirement income and health policy questions does not require highly refined long-term projections. "The advantage of public versus private management or of DB [defined benefit] versus DC [defined contribution] pensions do not depend on any long-term projection other than whether the future will be radically different than the present" (Aaron, 2002, p. 75). Long-term projections may serve to constrain legislative spending, encourage politicians to apply a longer time frame and, on occasion, provide a rationale and framework for legislative action.

Such forecasts provide justification for increasing national savings in preparation for the aging of baby boomers. However, decisions about the structure of Social Security and health care programs are not highly dependent on information provided by long-term forecasts. Indeed, these are political choices, driven primarily by politics and interest group alignments.

Although much discussion focuses on the national level, it should not be overlooked that the aging of baby boomers poses significant economic challenges at state and local levels. For example, some communities—retirement magnets—will experience a slow influx of the more affluent baby boomers. Many “Sunbelt communities” have already benefited from an influx of boomers who relocated in response to better economic opportunities. These communities are likely to benefit as their more affluent boomer residents may age in place and as newly retiring boomers migrate in (Frey 2003; Serow, 2003), bringing significant economic and human resources. Yet, growing numbers of older residents, regardless of income profile, also bring challenges, such as increased need and demand for responsive public transportation, alternative housing, educational, vocational, work, and volunteer opportunities, and social and health services. Other communities outside the Sunbelt are likely to experience a loss of aging boomers, leaving behind a lower tax base, a depleted source of human and economic resources, and a greater proportion of lower income persons in need of economic support (Frey, 2003). Both scenarios carry important economic implications for local communities.

Although all metropolitan areas will be challenged by the aging of baby boomers, mid-size metropolitan areas, primarily in the Midwest and Northeast, are at significant risk. With shifts from a manufacturing to a service-based economy, many mid-sized metropolitan areas have experienced substantial job loss and regional economic decline, such as Flint, Michigan; Milwaukee, Wisconsin; New Haven, Connecticut; Syracuse, New York; Toledo, Ohio; and Worcester, Massachusetts (Frey, 2003). Historically, about 5% of elderly persons move annually, mostly within a few miles, and another 1% move across state lines. Those moving out of state tend to be among the more affluent elders whose movement has fueled the growth of retirement communities in other localities (Serow, 2003).

Simultaneously, many of these metropolitan areas have seen their populations decline or grow very little as a result of younger, better educated people also migrating to the more economically robust Sunbelt. “Central cities, inner suburbs, and metropolitan areas in regions that have suffered economic and demographic decline in recent decades

will continue to house disproportionate numbers of the nation's 'demographically disadvantaged' elderly," (Frey, 1999, pp. 2–3), often a result of aging in place.

Threats to the Economic Well-Being of Baby Boomers: Real, Not Imagined

As previously noted, many baby boomers are almost certain to face the prospect of new financial challenges and declining living standards during their later life, and for some, old age will simply be a continuation of poor living standards experienced through much of their lives. Moreover, the economic status of baby boomers in their old age will depend on hard-to-predict demographic and economic developments, including changes in life expectancy, immigration, changes in government benefits, unexpected changes in their marital or health status, returns on investments, health insurance protections, and employment and earnings opportunities. Most fundamentally, the aggregate economic well-being of baby boomers and other elders of the future will depend on the nation's economy as well as how Social Security financing problems are addressed, financial instabilities in occupational pension systems, health care access, and financing and risks related to long-term care (see Brown and Kingson, in press).

Caregiving, another important but often hidden economic challenge, also presents significant challenges for the financial well-being of baby boomers. Care provided informally in the context of families and friendships carries substantial economic benefit for society, with the costs accruing most heavily to women. Assigning a value of \$6 an hour (in 1979 dollars) to informal caregiving, analysis by economist James Morgan led him to conclude that the family "is by far the most important welfare or redistributive mechanism even in an advanced industrial country like the United States with extensive public and private income programs" (1983). He estimates the value to the economy of all informal care—normal care (e.g., diapering, preparing meals, running errands for an older parent) and extraordinary care directed at sustaining functionally disabled family members—is equivalent to 30% of the gross national product.

Arno, Levine, and Memmott (1999) apply a more circumscribed estimate of informal caregiving to seriously disabled, chronically ill, or terminally ill adults. Using data from the Survey of Income and Program Participation and other data sources, they estimate that 25.8 million people provided "extraordinary care" in 1997, averaging 17.9 hours per week for each caregiver—about 24 billion caregiving hours per year across all

caregivers. Assuming a value of \$8.18 per hour of care, the national value of this care was \$197 billion in 1997—nearly one-fifth of total national health expenditures and 175% greater than the total expenditures on nursing home and community-based care. Clearly, decisions to expand or contract public benefits that support the care of functionally disabled elders will have economic consequence for baby boomers in their middle and early old ages as many care for parents and in their more advanced old ages when many will need such care. Hence, it is important to incorporate the economic cost of informal care of parents and elder boomers (e.g., lost earnings and other opportunity costs) as well as the value of public services that support caregivers into economic analyses of the boomer cohort.

CONCLUSION

Policy discussions about the economic impact of aging baby boomers are driven, in large measure, by the assumptions and values on which they are based. The decisions that follow will have a significant impact on the economic state of aging boomers, our nation, and our local communities. Consequently, it is important that these discussions proceed unhampered by stereotypes and ideological blinders.

As the preceding discussion points out, pop culture notwithstanding, early images of baby boomers as “hippies,” then “yuppies” (young urban professionals), and “dinks” (dual income, no kids) who metamorphose at “thirtysomething” into parents simply did not begin to describe the way most members of this generation live. Moreover, the notion that nearly all baby boomers are being cheated by Social Security and Medicare and are likely to face dismal retirements misses the mark (see Longman, 1987). Such stereotypes are inaccurate and provide an unsound basis for planning policy responses to the aging of baby boomers. They also overlook the reality that barring unforeseen economic calamity, there is every reason to believe that Social Security can provide a very effective floor of income protection for baby boomers, just as it does for current cohorts of elders.

So, how should we begin to think about public policy responses to the aging of this vast and diverse group of Americans? Policy discussions need to be framed in a manner that recognizes the diverse circumstances and needs of baby boomers. Recognition of the diversity of baby boomers should appropriately focus attention on the potential of most to make social contributions in their old age and on what those who are economically or physically able should return to society during their old age.

Very importantly, awareness of this diversity should also highlight that while the retirement security of many baby boomers is all but certain, the retirement years for many others such as the currently poor, single parents, low-wage workers, those closed out of homeownership, or those currently lacking adequate pension coverage are likely to be bleak. Failure to focus on the needs of those at greatest risk will likely result in greater inequality of retirement circumstances than is currently the case for today's elderly persons.

Although the exact numbers cannot be estimated, they can be found disproportionately among the nearly 12 million boomer women who were either divorced, separated, widowed, or never married in 2005 and among the roughly 11.6 million boomers who did not have private or public health insurance coverage in 2004 (U.S. Bureau of the Census, 2005b). They are also likely to be found among the roughly 6.7 million baby boomers—including about 7.4% (almost 5 million) of all White boomers and 16.5% (nearly 1.5 million) boomers classified as African American with incomes below the official poverty line in March 2005 (U.S. Bureau of the Census, 2005a); among the roughly 8 million boomers reporting a health problem or disabling condition that prevents or limits working; and among the 8.4 million reporting they did not receive an high school diploma. They are likely to be found disproportionately among the roughly one-half of full-time private wage and salary workers who are not covered by private pensions, and they are likely to be found among the one in four baby boomers, roughly 19 million, who do not own homes and therefore do not have housing equity in 2005 (see U.S. Bureau of the Census, 2006).

Current national debate has focused predominantly on the financial solvency of Social Security and the future of Medicare and Medicaid. What is especially telling is the extent to which differing positions are grounded in fundamentally different values—values that will continue to shape public policy reforms for years to come.

Indeed, values and assumptions about baby boomers structure the contemporary policy discussions about the economic consequences of their aging, perhaps more than the objective conditions. Arguably the most fundamental set of opposing values today are those that are aligned along the traditional “individualism” versus “shared responsibility” axis. President George W. Bush's proposal, for example, to carve private accounts out of Social Security, is part of a larger policy strategy, the so-called “ownership society” that places more value on the individual than on shared risk. In contrast, proponents of modest incremental reform seek to protect core values behind the program, the most prominent being shared responsibility for the well-being of all Americans.

Because political ideology structures policy discussions and because stereotypic notions of baby boomers are so common, we conclude that analysis of the economic implications of the aging of baby boomers should:

- seek to make value choices more explicit,
- be based on an understanding of the great variability existing among and between differing groups baby boomers, and
- place more emphasis on the concerns of those baby boomers at greatest risk.

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Futures for the Baby Boom: Described, Inscribed, and Prescribed*

David J. Ekerdt

I have always shied away from predicting the future, even now, when I am asked with some frequency about the retirement of the baby boom cohort. I find the topic hard to discuss because after I consider all the contingencies that may occur over the next 10 or 20 years—the nature of the economy, the labor market, financial markets, fertility, mortality, immigration, what the other cohorts are up to, policy for the welfare state, and the really big contingency, the cost of health care—I really don't know. So I like to say, about the future for the baby boom, it depends.

But let me also say this about the act of pre-announcing the future: People love it. They are happy to hear that “baby boomers will retain large houses as havens to which their children and grandchildren will return.” No, wait: “They will shed themselves of excess real estate and travel lightly across the land in pursuit of simpler pleasures.” Whatever the vision of the future, if the forecast is optimistic and promises something novel, people seem to feel prepared, informed, and grateful for the seer's thoughtfulness. “To conceive extravagant hopes for the future,”

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observed the 18th-century statesman Edmund Burke, is one of “the common dispositions of the greatest part of mankind.”

The other thing about playing the prophet is that there is no apparent penalty for being wrong. No one checks up. Where, for example, are the authors of the 1999 book, *Dow 36,000?* Its thesis was: “Stocks are now in the midst of a one-time-only rise to much higher ground—to the neighborhood of 36,000 on the Dow Jones industrial average. . . . The Dow should rise to 36,000 immediately, but to be realistic, we believe that the rise will take some time, perhaps three to five years” (Glassman & Hassett, 1999, pp. 4, 18). Of course, the Dow never rose even one-third as high as that prediction, but never mind. James Glassman is sailing along as a fellow of the American Enterprise Institute and as financial columnist for Scripps Howard News Service and, until recently, *The Washington Post*.

More relevant to the present topic is a 1990 chapter by Gregory Mankiw and David Weil on “The Baby Boom, the Baby Bust, and the Housing Market” that examined the impact of major demographic changes on residential real estate. The authors reasoned and concluded:

Since the Baby Bust generation is now entering its house-buying years, housing demand will grow more slowly in the 1990s than at any time in the past forty years. If the historical relation between housing demand and housing prices continues into the future, real housing prices will fall substantially over the next two decades. (p. 235)

The housing bust has not yet occurred, and the 2 decades are almost up. What did happen, though, is that Gregory Mankiw was tapped to serve from 2003 to 2005 as the Chairman of the President’s Council of Economic Advisors in the Bush Administration.

So we can make people happy by predicting the future. In so doing, we can be wrong but it will not be held against us.

THREE APPROACHES

In considering the near- and long-term prospects of the baby boom, I would suggest that there are three approaches to the question. I call their practitioners the Describers, the Inscribers, and the Prescribers. The Describers write *about* the cohort; the Inscribers write *upon* the cohort; and the Prescribers write *directions for* the cohort. About the first group, the Describers, I will pass over their practices for the moment because it is in this context that I want to make some observations about the chapter by Eric Kingson (chapter 7, this volume).

The Inscribers are those who write upon. These are people who attribute to baby boomers a collective personality or cohort-specific traits and motivations. Baby boomers are hedonistic; they are self-centered; they are spendthrifts; they are altruistic; they strive to self-actualize. This is done in the way of predicting some cultural shift that the baby boom will herald, around which there are likely to be commercial possibilities. Ken Dychtwald's book, *Age Wave* (Dychtwald & Flower, 1989), was an early inscription upon the cohort: "Because they love their youth so much, they will do everything possible to take it with them into old age" (p. 20). "They have learned to spend their money fast and to borrow rather than save" (p. 277). Music to a marketer's ears. And there has been no shortage of others who try to pin down the baby boom so as to sell things to it (Morgan & Levy, 2002; Moschis, Lee, Mathur, & Strautman, 2000; Smith & Clurman, 1997). The breezy bullet points of Inscribers are also irresistible to journalists, as Kingson notes. Nevertheless, the Inscribers' impressions of the cohort may be just accurate enough to give their readers and clients a leg up in the marketplace.

The Prescribers seek to direct the cohort, primarily by promoting the moral advisability of third-age altruism. They begin with a bit of inscription: As family and work wind down, the baby boom will be looking for meaning in their lives and for rewarding experiences, which they can find in service to family, community, church, or the common good. One of the seminal Prescribers was Elbert Cole, founder of the national Shepherd's Center movement, whose new vision of aging endorsed what might now be called the purpose-driven retirement (Clement, 1976). More recently, Marc Freedman, in his (1999) book, *Prime Time: How Baby Boomers Will Revolutionize Retirement and Transform America*, has argued for the reinvention of retirement toward more service activities and opportunities to give back to society. Freedman's organization, Civic Ventures, foresees a great "experience dividend" flowing from the social capital that resides in this new cadre of volunteers. Foundations and funders have now taken up the promotion of "civic engagement" among the coming cohort of retirees. The Prescribers, like the Inscribers, have a message about the aging baby boom that is optimistic, hopeful, and expansive.

The Describers start with empirical profiles of the cohort and then proceed to model or extrapolate the cohort's likely behavior or effect on social institutions. They do this to the best of their ability and not without the value-laden analytic frameworks to which Kingson refers. For example, a substantial proportion of the baby boom has never married. What then are the implications of this pattern for lifelong wealth building or for the provision of long-term care? One thing that distinguishes Describers from Inscribers, apart from the analytic versus commercial motive, is that the Describers tend to be more attentive

to the heterogeneity of characteristics within the cohort, whereas the Inscribers blanket some 70 million people with the same trait or just take the top quintile for the whole. Another thing that distinguishes the Describers is that they are not constrained to be optimistic about the future. Indeed, hand wringing about the impact of the baby boom cohort has become a cottage industry.

Describing and projecting the future are worthy and responsible things to do, even though the scenarios thus generated will likely be wrong in some way (confer Mankiw & Weil, 1990). The most prominent Describers of future aging are the Social Security and Medicare Boards of Trustees. Each spring, as required by law, the Trustees project the finances and solvency of these programs a full 75 years into the future. And each succeeding year, the Trustees revise their projections based on emerging assumptions about a host of factors. Kingson cites other recent examples of empirically based forecasts about baby boom aging (e.g., Butrica, Iams, & Smith, 2003; Congressional Budget Office, 2003; Hughes & O'Rand, 2004), to which may be added a number of chapters in this volume. To the extent that demography is destiny, the size of the baby boom cohort alone will continually compel curiosity about its next stop.

TWO STORIES

The economic consequence of baby boom aging is conventionally a story about one of two things. One focus is the future economic well-being of individuals. Measured against their elders or their former selves, what levels of wealth, income, and financial security will individuals in this cohort have? The other focus is the future of the welfare state. What old-age entitlements will baby boomers have or should they have? And, implicating other cohorts, how will these entitlements be financed? In pondering what will befall the baby boom, Kingson discusses both of these dimensions.

Describing the cohort's economic security now and to come, Kingson is emphatic about the contingencies involved, those "hard-to-predict demographic and economic developments." Importantly, he reminds us that many of these contingencies do not just happen. Interest group alignments for the exercise of political power shape the labor market, the national accounts, immigration, public health, and the nature of public commitments. Political will is an actor in the baby boom drama.

Kingson hazards projections about housing, geographic migration, and retirement income prospects. All the while, he stresses that this mega-cohort is internally diverse in its history and characteristics.

Sweeping statements about the whole cohort “displace attention away from those likely to be at greatest risk” for economic disadvantage. One wrinkle new to my attention is the way that baby boom futures may differ by locale. When retirees or persons of any age relocate, communities stand to gain and lose economic, human, and social capital. This seems a compelling topic for future scholarship—to focus not just on the wealth of the cohort but also where it concentrates and where it thins.

Turning to the welfare state, Kingson notes that there is widespread agreement that that baby boom aging will strain the finances of Social Security, Medicare, and Medicaid. On this topic, he knows whereof he speaks, given his long involvement with old age policy and his service for two national panels, the 1983 National Commission on Social Security Reform and the 1994 Bipartisan Commission on Entitlement and Tax Reform. Kingson observes that, since the early 1980s, conservative policy interests have spun a dark story about the future burden that elders will place on the public purse. He contends that ideology and arithmetic have been conflated into a willfully constructed “crisis” that the alarmists say can only be resolved by curtailing social insurance programs for older Americans. Kingson’s own view is that these programs can be shored up with incremental reforms within existing frameworks.

Kingson cites a remarkable article from a 1983 issue of the libertarian *Cato Journal*, whose authors outlined a strategy for building a political coalition to privatize Social Security (Butler & Germanis, 1983). It is astonishing to read this statement now, over 20 years later, because it is the exact campaign for Social Security privatization that was mounted in early 2005. This initiative by the right, propelled by the Bush Administration, included such tactics as chilling out older voters (your benefits are safe), enlisting younger voters to the privatization cause, and hammering away at the unsustainability of current arrangements—all exactly as specified back in 1983.

The other astonishing thing about this plan of battle is that, had it ramped up fully at the time it was proposed, it would actually have been a thrust against entitlement spending not for the baby boom, as in 2005, but against the so-called “greatest generation.” The entitlement spending that was eventually disparaged across the late 1980s and 1990s was spending on cohorts born prior to the Great Depression. My own metropolitan newspaper campaigned against entitlement spending in 1996 with insinuations that many beneficiaries of Social Security and Medicare are undeserving and a weight on the young (Ekerdt, 1998). So the concern is not about the baby boom per se—their particular history and characteristics—although in size, the cohort is conveniently apocalyptic and a handy way to extrapolate to the future. Rather, the aged of whatever generation simply serve as a category, an opportunity

to make the argument that population aging raises urgent issues for the national agenda.

A RISING STORY ABOUT THE BABY BOOM

In addition to well-being and state support, we should also acknowledge a third major story about the economic impact of the baby boom, one that likewise originates in the non-ignorable size of the cohort. In this story, older Americans, more specifically the young-old, are an object of economic activity—they are a market.

Theorists of consumer society observe that my identity, my narrative about myself, proceeds in part from the choices that I make in the marketplace, from my consumption (Bauman, 1988; Giddens, 1991). I make *choices*. In this elevation of agency, the assembly and periodic makeovers of my identity are a continual undertaking. The social structures that once afforded people fixed identities have lost their force in the current era, replaced by an ongoing self-directed project to “be” someone or something. And one important way to be something is to buy something.

So here comes the baby boom toward later life, wearing the life-long habits and having internalized the norms of a consumer society, to seek engaging experiences and lifestyles. The open-endedness of the consumerist manifesto—“I choose!”—fits hand-in-glove with a cohort among whom many will enter later life untethered to jobs, daily family responsibility, and community. “The freedom to live exactly how you choose,” reads an October 2005 advertisement from Merrill Lynch, “that’s what the new retirement is all about.”

The “agentic third age” will not include everyone, but it advertises “to those who wish to listen that a new style of being an older person is exciting, desirable and ultimately attractive and consumable” (Gilliard & Higgs, 2000, p. 40). Although lifestyle remodeling to its full extent will be done by few, it will speak to many. Even now, few retirees enact a Sunbelt or RV-going-down-the-road retirement, but everyone has seen this model and thought about doing it themselves.

The selling of retirement and selling to retirees has been under way since the 1950s (Calhoun, 1978), but the economic consequence of the baby boom’s arrival will raise the profile of the 55- to 70-year-old demographic. Burnished and heralded by the Inscribers, the third age will outshine the fourth even more brightly than at present. Among the products and services that can satisfy the desire for experience, real estate, and housing have long been in the game. Kingson reminds us

that communities will be competing for affluent baby boomers. Travel and learning packages also have appeal to the lifestyle explorations of retirees. But the mature market has room for new stalls. We can expect to see a repositioning of other product categories to serve as signifiers of identity for retirees: food, beverages, restaurants, apparel, autos, and technology. Financial services already promote themselves as a way to stage the retirement of your choice. Their advertising carries a three-part message: (1) retirement is a state of freedom and leisure for personal pursuits, (2) financial security is the means to that state, and (3) our services are the means to financial security (Ekerdt & Clark, 2001). So give us a call, and we will manage things so that you can have time for the project that is yourself.

There is huge potential in the selling of cosmetics, self-care products, and anti-aging regimens to resist the lost appearance of youth (Katz & Marshall, 2003). With these items, people can choose to control signs of aging and impaired functionality. Another thing to be merchandized is the experience of grandparenthood. An open-ended role awaiting specificity (Robertson, 1995), grandparenthood can be discharged with the benefaction of toys, books, electronics, travel to theme parks, and even funds for college. As noted earlier, the Inscribers stand ready to assist retail entrée to the elder market.

The Prescribers, who advocate an other-oriented retirement, will need to hone their exhortations to compete with the self-oriented imperative toward consumption. Or maybe not. The absence of an enclosing social structure for the third age means that a baby boomer can be one thing on Monday (community volunteer) and another on Tuesday (connoisseur). Ironically, the Prescribers will be able to profit from the “I choose” ethos of identity formation because it will make the moral renunciation of empty leisure *itself a choice* on the way to the construction of an authentic self.

Baby boom aging is a contested reality among the Inscribers, who focus on traits and essences; the Prescribers, who issue a moral challenge; and the Describers, who project diverse futures for the cohort, sometimes with an ideological edge. And about the rising consumer market, I could be wrong, but you won't hold it against me.

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Immigration Effects on Health Care for Older People*

Jacqueline L. Angel

In the United States today, as in other developed nations, immigration and the income and health care needs of the older population are among the most pressing and interrelated issues the nation faces. As the population ages and as the fertility of old-stock Americans decreases, immigrants and their offspring assume a greater role in the labor force of the future. As they age themselves, these immigrants will change the ethnic profile of the older population itself. This chapter explores the ways in which these two issues—immigration and the age profile of the population—are related and discusses the potential health consequences of the changing makeup of the population in late life.

First, we begin by focusing on immigrants and examine what is known of their health care needs as they age. A significant number of immigrants have come to the United States in recent years, and they will comprise a growing proportion of the older population in the future (U.S. Census Bureau, 2006). One projection shows that the aged immigrant population will swell to 4.5 million by 2010 (Wilmoth, De Jong, & Himes, 1997).

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This demographic projection has profound health care implications for the older foreign-born population, which is very diverse and retains certain idiosyncratic features unique to each subgroup's own immigration experience and history in the United States. Among elderly U.S. residents, those who were born outside the United States tend to be poorer and less educated than those who are native born (Angel, Buckley, & Sakamoto, 2001). Immigrants account for nearly half of those 65 and older who lack health insurance (He, 2002). Many of these immigrants come from countries in which the culture of caring for the elderly is very different than it is in the United States. What will the health care needs of these immigrants be as they grow old in America, and what resources will they have to obtain health care?

Over the next few decades, the swiftly aging population is expected to create unparalleled changes in the delivery of health care services for the old (Carr, Pemmarazu, & Rice, 1996; Crystal & Shea, 2003). Fueled in part by elders with longer life expectancies than past generations (Land & Yang, 2006), this aging trend will affect the number of consumers demanding both acute and chronic health care services (Crimmins, Saito, & Ingegneri, 1997) as well as social policies (Uhlenberg, 1992). Those residents surviving to the "fourth age" (85 years and over), a period of the life course in which many persons experience dependency, will constitute a larger proportion of the elderly population, doubling from 12.1% of the total number of older people in 2000 to 24.1% by 2050 (U.S. Census Bureau, 2004–2005). The number of these individuals who need to access long-term care services is expected to rise over 100%, more than doubling from 8 million to 19 million in 2050 (U.S. Department of Health and Human Services, 2003).

The second aspect of immigration and health we will examine is the phenomenon of immigrants providing care for older people in the United States. Immigrants have historically played an important part in the labor force. For the most part, they arrive as laborers and enter the lowest rungs of the labor force, from which they might work their way up. Some highly educated immigrants are welcomed for their special skills. Today, the shortage of nurses makes nurses from other nations a desirable immigration category. Given the fact that immigrants often find work in the service sector, and because of the fact that caring for the elderly is not a highly paid or prestigious occupation, we would expect that immigrants will assume a greater role in paid domestic work or elder caregiving as the population ages (Hondagnue-Sotelo, 2001).

The aging of the population and the nature of the immigration process, therefore, are potentially intertwined. As the population ages, the demand for health care workers can be expected to increase, and

consequently, foreign-born health care workers will become more necessary to U.S. employers (U.S. General Accounting Office, 2004). What were the political and economic forces that led to this outcome? As the rapid aging of the population in coming decades increases the demand for health care workers, will even more immigrants be recruited to fill these jobs? What are the implications of increasing reliance on poor, non-White immigrants to meet the basic care needs of affluent White Americans who experience disabilities in late life? The discussion that follows is organized around these broad questions about the linkages between immigration and health. The chapter ends with suggestions of avenues for future research.

ELDERLY IMMIGRANTS AND THEIR HEALTH CARE NEEDS

In the last 50 years, the composition of immigrants has changed dramatically as a result of the passage of amendments to the Immigration and Nationality Act of 1965. Until 1950, 90% of immigrants were people of Canadian or European ancestry, but since the 1980s, 75% of immigrants admitted to the United States are of Asian or Hispanic heritage (U.S. Department of Homeland Security, 2006a). As migration flows from Latin America and Asia swell, the magnitude of older immigrants' health care needs should surge due to aging and the extended life expectancy among certain racial and ethnic groups (He, 2002).

For many conditions, including the risk of death and dementia resulting from type 2 diabetes, foreign-born people have lower age-adjusted mortality rates than native-born people (Markides & Eschbach, 2005). But the mortality advantage exhibited among older foreign-born Mexican Americans has serious health consequences. Although Latinos, as a group, tend to rate their health more like that of Whites than of African Americans, they are disproportionately impacted by diabetes, mental illness, substance abuse, HIV/AIDS, and some other conditions, like Alzheimer's disease, in late life (Haan et al., 2003). Compared with elderly Mexican Americans born in the United States, elderly Mexican American immigrants are less likely to rate their health status as excellent or very good. They also report more serious limitations in basic activities of daily living, such as bathing, dressing, and eating, and a greater need for assistance with instrumental or household activities of daily living than native-born people (Angel, Angel, McClellan & Markides, 1996). Such findings suggest that behavioral and cultural changes associated with migration to the United States may increase the risk of certain chronic conditions and their negative outcomes (Dey & Lucas,

2006; Escarce, Morales, & Rumbaut, 2006; Jasso, Massey, Rosenzweig, & Smith, 2004).

These patterns in compromised health and functioning have long-reaching effects on potential sources of long-term care available to older minorities and immigrants (Angel & Hogan, 2004). Social forces, in particular, will undoubtedly bring about some changes in informal caregiving patterns (Olson, 2003). The decision to care for a loved one at home will occur at a time when demographic changes, notably higher rates of geographic mobility, family disruption, and female employment than in the past, will increasingly affect the immigrant Mexican American family's ability to care for aging parents (Angel & Angel, 2006). Once, Mexican American women, especially daughters, were the primary caregivers to elderly parents. But in recent years, increasing labor force participation rates in the working-age population has meant many women are unable to provide care for aging parents (Angel & Angel, 1998). The rate of Hispanic females between the ages of 25 and 54 working outside the household grew from 42.4% in 1996 (U.S. Census Bureau, 1997) to about two-thirds (61.7%) in 2004 (U.S. Department of Labor, Bureau of Labor Statistics, 2005).

Geographic mobility also affects the availability of caregivers. Adult Hispanics, including children of elderly Mexican Americans, are establishing residency across the United States, defying conventional migration patterns associated with the Hispanic population (Durand, Telles, & Flashman, 2006). Several states in particular, such as North Carolina, Nevada, and Georgia, experienced a dramatic growth in Hispanic populations between 1990 and 2000 (392%, 299%, and 218%, respectively). These changing migration patterns are age-graded and predominantly found in the working-age and baby boomer population. On the positive side, the redistribution of Hispanics gives way to the development of ethnic enclaves, new social networks, and labor-market opportunities. However, such incentives for settling permanently in an area may strain intergenerational opportunities for caregiving in the Hispanic family. In many cases, elderly parents do not follow their adult children.

Research has begun to illustrate that as the Mexican American family comes under the same pressures that affect non-Hispanic families, its members may be less able or willing to provide such care. The physical and/or emotional toll may be too great for caregivers, given that Hispanic elders tend to delay institutionalization and the level-of-care responsibility is much greater than in the general population. One reason for this is that elderly Hispanics are far less likely than non-Hispanics to enter a nursing home, and as result, most frail and disabled older

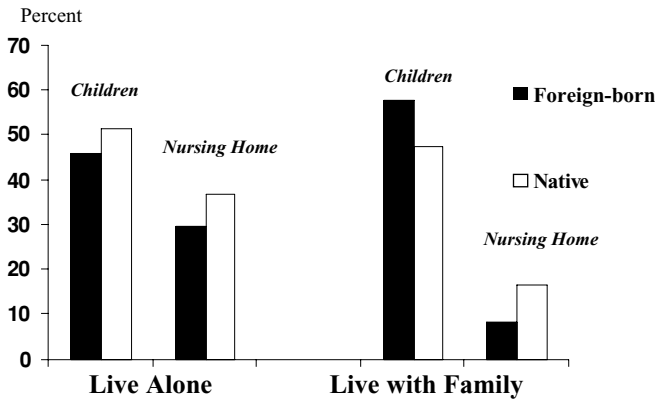


FIGURE 9.1 Living arrangement expectations in the event of illness for elderly Mexican American women. (Source: H-EPESE 1993–1994.)

Mexican Americans receive long-term care in the community, relying exclusively on unpaid family caregivers (*la familia*). Compelling evidence from the Hispanic Established Populations for Epidemiologic Studies of the Elderly (H-EPESE) demonstrates that nativity and the timing of immigration particularly affect the decision to live with family in the event of infirmity (Angel, Angel, & Markides, 2000). As the data in Figure 9.1 illustrate, foreign-born Mexican American elderly women living in families express a stronger preference than native-born women to continue living with family in the event they can no longer take care of themselves (Angel et al., 1996). On the other hand, twice as many native-born as foreign-born people who are currently living alone chose a nursing home as an option in care arrangements (Angel et al., 1996). Moreover, the dependency on family is strongly associated with the timing of immigration. Mexican-origin individuals who immigrate after age 50 are far more likely to move in with others than to have someone move in with them, especially when they become ill (Angel et al., 2000).

Additionally, the spiraling medical care costs predicted for the 77 million baby boomers approaching retirement have prompted many researchers to address the potential effects of immigration on federal health care safety net programs, especially Medicaid (cf. Smith & Edmonston, 1998). Some welfare benefits were cut or drastically reduced as part of welfare reform. On August 22, 1996, President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act that ended welfare as we knew it (Zimmerman & Tumlin, 1999). The bill restricted eligibility for all immigrants to federal means-tested entitlement programs and was driven in large part by anti-immigration

sentiments and the perceptions that primary dependency on government services for subsistence leads to older immigrants becoming public charges (Angel, 2003; Borjas & Hilton, 1996; Smith & Edmonston, 1998). Elderly immigrants receiving Supplemental Security Income, an anti-poverty program established in 1972 as Title XVI of the Social Security Act, were specifically targeted, and many elderly immigrants and refugees were denied Medicaid benefits (VanHook & Bean, 1999). Many elderly immigrants lost their eligibility for cash assistance and faced destitution (Pear, 1997). After the bill passed, certain states restored some benefits to elderly immigrants, although the ambivalence in popular opinion continues to cloud public debate on their access to federal entitlement programs.¹

IMMIGRANTS AS CARE PROVIDERS

Immigrants provide labor for critical U.S. economic sectors, such as agriculture, construction, and health care (Borjas, 2001). They play a considerable role in reducing the shortage of doctors, nurses, nurse aides, and home health care workers, and as the population ages, they are expected to continue to make important contributions to the formal caregiving systems (Rogers & Raymer, 2001). Much attention has been focused on educating the predominantly non-Hispanic White health care providers on how the cultural differences of individuals can affect the care they seek and receive (Bagley, Angel, Dilworth-Anderson, Liu, & Schinke, 1995). As of yet, however, little is known about the implications of cultural differences among those *providing* patient care to older adults who need assistance and interventions.

Immigration patterns play a significant role in shaping the character of the health care infrastructure, including human resources. Although the older population will become ethnically diverse along with the rest of the population in coming decades, it is a demographic fact that the U.S. health care system will increasingly rely on a dwindling working-age population (15–64 years) made up disproportionately of minorities and recent immigrants (Angel & Hogan, 2004). New arrivals admitted to the United States, particularly from developing countries in Central America, fill crucial jobs in the health care sector. But the retired age strata of 65 years and over is likely to remain disproportionately non-minority and constitute a White gerontocracy (i.e., a shrinking younger generation supporting an older population that will wield significant political clout and vast influence over the economy) with socioeconomic advantages and special preferences for long-term care and medical care,

according to some scholars (Angel & Angel, 2006; Hayes-Bautista, 2004; Torres-Gil, 2002).

Some evidence suggests states like California and Texas—with a high proportion of Hispanic immigrants—will confront major challenges of coping with intergenerational interests in an age-ethnically stratified society (Hayes-Bautista, 2004). The growing young working-age Hispanic population will bear much of the retirement cost of the non-Hispanic White population. As the result of the electoral clout of English-speaking non-Hispanic White retirees, we might also anticipate widespread support for initiatives that disproportionately affect foreign-born people of Mexican ancestry. One can turn to California as a case example. Voter approval ratings soared for Governor Pete Wilson as a result of the passage of three antimulticultural legislative bills that denied immigrant access to health and economic benefits, notably Medicaid long-term care (Proposition 187), abolished affirmative action/racial quotas (Proposition 209), and restricted bilingual education (Proposition 227). Clearly, these types of state legislative proposals are aimed at restricting or eliminating program eligibility and some essential health benefits, including state-funded social services supporting elderly immigrants (Jaret, 1999; Smith & Edmonston, 1997).

These major demographic shifts, including the convergence of increasing numbers of culturally distinct immigrant elderly and shrinking numbers of working-age people, are influencing who will care for older adults in years to come and creating a startling problem in our health care system. Specifically, there are too few health care personnel to provide a full range of health and social services (Stone, 2000). Because immigrants account for the growing diversity of the labor force (Larsen, 2004), they can affect the structure and quality of the care delivery system for elderly individuals (Stone, Dawson, & Harahan, 2004).

IMMIGRATION AND THE CARE GAP

For more than 200 years, the United States has been home to a large immigrant population. Yet, not since the early 1900s have we witnessed such a dramatic change in international migration (Foner, Rumbaut, & Gold, 2000). In the early 1900s, the inflow of individuals to the United States was from Europe, but today, the influx of migrants comes from developing nations in Latin America and Asia. People migrate to the United States for many reasons—family, work, education, and politics (Foner et al., 2000). Many foreign-born individuals come to the United States to seek new and often better employment opportunities. They

tend to fill jobs along the extreme ends of the industry continuum, from high-technology to those in agricultural and the service sectors, notably health care (Borjas, 2001). As the evidence will show, based on analyses of Census Bureau data, one notable role of immigrants is filling positions in geriatric care occupations.

Since the 1940s, educational attainment of new waves of migrants arriving in the United States has been declining relative to that of native-born U.S. residents (Smith & Edmonston, 1997). As a result, they take low-paying jobs in the health service sector that often barely cover the cost of living expenses—including health insurance (Camarota & Edwards, 2000). These health care workers, especially individuals employed in long-term care facilities, earn low wages and receive few benefits, and are themselves unable to save for retirement. They are mainly composed of disadvantaged minorities, international medical school and nursing graduates, and undocumented workers. Recent immigrants, in particular, fill relatively low-wage, often dead-end jobs (Borjas, 2001).

Ironically, although many U.S. corporations reduce manufacturing and customer service costs by outsourcing to countries such as India, the acute and long-term care industries are now reducing labor costs by in-sourcing labor from other countries, predominantly Mexico and the Philippines. Although often overlooked or marginalized in the organization and delivery of health care services, these workers are playing a particularly vital role in the care of the elderly, particularly the oldest-old (Olson, 2003). The nation's reliance on a pool of immigrant health care providers has led to labor market segregation, leaving women of color to provide what is seen mostly as "domestic" work for a less-diverse aging population (Diamond, 1992). Thus, an increasing number of immigrants will influence not only the expectations of those receiving care but also the knowledge and skills needed by future health care providers. Immigrant providers will be in great demand by the time the huge wave of baby boomers begin to retire in 2006 and especially by the oldest baby boomers who start turning 85 in 2030 (Knickman & Snell, 2002). These foreign-born workers will need to respond to a long-term care market that is increasingly becoming specialized, diversified, and medicalized due to higher expectations for quality long-term care services than the current elderly cohort (Redfoot & Pandya, 2002). As some futurists prognosticate, many baby boomers entering old age will not only want state-of-the-art medical care, but also will expect access to long-term care services and supports, reflecting the lifestyle that they have become accustomed to and that emphasizes the freedom of choice in care

TABLE 9.1 Health Care Workforce by Nativity and Citizenship Status: 2000 (unweighted n's in parentheses)

	U.S.-Born Workers	Foreign-Born Workforce	
		Naturalized	Noncitizen
Total—All U.S. Workers	78.0%	9.1%	12.9%
16 and Older	(148,750,068)	(9,115,530)	(12,911,101)
Physicians	74.5%	16.5%	9.0%
Registered Nurses	88.8%	7.1%	4.2%
Nurses Aides	83.4%	8.2%	8.4%
Total—Health Care Providers	(7,679,547)	(703,069)	(510,143)

Source: Author's tabulations from U.S. Census Bureau (2000). Public Use Microdata Sample (1%).

arrangements based on a noninstitutional model (Dychtwald, 1999). Access to and quality of care could be diminished in the event that the demand for supportive care services exceeds the supply of qualified foreign-born workers employed in resident, assisted-living, and nursing homes (Stone, 2001).

To be sure, since the 1950s, health care executives have used immigration policy to manage the health care workforce (Paral, 2004). Health care providers generally favor relaxed immigration policies as a way to expand the labor supply of workers willing to accept low wages (Dawson & Surpin, 2001), but as of yet there has been little comprehensive research on the ability of immigrants to alleviate workforce shortages (Lowell & Gerova, 2004; Rogers & Raymer, 2001). What is known is that foreign-born professionals play a crucial role in filling severe shortages within the two largest health care occupations: physicians and nurses. Approximately 1.2 million immigrants accounted for 22% of employees in the U.S. medical care industry in the 2000 Census (see Table 9.1).

Table 9.1 also examines the relationship between nativity and occupation in the 2000 Census. The data are drawn from the 1% Decennial/Public Use Microdata file. Of the Public Use Microdata 1%, the census classifies occupations into 509 specific job types for employed people arranged into 23 major groups based on the Standard Occupational Classification Manual: 2000.² What these data reveal is that foreign-born people account for 25.5% of all physicians and surgeons, 11.3% of registered nurses, and 16.6% of nursing, psychiatric, and home health aides.

During the 1990s, immigrant employment grew by 114% in home health care, 72% in nursing care facilities, and 32% in hospitals (Paral, 2004). Almost a quarter million (240,800) nursing home employees were immigrants, and more than half lacked U.S. citizenship. Immigrants are also more likely than native-born workers to be employed in nonallopathic medicine and allied health professions, including dentistry, pharmacy, and clinical laboratory technology (Paral, 2004). With the aging of the population, these workers will be critical because they provide the bulk of direct health care to frail elderly individuals at home, in the hospital, and in nursing homes.

Despite the increase of immigrants in the last three decades, overall, the number of new arrivals declined for several years after 2001 (U.S. Census Bureau, 2004–2005). A recent analysis of past and current trends in immigration flow suggests that the number of long-term care workers relative to elderly patients (the worker-dependency ratio) could be insufficient to keep pace with the rapid growth of the older population in the United States (Rogers & Raymer, 2001). Moreover, training and recruitment of foreign-born health care workers has become extremely difficult in recent years. This is a consequence of the anti-immigrant movement that developed after the devastating events of September 11, 2001 (Organization for Economic Co-operation and Development, 2003).

The subsequent immigration restrictions enacted after September 11th are just the latest policies aimed at controlling immigration (Jachimowicz, 2003). Table 9.2 presents a selected list of the immigration laws that have been enacted over the last 50 years to help manage the supply of foreign-born workers employed in the United States, including in our health care system. Although immigration laws and related regulations are complex, ever changing, and difficult to understand, the system generally classifies noncitizens into two visa categories to enter the country and work each year. Noncitizen immigrants must apply for either a temporary or legal permanent resident status (green card) visa to enter the United States. Two of the most common pathways to achieve permanent-resident status are through the deeming process, whereby a family member who is already a U.S. citizen sponsors a relative without citizenship, or by obtaining a U.S. employer-sponsored job. Most immigrants gain admittance to the United States by being the relative of a U.S. citizen. In 2004, almost 60% of new arrivals were admitted to the United States as family-sponsored immigrants (U.S. Department of Homeland Security, 2006b). Many of these family-sponsored immigrants are not seeking high-skilled employment opportunities, but are accepting low-skilled jobs in the service industry, like long-term care (Stone, 2001).

TABLE 9.2 Chronology of Major Immigration Legislation Affecting Nurses and Physicians

Date	Law
The 1952 Immigration and Nationality Act (INA).	Combined quality control exclusions with a national origins quota system and a preference system for certain categories of immigrants. The National Origins Quota System favored immigrants from the western hemisphere and set tight limits on immigrants from continents in the eastern hemisphere.
The 1965 amendments to the Immigration and Naturalization Act of 1952.	Ended racist and controversial national origins quotas and established per-country quotas. Shifted priority to immigrant visa selection system of those who could demonstrate possession of valued skill, talent, knowledge, or experience.
The Immigration and Naturalization Act was again amended in 1970.	To relieve nursing shortage, allowed the U.S. entry of foreign registered nurses under the h1a category, which permits employment of foreign registered nurses in permanent jobs.
In 1986, Congress passed the Immigration Reform and Control Act of 1986 (IRCA).	Addressed the problem of illegal immigration by granting a one-time amnesty for 3 million out-of-status foreign nationals. Penalties were introduced for employers that hire undocumented workers.
Immigration Nursing Relief Act (INRA) of 1989.	Created a special visa category for registered nurses, allowing health care facilities access to foreign nurses while requiring employers to provide new protections to native-born registered nurses and reduce dependency on foreign-educated nurses.
The Immigration Act of 1990.	Increased legal immigration by 35%, enabling an additional 175,000 immigrants sponsored by family and employers. One-half of the extra visas are reserved for skilled applicants. Needed unskilled workers are limited to 10,000 visas.

(continued)

TABLE 9.2 Chronology of Major Immigration Legislation Affecting Nurses and Physicians (Continued)

Date	Law
Illegal Immigration Reform and Immigrant Responsibility Act of 1996.	Law increased penalties for many immigration violations. The law also imposed new certification requirements on employer sponsors of foreign-born health workers, other than physicians. In 2003, mandated new certification requirements of nonimmigrant health care workers who under prior statute could receive waiver.
The Health Professionals Shortage Area Nursing Relief Act (HPSANRA) was enacted in 1997.	Replaced INRA after HPSANRA expired.
Enacted the 1995 North American Free Trade Agreement (NAFTA).	NAFTA permitted relocation of registered nurses from Canada.
President Clinton enacts on November 12, 1999 the Nursing Relief for Disadvantaged Areas Act of 1999, Pub. L. No. 106-95.	Remedy certain narrow interpretations of existing law that make it difficult to bring doctors and nurses to severely underserved areas.
The U.S. Patriot Act of 2001. Reauthorized and signed by President G.W. Bush on March 9, 2006.	Toughened security clearances and background checks for nonimmigrant and immigrant admittance into the United States, tightened coordination between immigration-related government agencies, and increased the U.S. government's ability to track foreign nationals in the United States.

Sources: The above table adapted from information available in the following Web sites: U.S. Citizenship and Immigration Services accessed Immigration and Nationality Act, 2004. Retrieved June 13, 2006, from <http://uscis.gov/graphics/lawsregs/INA.htm>; and True, Walsh, & Miller, 2005, *Overview of U.S. Immigration Law*. New York, New York. Retrieved June 13, 2006, from <http://www.twmlaw.com/resources/general20cont.htm#14>.

Immigrants also use temporary visas to gain a working foothold in this country by filling temporary health care positions (Vaughan, 2003). Like other immigrant professionals, a large percentage of health care workers view the class H-1 visa as a stepping stone, which allows them to remain permanently in this country (U.S. General Accounting Office, 1992). On the flip side, some employers may agree to sponsor foreign professionals, like physicians and surgeons, for eventual permanent residency under the H-1B as part of an enticement to accept a position or remain in it (U.S. General Accounting Office, 2003). According to the Government Accountability Office, 85% of immigrants in the medical industry who held temporary work visas occupied health care jobs intended to be permanent positions (U.S. General Accounting Office, 1992).

The specific rules and regulations of the statutes shown in Table 9.2 suggest why shortages of physicians and nurses exist today. Immigration reform during the 1960s and 1980s sought to remove many barriers to migrants seeking permanent residence. For instance, the 1965 amendments to the 1952 Immigration and Nationality Act (INA) helped to eliminate discrimination against non-European countries by establishing equal national quotas, family reunification principles, employment sponsorship, and a nonpreference category for those lacking a family or employer sponsor. The INA set an annual limitation of 170,000 visas from eastern-hemisphere countries where no more than 20,000 aliens could be admitted per sending nation. This policy removed the old quota system, and in the end, facilitated immigration from developing countries in Asia. The Immigration Reform and Control Act of 1986 favored 2.7 million undocumented workers, the vast majority (70%–80%) of whom included beneficiaries from Latin America. These workers were granted amnesty on the basis of whether they had spent at least 5 years in the United States or were employed to perform agricultural labor during the past 6 months (Durand et al., 2006). They were also given the right to apply for naturalization and in some Latin American countries, such as Mexico, dual citizenship (Durand et al., 2006). These earlier immigration policies helped to fill gaps in the health care workforce.

In the last decade, policy makers have proposed new numerical limits and preference categories to regulate legal immigration. The U.S. Commission on Immigration Reform recommended an increase in admission of highly skilled applicants and a decrease in the number of visas available to unskilled workers (U.S. Commission on Immigration Reform, 1995). The passage of the Immigration Act of 1990 (IMMACT) revised the INA by substantially increasing the admission rate of immigrants (Center for Immigration Studies, 1995). The IMMACT provisions

TABLE 9.3 All Residents in Allopathic Programs by Place of Medical Education

Academic Year	Foreign-Born	U.S. Citizen	Total		Total
	International	International	International	U.S.	
	Medical Graduate	Medical Graduate	Medical Graduate	Medical Graduate	
1988–89	7,227	4,329	11,556	71,235	82,791
1989–90	8,726	4,595	13,321	73,675	86,996
1990–91	10,949	5,067	16,016	75,762	91,778
1991–92	12,881	5,258	18,139	77,016	95,155
1992–93	15,621	5,272	20,893	77,716	98,609
1993–94	18,558	5,162	23,720	78,562	102,282
1994–95	21,199	4,481	25,680	78,074	103,754
1995–96	22,565	4,198	26,763	77,849	104,612

Source: Residency data from Association of American Medical Colleges, Council on Graduate Medical Education (1998).

increased the admission rate of immigrants by over 40%, or 700,000 visas, in the period from 1992 to 1994 and in subsequent years, created a cap of 675,000 (U.S. Citizenship and Immigration Services, 2003). IMMACT had the unintended consequence of creating a backlog of family and employment preference visa categories and limiting the entry of low-skilled immigrants. The legislation retained preferences for family-based immigration and placed more emphasis on highly skilled immigrants. IMMACT placed a ceiling of 10,000 on admissions of unskilled workers. In effect, this reduced the number of available visas for certain categories of labor, including nurse aides and home care workers.

DEMOGRAPHY OF IMMIGRANT HEALTH CARE WORKFORCE

Physicians

An abundance of research has documented the migration of physicians trained outside the United States and the role they play in the U.S. health care system (Mick, Lee, & Wodchis, 2000). According to the Association of American Medical Colleges, the number of foreign-born medical residents nearly tripled between the years 1988–1989 and 1995–1996 (shown in Table 9.3). Between 1990 and 2000, the number of international medical graduate (IMG) allopathic physicians increased by 100%, growing from 12,259 to 25,880. In 2005, 23.5% of physicians and 26.9% of residents/fellows were foreign-born medical graduates in

the United States (American Association of American Medical Colleges, 2006).

There is a continuing debate over whether there is a surplus or shortage of physicians trained overseas in the United States (Weiner, 2002). Over the past 50 years, policies and programs aimed at restricting the “large and consistent” inflow of new IMGs in U.S. medicine have been in large part unsuccessful (Mick, 2004). Although the debate on the increasing supply of physicians attributable to IMGs in U.S. medicine waxes and wanes, recent studies indicate a looming physician shortage in certain medical specialties (Cooper, Getzen, McKee, & Laud, 2002).³

Research shows that IMGs provide an important safety net in the U.S. health care system (Mick & Lee, 1997). In general, the shortage of physician practices tends to be found in locales ignored by U.S.-trained physicians. The migration of IMGs to these areas is characterized as high in need or medically underserved, many of which are made up of elderly people (Cooper et al., 2002; Mick & Lee, 1997; Mick et al., 2000).

IMG physicians fill positions in areas shunned by many U.S. graduates, such as urban centers (Council on Graduate Medical Education, 1998). Tertiary hospitals located in large metropolitan areas have become very dependent on the services provided by IMGs and on the substantial subsidies received from the Medicare program to fund both direct and indirect medical education. Minority elders tend to reside in urban communities and rely heavily on physicians who will accept Medicare. Thus, any policies attempting to limit the influx of IMGs into the United States could hurt elderly populations in areas of medical underservice, including rural areas (Mick & Lee, 1997).

IMGs are more likely than U.S. medical graduates to locate their practice in metropolitan areas, but they nonetheless also represent a large number of rural physicians (Baer, Ricketts, Konrad, & Mick, 1998; Mick et al., 2000). One main reason for this is a condition of the J-1 Visa Waiver program, which requires IMGs to practice in underserved small cities and towns where critical services are needed most, for a minimum of 3 years after they complete their medical training (Verghese, 1994). This is an important immigration program because without a J-1 Visa Waiver, IMGs must return to their place of residence for at least 2 years before returning to work in the United States. These designated health manpower shortage counties have low physician-to-population ratios and render services to the most vulnerable populations, such as frail and disabled elders (Mick et al., 2000; White, 1993). Rural America tends to be older than urban America (Carr et al., 1996). Poverty levels of older persons are also highest in rural areas (McLaughlin & Jensen, 2000). Because one-fourth to one-third of the elderly population lives in rural

settings, especially in the Midwestern states, these individuals have come to count on IMGs who locate in these communities for their care (Mick et al., 2000). Baer, Konrad, and Miller (1999) estimate that one-quarter of community health centers depend on international medical graduates to fill physician openings.

Although policy makers use IMGs to alleviate the shortage of rural and urban physicians, sustaining a residency pool consisting of IMGs exacerbates geographic maldistribution, creating a “brain drain” of physicians from developing nations that so vitally need highly trained clinicians (U.S. General Accounting Office, 1997).⁴ These countries are undergoing an epidemiological transition from infectious diseases, some of which are reemerging, like tuberculosis, to chronic disease, and therefore require a large supply of primary care physicians and medical specialists (Breslow, 2006). Almost two-thirds of IMGs were educated in developing nations, with India as the number one sending country since 1981 (Hagopian, Veninga, Fordyce, Johnson, & Hart, 2004).

Another limitation in the visa waiver program is the fact that recent changes to federal law have seriously reduced the number of visas issued to foreign-trained doctors to work in underserved areas, such as rural counties. Historically, the U.S. Department of Agriculture ran the program. However, in 2002, the program was taken over by the U.S. Department of Health and Human Services, and the new policy restricts the total number of physicians permitted to remain in the United States. This number is far below what is needed in rural areas. In 2001, only about 1,050 immigrant doctors holding temporary J-1 exchange visitor visas were permitted to stay in the United States in exchange for their commitment to exclusively treat patients in underserved areas (Paral, 2004). This was down from 1,583 in 1999. By one calculation, 16,000 doctors are needed to staff underserved areas fully, many of which consist of a high concentration of vulnerable elderly minorities and immigrants (Paral, 2004). Thus, further attempts to stem the admission of emigrating doctors could be detrimental to underserved areas. On the other hand, recruiting doctors overseas could exacerbate “brain-drain” migration, undermining health care for those source countries that need them the most.

Nurses

Nursing is the largest health care occupation in the United States, with more than 2.5 million licensed registered nurses (U.S. Department of Labor, Bureau of Labor Statistics, 2002). But over the past 40 years, the demand for nurses has often far surpassed the supply, and in recent years, the problem has only worsened. Some experts estimate a

national shortage of about 800,000 nurses early into this century (AcademyHealth, 2006). Estimates vary, but the number of vacant registered nurse positions in hospitals is estimated at between 126,000 and 153,000 (American Hospital Association, 2001). Three-quarters of all hospital vacancies are for nurses (American Hospital Association, 2001). There are many reasons for the nursing shortage, including fewer people entering the field of nursing, a disproportionate fraction seeking to practice in hospital settings, and a growing number of patients needing high levels of care. The widespread practice of layoffs of hospital nursing staffs during the 1990s has exacerbated nurse staffing shortages (Lafer, Moss, Kirtner, & Rees, 2003).

To address the nursing shortage, similar to the strategy for addressing the physician shortage, policy makers have started using immigration policy (Glaessel-Brown, 1998; National Center for Health Workforce Analysis, 2006). Foreign-educated nurses continue to represent a large share of employment growth among registered nurses, accounting for one-third of the growth in the nurse labor force between 2001 and 2003 (Buerhaus, Staiger, & Auerbach, 2004). The data summarized in Table 9.1 shows that among all health workers, over 11.3% of registered nurses were born outside the United States. Florida, the state with the highest percentage of people aged 65 and older and 85 and over in 2000 (He, Sengupta, Velkoff, & DeBarros, 2005), had the second highest percentage of foreign-trained registered nurses, based on preliminary estimates of the 2004 National Sample Survey of Registered Nurses (U.S. Health Resources and Services Administration, 2004a). To help alleviate the state nursing shortage, a situation exacerbated by the aging demographics of nurses, 40% of hospitals are recruiting foreign nurses to fill vacancies, predominantly from the Philippines (Florida Hospital Association, 2002).

The J-1 visa program also allows qualified nurses to enter the United States to meet immediate staffing needs and to provide much-needed medical care in underserved areas. International nursing graduates represent one out of every five nurses working in central cities (Glaessel-Brown, 1998). Foreign nurse graduates provide essential care to urban elderly U.S. residents, filling slots in inner-city hospitals, late-night shift work, and clinics where patients often do not have a usual source of care (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004). Moreover, many rural states, like Vermont, use the fees paid by employers applying for H-1B visas to fund additional nurse positions (Commission on Graduates of Foreign Nursing Schools, 2002). These visa programs are designed to resolve the intermittent nursing shortages, but, federal policies designed to permit U.S. entry of foreign-trained nurses have become increasingly restrictive since the mid-1990s. Nonetheless, recent

recommendations offered by the Center for Workforce Studies suggest that immigration policy could ease the nursing shortage (National Center for Health Workforce Analysis, 2006).

Research findings demonstrate, however, that the migration of foreign-born nurses will not eliminate the shortage of nurses in rural areas, which has become even more critical in recent years (Aiken et al., 2004). As Aiken and her colleagues put it:

Sustained underinvestment in nursing education is a theme across the countries that are now turning to aggressive international recruitment. . . . The world's nurse supply appears insufficient to meet global needs now and in the future. Countries that use the most nurses should make the biggest investments in nursing education in both their own and the developing countries from which they recruit nurses. (p. 76)

Tabone (1999) goes further to suggest that the reluctance to develop a comprehensive medical workforce policy will only exacerbate the chronic registered nursing shortage in the United States and worldwide. Although current international recruitment strategies ease the nursing shortage conditions in the United States, they diminish the supply of nurses in the host nation. Although the supply of nurses in some developing nations is more than adequate, there is the concern of "brain drain" when developed countries all actively recruit experienced nurses, raising significant policy issues surrounding the ethics of international nurse immigration (Rothchild & Bowman, 2001). Nurse migration from the Philippines, the country with the largest number of nurses (4,594) who passed the nursing and English exams to qualify for a visa to the United States in 2005, combined with a reversal of Filipino doctors to become nurses, have put a severe strain on their home country's health care system in recent years (Dugger, 2006). U.S. immigration policies that essentially lure nurses from poor nations to the United States to cope with the growing nursing shortage, especially in hospitals, underserved communities, and immigrant clinics, may cause great harm for these countries that are experiencing an acute nursing shortage due to the health care needs of a growing elderly population.

Paraprofessionals

Long-term care workers provide direct care to people who are elderly, disabled, or chronically ill and generally fall into three occupational categories: nursing assistants, home health aides, and personal and

home care aides (National Clearinghouse on the Direct-Care Workforce, 2004). Frontline workers, as discussed later, are typically paraprofessionals—unlicensed or nonregistered staff who provide assistance with activities of daily living (Schnelle et al., 2004). Nurse aides are a critical component of any quality health care delivery system. They also provide critical services for elderly needing care in both home and community-based settings (National Clearinghouse on the Direct-Care Workforce, 2004). Home care is essentially a substitute service in the long-term care supply market, replacing the nursing home or other residential care (Burbridge, 1993). Additionally, the use of home and community-based long-term care services has been steadily increasing, due in part to increased consumer demand and restructuring, partially because of federal policies in response to the *Olmstead v. L.C.* Supreme Court decision in 1999, which gives persons with disabilities the right to receive care in the least restrictive environment (U.S. Department of Health and Human Services, 2003).

Typically, these workers provide paraprofessional, nonmedical services; however, the care provided plays a vital role in managing the everyday health and welfare of the recipient. Most health care paraprofessionals assist clients with both activities of daily living and instrumental activities of daily living (Russonello, 2001). Various researchers have noted that direct care, although critical to maintaining a high quality of life for long-term care recipients, is a highly strenuous task that requires a great level of physical as well as emotional exertion (Dawson and Surpin, 2001; Diamond, 1992; Feldman, Sapienza, & Kane, 1990). This indicates that direct care may be a rewarding but challenging job.

Paraprofessionals, including nursing assistants, home health and home care aides, personal care workers, and personal care attendants, account for up to 90% of hands-on care in nursing homes, the community, and private homes. The demand for these direct-care professionals is expected to increase significantly in the near future because of the growing number of aged and disabled persons in need of long-term care (National Conference of State Legislatures, 2005). Data from the U.S. Bureau of Labor Statistics reveal that between 2002 and 2012, the expected employment growth of home health aides is 48.1%, personal and home care workers is 40.5%, and nursing aides, orderlies, and attendants is 24.9% (Fishman, Barnow, Glosser, & Gardiner, 2004). Despite this considerable growth in the total supply of direct-care workers, government officials warn that the demand may exceed the supply of workers needed to care for the frail and infirm elderly population, especially for the large cohort of baby boomers who turn 85 beginning in 2030 (U.S. Department of Health and Human Services, 2003). According to

TABLE 9.4 Characteristics of Nurse Aides and Other Long-Term Care Workers

Percent	Nurse Aides				
	Nursing Home	Home Health Care	Hospitals	Service Worker	All Workers
Mean age (years)	37.0	41.3	38.7	37.3	44.8
Female	91	89	80	67	52
Black	32	34	33	18	12
Hispanic	12	18	4	22	15
Immigrant	11	20	13	19	12
High school education or less	73	62	54	67	50
Unmarried with children under 18	32	25	20	21	11
Below poverty	18	19	8	16	11
Uninsured	25	32	14	31	16
Receiving food stamps	14	15	5	9	6

Source: U.S. General Accounting Office, 2001, *Nursing workforce: Recruitment and retention of nurses and nurse aides is a growing concern*. GAO-01-750T. Washington, DC.

government projections, nursing homes will need almost 800,000 new aides in 2010 (U.S. Department of Health and Human Services, 2003).

Immigrants represent a large portion of the long-term care workforce, representing one-fifth of all home health care aides (Table 9.4). The majority of the long-term care workforce consists of generally low-skilled and low-wage occupations, filled primarily by women (Crown, 1994; Stone & Wiener, 2001). Because paraprofessional health care occupations are considered low-skilled occupations, little or no formal education is required other than the legally mandated training for workers serving certain clients (Diamond, 1992). Therefore, the traditional supply of long-term care workers has come from middle-aged women who have not completed higher levels of education and have at least one child at home (see Table 9.4). Not surprisingly, many of these immigrant workers lack English-language proficiency (Crown, Ahlburg, & MacAdam, 1995). They are recent immigrants originating from Asia and Latin America, and are willing to work for depressed wages (Borjas, 2001; Wright, 2005).

These nurse aides often undergo job discrimination and face substantial challenges in economic incorporation, including relatively low wages and few benefits in these positions (U.S. General Accounting Office, 2001). Based on an analysis of the Bureau of Labor Statistics wage data from 2000, direct-care jobs, which are not competitive in the

current labor market, employ mostly low-income working women (U.S. Department of Labor, 2002). The report compares the median wages of several low-wage occupations, and the data illustrate the noncompetitive position of direct-care occupations. With median hourly wages between \$7.50 and \$8.89, direct-care jobs paid far below other occupations in 2000 (U.S. Health Resources and Services Administration, 2004a). In 2003, nationally, direct-care workers improved their earnings, averaging \$9.20 per hour, but this is still significantly less than the average U.S. wage of \$13.53 for all workers (Paraprofessional Healthcare Institute, 2006). Additionally, between one-third and one-fourth of direct-care workers lack health insurance, whereas 10% to 11% receive publicly financed health care, that is, Medicaid (Paraprofessional Healthcare Institute, 2003). Having no access to employer-sponsored health care also decreases the competitiveness of direct-care occupations in the current labor market.

The overall quality of direct-care jobs has a profound impact on the ability to fill vacant positions. For the most part, direct-care occupations place high physical and emotional demands on the workers, who generally rate overall job quality as very low (U.S. Department of Health and Human Services, 2003). On-the-job injury rates, which serve as one job-quality indicator, clearly demonstrate the problems the health care industry has attracting workers. Compared with other industries, direct-care jobs have much higher workplace injury rates. In 2003, 13.9 per 100 employees in nursing and personal care facilities sustained on-the-job injuries compared with 5.3 employees per 100 in restaurants and bars (U.S. Department of Health and Human Services, 2003). Job quality is also affected by workloads, which are increasing as job vacancies go unfilled and more work is demanded of current employees (U.S. Department of Health and Human Services, 2003). The structure of direct-care jobs also leads to an undervalued perspective on the part of the workers themselves, as they are seen as the menial laborer at the bottom of the health care hierarchy, with little or no career mobility (Diamond, 1992; U.S. Department of Health and Human Services, 2003). Although the quality of direct-care jobs affects the turnover rates more than it does new worker recruitment, the problem contributes to the "care gap" by decreasing the supply of long-term care workers who leave the market sector for higher-quality and higher-paying jobs.

Family Caregivers

There is substantial literature on the role family plays in relation to the provision of long-term care. Across the spectrum of long-term care providers, informal caregivers provide a majority of the long-term care

services provided in the United States (U.S. Department of Health and Human Services, 2003). Thus, any decrease in the availability of informal care will increase the demand for paid long-term care services (Miner, 1995). Based on the demographics of the baby boomer generation as it begins aging past 65 years, informal unpaid long-term care may not be as readily available. Individuals born between 1946 and 1964, with fewer adult children available to provide informal care, will be at highest need of formal long-term care services (U.S. Department of Health and Human Services, 2003). The availability of informal caregivers is also affected by the high labor market participation of women, who are the traditional source of unpaid care (Burbridge, 1993; Stone, 2000).

However, this assumption is made absent the considerations of any significant demographic changes regarding the racial and ethnic composition of the caregiver pool. The American Association of Retired Persons (AARP) found that the likelihood of providing informal care varies depending on the racial or ethnic background of the family (Russonello, 2001). Among Asian and Hispanic families, long-term care is more likely than among non-Hispanic Whites to be provided by family members, usually adult children (Angel & Angel, 2006). African American families tend to rely on extended family to assist with caregiver responsibilities. This caregiver network consists of friends, neighbors, coworkers, adult children, and other relatives, such as siblings (Russonello, 2001).

Furthermore, recent immigrants are also more likely to rely on informal caregiving support from family members than on paid workers (Angel & Angel, 2006). These cultural systems factor into the composition of the demand for paid long-term services, and the effect is reflected in the larger use of paid long-term care services by non-Hispanic Whites than to any other group (Pandya, 2005). With respect to those findings and current immigration trends, the availability of informal care support in the future may not be as limited as projected by government officials (U.S. Department of Health and Human Services, 2003).

POLICY IMPLICATIONS

Policy solutions must be crafted with both caregiver and care recipients in mind, yet, the solutions must be multifaceted. As research indicates, Mexican-origin immigrants are disproportionately represented among those who suffer labor market disadvantages, a fact that has serious negative consequences for their material well-being and health care access throughout their lives. The extent to which health inequities exist is

particularly salient for states heavily populated by Hispanic immigrants, who make up one-quarter of the aged foreign-born population. In Texas, for instance, 14% of elderly Mexican Americans who immigrated after age 50 do not participate in the Medicare program, even after they become eligible. Those who do participate are less likely than other groups to own supplemental Medigap plans to cover the costs of what Medicare will not pay (Angel, 2003). Because of lifelong labor force disadvantages, retirement-age elderly Mexican American immigrants have far less wealth than non-Hispanic Whites with which to buy health care services or long-term care. The consequences of these lifelong disadvantages in health care coverage place Mexican Americans at elevated risk of preventable health problems and a diminished quality of life.

Elderly immigrants' lack of access to health care affects communities all over the country, both economically and in terms of the nation's health. Immigrant elderly and their families are integral to the future of our communities, yet without full access to high-quality care, their own futures are at risk. In the short term, health policy makers and advocates must preserve the current safety net for immigrant elderly individuals, but in the long run they must also look toward major reform. While states and localities have the authority to provide a safety net for both legal and illegal elderly immigrants, major comprehensive immigration reform could bridge the current disparities in access to care. In the absence of such comprehensive reforms, an incremental solution could be justified based on the contribution of IMGs in the U.S. health care system. For example, since IMGs are now a permanent part of the medical workforce and have been since the 1950s, a sustained commitment of helping foreign-educated health workers and their families obtain visas would be essential, especially because they often provide care to older adults, minorities, and immigrant communities.

Furthermore, a declining supply of traditional paraprofessional health care workers makes it imperative to develop new sources of workers to fill these occupations (Stone, 2001). Recommendations have included recruiting unemployed workers and veterans, immigrants, younger workers, and former welfare recipients. The Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services has explored different partnerships with various agencies to increase the supply of long-term care workers. These partnerships have been built around various avenues of access to previously untapped workers, such as partnering with One-Stop Career Centers (part of the U.S. Department of Labor system) to conduct outreach to unemployed workers and welfare recipients under the "welfare-to-work" initiatives. An important group of potential workers is repeatedly

mentioned in the literature: immigrants. Immigrants are viewed as a very plausible solution to the care gap, as they currently comprise large segments of the low-wage occupation sector (Stone, 2001), and most researchers have viewed this group as an easy fix to the current labor supply shortage. Recommendations include active recruitment of immigrants as well as relaxed immigration policy (U.S. Department of Health and Human Services, 2003). Some observers note, however, that using immigrants as an alternative source of workers is a viable option only if the quality of jobs is increased and worker protections are strengthened (Stone & Wiener, 2001). As Stone and Wiener note, having recent immigrants making up a disproportionate fraction of entry-level jobs in the long-term care industry could result in “culturally discontinuous” interactions between the client and the caregiver. In other words, the immigrants’ style of caregiving may be in conflict with the elderly client’s cultural expectations and needs. This recommendation has significant implications on the quality of long-term care service delivery in the future.

But many researchers provide a compelling argument for not relaxing immigration policy. Camarota (1998), for instance, identifies the potential negative impact increased immigration can have on low-wage occupations. When examining the impact of immigrants on the labor market, it appears that because immigrants comprise a large segment of the low-wage labor market, they compete with other low-wage workers for the same jobs, driving wages down further, some estimates claim by as much as 3.5% (Camarota, 1998). Although this phenomenon is not repeated in higher-paying occupations based on Camarota’s extrapolations, presumably the effects of immigration on paraprofessional health care occupations would be to drive wages lower, which is counterintuitive to achieving equilibrium through wage increases.

As the findings suggest, much of the workforce who will serve the future cohort of aging baby boomers will come from ethnic groups traditionally underrepresented in health professions and from new immigrants to the country. Health care industries need large numbers of unskilled workers who work for low wages, so they seek new alternatives to keep their labor costs down (Borjas, 2001). For example, in the future, nursing homes and other assisted-living facilities may be modeled on the manufacturing maquiladoras currently operating in the Rio Grande Valley. Established in 1965 by Mexican President Ordaz, a maquiladora program gives the U.S. preferential tariffs to promote economic development in Mexico. Future nursing homes could be operated on the border using unskilled labor drawn entirely from Mexico. The advantage to U.S. employers is the lower cost of labor in Mexico and the scarcity of

unions. Again, the disadvantage to paraprofessionals is that maquiladora workers often receive meager wages along with few or no employee benefits. Addressing the stigmatization and marginalization of low-income, direct-care workers is equally complex, as it “stands at the intersection of three public policy worlds—health care, labor, and welfare—each formed in isolation from the other” (Paraprofessional Healthcare Institute, 2001, p. 16). Improving training opportunities of workers seemingly results in higher job quality for direct-care occupations. The different training programs piloted in various states use different “career ladder” incentives so that along with additional education and training, workers have the opportunity to develop their careers (U.S. Department of Health and Human Services, 2003). These programs were shown to have high success rates because they combined two approaches to solving the care gap.

CONCLUSION

The basic conclusions of this chapter are three-fold. First, the rapid growth of new arrivals to the United States, including those who immigrated decades ago, will transform the lives of aging U.S. residents. The unique health care needs of the immigrant populations from Asia and Latin America will pose distinct social-policy challenges. Second, it is clear that foreign-born workers will continue to play a significant role in providing health care for older adults, affecting access to services and support in later life. Immigrants have historically played an important part in the labor force. For the most part, they arrive as laborers and enter the lowest rungs of the labor force, from which they might work their way up. Some highly educated immigrants are welcomed for their special skills. Today, the shortage of nurses makes nurses from other nations a desirable immigration category. Given the fact that immigrants often find work in the service sector, and because of the fact that caring for the elderly is not a highly paid or prestigious occupation, we would expect that immigrants will assume a greater role in caregiving as the population ages. The aging of the population and the nature of the immigration process, therefore, are potentially intertwined. In this chapter, we examined the phenomenon of immigrants providing care for older people in the United States. The linkages between immigration and changes in the age structure of the population are strong. Although the United States is aging and consists of people of different racial and ethnic backgrounds, the older population will remain predominantly White and non-Hispanic, even through the middle of this century; yet,

their caregivers will be predominantly poor minorities and immigrants. Third, and perhaps most important, immigration laws will greatly impact the supply of physicians and nurses in the United States.

Policy evaluation data will be necessary to gauge the effects of public policies on the general well-being of immigrant health care workers. Future studies should examine ways of enhancing training and job quality to ensure equity for immigrants in the health care workforce. Clearly, most health care professionals from developing countries seek to improve their economic status. Yet, many immigrant nurse assistants find themselves professionally marginalized and economically disadvantaged. Identifying specific ways to reconcile the need for a larger pool of workers and the reality of workforce segregation will be crucial, especially in light of large streams of immigrant workers who cross the U.S.–Mexico border (Baker, Latapi, & Weintraub, 1998).

One potential solution to this problem calling for further investigation is the merit of regularizing direct-care workers' activity through immigration reform. Some U.S. officials propose an updated guest-worker program that could facilitate admission of Mexican workers seeking temporary employment opportunities. Although such a program would be fairly easy to implement, opponents maintain that this solution is unrealistic and, more significantly, morally unjust mainly because undocumented workers already here or who want to migrate to the United States would not benefit from government services, especially medical care and education, in the absence of obtaining permanent residency status. Undocumented workers who apply to participate in the guest-worker program would not be able to stay in the United States indefinitely, and therefore they would give up their rights to social benefits like Medicare and Social Security. The consequences of immigration proposals, such as a highly regulated guest-worker program, on the health care labor force are yet to be determined. But it is certain that further understanding of the effects of immigration on health care providers for elderly U.S. residents is a topic that deserves more attention from research.

NOTES

1. One study found that after the media explored the adverse effects of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) on access to care, especially long-term care, attitudes toward elderly immigrants changed from viewing them as the “undeserving” poor to individuals “deserving” of assistance (Yoo, 2001).
2. Census Bureau categories of occupations include professional and paraprofessional health care occupations: chiropractors, dentists, dieticians and

- nutritionists, pharmacists, physicians and surgeons, physician assistants, podiatrists, registered nurses, audiologists, occupational therapists, physical therapists, recreational therapists, respiratory therapists, speech–language pathologists, health diagnosticians, clinical laboratory technologists, dental hygienists, emergency medical technicians, licensed practical and licensed vocational nurses, opticians, and nursing, psychiatric, and home health aides.
3. The medical manpower shortage is documented by the increasing number of visa applications available to doctors. Prior to the beginning of the 21st century, both the number and proportion of IMGs in residency programs rose primarily due to the large number of exchange visitor visas and other temporary visas issued to IMG residents (U.S. Health Resources and Services Administration, 2000). To enroll in a residency program, foreign medical graduates can obtain either a J-1 visa or an H-1B visa, the visa program for highly skilled temporary workers sponsored by the employer. IMGs must maintain their visa status in order to receive compensation for their employment during their medical residency (American Medical Association, 2005).
 4. We should note that the physician and nursing shortages in the United States directly affect the supply of health workers in both developed and developing nations worldwide (AcademyHealth, 2006).

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Migration and Health Care for Older People: Developing a Global Perspective (Commentary)*

Chris Phillipson

Western countries experience the impact of demographic change across a number of levels, with the pressures placed on health care services being among the most important. The rapid growth of the population in the old and very old age categories in industrialized societies is creating a growing gap between the demand for health services and the supply of skilled health personnel. Additionally, there is persistent concern over the quality of the care provided to dependent older people. One response, common to both the United Kingdom and North America, has been to recruit workers from overseas to meet shortages of personnel within the health care system. Yet, as Angel clearly demonstrates in her valuable analysis of this issue, this strategy itself raises significant dilemmas—both for the countries sending as well as those receiving health care workers.

The context for Angel's chapter (chapter 9, this volume) concerns the growth of international mobility and migration among key health care personnel, such as nurses and physicians. Buchan and Sochalski

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(2004) make the point that developed countries are able to exploit the factors that encourage migration from the global south, including relatively low pay, poor career structures, and limited professional development opportunities. Taking the example of nurses, the researchers go on to note that:

This migratory flow is becoming substantial in a number of instances. For example, in 2000 more than 500 nurses left Ghana to work in other industrialized countries: that is more than twice the number of new nurses who graduated from nursing programmes in the country that year. . . . In Malawi, between 1991 and 2001 over 60% of the entire staff of registered nurses in a single tertiary hospital (114 nurses) left for jobs in other countries. . . . Between 2000 and 2001 alone, 10% of nurses in Barbados left the nursing sector, the majority of whom left the country for employment elsewhere. (p. 587)

In her discussion of immigration and health care in the United States, Angel draws out a number of significant issues, including:

- the influence of immigration in shaping the character of the health care infrastructure;
- the role of foreign-born professionals in the United States in filling vacancies for physicians and nurses;
- the occupational distribution of the immigrant health care work force;
- the placement of migrant health care workers (new immigrants, in particular) in what are likely to be relatively low-wage, often “dead-end jobs”; and
- the case for improvements to working conditions and training alongside mechanisms to improve compensation for care workers.

All of these issues can be treated as national concerns reflecting the needs of particular health care systems. On the other hand, Brown and Connell (2004) make the point that the global rise in the migration of skilled workers has itself been perceived as a “response to the accelerated globalization of the service sector [with] professional services [such] as health care . . . very much part of the new internationalization of labour” (pp. 2195–2196). In this context, theoretical approaches used in the study of globalization might be helpful in considering the various forces discussed by Angel, notably, those relating to immigration as a factor influencing the shape of health care systems.

HEALTH SERVICES AND THE INTERNATIONALIZATION OF LABOR

The issues identified by Angel can be found in debates affecting most countries in the global north and are affecting virtually all the professions in the health care sector. Since the 1950s, professional migration has sustained a number of welfare services, certainly within the British National Health Service (NHS) in the United Kingdom, in North America, the Middle East, and the more developed economies of East Asia. Just to reinforce the points made in the chapter by Angel, in the case of the United Kingdom, taking 2002 (the year for which the most recent figures are available), nearly half of the 10,000 new full registrants on the General Medical Council (GMC) Register for doctors were from non-European overseas countries. In the period of the early 1990s, nurses from overseas represented around 1 in 100 of those entering the United Kingdom nursing register. The contribution, however, from overseas countries rose rapidly in the late 1990s, both in terms of numbers and as a percentage of total new entrants.

Buchan, Jobanputra, Gough, and Hutt (2005, p. 6) note that over the period 2000 to 2004, overseas countries have, on average, contributed to about 45% of the annual number of new entrants to nursing in the United Kingdom, this coming down from a peak of around half in 2001–2002. Key sources of recruitment have included Australia, Ghana, India, Nigeria, the Philippines, and South Africa. Overseas recruitment has been especially important for hospitals in urban areas, particularly those with settled immigrant populations. London is an obvious example, with one in three registered nurses coming from overseas compared with a national average in the United Kingdom of 1 in 10 (Winkelmann-Gleed & Seeley, 2005).

Research also suggests that foreign-born workers come with a mix of experiences, motivations, and backgrounds. To be sure, as Angel's chapter acutely demonstrates, many (women, in particular) do come from poorly educated backgrounds, subsequently entering "low-skilled and low-wage occupations," notably in the long-term care sector. However, what is equally striking from her research is the diversity of positions filled by immigrant workers in the United States and their importance at all levels of care—from physician and surgeon, pharmacist, and registered nurse to nursing home assistant and home care worker (Angel, this volume).

Differences in occupational backgrounds and skills may be matched by variations in motivations and career intentions. Studies in the United

Kingdom of migrant nurses demonstrate considerable diversity, for example, between:

- recently qualified nurses planning a short stay to gain experience;
- migrant nurses coming with the objective of remitting money to their country of origin;
- older nurses—in their 40s and 50s—seeking professional development; and
- nurses staying temporarily before moving on to another country—the United States being one of the most commonly favored (Kingma, 2001; Buchan, Jobanputra, et al., 2005)

Buchan (2001) makes the point that the demographics of many developed countries—an aging population and an aging health care workforce—mean that many countries will continue to be active in encouraging the inflow of health care workers from the global south. Angel draws the conclusion from this that immigration, in countries such as the United States, has itself become a key variable accounting for the diversity of the health care labor force, as well as proving an influence on the structure and quality of the care experienced by older people. Accepting this argument, however, we might wish to probe further and investigate the nature of migration in a global context and the potential influences it might have on the activities of workers in their various roles, including that of caring for and supporting older people.

GLOBALIZATION, MIGRATION, AND HEALTH CARE WORK

The various factors relevant to a discussion of immigrant workers can be summarized under a number of headings: (1) the impact of transnationalism, (2) the role of gender, (3) relationships between migrant carers and older people, (4) issues for sending countries, (5) the implications of migration for gerontology, and (6) areas for further research.

On the transnational theme, running through the chapter is an important question about the relationship between the migrant and the country they leave behind. Winder (2004) makes the point that we are rarely sympathetic to the ambivalent feelings of migrants about their movement to a new country. As he puts it, “They [the migrants] might come with one eye fixed optimistically on the prospect of a bright future in new surroundings; but [with] the other [eye] . . . glancing over their

shoulder at the home they have left (p.12).” Acknowledging this, we talk about the “transnational communities” to which migrants are attached. Following Levitt’s analysis of migrants from the Dominican Republic to Boston (2001, p. 4), such communities reflect: “how ordinary people are incorporated into the countries that receive them while [they] remain . . . active in the countries they come from” (see Phillipson, Ahmed, & Latimer, 2002; Torres, 2004, 2006). Brown and Connell (2004, p. 2207), in their analysis of the migration of health professionals from the Pacific islands, note how migration is “embedded in an extended family context, where decisions to migrate and return are linked to household, as much as individual aspirations and goals.”

The research question prompted by Angel’s chapter concerns the extent to which the provision of formal care may be influenced by the ties associated with membership of a transnational community. Transnational relationships may involve individuals holding together care tasks and financial responsibilities that may be strung across continents: a nurse or home care worker, for example, supporting both family members who have migrated with her but also those left behind in the country of origin. Buchan, Jobanputra, et al. (2005), in a survey of overseas nurses working in London, found a number of respondents in this situation. One in three workers in the study reported having left some of their children back in their home country. The migrant worker may also be the key provider in terms of financial support. Again, Buchan, Jobanputra, et al. (2005, p. 13) reported that “most of the nurses were the major or sole ‘breadwinner’ contributing to household income. One-third (37 per cent) were contributing to all of the household income, a further quarter (25 per cent) contributed more than half, and a further one in five (20 per cent) contributed about half.”

GENDER AND CARE WORK

A second major issue raised by Angel’s chapter concerns issues relating to gender and the role of women as formal and informal carers. In many instances, it is likely to be women who will be the dominant group affected by the issues identified in the discussion. In this context, exploring the questions raised from the perspective of gender is vitally important. A strong focus on gender is essential for understanding issues about the low pay and poor quality working conditions that are highlighted in the chapter (Yeates, 2004). From one point of view, the migrant health worker might be seen as part of a global underclass serving another marginalized group (in this case, older people) within

the first world. The case of the nurses, home care workers, and personal aides may also be seen as illustrative of what Hochschild (2000, p. 131) refers to as “global care chains,” representing what the writer sees as the “personal links between people [invariably women] across the globe based on the paid or unpaid work of caring.” Hochschild’s point in her essay was to expose what she saw as the “*unequal links*” (my emphasis) in these chains—between the third world mother who migrates in search of work and a first world economy that places a low market value on the performance of care work (see, further, Yeates, 2005).

On the other hand, the literature also points to the way in which migration may bring new opportunities for women, providing, as one study argues, “an economic and social escape route” (Westwood & Phizacklea, 2000, p. 108). Or, as another researcher puts it in the following question: “Does international migration provide women with an opportunity for liberating themselves from subordinate gender roles in their countries of origin, or are traditional gender roles perpetuated in the host societies?” (DeLaet, 1999, p. 2). Clearly, the answer to the previously cited questions will depend on a variety of social structural and cultural circumstances within both receiving and sending countries. From a gerontological perspective, however, the research question concerns how these different options might influence the position of immigrant workers within the care system, as well as the nature of the care that different groups provide.

A third and linked question raised in the chapter concerns what is known about the impact of immigrant workers on relationships in the care setting or, as Angel puts it, “the cultural difference implications of those *providing* [author’s emphasis] patient care to older adults with changing needs for assistance and interventions.” In the U.K. context, there has been some work addressing, for example, issues about the integration of migrant nurses within the NHS (Winkelmann-Gleed & Seely, 2005), as well as the impact of racism on different health care groups (Kyriakides and Virdee, 2003). Systematic study of these and related issues has, however, yet to be carried out. In particular, we need to know much more about the type of discrimination that may be experienced by overseas health care workers and the impact this might have on the nature of care provided within hospitals, nursing homes, and other settings. Another thought prompted by Angel’s chapter concerns the potential value of ethnographic work in providing insights regarding the extent to which cultural differences might be an issue influencing the quality of care. Certainly, this type of methodological approach would seem ideally suited to investigating the human resource issues raised in her discussion.

NURSE MIGRATION IN A GLOBAL CONTEXT

A fourth concern raised by Angel concerns the importance of developing what Angel refers to as a “comprehensive medical workforce policy,” both to relieve the nursing shortage in the United States and that faced by other countries in the global north. Laurance (2003) argues that there is a global shortage of nurses and an associated market that government, commercial agencies, and enterprising individuals are learning to exploit (see Kline, 2003; Buchan, Kingma & Lorenzo, 2005). Some countries have turned the need for skilled medical labor to their advantage, benefiting from the remittances that flow from the global north to the global south. Studies in the United Kingdom suggest that nurses from the Philippines and South Africa regularly remit a quarter or more of their income back to their home countries—a significant flow of income, certainly several thousand dollars per year per nurse. Buchan, Jobanputra, et al.’s (2005) survey of overseas nurses in London found more than half of the respondents (57%) reporting that they regularly sent remittances to their home country, with the highest proportions found among Filipino nurses and those from sub-Saharan Africa and South Africa. Brown and Connell (2004, p. 2207) reported that among Tongan and Samoan migrant nurses, remittances were sustained at a “high level . . . this [contributing] substantially to the welfare of kin in the home country.”

The benefits of remittances must, however, be weighed against the way fragile health care systems in the global south may be undermined by the migration of skilled labor. Although the World Health Organization recommends a minimum of 500 nurses and 20 physicians per 100,000 people, many sub-Saharan African countries, for example, have just 50 nurses and 5 physicians per 100,000, compared with 164 physicians per 100,000 in the United Kingdom and 279 in the United States (Hagopian, Thompson, Fordyce, Johnson, & Hart, 2004). For the Caribbean and sub-Saharan African countries, the problem of health worker migration is a serious threat to health systems already struggling to cope with the HIV/AIDS epidemic (McIntyre, 2004). Kline (2003) argues that the movement of nurses from donor to receiving countries can create hardships in donor countries because of the loss of skilled personnel and loss of economic investment in education. In the case of sub-Saharan Africa, she concludes that “difficulties created by migration . . . come less from the loss of people in absolute numbers than from the loss of the few qualified professionals. . . . The loss of nurses in this region results in even fewer skilled nurses, increased care demands on the nurses who

remain, and further deterioration of inadequate health care systems” (Kline, 2003, p. 109).

The “exporting” of physicians and nurses to the global north may of course prove of considerable benefit to older people and other groups in those countries. For equivalent groups in the global south, on the other hand, it may further reduce their access to health care support. The acceleration in international health worker mobility is coming precisely at a point when the need for health care is rapidly increasing, first because of aging populations (the number of people aged 65 and over is projected to increase by about 10 million in sub-Saharan Africa between 1999 and 2015) and second, as a result of HIV/AIDS, which in many cases has left grandparents as the main source of support to children (United Nations estimates suggest that about 11 million children have been orphaned by HIV/AIDS in sub-Saharan Africa).

Angel’s chapter clearly demonstrates the importance of responding to demographic change as an issue, one which recognizes the interdependency of social structures. The immigration effects she describes are global in scope but may be unequal in their consequences—the benefits for health care systems in the global north may be outweighed by the negative consequences in the global south. The enrichment of formal care in the north may again come at the expense of formal and informal care systems in the south. Set against this, there may well be benefits for both sides—remittances, cultural freedoms, and professional development for the migrant; the filling of vacancies for key staff and specialist posts in the case of Western health care systems. But the relationship between the two sides is unlikely to be one of equality, and the impact of this unequal exchange on older people—in the sending as well as receiving countries—is certainly worthy of further research.

RESEARCH ISSUES FOR SOCIAL GERONTOLOGY

We might also consider in more detail the implications of migration—and especially transnational migration—for research in gerontology. Migration invariably entails biographies of “disruption” and “discontinuity” (Hoerder, 2001), and these are certainly implicit in many of the illustrations in Angel’s chapter. Migrants may return to their country of origin or stay in their new country, or go back and forth over a long period of time (Gardner, 1995). What this points to is the distinctive shape of the life course produced by the migration experience, one that is markedly different from the orderly sequence of education, work, and retirement

that has been assumed as typical in Western models of the life course (Phillipson & Ahmed, 2004). The journey of the migrant points toward other possibilities for social change, these becoming more typical of the life course for a range of groups. In this context, migrants may be creating a new type of social structure, where issues relating to discontinuity in life course transitions become of considerable significance in understanding patterns of adjustment in later life (Dannefer, 2003). One writer on this topic refers to the “turbulence” created by migration (Papastergiadis, 2000), meaning by this the way migration changes personal identities and biographies as well as social institutions. Thus, on the one side, Angel is right to observe that immigrants “can affect the structure and quality of the care delivery system for elderly individuals.” Equally, however, migrants can bring distinctive views and attitudes about the nature of growing old, these having the potential to influence more general social and cultural perspectives about the aging experience within the global north.

Finally, Angel identifies significant issues for further research on the themes raised in her chapter. Health care systems will continue to require new foreign-born workers, given the pressures associated with population change. Attention needs to be given as to how the benefits of migration can be distributed more evenly between sending and receiving countries and how the conditions and experiences of migrants can be improved. Buchan, Kingma, et al. (2005, p. 23) argue the case for a “mutual approach” to international recruitment, which can assist those wishing to take their skills back to their home country. Angel herself highlights the need to examine ways of enhancing training for immigrants in the health care workforce. Given that many come for reasons of professional development, this would seem an important area for further investigation. Additional research is also needed on the extent to which immigrants are affected by discrimination within the workplace and the impact this has on their professional and personal lives.

CONCLUDING COMMENT

From a theoretical perspective, the application of gerontological approaches, such as political economy theory (Estes, Biggs, & Phillipson, 2003; Baars, Dannefer, Phillipson, & Walker, 2006) and exchange theory (Dowd, 1975), may be especially valuable to apply to the situation of immigrant workers. The former might highlight the structures of inequality influencing the labor market position of migrant carers; the latter, issues arising from differences in power in exchanges between immigrant and

native-born carers and between foreign-born carers in providing health care for (mainly White) older adults. Finally, more work is needed using techniques such as oral history and biographical approaches that draw out the views and experiences of migrant workers themselves. The backgrounds and motivations of health care migrants are likely to be diverse. Some will be escaping from societies affected by political instability of various kinds. Others will be seeking new opportunities for career advancement. Many will simply want a better life for themselves and their families. Drawing out how these different experiences might affect their activities as carers, the support and training they might need, and what they bring to raising the quality of care for groups such as older people, is an important task to develop in gerontological research. Jacqueline Angel is to be congratulated for bringing these issues to our attention and for setting out a promising new research agenda for the years ahead.

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Immigration, Race/Ethnicity, and Health Care (Commentary)

Robert A. Hummer

This discussion chapter comments on four important themes running through the literature linking the topics of immigration and health of older adults. First, I summarize critical demographic changes in the U.S. population that are related to immigration. Second, I comment on possible effects of immigration on the supply of health care workers in the United States, as discussed more comprehensively by Jacqueline Angel's chapter in this volume (chapter 9). Third, I discuss some of the influences of immigration on the demand for health care among the U.S. elderly population. Finally, I briefly comment on the relationship between immigration and health care receipt among the elderly in the context of the highly stratified, diversifying, and aging United States of the early 21st century.

IMMIGRATION AND DEMOGRAPHIC CHANGES IN THE U.S. POPULATION

It is clear that immigration is playing a vital role in shaping demographic change in the 21st-century United States. Since the major shifts in policy that began with the enactment of immigration reform in the mid-1960s, immigration has profoundly affected the country's overall population size, nativity composition, racial/ethnic diversity, and age structure. Immigration to the United States (both documented and undocumented) exceeded 1 million persons per year during each and every

year in the 1990s, reaching an estimated peak of over 1.5 million in 2000 (Passell & Suro, 2005). Thus, the U.S. Census recently estimated that 11.7% of the population, encompassing a record 33.7 million people, was foreign born (Larsen, 2004). While a dip in immigration levels occurred from 2001 through 2003 following the September 11th terrorist attacks of 2001, the United States has again experienced another recent rise in immigration such that an estimated 1.2 million persons entered the country on a permanent basis in 2004 alone (Passell & Suro, 2005). Although the impact of immigration on long-term population outcomes is notoriously difficult to predict, recent U.S. Census Bureau projections suggest that immigrants and their second-generation descendants may make up one-quarter or more of the nation's population by 2050.

Also well known is that the source of the post-1965 surge in immigration has been largely from countries in Latin America and Asia, a far different pattern from early 20th-century immigration, which largely involved people originating from Europe. As a result of changing migration patterns, Hispanics became the largest minority group in the United States in 2000, and Asian Americans continued their extremely rapid rate of population growth. The rapid growth of these two racial/ethnic groups was fueled largely by immigration and (for Hispanics) by relatively high levels of fertility among immigrant women (Bean, Lee, Batalova, & Leach, 2004). Although non-Hispanic Whites will continue to comprise the vast majority of the elderly population in the coming decades, their percentage is declining, and Hispanic and Asian elders will comprise an increasing percentage of elders in the coming decades.

Less well known demographically is that the substantial increases in immigration in the United States over the last few decades have been accompanied by a dramatic shift in the age composition of the foreign-born population. In 1970, following decades of relatively low levels of immigration, the median age of the foreign-born population was 52.0 years; by 2000, the median age of the foreign-born population had declined to 38.1 years (Schmidley, 2001). This change was, of course, driven by the immigration of large numbers of young adults to the United States for labor force reasons. At the same time, the median age for the native-born population in 2000 was 34.5 years, an all-time high. Thus, the foreign-born population continues to be "older" than the native-born population, at least in terms of median age, a demographic fact that has received little attention. However, the difference in median age between the foreign- and native-born populations is no longer very substantial. Moreover, the overall higher median age of the foreign-born population is not driven by age-structure differences among the older age groups. Indeed, although about 20% of both the native-born and

foreign-born populations was 55 years and older in 2000, only about 11% of the foreign-born population was aged 65 or older, compared with 12% of the native-born population.

In all, six important immigrant-related demographic trends have very important implications for the context of health care receipt among older people in the United States in the coming decades. First, the foreign-born population in the U.S. is larger than ever and continues to grow rapidly, even after the tragic events of September 11, 2001. Second, a vast majority of U.S. immigrants are currently in the working ages; but most of these immigrants are expected to remain in the United States and, like others in this age category, will shortly begin aging into the retirement years. Third, the latest wave of immigrants is largely of Latin American and Asian origin, compared with earlier waves, who were largely of European origin. Fourth, Hispanic and Asian American population growth has been particularly dramatic in recent decades, with the immigration of young adults from Latin America and Asia and the relatively high fertility of Hispanic immigrants driving that growth. Fifth, although the median age of foreign-born individuals continues to be higher than that of native-born individuals, the majority non-Hispanic White population is much older, on the whole, than Hispanics and Asian Americans. Non-Hispanic Whites will continue to make up a large majority of the elderly population for a number of decades to come. And sixth, the most important overall shifts that are taking place—an older, more demographically diverse population fueled by low fertility, low mortality, and relatively high immigration levels—will most likely continue for the foreseeable future. These trends, then, have very important implications for health care among the older population in the United States. I touch briefly on just three such themes in the remainder of this discussion.

IMMIGRATION AND THE SUPPLY OF HEALTH CARE PROVIDERS

Jacqueline Angel (2006) focuses on the impact of immigration on the supply of health care providers in the United States and problems associated with that supply. On the upside, immigrants have stepped in to fill clearly needed jobs in the growing health care industry: Her data show that over 25% of all physicians are foreign born and that foreign-born individuals have comprised a substantial fraction of the growth of medical residency programs in recent years. Further, 11.3% of all registered

nurses and 16.6% of nurse aides are foreign born. As the U.S. population ages throughout the first half of the 21st century, it is likely that we will continue to see substantial involvement of immigrants in the health care industry; the need continues to be great and demand is projected to grow. Thus, simply continuing to supply the needed number of workers in the health care industry is a challenge, particularly with tighter immigration restrictions following September 11, 2001. What is also worrisome, according to Professor Angel, is a “mismatch” between health care providers and recipients. Although demographically, the elderly population is currently and will continue to be largely non-Hispanic White for the next few decades (although less so as time goes on), health care providers are increasingly immigrant and non-White. Thus, there exists the potential for cultural misunderstandings and language differences to impact the overall quality of care received by the elderly. Moreover, Angel points out that this is especially the case among nursing aides and other paraprofessionals (the front lines of health care workers) who have relatively low educational levels and work under less-than-ideal conditions. In short, the policy-related questions on the supply side are substantial, important, and include such examples as: (1) Can enough highly trained workers—doctors, nurses, and paraprofessionals—continue to be produced and/or found, given the exploding size of the health care industry in the United States? (2) How can health care settings be sensitive to racial/ethnic, cultural, and language mismatches between providers and recipients? (3) Will the supply of trained and experienced front-line health care workers be most problematic, given the low wages, high turnover, and difficult working conditions associated with these positions? These are critical questions and policy issues that are generated by a rapidly aging and ethnically diversifying population.

IMMIGRATION AND DEMAND FOR HEALTH CARE

Less central to Angel’s chapter, but of equal importance, are health care demand issues. With an aging population, higher life expectancy, and continued thirst for high-tech and expensive medical care, it is clear that the overall demand for health care among our elderly population in the United States will continue to grow. How will immigration play into this? Immigration has an impact on the health care of older people in at least three important ways. First, even though the elderly population will continue to be largely non-Hispanic White for many years to come, we will see steady increases in the Hispanic and Asian elderly percentages over

the next half century. And although Asian Americans, on the whole, have been shown to have low rates of disability (consistent with their overall low rate of mortality), Hispanics are characterized by a low rate of mortality coupled with a relatively high rate of disability (Hayward & Heron, 1999; Rogers, Hummer, & Nam, 2000). Further, Hispanic adults and elders—particularly Mexican Americans—are the least likely ethnic group to be covered by health insurance through the life course (Weinick, Jacobs, Cacari Stone, Ortega, & Burstin, 2004). Thus, health care concerns among the Mexican American elderly will be an increasingly important issue.

Second, the effects of the high levels of immigration throughout the 1990s and into the 21st century will be felt most heavily in gateway immigration states: California, Texas, New York, and Florida. At the same time, one of the important lessons learned from the 2000 U.S. Census was that the Hispanic population was not only larger than almost everyone thought it was, but also more dispersed as well (Saenz & Morales, 2005). States like North Carolina, Georgia, South Carolina, Nevada, and Michigan experienced explosive growth in their Hispanic populations between 1990 and 2000. And there are two important aspects of immigration-related population growth: (1) persons are most often added to the population at ages 18 to 30, rather than at age zero, as in the case of births. Thus, immigrant populations have the potential to age more quickly compared with population growth that is fueled by high birth rates; (2) many immigrants, especially those from Mexico and other parts of Latin America, work in some of the most difficult and physically demanding jobs in the United States, and they often work without health insurance or government benefits. Together then, the effects of immigration on health care demand among the elderly will be geographically widespread and potentially complex in terms of languages and cultures. This increased immigration-fueled demand for health care among the elderly will occur in the not-so-distant future.

Third, immigrant elder care will be characterized by a complex mixture of demands, with elements from the United States and from immigrant home countries most likely blended together in communities with substantial percentages of immigrants. Likewise, the relative ease of travel in modern society will continue to allow many immigrants to obtain at least some of their care in home countries—either for reasons of preference or for those of cost. Thus, as the United States continues to diversify, such demands will be relevant in a policy sense. Questions regarding complex forms of care and the transferability of government

and private benefits across national borders will become increasingly important in the coming decades.

IMMIGRATION, SOCIAL STRATIFICATION, AND HEALTH CARE

A last remark concerns the socioeconomic standing and progress of U.S. immigrants and the second- and higher-immigration generations and its impact on well-being for people of all ages in the United States. Some groups of immigrants, for example, Asian Indians, are on the whole very highly educated and tend to fill jobs in high-tech and relatively well paying fields, including medicine (Xie & Goyette, 2005). Of greater concern here, however, are the millions of immigrants from Mexico, other parts of Latin America, and poorer countries in Asia—especially those who are undocumented and those who are employed in the construction, service (e.g., restaurants, hotels), and agricultural sectors. Although a vast majority of such individuals will earn far higher wages than they would have in their country of origin, many will also work in extremely difficult positions for very low pay in the context of the United States (Kritz & Gurak, 2005). As Professor Angel's overview of U.S. immigration policy pointed out, the reception of such individuals has been varied across time, depending on the political climate and the economy, and it has varied geographically by state. Sociologists and economists have also been interested in the children and grandchildren of working-class immigrants, asking questions such as: (1) What kind of educational opportunities will the children and grandchildren of working-class immigrants have? (2) Are the children of working-class immigrants covered by health insurance? (3) Will the second and third generations of working-class immigrants be able to help support their aging parents, many of whom have worked extremely hard and under very difficult life circumstances? These are perhaps some of the most difficult questions for which answers will only slowly be uncovered in the coming decades. At present, there is also very little high-quality social science data to adequately tackle such important questions, although, at least for legal immigrants, the longitudinal New Immigrant Survey (Jasso, Massey, Rosenzweig, & Smith, 2000) should go a long way in helping the demographic and policy communities in better understanding such processes.

Although there are some positive health indicators for recent immigrant populations, such as the relatively low mortality rates experienced by immigrants and the infants of immigrant women (Hummer,

Biegler, et al., 1999; Hummer, Rogers, Nam, & LeClere, 1999), some very difficult issues will also need to be confronted in terms of the health and well-being of both immigrants and native-born residents of the United States. I'll close with two of the most pressing. First, we must confront the challenge of the upwards of 10 million undocumented immigrants in the United States who work extremely hard in crucial jobs for low wages and who pay taxes but are also largely excluded from the social services and legal protections that cover documented workers. This is a national embarrassment for which we need a humane, responsible policy solution. It is also likely that many undocumented immigrants will continue to live in the United States as they age into older adulthood. If their largely difficult working circumstances and low pay are combined with low levels of health care utilization over several decades of adulthood, the aging of this large group of undocumented immigrants could result in a very pressing health policy issue in the not-too-distant future. Now, rather than later, is the time to address the very difficult issues of undocumented immigration as well as social service eligibility and paths to citizenship for currently undocumented immigrants.

Second, educational opportunities for immigrants, the children of immigrants, and minority group children in general are going to be *the* key in helping the United States deal with the aging of the baby boom generation over the next three decades, the aging of minority elders, and the future health care needs of these children as they age. In large, majority-minority states—such as my home state of Texas—the future well-being of the entire population is closely tied to the well-being of the Hispanic population. A recent report from the State Demographer's Office (Murdock et al., 2002) shows that Texas's future economic productivity, tax receipts, social service spending, institutional spending, and health spending will most likely be strongly associated with how well the state fares in educating its rapidly growing Hispanic population. Recently, however, the state's concerns over "tax reform" (i.e., reducing property taxes for the middle and upper classes) have overridden the much more crucial issue of improving the quantity and quality of education for young people across the state. Thus, public schools (in particular) and universities are increasingly underfunded and overburdened, with immigrant and second-generation children bearing a substantial brunt of that public policy decision. Over the long term, this may be the single most important issue related to immigration and well-being in American society, not only for the health and health care of the elderly, but also because of education's powerful role in influencing health (Mirowsky & Ross 2003), for long-term health trajectories and economic successes in the United States.

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The Aging of the Second Demographic Transition*

Mary Elizabeth Hughes and Linda J. Waite

In the last four decades, the American family has been transformed. People now marry later in life and are quite likely to cohabit prior to marriage, an almost unheard of arrangement 40 years ago. Divorce is common and much less stigmatized than in the past. A sizeable fraction of births occurs to unmarried women, and many children grow up without sustained contact with their biological fathers. These changes have occurred to varying degrees in all developed nations. They are so profound that some scholars refer to them as the Second Demographic Transition, granting them the same significance as the declines in mortality and fertility that began in the 18th century and accelerated world population growth (Lesthaeghe, 1995).

A large research literature considers the causes and consequences of this transformation in family life. Most of this work is devoted to family experiences early in the life course; we know much less about family change in midlife and old age. This imbalance is not surprising. The behaviors that changed the family, principally union formation and childbearing, occur relatively early in adulthood and have obvious links

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to children's well-being. Moreover, current elderly did not fully participate in these new behaviors, so research about family change and aging has usually been limited to the impact of changes in the behavior of younger generations on older generations. However, the cohorts at the forefront of family change are now approaching old age. In the coming years, family and life course scholars will face the challenge of assessing and explaining the implications of the Second Demographic Transition for later life.

In this chapter, we look ahead to the aging of the new American family. We begin by describing the dimensions of the Second Demographic Transition, illustrating the ways in which it is reflected in the family histories of successive cohorts. We then review what we know about how the family influences well-being in later life. With this backdrop, we discuss how the experiences of the cohorts involved in the Second Demographic Transition might compare with those of earlier cohorts, offering a series of general questions as guides for future research.

CHANGING FAMILIES, CHANGING LIVES

In the United States, as in most developed countries, families are social networks formed by ties of blood or marriage. Beginning in the 1960s, the basic processes by which families are created, maintained and dissolved—union formation, union dissolution, and childbearing—underwent considerable change. The same period also saw a weakening of the links between these social processes, with sexual activity and childbearing more often taking place outside marriage and the development of new forms of traditional relationships, such as cohabitation. These changes, which were part of other large-scale social transformations gaining momentum at this time, altered the structure of American families and the roles and relationships within them. The hallmark of these changes has been increased diversity. The families of today often look different from the families of a generation ago, *and* they more often look different from each other. In short, the notion of a family “life cycle,” a relatively predictable order of family events and statuses experienced by the majority of the population, is obsolete.

Because these changes in the family were so substantial, some demographers have termed them a Second Demographic Transition (Lesthaeghe, 1995). The (first) Demographic Transition was a decline in mortality followed by a decline in fertility, which led to rapid population growth and ushered in our modern demographic regime (Kirk, 1996).

Western nations experienced this transition slowly between approximately 1700 and 1900; other nations experienced the transition over only a few decades in the 20th century, and some nations have yet to complete it. To some, though not all, demographers, the family changes experienced by Western nations in the second half of the 20th century are similar in scope and implications to this prior transformation.

Many of the milestones marking family research over the last several decades have been devoted to documenting and explaining these shifts in family behavior (e.g., Bumpass, 1990; Cherlin, 1992). A full review of this literature is beyond the scope of this chapter, but we present the broad outlines of family transformation as a backdrop for our subsequent discussion of family change and the later life course. Casper and Bianchi (2002) provide an excellent overview of the causes and consequences of family change in the United States.

A dominant perspective argues that family change occurred as people reacted to new economic imperatives. These reactions were guided by both traditional ideas about the link between economic security and family formation and new ideas about the meaning of gender, self, and society (Hughes & O'Rand, 2004). The shift to a service and information-based economy differentially changed opportunities for economic success; some people found that the new economy demanded longer educational investments but offered unprecedented rewards, whereas others found economic security out of reach (Levy, 1998). These realities translated into delayed marriage for most and marriage forgone for some (Goldstein & Kenney, 2001; Oppenheimer, 1994). The same forces acted to shift the age of childbearing later for some women, and the resulting increase in the proportion of young women who were unmarried and/or cohabiting helps to explain the increased share of births occurring outside of marriage. However, another perspective argues that economic conditions tell only a part of the story. A "silent revolution" (Inglehart, 1990) in cultural values also reshaped the family (Lesthaeghe, 1995). The weakening influence of traditional authority and increasing legitimacy of claims for individual freedom profoundly altered Americans' ideas about gender, sexuality, equality, and freedom (Thornton & Young-DeMarco, 2001). These ideas led, in turn, to alterations in values and attitudes toward such personal and family behaviors as marriage, divorce, cohabitation, unmarried sexuality, and voluntary childlessness, which were increasingly reflected in the choices people made in their own lives.

These new economic and cultural realities dramatically altered not just the context in which people decided about family life but the

meaning of the family itself (e.g., Cherlin, 2004). We trace the resulting changes in behavior in the lives of six successive 10-year birth cohorts of American women. These cohorts begin with the women born at the start of the 20th century and end with the second half of the baby boom (an exceptionally large cohort now standing at the brink of retirement). Together, these cohorts encompass women born in the first two-thirds of the 20th century. Scholars debate the importance of cohort versus period phenomena as causes of family change (e.g., Macunovich, 2002; Ni Bhrolchain, 1992). We are agnostic with respect to this debate; we simply trace the way family change has been manifested in the lives of successive birth cohorts of American women. We examine changes across these cohorts in key family behaviors: marriage, divorce, remarriage, living arrangements, and fertility.

We begin with marriage. Figure 12.1 shows the percentage of women who have ever married, by age, in each cohort. This figure shows a pattern of early and nearly universal marriage among the early cohorts, with a marked break beginning with women born just after World War II. These women, and the youngest cohort we studied, those born in the second half of the baby boom, delayed marriage considerably. The women born in the late 1940s through early 1950s, now reaching middle age, were virtually as likely as their mothers and older sisters to have ever married. The much lower levels of marriage at each age shown by the youngest women raise questions about the proportion who will ever wed. Unless the pace at which these women marry increases dramatically, by old age, a higher proportion of women in this cohort will have never married compared with cohorts born in the 20th century (although this proportion will not be higher than cohorts entering old age in the early part of the 20th century). This will have important implications for their family life in old age.

Figure 12.2 shows the proportion ever divorced across the cohorts of women born in the 20th century. It paints a striking example of social change. Among women born in the early 1900s, only about 15% ever divorced. Marital instability increased modestly but steadily through the cohorts born during the Depression, then skyrocketed among the cohorts of women born during and after World War II. The two younger cohorts of women came of age in the 1960s and 1970s, a time of profound change in attitudes and behavior, and these women's lives were affected by the forces weakening the institution of marriage. More than a third of the women born from 1946 to 1954 had divorced by age 40, with the cohort right behind them on much the same trajectory. Many of these divorces took place in marriage with children, producing single-parent families, at least until and unless the women remarried.

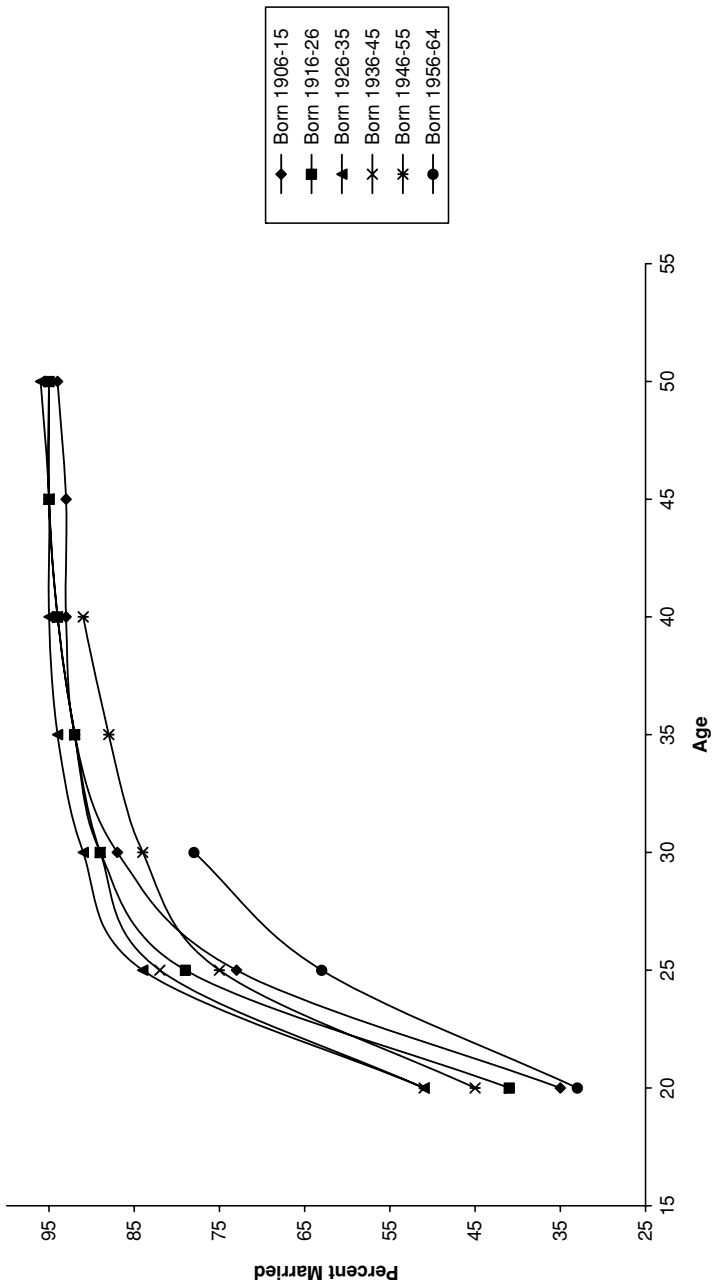


FIGURE 12.1 Percentage of women ever married by age in six birth cohorts of American women. (Source: Authors' calculations of data from the Survey of Income and Program Participation, 1986 and 1996.)

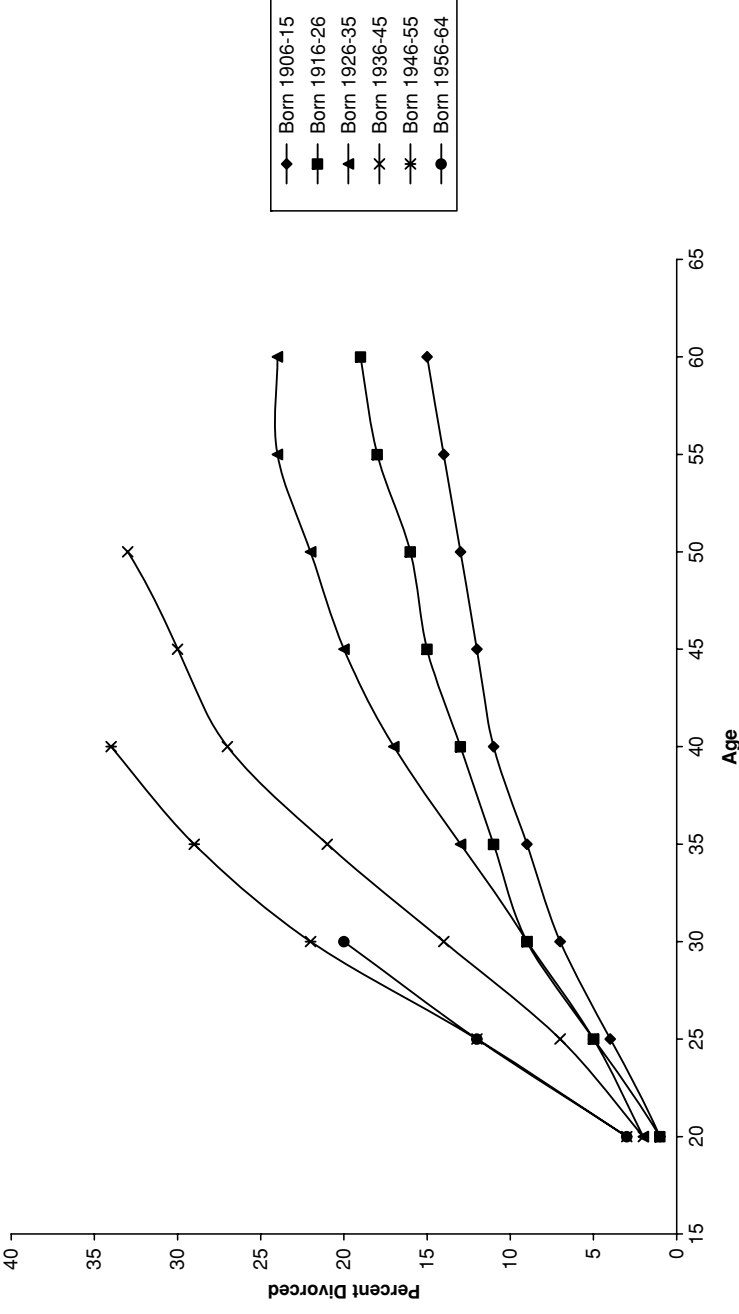


FIGURE 12.2 Percentage of women ever divorced by age in six birth cohorts of American women. (*Source: Authors' calculations using data from the Survey of Income and Program Participation, 1986 and 1996.*)

Commentators sometimes claim that increases in divorce signal abandonment of marriage. The best evidence against this is the relatively high level of remarriage (see Figure 12.3). In fact, by age 30, 12% of women born in the late baby boom have been married twice. Remarriage existed in earlier cohorts, and people actually remarried at higher rates than they do today. However, a much higher fraction of these remarriages occurred following the death of a spouse than in later cohorts.

One fundamental change in union formation is not reflected in these figures. Cohabitation began among the women during the early years of the baby boom, those born right after World War II, and diffused rapidly. Among women born from 1945 to 1949, only 7% had cohabited prior to age 25. The corresponding figure for women born 1960 to 1964 was 37% (Bumpass & Sweet, 1989). High levels of cohabitation are one reason the women born from 1956 to 1964 show such low levels of marriage in Figure 12.1; the percentage of these women who have formed unions of any kind is much closer to the percentage married among earlier cohorts (Raley, 2000).

Another family behavior with implications for quality of life at older ages is childbearing. The cohorts of women born from 1906 through 1964 show the substantial swings in both completed fertility and childlessness that accompanied the Depression, World War II, and the baby boom. Table 12.1 shows key fertility indicators for each cohort. Note first that completed fertility was variable for the cohorts of women born by 1945, with the mothers of the baby boom bearing about half a child more per woman, on average, than women in the cohorts just preceding and following them. As with the other indicators of family change we have reviewed, however, the real break came with the cohorts born during the baby boom. Even with the caveat that the women in the youngest cohort still have a few remaining years in which to bear children, completed family size for these women is projected to be quite low. Women born from 1946 to 1954 had fewer than two children apiece, on average, well below replacement levels. The youngest cohort we study, women born toward the end of the baby boom, seem poised to have families about as small.

About one in five of the women born at the beginning of the 20th century had no children. Between one in four and one in five of those in the youngest cohort were childless in 2001, although that proportion may fall slightly by the time this cohort completes its childbearing. Thus, the oldest and youngest cohorts we study appear quite similar on this dimension, but the cohorts born in between look quite different. Mothers of the baby boom, born primarily during the Depression, were much less

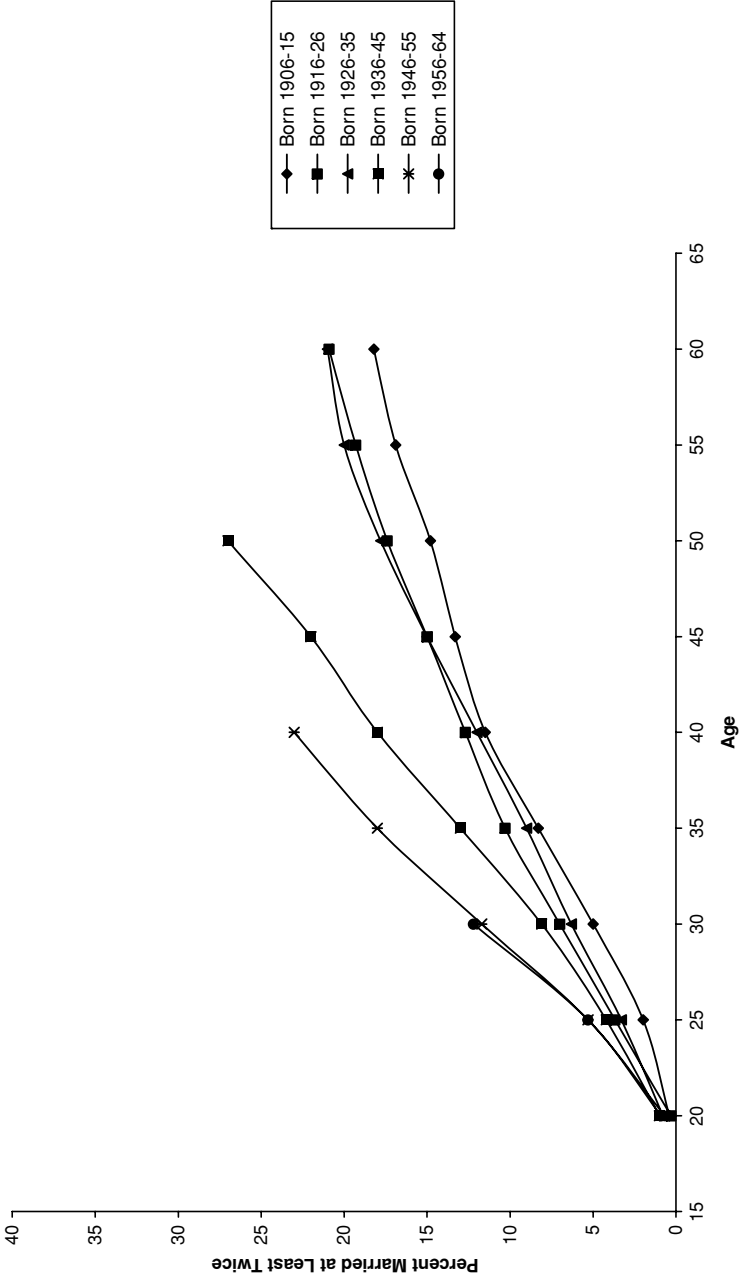


FIGURE 12.3 Percentage of women married two or more times by age in six birth cohorts of American women. (Source: Authors' calculations using data from the Survey of Income and Program Participation, 1986 and 1996.)

TABLE 12.1 Fertility Indicators for Six Birth Cohorts of American Women

	Young Progressives†	Jazz Age Babies	Depression Kids	War Babies	Early Boomers	Late Boomers*
Average number of children	2.4	2.6	3.1	2.6	1.9	1.8
Percent childless	19	16	11	12	17	22
Percent four or more children	22	26	35	24	12	10
Percent teenage first birth			23	29	25	22
Percent first birth age 30+			8	8	15	18
Percent nonmarital first birth			12	15	18	24

Source: Integrated Public Use Microdata Series, U.S. Census 1960–1990; Survey of Income and Program Participation, 1986, 1996, and 2001

*Some cohort members have not completed childbearing.

†Ever married women only.

likely to be childless, with 9 out of 10 having at least one child. In addition, the proportion of women with large families declined dramatically among women born during the baby boom. In this respect at least, these women are less diverse than women in earlier cohorts: Among women who have children, most have one or two (O'Connell, 2002).

However, this apparent homogeneity masks important change and variation. The way these fewer births are distributed over women's lifetimes and the circumstances under which children are born diversified greatly in the later cohorts.

First, the women born during the baby boom show a much greater diversity in the age at which they become mothers for the first time (Morgan, 1996). Although the percentage of women having a first birth as a teenager dropped in the cohorts born between 1946 and 1964, nearly a quarter had their first child as a teen. At the same time, a much higher proportion of these women waited until their 30s to begin childbearing. Among those born toward the end of the baby boom, this figure may well increase because not all of these women are past childbearing age.

Second, the fraction of births to unmarried women is higher in the later than the earlier cohorts. Nonmarital childbearing increased beginning with the cohorts born during World War II, but the increase was particularly sharp among the youngest cohorts. Thus, for many of these women, marriage and childbearing are not coincident. Of course, a sizeable minority of the births to unmarried women take place in cohabiting unions (Raley, 2001). However, since cohabiting unions are less stable than marriages, a sizeable share of these women end up raising children on their own. In combination with high divorce rates among the youngest cohorts, increases in nonmarital childbearing meant that the proportion of families headed by single parents rose precipitously.

The implications of these changes in unions and parenting are evident in households in which women lived during midlife. Figure 12.4 shows the proportion of people in each cohort who were living in different kinds of households at ages 44 to 53 and at ages 35 to 43. Household structure reflects patterns of marriage, divorce, cohabitation, and parenthood. For example, later age at marriage combined with the rising incidence of divorce increases the proportion of people living alone. Others' decisions also affect household structure; for instance, an increasing likelihood that adult children will return to their parents' homes increases the fraction of parent-child households.

Two patterns appear in Figure 12.4. First, the diversity of living arrangements is higher in the cohorts born more recently, especially the two cohorts born during the baby boom, than in the cohorts born earlier. That is, the percentage in the most typical arrangements, living

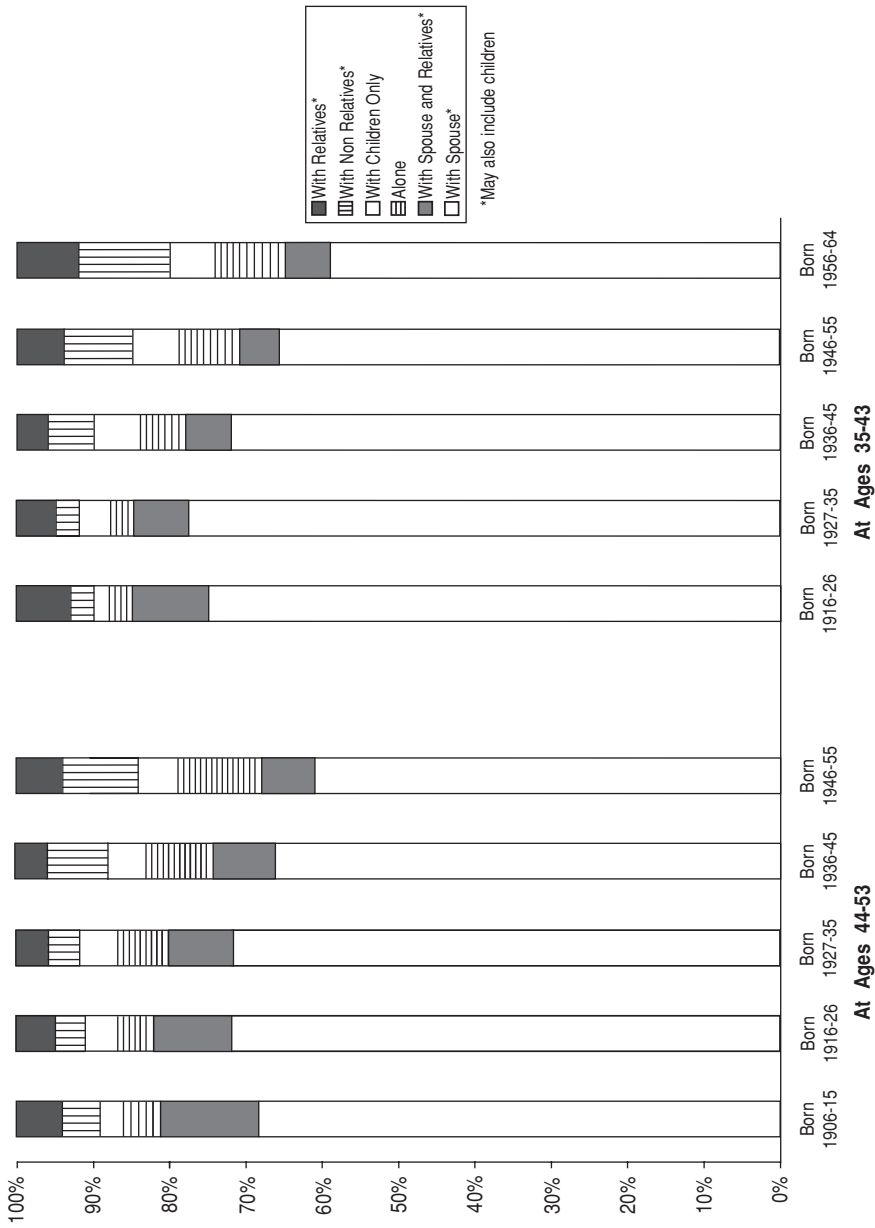


FIGURE 12.4 Living arrangements by age in six birth cohorts of American women. (Source: Authors' calculations using data from the Integrated Public Use Microdata Series, U.S. Census 1960–2000.)

with a spouse with or without children and other relatives, has fallen, whereas the percentage in less common arrangements, such as living alone, has risen. The increased diversity is noticeable at both ages, suggesting that family diversity extends across the life course and that a smaller proportion of the more recent cohorts will spend their lives in “traditional” households. Second, the fraction of people living in non-family households—alone or with nonrelatives—has risen dramatically in the later cohorts. The higher percentage of people living with nonrelatives primarily reflects the higher levels of cohabitation among members of the three later cohorts.

So far, we have described family change as a whole. This broad-brush picture conceals great variation in family structure by race/ethnicity and nativity. The general pattern of increasing diversity over time is true of nearly all groups. However, within groups, the level and pattern of change for each arrangement vary (Hughes & O’Rand, 2004). For example, native and immigrant Hispanics show no decline in the likelihood of living as part of a married couple in a complex household, consistent with research suggesting the greater salience of extended family living in the Hispanic community. Immigrant Hispanics and immigrant Asians show no increase in the likelihood of living alone. Blacks are especially likely to be living alone with children. These differences, which are due to both economic constraints and cultural conventions, add an additional dimension to family diversity (Angel & Tienda, 1982).

We have traced family change for cohorts of women born from the beginning of the last century through the end of the baby boom. The oldest women were born in 1906, the youngest in 1964. We see sizeable shifts in family-related behaviors, especially marriage, divorce, and child-bearing. The overarching impression from these indicators is of a break with the past for women born after 1945. These women were much less likely than their predecessors to marry in their 20s, dramatically more likely to divorce, less likely to become mothers at all, and if they had children, likely to have one or two. These trends have continued—and strengthened—in cohorts born after 1964 (e.g., Raley, 2000).

FAMILIES, THE LIFE COURSE, AND WELL-BEING

Family roles and relationships are central to people’s day-to-day lives and include some of the most intense bonds—and conflicts—in the human experience. However, they also link people to social structures and institutions and are thus one of the ways in which these structures and institutions shape individual lives (Fischer, 1982). This intermediary

position means that families have enormous potential for affecting people's well-being.

A large body of research considers whether and how family structures, roles, and relationships affect well-being. Most of this literature focuses on the impact of family on well-being in the first half of the life course. However, in the last decade or so, population aging has stimulated research on families in later life, so a critical mass does exist. In addition, because the life course is cumulative, many of the insights gained from family influences early in the life course are relevant to the later life course. Moreover, a growing body of research suggests that family experiences in childhood, young adulthood, and midlife affect well-being in later life. Again, a full review of this literature is beyond the scope of this chapter, and we summarize as background for our subsequent discussion. Bengtson, Rosenthal, and Burton (1996) and Treas and Lawton (1999) provide reviews of this literature.

Families and Social Connections

In the United States, family relationships are something of a paradox. Due to strong norms of individual and generational independence, they are often viewed as weak compared with family bonds in less individualistic cultures. However, family members form the core of most people's social networks (Fischer, 1982). Among married older persons, spouses are typically the hub of these networks. Adult children, grandchildren, and siblings are also important components of social networks and, for some people, more distal kin are important as well.

Like all social ties, family relationships bring tangible and intangible benefits and resources. Family relationships can also bring costs and demands, and they may be characterized by negative interactions, conflict, or ambivalence (Fingerman, Hay, & Birditt, 2004; Silverstein & Bengtson, 1997). Unlike other social ties, such as friendships, severing a problematic family tie is not always an option (Antonucci & Akiyama, 1995). Balancing these downsides are characteristics of family ties that tend to make them more valuable than and distinct from other social connections (Hughes & Waite, 2004). First, family relationships are built on social roles and are attached to a key social institution. These roles come with normative guidance for expectations and obligations, although these norms are clearer for some relationships than for others (Rossi & Rossi, 1990). Second, family relationships typically have long histories. They evolve over time, continuously renegotiated and reconfigured against the backdrop of changing life circumstances. The family of origin brings lifelong membership. Lengthening life expectancy and

fewer years spent within marriage increase the salience of adult intergenerational relationships and interactions with adult siblings (Bengtson, 2001; Treas & Lawton, 1999). Similarly, for most persons, parenthood brings a lifelong role that mirrors the role of the adult child (Logan & Spitze, 1996). For some persons, marriage may still bring a lifelong relationship, but even divorced people may experience significant long-term relationships with former spouses and in-laws, especially if shared children bring continuing contact.

These features mean that family ties are often extremely important to individual well-being. People have a deep need for social connections (Baumeister & Leary, 1995). When this need for intimacy and belonging is not adequately met, people experience a complex and painful set of feelings known as loneliness (Weiss, 1973). Loneliness may be especially prevalent among older people who are experiencing age-related losses, but older people with family ties appear less vulnerable to loneliness in old age (Gierveld, 1998; Green, Richardson, Lago, & Schatten-Jones, 2001; Pinquart, 2003; Pinquart & Sorensen, 2003). Family ties also bring both instrumental and emotional social support. Caregiving is among the critical services provided to older people by family members; most frail elders are cared for by a spouse or adult child, usually a daughter, and this care appears to enable frail elders to remain in the community (Freedman & Soldo, 1994; Liang, Brown, Krause, Ofstedal, & Bennett, 2005; Soldo, Wolf, & Agree, 1990). However, older people also provide support to younger family members; for example, flows of assistance between parents and adult children are usually reciprocal or on balance toward the adult children until quite late in the parent's life (Bengtson, Rosenthal, & Burton, 1990; Logan & Spitze, 1996). These exchanges are an important aspect of social integration, providing valued roles, identity, and a sense of belonging.

Families and Economic Well-Being

Families have direct and dramatic influences on income and wealth. First, for a number of reasons, household income is substantially higher for those who are married than for those who are not. Shared living arrangements bring substantial economies of scale, raising economic well-being. Both married men and married women earn more, on average, than otherwise similar people who are not married (Waite & Gallagher, 2000). In addition, the institution of marriage seems to encourage savings and asset accumulation, whereas divorce tends to be disruptive to these processes (Lupton & Smith, 2002; Waite & Gallagher, 2000).

Perhaps as a result, married people have higher per capita household incomes than do those who are single, divorced, or widowed. They also have greater wealth. Lupton and Smith (2002) estimate that among middle-aged adults, the median married couple (including remarried couples) had a net worth of just over \$132,000, or about \$65,000 apiece. Each spouse owned almost twice as much as the typical divorced person (\$33,670). Never-married individuals were only slightly better off, with a median wealth of about \$35,000. Widows and widowers fell in between, with a median net worth of just over \$47,000. The most disadvantaged were the currently separated, with assets of only \$7,600. It is noteworthy that even though the surviving spouse usually keeps all the couple's assets when a marriage is ended by the death of one partner, widows and widowers still have a net worth about \$19,000 lower than a typical married person.

A very substantial share of wealth is held in the form of their entitlements to pensions and Social Security. In fact, Social Security entitlements constitute the largest asset for most people in their 50s and 60s. Lupton and Smith (2002) report that when the expected value of pensions and Social Security is added to the wealth of married and unmarried people, the financial advantage of the married becomes even more dramatic. Married people typically have about \$205,000 each in wealth measured in this way, compared with \$151,141 for the widowed, \$153,829 for the divorced, \$167,014 for the never married, and \$95,669 for the separated.

Marital disruption generally has substantial negative effects on financial well-being. The economic resources of women tend to drop by about one third during the first year after a divorce, and losses often persist until and unless the woman remarries (Holden & Smock, 1991). Some men show increases in economic resources after a divorce, but especially as more married couples have two earners, the financial well-being of the majority of men declines if they divorce. Men's economic losses following divorce result from their inability to fully compensate for the loss of their wife's earnings and from voluntary and court-ordered support payments (DiPrete & McManus, 2001). Both spouses suffer from the losses of the economies of scale of sharing a household because following the divorce, the same number of people needs two dwelling units.

Although the processes leading to the marital loss are different for widowhood than for divorce, both tend to bring declines in economic well-being. Holden and Kuo (1996) found that among both Black and White adults at midlife, the currently widowed and those couples in which one spouse was previously widowed are no better off financially than their divorced counterparts.

One's history of marriage and marital disruption is also related to current wealth; those who have been married once and who remain married show the highest levels of wealth, on average, whereas those who have been divorced show significantly lower levels of asset accumulation (Wilmoth & Koso, 2002). Continuously married men are also more likely than single or divorced men to receive income from a pension. Currently married men and women were more likely to have a pension than single, divorced, or widowed men and women (Yabiku, 2000). Marriage increases assets through the mechanisms mentioned earlier: economies of scale; increased earning; incentives to save; and the institutionalized benefits that facilitate the accumulation of resources, such as tax laws and family health insurance. At the same time, marital dissolution is financially very costly, burning resources in the divorce process itself, reducing earnings, and decreasing ability to save (Wilmoth & Koso, 2002). Remarriage partially offsets the negative effects of divorce, perhaps by increasing the ability of individuals to save. Wilmoth and Koso found that the greatest wealth disadvantage appears for those who experience a marital dissolution and *remain unmarried*.

Families and Health

Families also have important effects on individual health and marital status, and marital transitions are fundamental to these effects. Married men and women have better mental health than their unmarried counterparts (Horwitz, White, & Howell-White, 1996; Marks & Lambert, 1998; Mirowsky & Ross, 2003; Umberson, Chen, House, Hopkins, & Slaten, 1996; Williams, 2003). Being married is also positively related to a variety of physical health indicators and to longevity (Lillard & Waite, 1995; Umberson, 1992). Studies of marital change and mental health find that people who separate or divorce show increases in depressive affect (Marks & Lambert, 1998; Simon, 2002), psychological distress (Mastekaasa, 1995), and hostility (Marks & Lambert, 1998). Simon (2002) also found increases in depressive symptoms among men and women whose spouse dies. In contrast, getting married tends to improve mental health (Horwitz & White, 1991; Horwitz et al., 1996; Marks & Lambert, 1998; Simon, 2002). The smaller literature linking marital transitions and physical health shows that both marital gain and marital loss affect physical health, although the direction and the magnitude of the impact may depend on gender, whether it is a first or later transition, and for marital loss, how the marriage ends (Hemstrom, 1996; Lillard & Waite, 1995; Williams & Umberson, 2004).

Overall, health-based selection does not appear to explain the better mental and physical health and longer lives of the married. However, some of the pathways through which marriage improves physical health depend on the quality of the marriage, suggesting that the benefits of marriage for physical health are conditional on good marital quality (Wickrama, Lorenz, Conger, & Elder, 1997). Similarly, the marital advantage in mental health appears only in marriages of at least moderate quality; being in an unsatisfying or unhappy marriage may be worse than being unmarried (Prince & Jacobson, 1995; Ross, 1995; Weissman, 1987; Williams, 2003). The health benefits of marriage do not appear to extend to cohabiting relationships (Brown, 2000; Wu, Pennings, Pollard, & Hart, 2003).

We know somewhat less about the health benefits of other family relationships. A great deal of research documents the benefits of social integration and social support for health (House, Landis, & Umberson, 1988; Thoits, 1995). Because family members form the core of most people's social networks, these findings provide indirect support for the importance of strong family connections to health. However, the existing direct evidence about the relationship between family structure and health is more mixed. For example, parents appear to have greater longevity, better physical health, and better health behaviors than comparable nonparents (MacIntyre, 1992; Umberson, 1992), although these relationships vary by age at first birth (Mirowsky, 2002) and number of children (e.g., Weng, Bastian, Taylor, Moser, & Ostbye, 2004). But in contrast to other social roles, parenthood does not appear to protect against depression; in fact, according to Evenson and Simon (2005), parents with children still in the home report higher levels of depressive symptoms, net of covariates. Parents with adult children are no less likely to be depressed than similar nonparents, suggesting that parenthood does not convey a long-term protection against depression.

Single mothers experience poorer physical health, more depression, and higher mortality than comparable mothers living with a spouse or partner (Benzeval, 1998; Hughes & Waite, 2002; Weitoft, Haglund, Hjern, & Rosén, 2002; Weitoft, Haglund, & Rosén, 2000). Living in complex households seems to have negative effects on the mental and physical health of persons in midlife, perhaps because these households often bring additional day-to-day demands (Hughes & Waite, 2002). Grandparents who take grandchildren into their homes sometimes, although not inevitably, experience health declines (Hughes, Waite, LaPierre, & Luo, in press). Finally, caregiving, which is usually provided to family members, often has negative effects on health (Schulz & Beach, 1999).

Health in later life also bears the mark of family histories. Some of these influences stretch back to childhood, with people whose parents divorced showing higher likelihoods of depression (Cherlin, 1998), poorer physical health (O'Rand & Hamil-Luker, 2005), and higher mortality in adulthood. Marital biographies influence later health as well; divorces earlier in life appear to leave a health "scar" that is apparent regardless of current marital status (Hughes & Waite, 2003).

The Aging of the Second Demographic Transition

At midlife, the families of cohorts born more recently thus look very different from the families of members of earlier cohorts. Members of later cohorts are less likely to be currently married, more likely to be living alone, and more likely to be living in a complex household. Their family histories are more variable. The incidence of cohabitation, multiple marriages, and nonmarital childbearing and childlessness will all be greater in these cohorts than in earlier ones. They will have spent less of their lives in married-couple households and more of their lives living alone, in single-parent or in complex households. Along with these differences in family structure have come both new and altered family roles and family relationships. Most importantly, these changes appear to have challenged people's ideas of what constitutes a family and what family members may or may not owe each other.

Research on the "aging family," stimulated in part by population aging, shows that family structure and relationships are linked to well-being in later life. People's well-being seems to depend on not only their current family situations, but their family histories as well. However, most of this research is based on the experience of current elderly, which cannot capture the full implications of the Second Demographic Transition for the later life course. The oldest of the cohorts on the forefront of family change, people born in the 1940s, has only just begun to enter what we conventionally call old age (over age 65).

Thus, one of the challenges for the next generation of research on family and life course will be to trace the ways in which the Second Demographic Transition unfolds in later life. This research will need to address two general questions. First, is family change continuing in the second half of life, and if so, what are its dimensions? Second, what are the implications of various family histories and statuses for individual and collective well-being in later life?

In the following sections, we discuss what the future might show for members of the cohorts involved in the Second Demographic Transition. We do not make predictions; family demographers have been mostly

unsuccessful at predicting the future, and we see no need to add to the list of misguided prognoses. Instead, we identify a series of issues and contingencies that will shape the future experience of aging families. In keeping with the speculative nature of these remarks, we pose them as questions in hopes that they will provide a guide for further research. We note, however, that these questions by no means exhaust the issues related to the aging of the Second Demographic Transition.

How Will the Second Demographic Transition be Manifested in Later Life?

The uncertainty surrounding the ways in which family change will continue to unfold as people age makes thinking about the aging of the Second Demographic Transition difficult. This important point sometimes gets lost in discussions about the prospects for aging families because the focus is usually the implications of current family structures for people's future well-being. However, future family structures are equally, if not more, relevant to people's future well-being, and we have yet to see how family change plays out in the later life course.

For example, family demographers are used to thinking that divorce rates are very low among the elderly—but this stylized fact is based entirely on the experience of cohorts who entered later life with lower lifetime likelihoods of divorce. Will higher likelihoods of divorce at young ages translate into correspondingly higher likelihoods at older ages? To the extent that higher lifetime likelihoods of divorce reflect greater emphasis on self-fulfillment, both inside and outside the marital relationship, we might expect the consequent higher divorce rates to continue in later life. However, people may place greater stress on stability and security as they age, dampening the divorce rate trajectory. Moreover, marriages that continue into later life, whether first marriages or remarriages, may be especially strong and at a lower risk of dissolution, and the declining risk of disruption with higher marital durations is well established. Thus, we may see higher proportions of people coupled than at earlier ages and relatively low divorce rates.

Similarly, rates of cohabitation are also low among current elderly. However, cohabitation was rare and limited to certain population subgroups when current elderly were young, so it may simply not be in the repertoire of family arrangements for most of them. Will future cohorts of elderly utilize cohabitation at the same rate as they did when they were younger? Cohabitation is especially prevalent prior to remarriages, suggesting that the prevalence of cohabitation will indeed be higher among future elderly, if only because higher fractions of people will be

divorced and thus at risk of remarriage. Complicated marital and child-bearing histories may make cohabitation attractive to new generations of older adults seeking to pass resources to children. Alternatively, people may be less likely to enter new relationships as they age.

Currently, the likelihood that people will marry or remarry in their 60s is quite low. Will histories of “serial monogamy” among future elderly mean that they will be more likely to remarry in later life than current cohorts of elderly? Even with constant rates of marriage or remarriage, the number of people marrying will increase, again because of larger populations never married and divorced. However, cohabitation or “living apart together” may be attractive alternatives. At some point, women’s remarriage prospects will begin to be constrained by the supply of living men.

The offsetting influences on the future of older families can be conceptualized in an age-period-cohort framework. Future cohorts of elderly will enter old age with unique family histories, they will experience age-related constraints and their own beliefs about what is age-appropriate, and they will encounter secular and period shifts in social contexts. The family life of future elderly will depend on how these forces interact.

How Will People’s Family Histories Affect Their Future Family Life?

The life course is cumulative in that a person’s options at a point in time are often contingent on prior events and experiences (Elder, 1998). By this line of reasoning, the families of future elderly will show many continuities with the families they formed earlier in their life courses. However, the specific forms these continuities will take are less clear.

Fundamentally, life course continuities mean that people’s family histories define their current family situations and thus the sheer possibility of certain family behaviors. Thus, a divorce earlier in life places an older person at “risk” of cohabitation and subsequent remarriage, whereas a person who remained married to his or her original spouse is not. Earlier behavior can also close some options off entirely; thus, women who do not have children prior to menopause will never have biological children or grandchildren, and fathers who lost touch with their biological children are unlikely to develop close relationships with them when they are grown. Future cohorts of elderly will have substantially different distributions of family histories and thus substantially different risk profiles.

Over and above this mechanistic relationship between the past and present is the likelihood that a person will make a particular choice, given

that he or she is in a certain “risk” group. The Second Demographic Transition was fueled in large part by new ideas surrounding family life and the meaning attached to family. Thus, we might expect future elderly to make different choices about family life than their predecessors. For example, Giddens (1991) has argued that contemporary family life is organized around the ideal of the “pure relationship” rather than institutionalized roles and norms (cf. Beck & Beck-Gernsheim, 2001). This insight suggests that patterns of union formation (including cohabitation) and dissolution will continue to be dynamic through later life.

Life course continuities suggest that family life among the future elderly will be characterized by the same heterogeneity they exhibited at younger ages. However, this does not imply that family heterogeneity will necessarily increase as these cohorts age. Diversity in family experiences may mean that individuals typically have a wider variety of experiences than their parents or grandparents did. However, diversity could mean instead, or in addition, that the number of pathways available to people increases dramatically, but that once on a pathway people tend to remain on it.

What Will be the Nature of Age-Related Constraints, Expectations, and Contingencies?

Although we expect continuities in the family lives of future elderly, aging will necessarily constrain some choices. Obviously, childbearing will not be an issue, at least for women. Declining health may change the calculus surrounding union dissolution and the odds of forming a new union. Death of a spouse or partner will be a much more important component of union dissolution. As noted earlier, differences in life expectancy between men and women will lead to sex imbalances at older ages, such that older women will be less able to form new unions.

At the same time, however, increases in life expectancy and improvements in health mean that age-related constraints are shifting later in life, at least among the advantaged, and a greater fraction of “old age” is spent healthy and high functioning. Thus, at the same time that the family is in flux, so are ideas about what is possible and appropriate later in life. The ways in which these expectations develop will be an important influence on the future of the Second Demographic Transition.

Finally, aging brings a host of other potential transitions, including retirement and sometimes residential mobility. These transitions will reflexively shape family life. For example, the life changes associated

with retirement might trigger divorce, or the new social networks formed on relocation may lead to formation of a new union.

What Kinds of Secular Changes and Period Effects Will Older Adults Encounter?

Although we are discussing the ways in which the Second Demographic Transition was manifested in successive cohorts of Americans, the Transition was shaped by secular and period forces (Hughes & O'Rand, 2004). Thus, we expect that future behavior will be shaped by yet unknown shifts in social and institutional contexts.

Although these forces have yet to materialize, we can speculate about the kinds of shifts that might affect older adults' family life the most. Prominent among these are changes in retirement rules, policies, or entitlements. Economics are still an underpinning of family life, and economic change was an important factor driving family change. In later life, people are less likely to be affected by economic opportunity structures, which were an important factor in family change earlier in the life course, and more likely to be affected by changes in institutionally based incentives. However, the family behavior of the young old who are still working, especially those on the economic margins, may be affected by economic booms and busts. Other potential social changes with implications for older families include changes in health care policy and in inheritance taxation.

Changes in the broader social contexts are likely to affect older people's families, not only directly but also indirectly through their effects on older people's children and grandchildren. The choices the younger generations make regarding family life will shape the extended families of future elderly. The apparent resilience of the Second Demographic Transition in cohorts who are now young adults, combined with the influence of childhood family structure on marriage and childbearing in adulthood, suggests that older people may see their descendents replicate their own family histories. However, unforeseen changes in economic opportunities, family-work policy, and gender roles might change this trajectory.

What Will Be the Implications for Well-Being?

Regardless of the ways in which future elderly arrange their family lives with age, it seems clear that the distribution of family histories and statuses among the elderly will shift toward types that previous research has linked to weaker, or at least more complex, social connections, lower

economic status, and poorer health. Thus, a logical conclusion might be that we will observe greater diversity in well-being and lower average well-being among the elderly.

However, although this dismal prediction might be accurate at a high level of generality, it offers little insight into the processes that will underlie this gross pattern. Furthermore, this scenario assumes that the relationships between family structure and well-being will remain the same as they were in the past. However, family change itself may undermine this assumption to the extent that it alters the meaning of particular family structures. We have identified several unsettled issues about the ways in which the Second Demographic Transition will affect the meaning of the family in people's lives.

How Will the Expectations and Obligations Associated With New and Changed Family Roles Develop?

One of the implications of new and more heterogeneous family structures is a greater variety of family roles. Some of these are new roles, such as never-married mother, step-parent, ex-spouse, partner, ex-in-law, and step-child. Most of these new roles are ill defined; that is, people lack the cultural "rule books" that tell them what kinds of behaviors and responsibilities accompany a particular role (Cherlin, 1978). Moreover, whether or not some of these are "family" roles at all is being debated (Popenoe, 1993; Stacey, 1993). Besides the creation of new roles, old roles have taken on new forms; for example, the role of mother has been redefined by increases in women's work outside the home and increases in nonmarital childbearing. The role of father may be bifurcating—the "good" dads who are fully involved with their children and are equal partners in maintaining the household and the "bad" dads who are absent and essentially divorced from their children (Furstenberg, 1988). Changes in established roles also introduce uncertainty surrounding the "rules" of family life.

Thus, commentators on the family note that we are in a time of tremendous uncertainty about who is family and what family members owe to each other (Giddens, 1991). The ways in which these uncertainties are resolved will shape the relationship between family structure and well-being in the future. We have described how family members are central to older people's social networks and how they provide the majority of social support and the majority of caregiving. A key issue is the extent to which new and reconfigured family roles will provide the same support and care. Lack of normative consensus suggests the potential for great heterogeneity in the safety net provided by family

members to older people and the same lack of consensus may make fulfilling the need for chronic and acute support more stressful for all involved. Individuals with particular histories, such as men who have lost touch with their biological children, may be particularly vulnerable to lack of support. However, as formerly unusual family roles become more common, greater normative consensus may emerge regarding what is owed to and expected from new families. In particular, the expectations and obligations associated with step-relative roles may begin to mirror those of blood relations. Families of choice may increasingly come to meet the needs of individuals for physical, emotional, and financial support as they age.

What Will be the Qualities of New and Redefined Family Relationships?

A related, but distinct, issue relates to the characteristics of ties between family members. Changes in family structure have also altered the structure of people's social networks. For example, step-families bring additions to social networks; thus, for many people, family change will bring an increase in the sheer number of family "ties." For example, a child whose divorced mother remarries may gain not just a step-father and step-siblings, but at least potentially, a set of step-grandparents, aunts, uncles, and cousins. In contrast, some people may experience fewer ties than they would in a traditional family structure, such as a never-married mother who is never able to establish strong links to the father of her child.

The key question, however, is whether these new family structures will bring fulfilling and lasting relationships and whether the absence of some family ties is necessarily problematic. New family structures bring opportunities for both increased family solidarity and increased family conflict (Bengtson et al., 1996). Riley and Riley (1993) argue that new family relationships are "latent" and as such are likely to be activated only on the basis of compatibility and mutual gain (cf. Beck & Beck-Gernsheim, 2001). However, as essentially dyadic relationships, they may be weaker, shallower, and more vulnerable to disruption than ties rooted in institutionalized family interactions. Divorce, remarriage, blended, and informal family relationships also bring the potential for greater conflict—not only between spouses, but also between parent and child and among siblings and others with various degrees of socially recognized relationships. As individuals adapt in their own ways to the ambiguities of new family roles, the chances of misunderstanding, disagreement, and conflict increase. However, loss or avoidance of uncomfortable or difficult relationships may enhance well-being; this is

certainly the case with the end of a poor-quality marriage (Wheaton, 1990; Williams & Umberson, 2004).

The long-term implications of family change for nuclear family relationships are also unclear. For example, how will the relationship of single mothers to their children develop as the children reach adulthood, especially in cohorts in which this experience is common? How will parental divorce and remarriage affect relationships among siblings and step-siblings in adulthood? Research on earlier cohorts suggests that children raised in single-parent households have less positive relationships as adults with both their mothers and their fathers (Lye, Klepinger, Hyle, & Nelson, 1995) and are less likely to provide help for parents, especially fathers, as they age (Cooney & Uhlenberg, 1990). Will these patterns persist in cohorts in which the experience of parental divorce, dissolution of cohabiting unions, and single motherhood were common? Will families find new ways to cement the bonds between parents and children who did not share the same household when the child was young? This is a particularly important issue for divorced men who have not maintained contact with their biological children.

The ways in which new and changed relationships unfold will have implications for well-being in later life. A related issue is how other types of relationships will substitute for absent or difficult family relationships. For example, childlessness may leave people more time to develop friendships and other voluntary associations, which, unlike families, are unambiguously beneficial to health (Antonucci & Akiyama, 1995). Although the sibling relationship is unique in its degree of shared experience, only children may compensate by investing in friendships or in relationships with senior family members. The possibility of adaptation to family "losses" is an important corrective to the view that lack of traditional family ties is inevitably harmful, especially because these adaptations may be beneficial for well-being.

What Types of Assistance and Support Will be Needed by Various Family Generations?

The literature on aging families has emphasized the extent to which family members will need to provide care for disabled and dependent elderly (Waite, 2005). Thus, an important determinant of future cohorts' well-being will be their physical and mental status itself, because all else equal, people with fewer needs are more likely to have these needs met.

However, research has shown that both emotional and instrumental support flows down the generational ladder until quite late in life (Bengtson et al., 1990; Logan & Spitze, 1996). Thus, mature persons'

well-being will also depend on the needs of their children and grandchildren. For example, coresidence with adult children is usually due to circumstances in the younger adults' life (Ward, Logan, & Spitze, 1992). To the extent that young persons in the future experience difficulties such as divorce or job loss, their parents may be called on to provide coresidence or other support. Adult children in the home increase the demands placed on parents, especially mothers and especially single mothers (Logan & Spitze, 1996). As another example, difficulties in the lives of adult children are leading to increases in the prevalence of grandparents providing custodial or coresidential care for grandchildren (Minkler, 1999). Here again, the senior generation is devoting time and resources to problems encountered in the younger generation.

How Will New Family Forms be Institutionalized?

Arguably, many of the effects of family structure on well-being emerge from the institutional arrangements surrounding the family. For example, if in general, people are not permitted to share employee health benefits with a cohabiting partner, this might result in a lower average level of health among cohabiting couples compared with married couples. Differential access to public transfers for those in married and cohabiting couple families may affect financial well-being. Thus, family structure may affect well-being, at least in part, through the costs and benefits imposed on particular family structures by law, policy, or custom.

Thus, the well-being of older persons will be affected by the degree to which changes in law or policy change the treatment of various family arrangements. Examples include the ways in which joint custody of children after divorce is managed, the rights and responsibilities of step-parents and grandparents versus biological parents, the tax code, and welfare policy. Note that although many of the benefits of law and policy are material, they need not be limited to material benefits; institutional recognition of a particular family form, such as custodial care of grandchildren, may make that arrangement less stressful simply because it does not fall between the cracks and need to be explained again and again.

How Will Race/Ethnicity and Gender Stratification Intersect With New Family Configurations?

Because family patterns differ dramatically by race and ethnicity, heterogeneity in the family will be cross-cut by race and ethnicity. Family change has gone hand-in-hand with changes in gender roles, although many

argue that the gender revolution is far from over. Structural inequalities based on race/ethnicity and gender are an important source of family economic inequality; for example, the economic disadvantages faced by single-mother families stem in part from women's disadvantages in the labor market and partly from social systems that encourage or discourage unmarried fathers from providing financial and other support to children. Thus, the ways in which these large systems change will have consequences for links between new family structures and well-being as well.

CONCLUSION

The aging of the Second Demographic Transition has special urgency because the cohorts at the forefront of family change include the large baby boom cohorts. The entrance of the boomers into later life will accelerate the aging of the U.S. population, the prospect of which has raised tremendous concerns among policy makers, pundits, and the public. However, just as important as the size of the boomer cohorts are the ways in which they differ from current elderly (Hughes & O'Rand, 2004). Although the implications of family change for the boomers' aging are unclear, it is quite clear that mature Americans will have increasingly heterogeneous family histories and statuses. Thus, the family is likely to become ever more important in differentiating the aging experience. For researchers, this offers many exciting opportunities to explore the new American family and clarify the mechanisms by which it shapes aging. Policy makers will face the challenge of designing flexible strategies to meet the needs of various kinds of aging families.

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The Second Demographic Transition, Aging Families, and the Aging of the Institutionalized Life Course (Commentary)

Dale Dannefer and Robin S. Patterson

Compared with the first, the Second Demographic Transition (SDT) is messy and complex. The first demographic transition concerned only the matters of individual existence (birth) and survival (death); SDT concerns the inherently more complex matters of how individual experience interfaces with relationships and with family and other institutions (Lesthaeghe, 1995). The first is defined by two relatively straightforward variables (fertility and mortality); SDT concerns multiple, complex features of individual lives and their contexts. The relationships and institutions are complex not only because they involve qualitative and categorical differences, but also because they are subject to constant redefinition and reformulation by the actors who participate in them. Thus, the dimensions and dynamics of the SDT will be unavoidably challenging to apprehend and understand.

The challenge is amplified further when one considers the *direction* of change SDT represents: It entails the reversal of a long-term secular trend toward greater homogeneity, conformity, and, in some respects, normativity in numerous domains of the life course. These domains include marriage, parenting, and other issues pertaining to the institution of the family (e.g., Hogan, 1981; Uhlenberg, 1974). Conformity

and homogeneity are, of course, always easier to depict and characterize than are diversity, contingency, and unpredictability.

Hughes' and Waite's analysis (chapter 12, this volume) leaves little doubt that there is a strong and continuing trend toward diversity of family relationships and structures. They extrapolate from these complex patterns to raise some provocative questions regarding the future of aging individuals and families, a future that is uncharted largely because of diverse configurations of personal life manifest in the recent past and present. The authors make clear that the events, decisions, and structures that have been part of the lives and family patterns of those in early adulthood in the late 20th century may lead to new kinds of challenges as these same individuals move into later adulthood as the 21st century progresses. These cohorts, whose members disproportionately delayed marriage, experienced divorce and/or single parenthood, or otherwise deviated from the normative structures and transition sequences of the life course (Uhlenberg, 1974; Hagestad, 1988) and family development (Aldous, 1996; Klein & Aldous, 1988), can be expected to survive into old age in unprecedented numbers. The sheer size of the baby boom cohorts, their projected longevity, and the complexity of their life patterns combine to pose new challenges for policy makers and social and behavioral scientists who seek to understand and anticipate the nature and consequences of their movement into and beyond late middle age.

Hughes' and Waite's analysis raises questions for researchers working in a range of areas, including family structure and parenting, values and culture, and the interrelationship of family, age, and life course. In this chapter, we consider the implications of their analysis for a related concept, one that is presently a matter of considerable controversy: the *institutionalized life course*. We begin by reviewing briefly the principal findings presented by Hughes and Waite and discussing the implications of their findings for the institutionalization of the life course. We then suggest how increased diversity of family structure may be clarified by specifying some dimensions of differentiation of the institutionalized life course itself and conclude with remarks about the relationship of agency and increasing family diversity.

THE SECOND DEMOGRAPHIC TRANSITION AND THE INSTITUTIONALIZED LIFE COURSE

Hughes and Waite present evidence for trends toward increasing diversity in family structure and the weakening of normative patterns on

several dimensions of family life. Compared with preceding cohorts, baby boomers tended to marry later, delay childbearing, and, increasingly, bear children outside of traditional marital partnerships. Those who did marry were more likely than those in earlier cohorts to divorce. Both “the single life” and single parenthood have become more prevalent and accepted forms of private life. As cohort members age, the complexity of their family and life course patterns is amplified as the emergent diversity of lifestyle arrangements and family structures has a concurrent diversity in temporal sequencing. The result is a kaleidoscopic picture of family histories and relationships. Under these new conditions, previously taken-for-granted assumptions and generalizations about family structures and patterns of family and life-course development increasingly seem implausible and out of date.

Hughes and Waite consider both cause and consequence of these developments. They identify a convergence of forces that operate at the individual level—on individual lives and decision making—that appear to be behind these trends of change in family life. These include both changes in *cultural values* and changes in *the opportunity structure* deriving from shifts in the labor market and the economy. They also consider the *effects* of disrupted family lives for the well-being of individuals and for the quality of family life.

As life course scholars will readily observe, Hughes’ and Waite’s analysis raises a number of questions that are also relevant to unresolved issues related to life course institutionalization, and it is on those questions that our reaction to the chapter is focused. In the sections that follow, we suggest that their analysis and their projections for the future indicate some significant avenues of refinement with respect to the future of the institutionalized life course itself.

THE INSTITUTIONALIZED LIFE COURSE

The terms *institutionalization of the life course* and *institutionalized life course* (ILC) refer to the well-documented *organization* of the life course—what might be called a *disciplining* of the life course—over the 20th century. The members of each succeeding cohort have tended to move through key life transitions, such as the transitions to adulthood and retirement, at increasingly similar ages, leading to standardized, age-linked life course patterns (Kohli, 1985, 1986; Meyer, 1986).

Although Hughes and Waite do not write explicitly about standardization or institutionalization of age-linked patterns, their analysis is

relevant for the growing debate over the ILC. Is the 20th-century trend of steadily increasing strength in the ILC continuing with the enduring advance of standardization fueled by educational upgrading, credentialing, and state regulation, and spilling into personal life through policies that impact parenting, health care, and retirement? Or, on the other hand, are these homogenizing tendencies being reversed, replaced by a trend of deinstitutionalization or destandardization?

The general argument of the deinstitutionalized life course includes the notion that individual lives are no longer so predictable or age-graded and that the result is more diversity in life circumstances, lifestyle, and life course patterns. Two distinct kinds of causal scenarios have been proposed in support of the deinstitutionalization concept.

One argument for deinstitutionalization is *cultural*, focusing on changes in values and preferences. This argument presumes a loosening of the institutional strictures on lifestyles, leading to greater variety and diversity in the experience and timing of key life events, roles, and transitions that are markers of institutionalization. This argument typically emphasizes the growing positive valuation of individual autonomy and self-determination, as well as the rejection of traditional values given voice by the youth rebellions of the 1960s and 1970s (Inglehart, 1977). The feminist movement and the sexual revolution sanctioned and nurtured opportunities for emotional and sexual gratification outside the family (e.g., Hoffmann-Nowotny, 1980; Brückner & Mayer, 2005). As Cherlin (2004) notes, the institution of marriage was half a century ago the sole setting for having children. Since then, the link between marriage, childbearing, and childrearing has been dismantled, indicating a trend of deinstitutionalization of marriage (Cherlin, 2004). Beck's emphasis on "patchwork" biographies (Beck, 1992; Brückner & Mayer, 2005) and "individualization" (Beck & Beck-Gernsheim, 2001) depicts these and other trends in individual life course organization.

Closely related to these arguments is the idea that historical changes in the construction of the individual life course reflect a growth in the "impulsive self" posited by Ralph Turner (1976). John Modell and colleagues characterize this change by saying that the life course is increasingly being constructed "ad lib" (Modell, Furstenberg, & Strong, 1978). The flip side of institutionalization, from this perspective, is the ascendancy of "personal autonomy" and the expansion of lifestyle options.

A second version of the deinstitutionalization argument is structural and economic, and it is considerably less upbeat in its interpretation of events. It focuses on the increases in individual loss of control and vulnerability, deriving from changing economic circumstances

and concomitant social policies. For example, O’Rand (1999) indicates how policies favoring privatization have introduced more unpredictability, risk, and variability into the structure and temporal ordering of the life course. Downsizing and outsourcing have compelled many in midlife to change careers, and the shift from defined-benefit to defined-contribution pension plans has created new challenges for retirement in the lives of individuals. Of course, the effects of such changes are a subject of ongoing debate between those who see such developments as leaving individuals who were formerly well integrated into the economy “out in the cold” and those who see them as providing individuals with “new opportunities and challenges.” From the latter perspective, risk and uncertainty are legitimated as “choice” for individuals. Whatever one’s position on such matters, there is little disagreement that these structural developments are likely to increase both inequality and also diversity in age-related transition behavior in the domains of education, work, and retirement (Dannefer, 1999a, 2000; George, 2005; O’Rand, 1999; O’Rand & Henretta, 1999).

In their analysis, Hughes and Waite observe the tension between some of these converging social impulses of economic constraint and necessity on one hand, and values and “preferences” on the other. They note that the increasing diversity in family configurations represents not an expression of values, but the repercussions of unemployment, career disruption, and other forms of economic uncertainty. They acknowledge an increasing bifurcation of the occupational structure: “The shift to a service and information-based economy differentially changed opportunities for economic success; some people found that the new economy demanded longer educational investments but offered unprecedented rewards, whereas others found economic security out of reach” (for similar arguments, see Levy, 1998; Reich, 2000).

Thus, the issues presented by Hughes and Waite bear quite directly on the institutionalization/deinstitutionalization controversy. Combining their analysis and insights with other recent work and with established principles of social theory, we propose a way to resolve this debate.

Specifically, we propose that the relevance of the “deinstitutionalization hypothesis” depends on two key factors: (1) the *domain of life experience* in question and (2) *available socioeconomic resources*. Whether the postulated source is cultural or economic, the general argument is the same: The tendency toward deinstitutionalization may differ across spheres of experience, as well as across social positions. To the extent that such differences exist, at least some of the debate over the direction of trends in institutionalization of the life course can be addressed by a clearer specification of the phenomenon.

THE DIFFERENTIATION AND STRATIFICATION OF THE INSTITUTIONALIZED LIFE COURSE

We propose that the ILC may be most accurately conceived *not as a homogeneous trend but as a stratified and differentiated one*—both at the cohort level and within individual lives. If so, the deinstitutionalization debate may itself be advanced by moving beyond the assumption that the ILC is a universal and pervasive juggernaut of late modernity. The fruitfulness of such a conditional approach can be illustrated by considering two axes along which the dynamics of institutionalization may themselves be differentiated: (1) the public/private dichotomy and (2) social class.

First, the differentiation of individual life experience into bifurcated domains of public and private represents the division of personal attachments and everyday experiences between family and personal pursuits on the one hand and work, schooling, and agencies of the state on the other. Second, life-course deinstitutionalization is likely to vary with resources, and hence with socioeconomic status. Economic resources may affect social resources, from marriage to friendship to kin relations. Romanticized images of love transcending poverty notwithstanding, evidence suggests that those with fewer economic resources are, *ceteris parabis*, less likely to be the recipients of the positive attentions and acts of others that form the basis of family and other valued relationships (Scanzoni, 1982; Van de Rijt & Macy, 2006). If so, they are less connected to others, less socially integrated, and less institutionalized. As these conditions endure through years of cohort aging, they are likely to be amplified by processes of cumulative advantage and disadvantage (Dannefer, 2003). If, in fact, the private sphere of the life course is increasingly deinstitutionalized, then the long-term direction of change described by Hughes and Waite, toward conditions of greater economic inequality and polarization, can be expected to increase still further. Such a trend suggests the likelihood of increasing hardship in later life for a sizeable and growing segment of each succeeding cohort.

DEINSTITUTIONALIZATION AND THE PUBLIC–PRIVATE DICHOTOMY

As noted earlier, Hughes and Waite make a convincing case for deinstitutionalization in many aspects of family life. Strong evidence is presented for trends indicating increasing diversity, unpredictability, and change in several family roles. These trends include: (1) increasing rates of divorce; (2) increasing intracohort diversity in age of

parenthood; (3) increasing diversity in marital status at parenthood; (4) an increased proportion of single-parent families; (5) increasing diversity in configuration of living arrangements, including “nonfamily households”; and (6) increasing diversity in types of family relationships, which can produce the almost bewildering array of extended relations that, as Riley and Riley (1994) observed, have more permutations than we have vocabulary to name. As diversity in family patterns increases, individuals may also encounter more *countertransitions*—or life course transitions imposed by the life changes of others (particularly marital disruptions and remarriage; Hagestad, 1988). Whether due to divorce, illness, or other factors, some of these family changes entail experiences of chaos, powerlessness, and stressful role ambiguities.

Thus, the indicators of deinstitutionalization are especially strong and clear with respect to family relations. In late modernity, family is located in the private sphere. Indeed, it is the most ubiquitous and powerful institutional form of the private sphere (Donzelot, 1979; Luckmann, 1967). The fragmentation and diversification in personal life has been extensively noted, both by commentators who see it as an existential or social problem (Berger, Berger, & Kellner, 1973; Zaretsky, 1986) and by those who see it simply as heralding an emergent postmodern era (Gilleard & Higgs, 2001, 2002). Indeed, family deinstitutionalization may be paralleled by deinstitutionalization in other domains of private life, such as religious involvement, the organization of free time, and participation in civic and neighborhood life (Dannefer, 1980; Inglehart & Norris, 2003). This argument is consistent with Putnam’s (2000) recent analyses of the decline of social capital in the United States.

In sum, a considerable literature supports the notion that, within the private sphere, the life course of individuals increasingly manifests deinstitutionalization and differentiation. Such a view parallels and complements the convincing case offered by Hughes and Waite, as well as by others (e.g., Brückner & Mayer, 2005; Cherlin, 2004), for deinstitutionalization within the family.

It is not at all clear, however, that these trends in personal life are matched by comparable trends in the public sphere. There are few indications of a slow-down in the age-graded regimentation of compulsory schooling and the attendant age-homogeneity of school-related transitions. There is little suggestion that the necessity of relating to institutions that provide employment or welfare has abated, nor has the importance of state-regulated imperatives of taxation and other obligations of citizenship. Indeed, in the United States, significant political initiatives can be seen as public efforts to impose conformity in reaction to variability and diversity in personal life, in areas such as same-sex relations. The contrast between these observations about the public sphere and

emerging diversity in the private sphere suggests a public–private differentiation of the extent to which life course patterns are institutionalized within individual experience and individual lives.

Thus, focusing on the public–private dichotomy points to an important specification of discussions of trends in the institutionalized life course. Although the earlier versions of the institutionalization argument included analyses of increasing conformity in age at first marriage (e.g., Hogan, 1981; Modell et al., 1978) and the rise of “standard” family life cycle patterns (Uhlenberg, 1974), depictions of the ILC have largely centered on institutional attachments to the public sphere, focusing on “stages and transitions” related to schooling, work, and retirement. Discussion of the ILC over the past 2 decades has emphasized heavily the increasing articulation of individual lives with state institutions (Dannefer, 2000; Kohli, 1985; Kohli, Kunemund, & Wolf, 1997; Mayer & Müller, 1986).

A general hypothesis derived from these considerations is the following: Overall, those focusing on deinstitutionalization have tended to give *more emphasis to issues of family and personal life*, whereas those focusing on institutionalization as continuing processes may have *tended to focus more on schooling and work, and related policy realities*. In other words, we propose that the emphasis on deinstitutionalization derives from evidence that is specific to the domain of personal life. When one looks at institutional connections to the public sphere, little evidence of “deinstitutionalization” is found. In the ongoing debate, little, if any, attention has been paid to the distinction between the dynamics of deinstitutionalization in personal life and in the public domain.

Thus, we suggest that the “institutionalization debate” might be in substantial part resolved if a systematic distinction between public and private was made. This proposition is supported by a recent analysis of German data, by Hannah Brückner and Uli Mayer (2005). Their findings indicate continuing institutional structuring of the life course within the school, training, and work spheres, including increasing homogenization due to convergence of men’s and women’s experience of work and school-related transitions. However, at the same time, they find increasing differentiation or destandardization in family formation in recent cohorts of adults. In short, the suggestion is that there may be increasing deinstitutionalization and fragmentation in private life, coupled with continuing institutionalization and regimentation in life course structures in the “public sphere” domains of schooling, work, and retirement. To the extent that there is a tendency toward deinstitutionalization with respect to career patterns and the transition to retirement (e.g., Henretta, 2001; Riley, Kahn, & Foner, 1994), it may be stronger in the United States than elsewhere (Dannefer, 2000). In any

case, public-sphere institutions continue to organize major aspects of biography through practices ranging from universal schooling (which faces relentless pressure for increasing standardization) to health care to retirement.

DEINSTITUTIONALIZATION, THE PUBLIC–PRIVATE DICHOTOMY, AND SOCIAL CLASS

As Hughes and Waite emphasize, one concomitant of aging for many members of the cohorts of the SDT will be economic stress and hardship, driven by the lack of resources that they will confront as they age. The lack of anchorage in stable family situations across the decades of middle life experienced by cohorts of the SDT, due to lower rates of family formation and higher rates of divorce, can be expected to contribute to this outcome. As the authors make clear, intact families provide an array of protections across the adult life course. These protections include (1) more resources early in life (with implications for future psychosocial development), (2) greater emotional well-being, (3) greater social support, and (4) lower mortality and better health.

Yet, economic resources are required to form and nourish a family. Socioeconomic status is inversely related to cohabitation (Bumpass & Lu, 2000; Edin, Kefalas & Reed, 2004; Smock & Gupta, 2002) and single parenthood (Edin et al., 2004; Rowlingson & McKay, 2005). Economic resources are also associated with a family's survival as an intact unit, as divorce is inversely related to social class (Goode, 1993; Haskey, 1984; Levine, 1981). The economic disadvantage associated with divorce has several dimensions. First, economic stress contributes to the initial likelihood of divorce (Martin & Bumpass, 1989; Smith & Meitz, 1985; South & Spitze, 1986; White, 1990). Beyond that, divorce itself tends to amplify economic and personal difficulties, adding to stress and hardship and contributing further to preexisting risks in a cycle of cumulative disadvantage (Crystal & Shea, 2003; Dannefer, 2003).

In the prior section, we proposed that institutionalization as indicated by participation in stable structures and relatively predictable transition points may be greater in the public sphere than in the private sphere. A consideration of the effect of social class suggests, further, that private-sphere deinstitutionalization may be greatest in the personal and family lives of individuals below the middle class. Thus, we contend that there is an interaction effect between social class and the public–private dichotomy of the life course: To the extent that divorce, single parenthood, or other adverse familial events derive from economic stress, one can suggest that deinstitutionalization in the private sphere results not

from an overall institutional collapse of the public sphere, but from the challenges imposed by the increasingly stratified regime of the public sphere, especially by an increasingly stratified and precarious labor market.

Although we consider this argument highly plausible, we acknowledge that the complexity introduced by the interaction effect may yet oversimplify the multiple dynamics involved in lived experience. Several other factors warrant consideration. For example, economic resources are also associated with gender, which stands as another dimension along which these issues of class differences in institutionalization may vary. And other important social forces of change have less to do with resources than with broad changes in cultural values. Such changes in values and norms also influence the risk of marital disruption. For example, serial monogamy, intentional single parenthood, same-sex relationships, and “swinging singlehood” have all been culturally idealized as plausible “lifestyle choices” and may cut across the dimension of socioeconomic status.

Despite this array of factors, some issues clearly connected to social and economic resources stand out, indicating a direct relationship between class and institutionalization is found consistently across multiple dimensions. Thus, we propose as a general hypothesis that one’s social class, which reflects key attachments in the public sphere (e.g., one’s workplace qualifications and position), dictates the likelihood of disruption in the private sphere, in personal life.

The hypothesis of a social class differentiation in the private sphere should not be taken to imply that there are no class differences to be found in levels of institutionalization in the public sphere. Labor force participation and job stability are associated with socioeconomic level (e.g., Hogarth, Elias, & Ford, 1994), and thus may index differences in level of institutionalization in the public sphere as well. Nevertheless, our hypothesis is that a substantial public–private difference in institutionalization exists across socioeconomic groups: For all citizens, the economic and political imperatives of individual survival and citizenship necessitate engagement with public-sphere attachments, whereas there is no such uniformity in private life attachments and structuring, particularly for those whose socioeconomic status ranks below middle class.

PUBLIC–PRIVATE DIFFERENCES, SOCIAL CLASS, AND THE SECOND DEMOGRAPHIC TRANSITION

Hughes’ and Waite’s analysis suggests that current and projected changes in the economy and labor market may accentuate further some of these

class-related tendencies for many aging families in the 21st century. To gain some perspective on what this might mean for the aging of these cohorts in decades to come, it is useful to consider the economic challenges members of these cohorts have already faced and face now. The postindustrial economies of the late modern West now seem to be shifting away from the information base of the economy, as more and more information-based jobs are being transferred offshore in what Tom Friedman (2005) has called the “flat new world.” Therefore, in addition to domestic changes in social and economic structuring of individual lives, the consequences of globalization for individual life courses in the United States and other late modern societies also warrant consideration (Baars, Dannefer, Phillipson, & Walker, 2006).

If current trends continue, social class differences in institutionalization across both public and private spheres can be expected to increase. New risks are imposed on the individual and the family, as major public social institutions withdraw guarantees of a safety net. Such changes are often framed in terms of new “opportunities” and painted with brushstrokes of “choice” and “personal responsibility” to heighten their legitimacy (Dannefer, 1999b). If such trends of risk displacement continue (if, for example, public safety nets continue to erode, and labor unions are forced into increasingly powerless positions in terms of securing jobs and job benefits), such developments can be expected to add to the economic strain and personal adversity experienced by less privileged members of these cohorts in later life.

One can speculate that, under these conditions of late modernity, the institution of the family may be increasingly vulnerable at the societal level without the regulation experienced with the growth of institutionalization across most of the 20th century. Under such conditions, the economic resources available to the family will influence its capacity to weather economic strains and the demands of work/family conflict. Only those families with higher economic resources to begin with may be likely to survive intact.

FAMILY DIVERSITY, THE INSTITUTIONALIZED LIFE COURSE, AND INTELLECTUAL SCHIZOPHRENIA

If there is more variety in private life patterns and lifestyles accompanied by a loosening of narrowly defined norms and values in the family arena, then it seems that individuals have more options. As noted earlier, Ralph Turner’s (1976) classic article, “The Real Self: From Institution to Impulse,” is often cited to support this notion (e.g., Baars et al., 2006;

Dannefer, 1984; Modell et al., 1978; see also Charmaz, 1999; Dowd, 2000; Rosenfeld, 1999). Turner argues that the shift from agrarian, preindustrial society has brought an emancipation of the self from the stultifying institutional constraints of traditional life. This, of course, relates directly to the notorious problem of agency and the relation of agency and structure. According to Turner, we have entered a historical era marked by increased “impulsivity” of individuals due to relaxation of institutional regimentation and anchorage of their lives. Such a notion is appealing, although it is clearly limited by its failure to consider the structuring of consciousness by implicit social control, regulated through mechanisms as diverse as education and advertising (e.g., Dannefer, 1999b; Schor, 2004; Wexler, 1977).

In the context of the present discussion, the “real self” or “impulsive self” manifests other problems. The new diversity of private-life social arrangements entails relationships and roles that are not well defined (e.g., Cherlin, 2004; Hagestad, 1988). Because these situations often entail novel kin configurations, individuals may experience stress from the lack of cultural “rulebooks” to define the expectations accompanying a role. Yet, freedom from such relationship-defining constraints is also precisely what is needed to avoid being stuck in the strictures of the institutionalized “life course regime”—to construct the life course ad lib, as Modell and colleagues (1978) put it. Isn’t freedom from institutional constraints precisely what, in Turner’s terms, is needed to have agency?

Hughes and Waite’s analysis thus points toward several problems with the “real self” formulation, problems that warrant continued consideration for those interested in understanding the dynamics of the institutionalized life course. One problem is that the simple affirmation of a new level of freedom of choice does not confront the challenge posed by perplexing expectations associated with new and complex kin relationships, nor by the tension, anxiety, and lurking prospect of anomie that may result from the unavailability of cultural rulebooks.

A second problem concerns not the *existence* of non-normative relationships and family diversity but the *sources* of it and especially the undue reliance on *choice* as a part of this explanation. Often, as we have shown, the affirmation of choice ignores strains deriving from the role of power and economic constraint: To assume, for example, that single parenthood is a straightforward matter of choice may be to sugarcoat a complex set of events and circumstances (e.g., divorce or breakup) as the product of volition alone. This assumption neglects the destabilizing social forces that lead to increasing private life deinstitutionalization, forces that often emanate from an unstable and unpredictable labor market, particularly for those in lower socioeconomic groups.

Thus, on several levels, there is a kind of “intellectual schizophrenia” concerning diversity and agency, where many of us have tried to have it both ways (see Broughton, 1987 and Dannefer, 1984, 1999b for further discussions of this). On the one hand, lack of a plausible rulebook, clear roles, or “one right way” to *do* family and private life may be interpreted as more freedom and more individual choice: a life course organized more according to preferences or Turner’s impulsive self. This interpretation views the “agency” glass half, or more than half, full. However, an alternative interpretation is that, in the absence of institutional anchorage in the private spheres of our lives, in the absence of role scripts to follow in our personal relationships, the freedom to ad lib is met with a broader range of choice within a context of minimal institutional support for these choices.

Like relationships without names and roles without norms, choice of possibilities without support or criteria may bring one to the brink of anomie. Thus, even the happiest spin deriving from the emergence of lifestyle pluralization and options carries its own risks. Of course, there are serious sociological questions about whether the impulsive self represents anything like ontological freedom (Dannefer, 1999b; Wexler, 1977). But there seems to be an assumption that it represents at least the experience of choicefulness, of the opportunity to navigate personal life with some autonomy.

Yet, as we have seen earlier, to the extent that choicefulness can be accepted as a meaningful term, it is an experience that is neither universally nor randomly distributed. The population is clearly stratified with respect to the degree of control that individuals have over their lives, even in the private sphere. For many, a real sense of choice and control in personal life will likely remain quite elusive. In the United States, broadly asserted cultural values still place preference on marriage and other more “traditional” forms of family life (Cherlin, 2004), and there is lack of equal access for all to all of the choices (e.g., gay marriage) and increased likelihood for “failure” of making both traditional (e.g., marriage) and alternative (e.g., cohabitation) private life structures *succeed*, particularly in the working class.

We thus consider both the celebration of diversity and the affirmation of new levels of choicefulness to be romantic but misleading. If individuals live in an unprecedented variety of family configurations, the lack of clarity of role definition may offset the presumed benefit of “having options.” Moreover, in many cases, the diverse paths that individuals take may result as much or more from economic exigency or personal powerlessness than from choice. If individuals are “freer” to make “choices” about private lives with a plurality of options, but (1)

have little institutional support and few roadmaps for how to navigate these new social roles and arrangements in private life, and (2) do so while attached to an increasingly stratified and uncertain labor market, then it is a “freedom” in which, for many, failure is all but assured, and the risk of failure in both work and family life is not randomly distributed.

As Herbert Blumer aptly reminded us, the first task of science is to respect its subject matter (1969), and this is true even when the subject matter is a moving target of increasing complexity. Just as the implications of the SDT for aging will be difficult to ascertain, understanding the family lives of maturing baby boomers and their relation to the deinstitutionalization of the life course will pose a challenge, as baby boomers’ advancing age adds additional complexities of relationships and intergenerational forms. In the situation of emergence and change that Hughes and Waite depict, understanding both family dynamics and the life course will require careful attention to diverse outcomes and to the forces that produce them. Although this will ultimately necessitate greater levels of specificity and differentiation than Hughes and Waite suggest and that we have proposed in this response, such attention to diversity and contingency is essential to the future of family and life course scholarship.

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CHAPTER 14

Some Thoughts on Aging, Marriage, and Well-Being in Later Life (Commentary)*

David M. Blau

The chapter by Hughes and Waite (chapter 12, this volume) describes changes in family structure across successive U.S. cohorts born from 1906–1964, spanning the Second Demographic Transition. The authors then review knowledge about how family structure influences well-being in later life and speculate about how observed changes in family structure experienced by recent cohorts will affect their well-being in later life. They present evidence suggesting that family structure has changed a lot, increasing in diversity and, on average, shifting toward structures that are associated with lower economic status and poorer health. Specifically, there have been trends toward less marriage, more divorce, more cohabitation, and more time spent without a spouse or partner. This suggests the likelihood of greater diversity in later life well-being and a lower average level of well-being in later life. This canvas is painted with a very broad brush, but it seems sensible, and appropriate caveats are supplied.

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I begin this discussion by providing an alternative perspective on family structure for the most recent cohort of women analyzed by Hughes and Waite—the “late boomers.” The broad changes in marriage, divorce, and fertility described by Hughes and Waite are undeniable and striking, but a closer look at the behavior of late boomer women, who were born from 1956 to 1964, is worthwhile. This descriptive analysis reveals stability as well as change and shows that the changes in behavior associated with lower well-being are concentrated in a relatively narrow segment of the population. This leads me to emphasize an issue mentioned only briefly by Hughes and Waite: the major differences in family structure between Blacks, Whites, and Hispanics. In the following section, I then suggest some further caveats about the conclusion that recent changes in family structure will lead to lower average well-being in later life, based on selection issues. The final section offers a few concluding thoughts.

A CLOSER LOOK AT THE LATE BOOMERS

The late boomer cohort is defined by Hughes and Waite to include people born from 1956 to 1964. These are almost precisely the birth years of the population included in the 1979 cohort of the National Longitudinal Survey of Youth (NLSY79). The NLSY79 cannot duplicate the broad portrait of cohort change provided by the Decennial Census and Survey of Income and Program Participation (SIPP) data used by Hughes and Waite, but it can be used to describe the behavior of the late boomer cohort in more depth. The NLSY79 interviews began in 1979 and were conducted annually through 1994 and biannually thereafter. Data are currently available through 2002. The survey contains rich data on employment, marriage, fertility, family structure, and many other domains. Here, I use detailed event history data on the female sample members constructed from the raw data files as part of an ongoing research project (see Blau & van der Klaauw, 2005, for more description). These event histories cover, among other things, marriage, divorce, cohabitation, and fertility.

Table 14.1 compares key sample statistics on the late boomers from the NLSY79 and the SIPP and Census data used by Hughes and Waite. The purpose of this comparison is to verify that the data are comparable, so in this table, I use only the representative (cross-section) part of the NLSY79 sample and restrict the analysis to women who were at least 35 years old at the date of their last interview. The first three rows of

TABLE 14.1 A Comparison of Data on the Late Boomers from the NLSY79, SIPP, and Decennial Census

	NLSY79	SIPP/Census
Mean number of children ever born	1.8	1.8
Percent with no children ever born	20	22
Percent with four or more births	8	10
Percent with first birth while a teenager	20	22
Percent with first birth at age 30 or older	22	18
Percent with nonmarital first birth	21	24
Percent married at age 35–43	68	67
Percent ever married (by age 30)	77	77
Percent ever ended a marriage (by age 30)	30	20
Percent ever married more than once (by age 30)	10	12

Note: The NLSY79 cross-section sample is used here. The sample is restricted to women who were aged 35 or older at the last interview, except for the last three rows. The SIPP/Census figures are taken from Hughes and Waite; the first six rows are from Table 12.1 (this volume), and the last four rows are estimated from Figures 12.4 and Figures 12.1–12.3, respectively (this volume).

Table 14.1 show that three summary statistics on fertility—mean number of births, percentage with no births, and percentage with four or more births—are very similar across the data sources. Two measures of age at first birth—percentage less than 20 years old and 30 or older—are also comparable. The percent of first births that were out of wedlock is 21 in the NLSY79 versus 24 in the SIPP. The percentage ever married as of age 30 is identical at 77% in the different sources. However, 30% have ever ended a marriage as of age 30 in the NLSY79 versus 20% in the SIPP. Part of this discrepancy is a result of the fact that I define a marriage as ending at the time of separation, whereas Hughes and Waite report statistics for “ever divorced.” (I ignore temporary separations of fewer than 2 years, and I censor cases that reunite after a separation of more than 2 years.) It is also possible that divorces are reported more thoroughly in a prospective survey such as the NLSY79 than in a retrospective module as in SIPP. The percentage ever remarried as of age 30 is quite close at 10% to 12%, and the percentage currently married at ages 35 to 43 is virtually identical in the different sources at 67% to 68%. This comparison suggests that the NLSY79 can be used with confidence to expand on the analysis of family structure behavior of the late boomer cohort provided by Hughes and Waite.

Table 14.2 provides a description of selected family structure patterns in the NLSY79 sample, separately for non-Hispanic Whites, Blacks,

TABLE 14.2 Marriage and Family Patterns of NLSY79 Women by Race and Hispanic Origin as of Last Interview

	White	Black	Hispanic
Percent ever married	91	66	84
Percent ever divorced (if ever married)	37	55	45
Percent ever married more than once (if ever divorced)	62	30	51
Percent ever cohabited	46	38	40
Percent of cohabitations that became marriages	48	21	17
Percent married at the most recent interview	74	37	63
Mean number of children ever born	1.78	1.95	2.09
Percent with no children ever born	20	19	15
Percent with nonmarital first birth	13	69	30
Sample size	1,935	1,106	695

Note: The Black and Hispanic samples include the supplemental samples. The White sample is restricted to the cross-sectional sample. The sample is restricted to women who were at least 35 years old at the last interview. Mean age at the last interview is 41 years.

Source: Computations from the NLSY79 in *A demographic analysis of the family structure experiences of children in the United States*, by D.M. Blau & W. van der Klaauw, March 2005, Chapter presented at the Population Association of America Annual Meeting, Philadelphia.

and Hispanics. The comparison across these three groups is motivated by the large and well-known differences in many family structure behaviors across these groups (see, for example, Blau & van der Klaauw, 2005; Brien, Lillard, & Waite, 1999). There are three main points worth noting about the results in this table. First, more than 90% of White women in the late boomer cohort had ever been married by their early 40s. This is a remarkably high figure in view of the apparent decline in marriage among the late boomer cohort documented by Hughes and Waite in their Figure 14.1. It suggests that late first marriages (at ages 30 and older) are quite common in this cohort and that the decline in the incidence of marriage in this cohort compared with previous cohorts is small among Whites. This observation does not contradict the findings of Hughes and Waite because in their analysis of whether women have ever married, they used data only through age 30 for the late boomers. They note that “The much lower levels of marriage at each age shown by the youngest women raise questions about the proportion who will ever wed. Unless the pace at which these women marry increases dramatically, by old age, this cohort of women will have much higher proportions that have never been married than any other women born in the 20th century.” Among White women, the pace of marriage certainly picked up

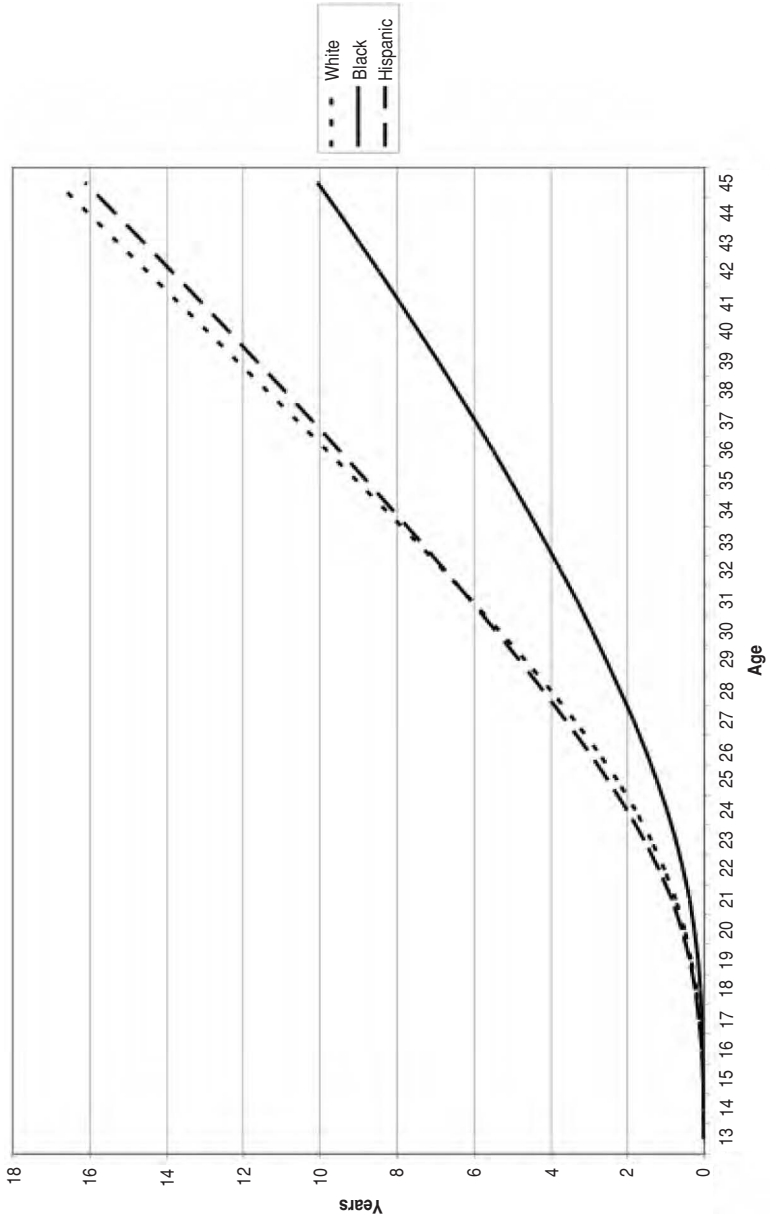


FIGURE 14.1 Cumulative time spent married by age. (Source: Computations from the NLSY79 in “A Demographic Analysis of the Family Structure Experiences of Children in the United States,” by D. M. Blau & W. van der Klaauw, March 2005, Chapter presented at the Population Association of America Annual Meeting, Philadelphia.)

substantially in the last decade. The concern expressed by Hughes and Waite is on target for Black women, however. By their early 40s, only 66% of black women had ever married. The figure for Hispanics is 84%. As in most of the comparisons in Table 14.2, Hispanics are in between Whites and Blacks, and closer to Whites. Seventy-four percent of Whites were married at the most recent interview (2002 for most cases), compared with 37% of Blacks and 63% of Hispanics.

A second important point is that in the last decade, the late boomers have maintained the high rates of both divorce and remarriage they exhibited in their younger years. And racial and ethnic disparities are again apparent: 37% of White women who had ever married experienced a divorce by their early 40s, compared with 55% of Black women and 45% of Hispanics. The disparity in the incidence of remarriage is even more striking: 62% of White women who had ever experienced the end of a marriage had remarried by their early 40s, compared with 30% of Blacks and 51% of Hispanics. The low rate of remarriage among Black women reinforces their relatively low rate of ever marrying and their high divorce rate. The result is that Black women in the late boomer cohort will enter later life with a much lower rate of partnership than Whites and Hispanics. Informal unions in the form of cohabitation are unlikely to compensate for the absence of formal unions. The differences across groups in the ever-cohabited rate are relatively small: 46% for Whites, 38% for Blacks, and 40% for Hispanics. However, cohabitations are relatively brief in duration on average (not shown in the table) and are much more likely to result in marriage for Whites: 48% versus 21% for Blacks and 17% for Hispanics.

A third pattern of note in Table 14.2 is the striking racial difference in the percentage of nonmarital first births: 13% among Whites and 69% among Blacks, with Hispanics at 30%. Marital status at birth is clearly important for children because a child spends much less time living with his biological father if the father is not present in the household at the time of birth. It is not obvious whether this is important for the partnership opportunities of women. Some research suggests that bearing a child out of wedlock reduces the chances of subsequent marriage if the mother does not marry during or shortly after the pregnancy (Bennett, Bloom, & Miller, 1995; Brien et al., 1999) and increases the risk of marital disruption (Upchurch, Lillard, & Panis, 2001; Waite & Lillard, 1991).

Figure 14.1 summarizes the implications of these patterns for the duration of time spent married from age 12 through age 45, the latest age observed in the NLSY79 data in 2002. The duration analysis is based on estimates of a set of discrete time monthly hazard models for

the occurrence of various events, including marriage, divorce, cohabitation, and childbearing. The models were estimated separately for Whites, Blacks, and Hispanics, and then simulated to generate the implications for time spent while married. Figure 14.1 shows that White and Hispanic women in this cohort can expect to have spent about 16 years married between their 12th and 45th birthdays, compared with 10 years for Black women. Almost all of the time spent married is after the teenage years, so from ages 20 through 44, White and Hispanic women spend about 64% of their time married (16 out of 25 years), compared with 40% for Black women (10 out of 25 years).

As noted earlier, there was apparently a high incidence of first marriages in the 30s among White women in the late boomer cohort. We cannot rule out the possibility that there will be a surge in marriage among Black women in this cohort in their 40s or 50s. But if we project current marriage patterns into later middle age for this cohort, we can expect to see large numbers of unmarried Black women. The next section turns to the issue of the consequences of this pattern.

WHY ARE MARITAL PATTERNS CHANGING, AND DO THE REASONS MATTER FOR LATER LIFE IMPLICATIONS?

Hughes and Waite discuss the causes of family change in broad terms: "People reacted to new economic imperatives guided by both traditional ideas about the link between economic security and family formation and new ideas about the meaning of gender, self, and society." Economic conditions changed, and cultural values underwent a "silent revolution," altering the meaning of the family. These ideas are no doubt largely correct, but their generality makes it difficult to use them to develop specific hypotheses about the consequence of changes in family structure. An alternative perspective is provided by an economic approach, which classifies changes by whether they affect constraints or preferences.

Consider the possibility that changes in family structure have been driven by a loosening of constraints facing women. Improved labor market opportunities for women, in the form of both higher earnings and a broader array of careers open to women, give them more choices in life. One alternative that may become more attractive as a result of improved economic opportunities is to forego marriage. Confronted with limited opportunities for supporting themselves through employment, some women might have concluded that marriage was the best of a set of bad alternatives. If improved economic opportunities for women result in a decline in marriage, then the women whose choices have changed as a result of the improved opportunities are better off on a lifetime

basis than they would have been under the previous regime of limited labor market opportunities. It is possible that they could be worse off in old age due to lower income and lack of emotional support, but unless they were very myopic at the time of their decision to forego marriage, they will be better off on a lifetime basis. Thus, one reason for low marriage among Black women could be growth in their earnings relative to those of Black men. The ratio of female to male median earnings of year-round full-time Black workers grew from 0.70 in 1970 to 0.80 in 1980 and has been in the range of 0.80 to 0.85 for the last 15 years (U.S. Census Bureau, 2006). The corresponding ratio for Whites has also grown, but is currently only about 0.72. These within-race comparisons by sex are just one possible metric among many for assessing improved economic opportunities for women, but they do provide an illustration of the issue.

Alternatively, suppose that decreasing marriage is a result of a tightening of constraints. For example, fewer marriageable Black men may be available as a result of a stagnant labor market opportunities and increased incarceration rates. This implies a smaller choice set for women and can be interpreted as a tightening of the constraints they face in the marriage market. In this case, less marriage would likely be associated with lower well-being in later life. Another example of tightening constraints is the change in divorce laws to unilateral divorce in many states. A unilateral divorce regime makes it easier for one member of a couple to end a marriage without the consent of the other spouse. It has been argued that women and children have been harmed by this regime change (Friedberg, 1998; Gruber, 2004). If this is an important cause of higher divorce rates, then the decline in marriage at older ages would again be associated with lower well-being.

Finally, consider the possibility that there has not been any change in constraints; rather, social norms and cultural values changed, resulting in changes in preferences. The implications for well-being in later life are unclear in this case.

Most likely, all of these forces have operated simultaneously, making it difficult to determine in practice whether observed changes in family structure will reduce well-being in later life. But in some cases, it may be possible to tease out causal effects, such as those associated with unilateral divorce.

CONCLUSION

Most people still marry. Those who do not or who spend less time in marriage are selected, likely in part on the basis of unobserved confounding factors that may affect both marriage and well-being. If they

are positively selected, then well-being might increase: Those who in an earlier era would have married but preferred not to can now forego marriage and be happy. If they are negatively selected, then well-being might decrease: Those who in an earlier era would have married but now cannot find a suitable spouse will now not marry and be unhappy. Or there may be no change in selection, just a general shift in preferences away from marriage, with no clear implications for well-being. It is also possible that some people will regret their choices and wish that they had married. Others may be happier than their counterparts in earlier cohorts who were married but unhappy. Hughes and Waite have clearly given us a lot to think about.

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The Impact of Demographic Changes on Relations Between Age Groups and Generations: A Comparative Perspective

Gunhild O. Hagestad and Peter Uhlenberg

Taking a comparative perspective, across historical time and societal contexts, we ask how demographic change combined with institutional and cultural forces are creating altered relations across age groups and generations in the United States and Europe. We start by outlining and describing new structures, both on a macro-level of society and on a micro-level of families. Then, we discuss some possible consequences of the new age-related constellations and challenges they represent for research and policy.

Before starting the discussion of relations across age groups, however, we need to address some conceptual issues. The discussion that follows involves three phenomena, which all at times are assigned the term *generation*. First, there are what we label *age groups*, that is, individuals in given life stages, such as children, youth, adults, and old people. Second, there are *historical generations*, that is, groups of birth cohorts that share certain characteristics. We prefer to use the term cohort here. Third, there are *family generations*, that is, locations in a system of ranked descent. For this phenomenon, we reserve the term generation. In focusing on these three, one is examining people who not only are anchored differently in dimensions of time, primarily biographical time/chronological age and historical time, but also the rhythm of

family time (Hareven, 1977). A host of challenging, yet neglected, issues lies in the intersection of these three phenomena.

The age composition of populations in modern societies has recently become a demographic issue of increasing interest. In the 1960s, a great deal of both scholarly and popular attention was directed toward rapid population growth, popularly referred to as the “population explosion.” But by the end of the 20th century, global population aging, the “graying of the world,” was the demographic phenomenon receiving most attention. Rapid population growth occurred around the middle of the 20th century because death rates had declined more rapidly than birth rates, resulting in a great excess of births over deaths. As birth rates subsequently declined around the world, however, population growth slowed and population aging began. From a historical perspective, rapid population growth was a short-term phenomenon; the marked change in age composition resulting from population aging is unlikely to be reversed in the future.

Across aging societies, there is extensive and animated discussion of economic and health care implications of the changing age composition of populations. (Note the voluminous literature on Social Security and Medicare reform in the United States.) Much less attention has yet been given to *the consequences of population aging for social relationships*, which is our central concern. In particular, we are interested in how connections between people of different ages might be affected by changes in the relative size of different age groups and family generations. We also ask how the organization of the modern life course might shape cross-age relationships. As we elaborate, cross-age ties of interest occur both within kin groups (across generations) and outside of kin groups, across cohorts and individuals in different phases of the life course.

SHIFTS IN POPULATION AGE STRUCTURES

The defining characteristics of aging societies are well known: the 8-decade life as “expected,” especially for women; a change from children vastly outnumbering old people in the population to a situation where there are about an equal number of old and young; and a near future when individuals aged 60 and over will outnumber children by a ratio of two to one. These changes have turned population pyramids into onions and increasingly into population structures that resemble columns. In the near future, some societies, such as the Mediterranean countries, will experience an inversion of the pyramid. Across nations, family networks mirror changes on the population level. It is, indeed, *a demographic revolution*.

TABLE 15.1 Number of Persons 65+ per 100 Children Under 15: United States, Norway, and Italy

	1950	2000	2050 ^a	2050 ^b
U.S.	31	57	120	105
Norway	40	77	150	157
Italy	21	128	271	410

^aUN projection assuming TFR = 1.85 in 2050.

^bUN projection assuming TFR is same in 2050 as in 2000.

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2004 Revision* and *World Urbanization Prospects: The 2003 Revision*. Retrieved February 9, 2006, from <http://esa.un.org/unpp>.

Figure 15.1 provides an overview of the relative size of the older population compared with the population of children in various regions of the world in 2000 and projections made by the United Nations (U.N.) of this ratio to 2050. A dramatic increase in the proportion of old is occurring in all regions of the world. By 2050, there will be more old people than children in every region except Africa. In Europe, old people will outnumber children by a ratio of 2.6 to one.

Further information on the shifting ratio of old to young in populations is shown in Table 15.1, where data are given for the United States, Norway, and Italy in 1950 and 2000, and projections are given for 2050 using two different assumptions.

Although each of these highly developed countries experiences rapid population aging over these 100 years, the patterns are distinct. Because of relatively low fertility in the first half of the 20th century, Norway had the oldest population in 1950. But after 1950, fertility rates in Italy fell far below those in Norway, and life expectancy in Italy surpassed that in Norway (Table 15.2), resulting in Italy having a much higher ratio of old to young by 2000. The U.N. standard projection assumes that fertility in both Italy and Norway will increase to a total fertility rate (TFR) of 1.85 by 2005. Under these conditions, the ratio of old to young will double in both countries. However, an alternative assumption could be that the fertility level existing in 2000 persists unchanged. Under that scenario, Italy (where the TFR in 2000 was only 1.28) would have 410 people over age 65 for every 100 children. Needless to say, a condition such as that previously sketched is so unprecedented in world history that it is difficult to imagine such a society. Of the three countries, the United States is exceptional because of its relatively high fertility and

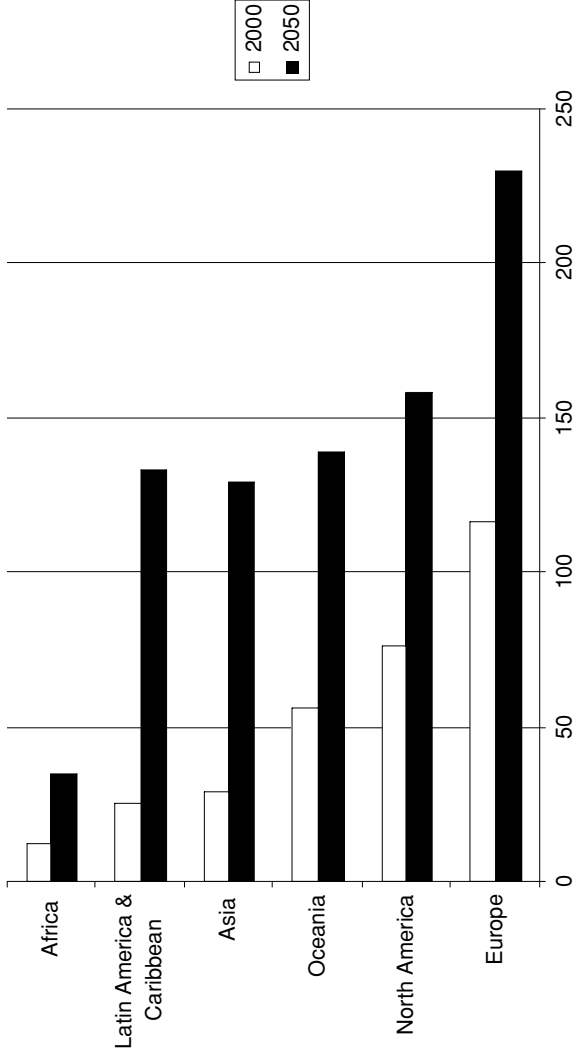


FIGURE 15.1 Number of persons 60+ per hundred children under 15, 2000 and 2050. (Source: UN 2005 World Population Prospects: The 2004 revision. Population division of the Department of Economic and Social Affairs of the United Nations Secretariat. Retrieved October 3, 2006, from <http://esa.un.org/unpp/>.)

TABLE 15.2 Total Fertility Rate and Life Expectancy in the United States, Norway and Italy: 1950–2050

	1950	2000	2050 ^a	2050 ^b
U.S.				
TFR	3.45	2.04	1.85	2.04
Life expectancy	68.90	77.30	82.40	82.40
Norway				
TFR	2.60	1.79	1.85	1.79
Life expectancy	72.70	79.30	82.70	82.70
Italy				
TFR	2.32	1.28	1.85	1.28
Life expectancy	66.00	80.00	85.10	85.10

^aUN projection assuming TFR = 1.85 in 2050.

^bUN projection assuming TFR is same in 2050 as in 2000.

Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2004 Revision and World Urbanization Prospects: The 2003 Revision*. Retrieved February 9, 2006, from <http://esa.un.org/unpp>.

low expectation of life (Table 15.2). Consequently, population aging has progressed more slowly in this country than in Europe. By 2050, the ratio of old to young in the United States will be less than it is in today's Italy.

The alternative assumption about the future of fertility (that the current level persists) produces even less aging in the United States than the standard assumption (because the current TFR exceeds the level of 1.85 assumed for 2050). Comparing these three countries shows how sensitive the balance in size of different age groups is to mortality and, especially, fertility levels in a population. Also, it is worth noting that despite the great attention given to population aging in the United States, this society will have a significantly younger population over coming decades than most other developed countries.

THE CHANGING INTERGENERATIONAL COMPLEXION OF FAMILIES

Altered patterns of mortality and fertility have made intergenerational structures in the family less "bottom heavy," more symmetrical and vertically extended. Although horizontal, intragenerational ties (to siblings, cousins) are shrinking, vertical ties along generational lines are more complex and durable than ever before in history. The most dramatic

TABLE 15.3 Percent Distribution of Persons Aged 10 Years and 30 Years by Number of Living Grandparents, Under Mortality Conditions Existing in Selected Years: 1900–2020 in the United States

Year	Number of Grandparents at Age 10				Number of Grandparents at Age 30			
	0	1	2–3	4	0	1	2–3	4
1900	6	25	63	6	79	20	1	0
1920	4	19	67	10	75	23	2	0
1940	2	13	71	14	67	28	5	0
1960	1	7	69	23	49	40	11	0
1980	0	4	65	31	32	45	23	0
2000	0	2	57	41	25	44	31	0
2020	0	1	51	48	18	41	40	1

Source: Calculated from “Mortality Decline in the Twentieth Century and Supply of Kin Over the Life Course,” by P. Uhlenberg, 1996, *The Gerontologist*, 36, pp. 681–685.

changes in the availability of vertical ties have occurred among the young. This illustrates the potential asymmetry of intergenerational structures. Families often look different from “the top” than they do from “the bottom” (Hagestad, 2001), and it is always important to be clear on where we anchor our structural descriptions—whose families are we discussing? Individuals who survived to old age in the past typically had children and grandchildren, but under past conditions of high mortality, many children had no surviving grandparents. Further, a relatively high proportion of children born a century ago also lost parents before reaching adulthood (Uhlenberg, 1996). We return to the challenge of asymmetry later.

Availability of Vertical Connections: The Case of Grandparents

Declining adult mortality produced dramatic historical changes in the supply of grandparents. The average number of living grandparents in the United States increased a great deal after 1900, as shown in Table 15.3. For example, the proportion of 10-year-olds with all four grandparents alive increased seven-fold between 1900 and 2000, from 6% to 41%, and by 2020, it is expected that about half of all 10-year-old children will still have all of their biological grandparents alive. In a current study of grandparent–grandchild relations in Norway, Hagestad finds a remarkably similar figure: Forty percent of children aged 10 to 12 have all four grandparents. Even more impressive is the increase in living

grandparents for young adults. An analysis of historical life tables for the United States suggests that about half of those reaching age 20 around 1900 had a grandmother still living. By 2000, over 90% of those reaching adulthood had at least one living grandmother (Uhlenberg, 1996).

Using data from the National Survey of Families and Households (NSFH) in the early 1990s, Szinovacz (1998) estimated that as youth entered early adulthood (ages 19–22) in the United States, almost 90% still had at least one surviving grandparent, and 70% had two or more. A recent British study produced similar figures: 80% of 20-year-olds had at least one grandparent living (Grundy, Murphy, & Shelton, 1999). And the change over the 20th century in the number of adult years lived with a cosurviving grandparent was even more impressive. The proportion of U.S. 30-year-olds with a grandparent alive more than tripled between 1900 and 2000—from 21% to 75%. By 2020, we can expect over 80% of those reaching age 30 to still have a grandparent, and half of these will have at least two grandparents.

Data from the Old Age and Autonomy: The Role of Service Systems and Intergenerational Family Solidarity (OASIS) study, which includes urban samples from England, Germany, Israel, Norway, and Spain, found that about one-third of European individuals aged 30 to 40 had grandparents living. Among persons in their 40s, however, the figure had dropped to under 10%. Recent data from the Norwegian Study of Life Course, Ageing and Generations (NorLAG) shows 10% of Norwegians aged 40 to 44 to still occupy the role of grandchild. The oldest grandchild in this study was a woman of 55.

Joint Survival—Durable Ties

Co-longevity has greatly increased the duration of family ties. As we have seen, the grandparent–grandchild bond may continue for 3 or 4 decades. Parent–child ties commonly last 6 or 7 decades. Table 15.4 presents data from a current survey conducted in 10 European nations: Survey of Health, Ageing and Retirement in Europe (SHARE). In 7 of the 10 countries, a majority of respondents aged 50 to 59 had at least one parent living. In the other three countries (the Netherlands, Austria, and Italy), the figure is only slightly under 50%. France tops the list, with 62% of respondents in their 50s still occupying the role of child. Similar figures emerge from NSFH data in the United States. Based on data from 1988, Soldo and Hill (1993) report that 52% of the population aged 53 to 61 had at least one surviving parent. Using the same data set but a different technique, Bumpass and Sweet (1991) reach a similar

TABLE 15.4 Proportion With at Least One Living Parent, by Country and Age Group, 2004^a

	50–59	60–69	70+
Austria	48	15	4
Denmark	57	16	1
France	62	23	7
Germany	55	14	4
Greece	56	19	4
Italy	49	16	9
Netherlands	47	14	2
Spain	55	16	5
Sweden	59	16	1
Switzerland	54	19	4
Total Europe	54	16	4
U.S.	60	27	NA

^aU.S. data are for 2002.

Source: “Health, Ageing and Retirement in Europe. First Results from the Survey of Health, Ageing and Retirement in Europe,” by A. Börsch-Supan et al. (Eds.), 2005, Mannheim: MEA, pp. 221–222; and GSS, 2002.

conclusion when they report that half of those reaching age 55 have a living parent. The same authors find that relatively few individuals were orphaned before midlife—85% still had living parents when they reached age 45.

More recent data from the General Social Survey (GSS) suggest that having a parent alive after one reaches midlife is increasingly common in the United States: 60% of respondents in their 50s in 2002 reported having a living parent. The figures are quite convergent with recent registry data from the NorLAG study in Norway. As can be inferred from Table 15.5, about 86% of respondents aged 40 to 49 had at least one parent living. Even when in their 60s, a substantial number (almost 20%) of Norwegians have a parent who is living. Among GSS respondents in their 60s in 2002, 27% still had parents. In the SHARE study, France is again on top among European countries with 23%, but Greece, Sweden, and Switzerland have nearly one in five of their adults in their 60s who are still children. Very similar results were found in the NorLAG study, where 19% of respondents aged 60 to 69 still had parents (Table 15.5). After the age of 70, the proportion who is still “children” typically drops to under 5% in European countries. But in Italy and France,

TABLE 15.5 Kin Structures in Different Age Groups of Norwegian Men and Women (Percent)

	40–49		50–59		60–69		70–79	
	Men	Women	Men	Women	Men	Women	Men	Women
No vertical ties	4	2	8	3	11	9	16	18
Parents only	17	14	9	7	3	2	–	1
Children only	10	9	21	15	12	7	7	5
Children, parents	63	60	26	21	2	3	–	–
Children, grandchildren	2	2	19	26	59	66	75	75
Children, parents, grandchildren	5	13	18	28	14	14	2	2

Source: NorLAG. Norwegian Social Research, <http://www.nova.no/subnet/lag/index.htm>

where 9% and 7% respectively of the 70+ population have living parents, the existence of very old children is not so rare. NorLAG also shows that in Norway, 8% or 9% of individuals in their 70s have living parents.

Because census takers around the world have tended to equate “family” and “household,” we have limited data on parent–child connections in the second half of life. However, the similarities we find in patterns across national surveys are striking and reassuring. We can with considerable confidence state that in most aging societies, 8 out of 10 individuals in their 40s have parents living; for those in their 50s, the proportion is about 1 in 2; and for those in their 60s, it is about 1 in 5 or 6. Clearly, such numbers suggest that multigenerational families are quite common, because the transition to grandparenthood typically occurs to people in their 40s and 50s.

The Emergence of Multigenerational Structures

A growing number of individuals will spend some time in lineages with four or more generations. Decades of life vary in their intergenerational complexity. There is also within- and across-societal variability in multigenerational structures. The SHARE study showed that 40% to 50% of respondents over age 80 in most of the Continental and Northern European countries are living in four generational kin groups. In Austria, Switzerland, and the Mediterranean countries, however, the figures drop to 20% to 30% (Kohli, Künemund, & Lüdicke, 2005).

The greatest variability in intergenerational structures occurs among respondents in their 50s. This is a period of the life course in which new generations often are added and old ones lost. OASIS found that nearly one in five urban Norwegian grandparents aged 50 to 59 had their own parents living. This constellation was the least common in Spain (7%). Soldo and Hill (1993) estimate that among NSFH respondents, 27% of those aged 53 to 61 were in lineages with four or more generations. Because they become parents earlier, women are more likely to find themselves in such structures. In the NorLAG sample, 28% of grandmothers in their 50s had living parents. This study found that among women in this age group, roughly one-fourth was in each of three constellations: (1) with children, parents, and grandchildren; (2) with children and grandchildren; and (3) with children and parents (Table 15.5). This table also reveals, however, that a substantial number of people have no direct intergenerational links—up or down. We return to such individuals later in our discussion. In SHARE, 25% of respondents aged 50 to 60 in Sweden, Denmark, France, and Austria were in four-generational structures (Kohli et al., 2005). Four-generational lineages are less common in the Netherlands, where only 13% of those in their 50s were found in this category. A similar finding emerges from a current large-scale survey of Dutch kinship patterns, NKPS (Dykstra & Komter, 2004), which reports that 12% of respondents in their 50s are part of four-generation structures. The low prevalence of four-generation units in the Netherlands is primarily due to late transition into parenthood (Knipscheer, Dystra, Utasi, & Cxeh-Szombathy, 2000). Overall, there is good evidence that in many aging societies, one out of four individuals in their 50s is in four-generational structures. The figure for individuals over the age of 80 is much higher, frequently reaching 40%.

Janus Generations: How Common Are “Squeezes”?

The nexus of intergenerational webs is the parent–child tie, both in individuals’ sense of responsibility and obligation and in the actual flow of help (Rossi & Rossi, 1990). As we have seen, over several decades of adulthood, individuals tend to occupy *Janus generations*: positions in which they are simultaneously parents and children. Individuals in an *Omega* generation have no generations above them; those in the *Alpha* position have no generations below them (Hagestad, 1984). Discussions of Janus generations have tended to have a negative tone, emphasizing stresses and strain. Headlines about “sandwich generations,” “women in the middle,” and “generational squeezes” abound (Soldo, 1996). As

Soldo points out, there are even Web sites devoted to the topic (e.g., www.empub.com/sandwichgen.shtml). Often, one senses an underlying assumption of a zero-sum phenomenon: What is given to one generation is taken from another. However, empirical research challenges the sensational “squeeze stories” on two counts. First, data suggest that cases of coinciding responsibilities of caring for parents and young children are relatively rare. Second, we have little evidence that intergenerational support is a zero-sum phenomenon.

In an overview of 12 European Union countries, Dykstra (1997) found that overall, only 4% of men and 10% of women had overlapping responsibilities for young children and old parents who required care. Similar findings have been reported from Canada (Rosenthal, Matthews, & Marshall, 1989). Typically, by the time parents need help, children are not in need of care. A British study (Agree, Bissett, & Rendall, 2003) found that among women aged 50 to 54 (the peak age for providing care to frail parents), only 2% of those who cared for a parent still had a child under 18 living in the household. In the United States, Spillman and Pezzin (2000) report that 5.2% of all women with children under age 15 had a disabled elderly spouse or parent. However, among individuals in this situation, fewer than 20% were actually providing care for the disabled person. In other words, less than 1% of all women with young children were actual caregivers for disabled older people. If competing needs arise, it is more likely to be between grandchildren and parents. And yet, a symposium at a recent gerontology meeting also questioned such a view. The participants showed remarkable convergence in findings from four countries (the Netherlands, Norway, United Kingdom, and United States): When individuals are faced with both younger and older generations, they give to both! There is little indication of a zero-sum phenomenon. In one of the papers presented, Grundy and Henretta (2004) reported that Janus generation individuals both in the United Kingdom and the United States give up and down—to parents and to adult children. They concluded that some families are “high exchangers” across several intergenerational links. In such families, those who provide help “up” also give “down.” A second chapter (Hagestad & Oppelaar, 2004) reported that grandparents with their own parents living provide the same amount or more help to children and grandchildren, compared with grandparents in three-generation structures. However, after further analyses of their data, Grundy and Henretta (2006) introduce an important caveat: the relative size of generations. They found that among Janus generation members with three or more children, there was a reduced likelihood of providing help to parents. Their analysis points to the importance of examining the degree of symmetry between

generations. In earlier work in the United Kingdom and the United States (Henretta, Grundy, & Harris, 2001), they have shown that socioeconomic status is a key factor here: Vertically extended, “top-heavy” lineages are typical in middle class settings, whereas relatively truncated, “bottom-heavy” structures are more common in working-class families.

In many societies, divorce and family reconstitution introduce added variability in intergenerational structures, especially among men. For example, men may have children and grandchildren who are the same age. It is beyond the scope of this chapter to address such family diversity. Within a comparative perspective, it becomes a daunting task to cover societies with starkly different divorce patterns.

Increased Symmetry and Intensity? The Case of Grandparent–Grandchild Relations

Several authors have discussed how altered fertility patterns have created increasingly symmetrical families, with about equal numbers of children and parents, grandchildren, and grandparents. This is in sharp contrast to “bottom-heavy” units of the past. Such discussions start from the premise that parental and grandparental time, attention, and material resources are finite entities and suggest that with increasing symmetry of children and adults in family units, children receive more attention and ties are intensified (e.g., Blake, 1989; Zajonc, 1976). Children living in the 1950s were in baby boom families and had many more siblings than did children living after 1980. For example, about 60% of U.S. children born in the late 1950s grew up with three or more siblings in their families, compared with less than 30% of the children born after 1980. Consequently, children born in the late 20th century have an increasing number of grandparents (because of declining mortality), and their grandparents have fewer grandchildren to focus on (because of declining fertility). Harper (2005) reminds us that demographic shifts have increased the number of generations but decreased the absolute number of relatives. She suggests that as a consequence, given intergenerational connections, such as the grandparent–grandchild tie, may become more socially prominent and personally significant.

Historical statistics that provide direct information on the distribution of people over the age of 60 by number of grandchildren do not exist. However, it is possible to estimate an equally meaningful statistic—the number of *sets* of grandchildren that older people had in the past. The number of grandchild sets for an individual is simply the number

TABLE 15.6 Percent Distribution of U.S. Women Aged 60–64 by Number of Grandchild Sets, 1950–2020

Year	Number of Grandchild Sets				
	0	1	2	3	4+
1950	27	20	17	12	24
1960	25	24	19	12	20
1970	27	26	21	11	15
1980	19	24	25	15	17
1990	14	19	25	18	24
2000	13	21	28	20	18
2010	20	28	31	14	7
2020	22	29	30	13	6

Source: Uhlenberg, P. (2005). Historical forces shaping grandparent-grandchild relationships: Demography and beyond. In M. Silverstein (Ed.), *Intergenerational relations across time and place. Annual Review of Gerontology and Geriatrics*, 24, 77–97.

of his or her children who have had children. For example, if a woman aged 60 has four children and three of them have become parents, she has three sets of grandchildren. Uhlenberg (2005) estimates the number of grandchild sets for U.S. women aged 60 to 64 in birth cohorts of 1886–1890 through 1956–1960. The results, shown in Table 15.6, demonstrate how fertility changes have differentiated the grandparent experience of successive cohorts entering old age. Among women aged 60 to 64, the proportion with four or more sets of grandchildren declined between 1950 and 1970, and the proportion with only one or two sets increased. But this downward trend in the number of sets of grandchildren competing for a grandparent’s attention was reversed after 1980, when the parents of the baby boom were becoming the new grandparents. Although baby boomers generally had small families, their parents typically had multiple sets of grandchildren. About 40% of the women aged 60 to 64 between 1990 and 2000 had three or more sets of grandchildren, and only 20% had a single set. So an interesting contrast between grandmothers and mothers occurred in the late 20th century and early 21st century. At a time when motherhood was no longer a full-time occupation for most young women, a large proportion of women approaching old age had multiple sets of grandchildren to attend to. Looking ahead a few decades, however, we can anticipate that the

proportion of grandparents approaching old age with more than two sets of grandchildren will decline to a historic low of only 20%. Other things being equal, baby boomers will have fewer sets of grandchildren than members of preceding cohorts, and thus may have more intense relationships with their grandchildren. Even if they invest less total time in the grandparent role, they can invest more in the grandchildren they have.

Using the same data, Uhlenberg switches anchoring and focuses on the grandchildren. He estimates that the proportion of young children who had four or more sets of cousins competing for the attention of a particular grandparent declined by half between 1950 and 2000 (from 48% to 24%). This downward trend accelerates after 2000, as children will increasingly have baby boomer grandparents who typically had few children. By 2010, only 10% of children will have as many as four sets of cousins competing for a particular grandparent. Not surprisingly, the proportion of children with little or no competition for grandparents' attention follows the opposite trend. Around 1950, about 24% of the young children had zero or one set of cousins linked to a particular grandparent; by 2020 this will be the experience of a clear majority (57%).

We have given a number of examples of how altered fertility and mortality patterns over the last century have dramatically altered the structure of intergenerational connections in the family realm. Young people have a more varied and stable gallery of kin; the balance between old and young has become more symmetrical, and what Moody (1988) has labeled "a new abundance of life" has given intergenerational ties an unprecedented duration. In sum, conditions have become more favorable for a broad spectrum of durable ties that span a wide range of ages and cohort locations. Over the same century, however, the societal structuring of age may have made cross-age relations *outside the family realm* more tenuous and problematic.

SOCIAL CHANGE AND CROSS-AGE CONNECTIONS: INCREASING SEGREGATION?

Authors who discuss the emergence of the modern life course during the 20th century (Kohli, 1986; Mayer & Müller, 1986) point out that a necessary condition for its development was reduced mortality. Only when it became expected that an individual would survive well into adulthood did it make sense to organize "normal, expectable lives." In addition to demographic change, the establishment of nation-states emphasizing

the individual as bearer of rights and obligations, as well as the development of the modern market and the emergence of formal organizations emphasizing qualifications, gave new impetus to chronological age (Chudacoff, 1989). The organization of the life course, in which rights, duties, and typical activities are tied to individual life stage or chronological age, divides life into three main parts—a tripartite life (Cain, 1964; Kohli, 1986). The first third is devoted to preparation, that is, education; the second to family building and work; the third, to retirement and leisure. Recently, we have argued (Hagestad & Uhlenberg, 2005) that this segmentation of individual life trajectories leads to multifaceted separation of persons who are in different phases of life. Thus, the organization of the modern life course tends to encourage age segregation. This segregation might be most pronounced in those welfare states in which the care of the very young and the very old has become a public responsibility. The segregation by age takes three forms: institutional, spatial, and cultural.

Institutional age segregation occurs when the principles and norms that define a social institution include chronological age as an eligibility criterion for participation, for example, in basic education. Age is also embedded in the way that social welfare policies and programs are formulated and implemented. Concerns related to the old typically fall under different government programs and offices than do matters related to children and youth. Furthermore, age segregation is reflected in research traditions. For example, very few social and behavioral scientists attend professional meetings both on child development *and* meetings devoted to aging. Indeed, researchers may need considerable help becoming aware of possible common ground in studying childhood and old age (Settersten, 2005). Research on the connections between state and family has emerged within two quite separate research communities—one focusing on families with young children and the other focusing on older persons and their children who are potential caregivers.

Policy discussions reflect a similar demarcation. It is interesting to note that “Family Policy” usually refers to policies affecting families with young children. A recent overview examining developments in family policy since the United Nations Economic Commission for Europe 1993 European population conference and the 1994 Cairo International Conference on Population and Development Programme of Action (Gauthier, 2005) hardly mentions old people. Much of the discussion in this report is carried out under the heading of “work–family interface.” In contrast, work on adult generations is carried out under the headings of “Aging Policies” or “Long-term Care Policies,” even though we know

that in many societies, most grandparents of young grandchildren are active in the labor market. For example, SHARE reports that whereas only 10% of Italian and Greek grandmothers are gainfully employed, the corresponding figure in Scandinavia is over 50% (Attias-Donfut, Ogg, & Wolff, 2005).

In much of the deliberation surrounding the U.N. World Plan of Action for aging, children and young people have been totally left out. This state of affairs is unfortunate because it neglects the fact that in today's aging societies, adults typically spend decades when they are both parents and children, as we saw earlier. The middle generation who relates "up" to old parents, relates "down" as parents (and often as grandparents also). Thus, research and policy tend to "chop up" long, interconnected intergenerational chains.

The central place of age in social institutions and organizations also fosters spatial and cultural separation. Spatial segregation by age occurs when individuals of different ages do not occupy the same space and hence cannot engage in face-to-face interaction. An extreme version of spatial age segregation occurs in intentionally age-homogenous housing, such as college dormitories, nursing homes, assisted living facilities, and retirement communities. Several publications use strong spatial metaphors to describe divisions based on age. At least three books discuss old age in the United States as *a separate country* (Hendricks, 1980; Pipher, 1999; Smith, 1995). Depictions of distinct territories have also been used in descriptions of youth. In the 1960s, Coleman (1961) portrayed *the adolescent society*, whereas Lofland (1968), who discussed U.S. college campuses, spoke of the *youth ghetto*.

Institutional and spatial separation by age is reflected and reproduced in cultural contrasts. A central factor in such differences is language, which draws us/them distinctions between age categories and marks differences in lifestyles. Mass media and marketing have strong economic incentives for reinforcing such distinctions. Of course, many cultural contrasts reflect the fact that when we separate by age, we also separate by cohort, that is, individuals anchored in distinct historical periods.

We have argued (Hagestad & Uhlenberg, 2005) that institutional, spatial, and cultural segregation lead to ageism and a cycle of reproduction, a segregation-ageism cycle. The key to this cycle lies in the age structure of social networks. Institutional and spatial age segregation restricts the age range in the pool of persons from whom network members can be recruited. Because of cultural age segregation, people occupying very different age categories are viewed as having qualities that make them "not like us" and hence unattractive for potential relationships.

The Age Structure of Networks

Networks play a key role in integrating individuals of any age into the larger society. Among network members, information, contacts, and support are shared, ways of thinking and seeing the world are fostered, and identities are shaped and sustained. Given the crucial importance of networks, their age composition deserves attention.

A recent review concludes that age consistently is found to create strong divisions (McPherson, Smith-Lovin, & Cook, 2001). In both his study of Detroit men (Fischer, 1977) and Northern California residents, Fischer (1982) reports striking age homogeneity in non-kin friendship networks. An analysis of discussion partner network data from the 1985 U.S. GSS showed that most non-kin partners were "similar" in age (Burt, 1991; Marsden, 1988). Young adults in this survey reported that only 3% of their non-kin discussion partners were over age 53, and those over age 60 reported that only 6% of their non-kin discussion partners were under age 36. However, quite a different age pattern emerged when the discussion partners were kin (excluding spouses). In this case, about one-fourth of the discussion partners of young adults were over the age of 53, and about one-fourth of the older people's discussion partners were under age 36. As we discuss in the following section, family ties seem to provide a basis for age integration that is missing in other social contexts.

Using data collected from the Netherlands in 1992 (for a description of the survey, see Knipscheer, de Jong Gierveld, van Tilburg, & Dykstra, 1995; see also Uhlenberg & Gierveld, 2004) and the United States in 1985 (GSS), we are able to see how severe the deficit of younger non-kin network members is for older people. Table 15.7 shows the ratio of the mean number of non-kin adult network members below ages 35 and 45 reported by older adults to the mean that would be expected if age were an irrelevant criterion. A couple of interesting findings emerge from these data. First, each ratio of actual to expected number of younger network members is far below one. This shows that older people have a dramatic deficit of young adults who are not kin in their networks. For example, people aged 65 to 74 in both the United States and the Netherlands have only about one-tenth as many network members below age 35 as they would have if the age composition of their network resembled the age composition of the entire adult population. At older ages, the deficit of younger network members grows even larger. Second, there is a striking similarity in the results found in the United States and the Netherlands. In both countries, it is quite exceptional for older people to report that they have any important connection with younger adults who are not their children or grandchildren. In fact, in both

TABLE 15.7 Ratios of Actual to Expected Number of Non-Kin Network Members Under Selected Ages for Older Respondent in the Netherlands (NL) and United States (U.S.), by Age

Respondent's Age	Network Members Below Age			
	35		45	
	NL	US	NL	US
55–64	.18	.15	.38	.39
65–74	.10	.12	.21	.23
75+	.07	.03	.14	.14

Sources: The Netherlands Living Arrangements and Social Networks of Older Adults, 1992 ($n = 4,032$), and U.S. General Social Survey, Social Network Module, 1985 ($n = 1,395$).

countries, fewer than 10% of respondents over age 65 report having even *one* non-kin network member who was younger than 35, and in the United States, almost no respondent aged 75 and over reported having any.

ROUNDING UP

Recent demographic and social changes present a complex picture of relationships across age boundaries and generations. From a kinship perspective, long lives provide unprecedented potential for strong and durable intergenerational ties in the private realm of the family. Young people have access to more ascendant kin and have less “competition” from generation peers in building and maintaining such cross-age ties than ever before. Older family members find themselves in more symmetrical structures and have a smaller number of younger kin than in earlier times. In some ways, the symmetry may create stronger, more complex ties. Given the increasing concentration of deaths among older people, it is also less common for older adults to outlive children than was the case a century ago. In contrast to the family realm, however, institutional arrangements and public arenas have separated old and young more than ever before in European and North American societies.

We are now back to an opening theme: the intersection of micro- and macro-age structures. As we saw earlier, the family represents the *only* truly age integrated social institution in today's Western societies. Thus, for most people, the family is unique in providing core network

members who are not age and cohort peers. And yet, it is important to recognize the great inequality that exists across families with regard to economic, social, and cultural capital—factors that influence the quality of intergenerational ties. Furthermore, availability of kin in other generations, what we might call *demographic capital*, is not uniform for either the old or the young. Geographic mobility, psychosocial problems, lack of resources, and contrasts in family fertility and mortality patterns leave many individuals with no or few viable cross-generational ties.

We know that strong interpersonal ties across family generations contribute significantly to individual well-being. Much less is known about the significance of cross-age relationships outside the family. The important questions of what the determinants and consequences are of having significant non-kin cross-age relationships are among a host of unexplored issues related to age structures in aging societies. What are the consequences of having age-segregated versus age-integrated social networks for individual well-being? Who has the narrowest versus the broadest age spectrum of interpersonal ties outside the family? Do individuals with contrasting network composition differ with regard to embeddedness in social institutions and community contexts? What are the social contexts that foster age-heterogeneous bonds? What are possible relationships between intergenerational ties inside and outside the family realm? Several authors (Caspi, 1984; Uhlenberg, 2000) have argued that individuals with strong intergenerational family ties relate more easily to non-peers outside the family. However, we also need to ask if close non-kin ties across age-cohort lines increase empathy and flexibility in dealing with family members in other generations.

Research has generally neglected older persons with no direct vertical connections to younger kin. Indeed, many studies of “family support” start with a sample of older parents! We have limited knowledge of the childless old and we know even less about “non-grandparents.” The NorLAG study allows us to explore contrasts between grandparents and individuals who do not have grandchildren. Persons with no ties “down” are less likely to participate in volunteer work. (This trend holds for both men and women aged 60 to 79, but is significant only for men in their 60s.) Similarly, grandparents were found to be more supportive of funding for daycare than were non-grandparents. Thus, it seems likely that ties to children and grandchildren increase what some authors recently have called *societal generativity*: “the adult’s concern for and commitment to the next generation” (de St. Aubin, McAdams, & Kim, 2004, p. 4).

Two decades ago, Eggebeen and Uhlenberg (1985) expressed concern over a historical decrease in men’s involvement with children, suggesting that this trend will reduce men’s investment in local

communities. More recent demographic trends and new work on generativity seem to indicate that this issue needs to be put on research and policy agendas. Based on a study of men over 4 decades, Snarey (1993) concludes that societal generativity is more difficult without the experience of parenting. A more recent study (McKeering & Pakenham, 2000) found that parental generativity (time invested in care activities and psychological involvement in parenting) is more strongly related to societal generativity for men than for women. A relatively large number of middle-aged adults were childless in the early 20th century. But the growing number of childless men in recent cohorts moving through the adult stages of life is different in two important ways. First, these recent cohorts of childless men have grown up in a much more age-segregated society. Second, these men have fewer nieces and nephews to provide age-integrated relationships in kin groups. In a number of Western countries, more than a fourth of men who are now in early middle age, that is, who were born in the 1960s, are childless. In Norway, the figure is 26% among men currently in their early 40s. If we in addition consider the proportion that have infrequent or no contact with their children because of divorce and fertility outside stable partnerships, the figure increases significantly. There may be good reason to be concerned about the future old age of these men, both in terms of their potential network support and wider community integration.

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The Future of Intergenerational Relationships—Variability and Vulnerabilities (Commentary)*

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Demographic and family structural changes since the mid-1900s will shape family relationships well into the 21st century. Hagestad and Uhlenberg (chapter 15, this volume) argue that these demographic changes promote age integration and closeness in intergenerational relations while at the same time enhancing age segregation in nonfamily social structures. Their rather rosy depiction of intergenerational relationships contrasts sharply with the more bleak picture of “dying” family bonds and of intergenerational conflict painted by other scholars (Kornhaber, 1996; Williamson, Watts-Roy, & Kingson, 1999). While Hagestad and Uhlenberg’s chapter depicts historical trends in intergenerational relationships, this commentary addresses the questions of whether and to what extent future intergenerational relationships will benefit from recent and continuing demographic and family structural changes. Focusing on intergenerational relations in the United States, I will first explore demographic changes other than those

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noted by Hagestad and Uhlenberg that influence intergenerational relationships, most importantly, trends in divorce and the timing of parenthood. Second, I will address heterogeneity in demographic changes among subpopulations and resulting variability in the future of intergenerational relationships. Third, I will discuss the potential vulnerabilities in intergenerational supports, especially care for the elderly and grandparents' access to and care for grandchildren.

CHANGING FAMILY STRUCTURES

Hagestad and Uhlenberg base their assessment of age integration in intergenerational relationships exclusively on trends in mortality and fertility. Although the potential for age integration in kin relationships may be primarily a function of mortality and fertility, future intergenerational relationships will also be influenced by other demographic changes that may counteract the presumed positive effects of increased longevity and declining fertility on intergenerational bonds and personal well-being. These trends include the rise in divorce during the later decades of the 20th century and delays in the timing of parenthood.

Divorce

Although divorce rates have stabilized since the 1990s, a considerable proportion of marriages can be expected to end in divorce well into the 21st century (Kreider, 2005; Norton & Miller, 1992). In 2001, only just over one-half of White men and women and fewer than one-half of Black men and women aged 40 to 59 were in intact marriages or widowed from their marriages. However, the proportion in intact marriages (those who are married or widowed but never divorced) is higher among Hispanics and especially Asians (Table 16.1). Note that due to late-life divorces, the proportion of intact marriages for the younger birth cohorts is likely to decrease further as they reach old age. It is only among the much earlier birth cohorts (those aged 70 and over) that a substantial majority of individuals of all races and ethnic groups married and never divorced.

Although the data shown in Table 16.1 clearly reveal a rise in divorce rates, we do not find a similar trend for remarriages. This discrepancy occurs because not all divorcees remarry and remarriages can follow widowhood rather than divorce. However, the proportion of remarriages that occur after divorce rather than after widowhood (not shown) is likely to increase among the more divorce-prone birth cohorts. This is important

TABLE 16.1 Marital History of Middle-Aged and Older Individuals—2001, by Race and Ethnicity

		40–49	50–59	60–69	70+
		Years (%)	Years (%)	Years (%)	Years
White men	Intact marriage(s)	55.1	51.5	64.7	78.4
	Never married	12.8	5.7	4.0	3.5
	Ever divorced	32.1	42.8	31.3	18.1
	Married once	64.5	60.8	67.3	75.1
	Ever remarried	22.7	33.5	28.8	21.4
White women	Intact marriage(s)	53.1	54.6	68.0	79.7
	Never married	8.1	5.0	2.9	2.9
	Ever divorced	38.8	40.4	29.1	17.4
	Married once	64.1	63.8	72.8	78.1
	Ever remarried	27.8	31.2	24.4	19.1
Black men	Intact marriage(s)	46.8	48.2	54.7	70.0
	Never married	25.1	11.6	10.2	3.1
	Ever divorced	28.1	40.2	35.1	26.9
	Married once	57.5	62.0	60.8	72.3
	Ever remarried	17.4	26.4	28.9	24.7
Black women	Intact marriage(s)	41.7	47.4	59.3	69.5
	Never married	27.9	14.4	10.4	6.8
	Ever divorced	30.4	38.2	30.3	23.7
	Married once	56.0	66.1	67.5	72.4
	Ever remarried	16.2	19.5	22.1	20.9
Hispanic men	Intact marriage(s)	67.3	60.5	73.6	79.9
	Never married	14.3	5.8	2.8	1.3
	Ever divorced	18.4	33.7	23.6	18.8
	Married once	72.2	70.8	75.1	83.0
	Ever remarried	13.5	23.4	22.2	15.6
Hispanic women	Intact marriage(s)	65.3	59.2	67.1	73.7
	Never married	8.6	10.4	8.8	6.1
	Ever divorced	26.1	30.4	24.1	20.2
	Married once	76.4	71.0	76.2	76.5
	Ever remarried	15.0	18.6	15.0	17.4
Asian men	Intact marriage(s)	76.6	81.1	83.6	87.3
	Never married	7.9	5.0	3.7	2.1
	Ever divorced	15.5	13.9	12.7	10.6
	Married once	80.5	84.2	81.8	83.9
	Ever remarried	11.6	10.9	14.5	14.0

TABLE 16.1 (Continued)

		40–49 Years (%)	50–59 Years (%)	60–69 Years (%)	70+ Years
Asian women	Intact marriage(s)	75.9	71.2	89.7	92.8
	Never married	8.0	7.9	0.4	2.3
	Ever divorced	16.1	20.9	9.9	4.9
	Married once	80.6	80.0	92.2	87.1
	Ever remarried	11.4	12.0	7.4	10.6

Note: Intact marriage refers to individuals who married and were never divorced; they may be currently married or widowed and may have remarried after widowhood. Percentages do not add to 100% because several categories overlap; specifically, “intact marriages” plus “never married” plus “ever divorced” add to 100%, and “never married,” “married once,” and “ever remarried” add to 100%. Selected percentages calculated by author.

Source: U.S. Census Bureau, Survey of Income and Program Participation (SIPP), *Detailed Table I—Marital History for People 15 Years Old and Over by Age, Sex, Race and Ethnicity: 2001*, 2001 Panel, Wave 2 Topical Module. Retrieved July 20, 2006, from <http://www.census.gov/population/www/socdemo/marr-div/p70-97-tab01.html>.

as step-child–step-parent relationships as well as relationships between children and their remarried biological parents may differ depending on whether the remarriage followed divorce or widowhood.

The continuing high divorce rates, especially in combination with declining fertility, will have important consequences for future intergenerational relationships. One of these consequences is that an increasing proportion of individuals will enter middle and old age with step-children and without biological daughters, and a noteworthy proportion of children will have experienced their parents’ divorce and remarriage. Because Census data pertain only to children of householders (i.e., they do not provide information on children who have left home), I estimated the composition of individuals’ children by gender and relationship using the Health and Retirement Study (Juster & Suzman, 1995). These data indicate that among White men and women the youngest birth cohorts (ages 49–53 in 1998) were slightly less likely to have daughters and much more likely to have step-children than Whites born between 1920 and 1944 (Table 16.2). Among Blacks, on the other hand, the proportion of daughters remains high (over 70%) for the younger birth cohorts, but younger Black birth cohorts (especially those born after 1945) also report more step-children than the older birth cohorts. Although there are still relatively few individuals who have exclusively step-children (under 6% for any racial/ethnic group), this proportion is likely to rise as the more divorce-prone and lower-fertility cohorts approach middle and old age.

TABLE 16.2 Distribution of Biological and Step-Children Among Respondents With Children by Gender, Race/Ethnicity, and Cohort

	Birth Cohort	No Children	Own Children			Own Daughters		Own Sons		Own Children & Step-Children		Own Sons & Step-Children		Own Daughters & Step-Children		Own Sons & Step-Children		Own Daughters & Step-Children		N
			Only	Both Sexes	Both	Only	Only	Only	Only	Only	Only	Only	Only	Only	Only	Only	Only	Only	Only	
Male	White	1910-1919	27.82	13.53	13.06	32.99	1.97	2.54	5.36	2.73	53.85	12.59	1,064							
		1920-1929	12.97	11.29	12.51	51.23	1.99	1.84	5.57	2.60	70.07	12.00	1,958							
		1930-1939	9.10	11.77	14.40	55.90	1.45	1.29	4.90	1.18	74.03	8.83	2,549							
		1940-1944	8.98	13.57	13.67	49.20	2.40	2.20	6.29	3.69	71.46	14.57	1,002							
		1945-1949	10.87	15.57	18.55	38.17	3.20	3.84	4.90	4.90	61.83	16.84	469							
Black	Black	1910-1919	31.71	7.93	9.15	32.32	3.66	2.44	7.32	5.49	51.22	18.90	164							
		1920-1929	17.36	13.64	4.96	47.52	4.13	2.48	5.79	4.13	71.07	16.53	242							
		1930-1939	10.94	10.73	13.30	51.07	2.15	1.93	8.37	1.50	72.32	13.95	466							
		1940-1944	13.41	9.50	15.08	48.60	3.91	2.79	5.59	1.12	67.60	13.41	179							
		1945-1949	10.61	15.15	9.09	39.39	7.58	4.55	10.61	3.03	72.73	25.76	66							
Female	White	1910-1919	24.58	16.76	14.40	35.69	1.43	1.68	4.10	1.37	57.98	8.57	1,611							
		1920-1929	12.72	14.14	14.57	48.53	1.64	1.81	5.04	1.55	69.35	10.04	2,320							
		1930-1939	7.08	11.84	13.57	52.64	2.15	2.96	8.17	1.59	74.81	14.87	2,838							
		1940-1944	7.30	13.30	14.75	45.05	3.11	3.54	10.27	2.68	71.73	19.60	1,383							
		1945-1949	6.71	13.90	15.90	36.16	6.48	4.95	10.48	5.42	67.02	27.33	849							
Black	Black	1910-1919	36.36	15.73	10.14	27.97	2.10	1.05	3.50	3.15	49.30	9.79	286							
		1920-1929	19.29	14.54	9.20	44.21	1.78	0.89	5.34	4.75	65.88	12.76	337							
		1930-1939	9.93	12.81	9.64	54.82	1.73	1.87	7.05	2.16	76.40	12.81	695							
		1940-1944	6.87	11.04	13.13	51.34	2.69	3.58	8.06	3.28	73.13	17.61	335							
		1945-1949	5.20	17.92	10.98	42.77	3.47	4.05	12.72	2.89	76.88	23.12	173							

Note: Based on the Health and Retirement Study (HRS), 1998. The data rely on the children file from 1998 and the RAND HRS data set from 2004 with corrections for inconsistencies in gender and relationship of the children; that is, if inconsistencies occurred, we assigned the gender or relationship that occurred most often over all waves. Own children are biological and adopted children. They may include adopted step-children if reported as adopted rather than step-child. No children refers to individuals who have neither own nor step-children. Individuals with missing reports on children ($N = 260$, 1.3%) are excluded. Data compiled by author.

Both the high divorce rate and the increase in step-families have ramifications for intergenerational relationships. Children of divorce have been shown to have fewer contacts and weaker emotional ties with mothers and especially fathers (Webster & Herzog, 1995; for a review, see also Ahrons & Tanner, 2003), and step-children feel less obligated to assist their step-parents than their biological parents (Ganong & Coleman, 1998, 2006). Similarly, step-fathers and nonfathers have fewer intergenerational relationships with their parents, adult children, and siblings than biological fathers (Eggebeen & Knoester, 2001). Divorce can also undermine grandparent–grandchild relationships. King (2003) reports, for example, that divorce in the grandparent generation negatively affects grandparent–grandchild relationships. As is the case for parental divorce, this negative effect seems more pronounced for grandfather–grandchild relationships as well as for relationships with paternal grandparents. Thus, although increased longevity provides the potential for enhanced intergenerational relationships, the concurrent trend toward high divorce rates is likely to undermine the quality of intergenerational relationships, especially with paternal ascendants.

Timing of Parenthood

The duration of intergenerational relationships, especially between grandparents and grandchildren, as well as the prevalence of four-generation families, depend not only on longevity but also on the timing of parenthood. In recent decades, parenthood has been delayed, especially among Whites. As shown in Table 16.3, the mean age of White non-Hispanic mothers at their first birth was 25.9 years in 2000, and their age at the third live-birth was 30 years. Across all race/ethnic groups, the average onset of parenthood rose from 21.4 years in 1970 to 24.9 years in 2000 (Table 16.3), and third live-births occurred at age 29 compared with age 26.6 in 1970. Furthermore, in 2004, nearly one-half of births to White non-Hispanic and over one-half of births to Asian mothers were to mothers aged 30 and over (Table 16.4). Particularly impressive is the rise in the proportion of mothers who gave birth to their first child after age 30 between 1990 and 2004 (from 20.71% to 29.72%). Second or higher-order births remained somewhat more stable, with close to one-half of mothers giving birth to their second or later child after age 30 (Table 16.4).

Although it is difficult to extrapolate the age of onset of grandparenthood from data on the timing of parenthood, these trends are at least suggestive about the future of grandparent–grandchild relations.

TABLE 16.3 Mean Age of Mothers at First and Third Live-Birth by Race/Ethnicity and for Selected Years

Year	First Live-Birth				Third Live-Birth			
	1970	1980	1990	2000	1970	1980	1990	2000
Total	21.4	22.7	24.2	24.9	26.6	27.3	28.3	29.2
White	21.7	23.0	24.6	25.2	27.0	27.7	28.8	29.5
Non-Hispanic White	na	na	25.0	25.9	na	na	29.1	30.0
Black	19.5	20.6	21.7	22.3	24.3	25.6	26.3	27.2
Non-Hispanic Black	na	na	21.7	22.3	na	na	26.3	27.1
Hispanic	na	na	22.4	22.7	na	na	27.4	28.1

Note: na = data not available.

Source: Centers for Disease Control and Prevention/National Center for Health Statistics, Table001x06, "Mean Age of Mother by Live-birth Order, According to Race and Hispanic Origin of Mother, United States, 1968–2000." Retrieved July 22, 2006, from <http://www.cdc.gov/nchs/data/statab/t001x06.pdf>.

They indicate, first, that the duration of grandparent–grandchild relationships and the survival of grandparents into grandchildren’s adulthood will vary considerably contingent on the birth-order of both mothers and children (the grandparents’ children and grandchildren). Although first-born grandchildren of first-born mothers may very well experience viable relationships with healthy grandparents into late adolescence and early adulthood, later-born grandchildren from later-born mothers are much less likely to share such long-term relationships. They will be more prone to experience the morbidity and mortality of grandparents in their adolescence and less likely to ever have great-grandparents. Furthermore, if the trend toward delayed parenthood continues over subsequent generations and does so mainly for specific racial/ethnic groups, we will see considerable variability in the duration and quality of grandparent–grandchild relationships in the future. Among many non-Hispanic Whites and Asians, the onset of grandparenthood will be delayed into the grandparent’s 60s and, in some cases, 70s, and the likelihood of great-grandparenthood will diminish drastically. Among Blacks and Hispanics, on the other hand, early parenthood (prior to age 25) continued to characterize close to one-half of births in 2004. Thus, the picture of long-lasting grandparent–grandchild relations and especially of four-generation families will be much more characteristic for these subpopulations.

Delayed parenthood over subsequent generations not only influences the duration of intergenerational relationships but also their quality. Some studies suggest that at least frequency of contacts between

TABLE 16.4 Distribution of Women Aged 15–44 Who Had a Child in the Last Year by Age of Mother, Race/Ethnicity, and Birth Order for Selected Years

June 2004		15–19	20–24	25–29	30–34	35–39	40–44	30–44
Age of Mother								
Total %		10.27	23.54	25.03	25.25	11.82	4.08	41.15
White, non-Hispanic %		7.99	20.06	25.69	28.33	13.67	4.26	46.26
Black alone %		17.86	27.18	24.27	16.31	11.07	3.30	30.68
Hispanic %		11.38	33.41	23.75	21.66	5.88	3.92	31.46
Asian %		7.83	14.78	25.65	29.57	16.52	5.65	51.74

Age of Mother	First Births				Second or Higher-Order Births			
	15–19	20–24	25–29	30–44	15–19	20–24	25–29	30–44
2004 %	14.99	29.38	25.92	29.72	7.22	19.75	24.46	48.57
2000 %	23.37	26.81	24.78	25.03	8.93	17.94	25.65	47.44
1995 %	17.43	34.07	24.32	24.18	4.21	20.94	26.76	48.09
1990 %	16.56	30.78	31.88	20.71	3.50	23.76	29.53	43.22

Sources: For June 2004: Dye, J. L., 2005, Fertility of American Women: June 2004, Current Population Reports, P20-555. Washington, DC: U.S. Bureau of the Census, Table 1, p. 2. Retrieved July 22, 2006, from <http://www.census.gov/prod/2005pubs/p20-555.pdf>. Percentages computed by author. Percentages may not add to 100% due to rounding. For 1990–2004 by birth order: U.S. Bureau of the Census, Current Population Survey Reports, “Table H6. Women 15 to 44 Years Old Who Had a Child in the Last Year and Their Percentage in the Labor Force by Selected Characteristics: Selected Years, 1990 to 2004.” Retrieved July 22, 2006, from <http://www.census.gov/population/www/socdemo/fertility.html#hist>. Percentages computed by author. Percentages may not add to 100% due to rounding.

grandparents and grandchildren decreases with age, although other dimensions of grandparent–grandchild relationships remain stable or even increase with age (Attias-Donfut & Segalen, 1998; Silverstein & Long, 1998; Silverstein & Marceno, 2001). Furthermore, in cases of delayed parenthood and delayed grandparenthood, many adolescent and young adult grandchildren will be faced with enhanced morbidity of their grandparents and thus experience grandparenthood in a very different way (e.g., as caregiver or caregiver helpers) than grandchildren with younger grandparents (Dellmann-Jenkins, Blankmeyer, & Pinkard, 2000).

Taken together these trends signify increased heterogeneity in future grandparent–grandchild relations and rising diversity in such relations among selected racial/ethnic subgroups. As will be shown in the next section, such variability applies to some extent also to the trends in fertility described by Hagestad and Uhlenberg.

VARIABILITY IN FERTILITY

Although there can be little doubt that fertility has been decreasing considerably during the past decades, it is also important to pinpoint variations in fertility among diverse U.S. subpopulations. First, the proportion of childless women (and not only men as emphasized by Hagestad and Uhlenberg) has increased during the past decades, from 10.2% in 1976 to 19.3% in 2004 (Dye, 2005). Childlessness prevails among Whites and Blacks (Table 16.5) as well as among women with college degrees (24% compared with 15% among women without a high school degree; Dye, 2005).

In addition, there are marked differences in fertility by race/ethnicity (Table 16.5) and socioeconomic status (Dye, 2005). Whites have the lowest fertility and Hispanics the highest. Indeed, among women who have children, 45% of Hispanics but only 33% of Whites had three or more children. Blacks are more likely than Whites to have either only one or three or more children. Similarly, fertility declines with educational achievement. In 2004, women aged 40 to 44 without a high school education had 2.48 children compared with only 1.56 children among women with graduate or professional degrees (Dye, 2005).

These data suggest considerable heterogeneity in fertility, both across and within subpopulations. This heterogeneity will then also be reflected in the availability of intergenerational bonds and can result in lack of informal supports in old age.

TABLE 16.5 Fertility of Women Aged 40–44, by Race/Ethnicity, 2004

	All Women (%)			Women With Children (%)			Mean Number of Children
	Number of Children			Number of Children			
	None	One	Two	One	Two	Three+	
All Races	19.3	17.4	34.5	28.9	21.6	42.8	35.8
White	20.0	16.9	36.8	26.4	21.1	46.0	33.0
Black	21.3	21.0	23.7	33.9	26.7	30.1	43.1
Hispanic	13.8	14.4	32.7	39.1	16.7	37.9	45.4
Asian	17.8	20.1	37.4	24.7	24.5	45.5	30.0

Source: U.S. Census Bureau, “Fertility of American Women, Current Population Survey—June 2004, Detailed Tables,” Tables 1 and 2. Retrieved July 22, 2006, from <http://www.census.gov/population/www/socdemo/fertility/cps2004.html>. Selected percentages computed by author. Percentages may not add to 100% due to rounding.

VULNERABILITIES

The demographic trends depicted by Hagestad and Uhlenberg provide opportunities for the intensification of intergenerational relationships. However, the same trends, as well as those described in the first section of this chapter, also can create significant vulnerabilities in intergenerational relationships and supports. These vulnerabilities apply especially to grandparent–grandchild relationships and to care for older parents.

Grandparent–Grandchild Relationships

Hagestad and Uhlenberg's positive assessment of future grandparent–grandchild relationships is based on the longer duration of these relations due to increased longevity as well as on lesser competition among grandchildren for grandparents' attention among lower-fertility cohorts. The latter factor applies foremost from the grandchildren's perspective. From the grandparents' perspective, on the other hand, reduced fertility means greater competition among grandparents for their grandchildren's attention. As the low-fertility birth cohorts become parents and eventually grandparents, each grandparent will have fewer grandchild sets (grandchildren from each of their children), and each grandchild set will contain fewer grandchildren. Importantly, fewer grandparents will have daughters (Table 16.2) and thus matrilineal ties to their grandchildren. Furthermore, increasing numbers of childless individuals in either the potential grandparent or the potential parent generation will lead to more middle-aged and older individuals without any grandchildren. For example, if the relatively high rate of childlessness among Blacks and Whites (>20%; Table 16.5) continues through two generations, of 100 grandparent-age individuals, 20 would have no grandchildren due to their own childlessness. Of the remaining 80 with children, 20% of the children would remain childless. Thus, more than one-quarter of grandparent-age individuals may spend their later years grandchildless. As noted earlier, grandparents' access to and relationship with grandchildren will be further negatively influenced by the rise in divorce rates. Thus, given the matrifocal character of intergenerational relationships in general and of grandparent–grandchild relationships in particular (Spitze & Ward, 1998), grandparents may very well be deprived of desired contacts with grandchildren if they themselves were divorced, if they had no daughters, or if their sons were divorced from the grandchildren's mothers. The cumulative impact of declining fertility, including childlessness, and the rise in divorce rates may very well be

that a substantial proportion of older individuals will lack meaningful relationships with young relatives.

Although some individuals will face middle and old age without meaningful relationships to grandchildren, others may be overwhelmed by too much responsibility for their grandchildren. The number of grandparent-maintained households increased considerably during the past decades (Casper & Bryson, 1998). In 2000, over 5.7 million grandparents co-resided with their grandchildren, and 42% of these grandparents were responsible for their grandchildren. These grandparents represented 3.6% of the population age 30 and over (Simmons & Dye, 2003). However, because many individuals aged 30 and over have not become grandparents and the data are cross-sectional, this percentage underrepresents the proportion of grandparents caring for grandchildren. Using data from the National Survey of Families and Households, Szinovacz (1998) estimates that 29.1% of Black grandmothers, 18.8% of Hispanic grandmothers, and 12.1% of White grandmothers ever had primary responsibility for a grandchild. Surrogate parenting by grandparents has been shown to influence grandparents' well-being, and it may also have long-lasting implications for relationships among grandparents, parents, and the grandchildren. Numerous studies have documented that surrogate grandparenting takes its toll on grandparents' physical and especially on their mental health (Minkler & Fuller-Thomson, 1999; Minkler, Fuller-Thomson, Miller, & Driver, 1997; Szinovacz, DeViney, & Atkinson, 1999). It also can be seen as an indicator of disrupted or at least problematic ties between the grandparent and parent generations on the one hand and the parent-(grand)child generations on the other hand. Although the long-term consequences of grandparents' assumption of parental roles are as yet unknown, it is likely that children raised by grandparents may feel less obligated to support their parents in late life than children raised by their parents. It also remains to be seen whether these grandchildren will feel more inclined to care for grandparents as they become frail or disabled.

Support of Older Parents

Perhaps the most problematic aspect of increased longevity, declining fertility, and high divorce rates is the impact of these demographic trends on the support networks of the elderly, especially as far as help by adult children is concerned. To assess this issue, it is essential to estimate the availability of adult children for care, adult children's lifetime risk of parent care, the extent to which siblings share or replace each other in

caregiving for their parents, and adult children's and especially adult child caregivers' other family commitments.

Several studies show that adult children play an important role in the support networks of the elderly. For example, updated data from the National Long-Term Care Survey (Wolff & Kasper, 2006) indicate that 41.3% of caregivers were children of the care recipient. As childlessness increases among future cohorts of elderly parents, many of them will have to rely exclusively on spouses and more distant relatives or friends for informal care. Care recipients' spouses may also be frail, and older women are bound to experience the death of their husbands and will then lack this source of support as well.

Declines in fertility will also reduce the ability of adult-child sibling networks to share care or to replace caregivers as needed. Our own analyses, based on respondents to the original Health and Retirement Study (individuals aged 51–61 in 1992 and their spouses) indicated that for parents who received care over two waves and had at least two adult children, some change in the composition of the adult-child caregiver network over a 2-year period occurred in about one half of cases, and in over one-quarter of cases, the primary caregiver changed during this period (Szinovacz & Davey, 2005). Among those where any change in adult-child caregivers occurred, close to two-thirds added a child to the network (either in addition to the previous caregivers or after dropping one or more of the previous caregivers). The probability of such changes was strongly influenced by the number of siblings and especially sisters. Thus, changes in fertility and, as mentioned earlier, the decline in the proportion of elderly with daughters are likely to reduce the viability of kin support networks among future elderly.

The same demographic trends leading to vulnerabilities in elders' support networks will also enhance the burden on adult-child caregivers. Cross-sectional data such as those noted by Hagestad and Uhlenberg and others (Rosenthal, Martin-Matthews, & Matthews, 1996) in regard to the preponderance of the sandwich generation can be quite misleading because they ignore lifetime risk of care responsibilities. Using data from the Health and Retirement Study (HRS), I estimated the prevalence of parent care responsibilities among the study respondents over five waves (1992–2000). The HRS is a longitudinal biannual survey of households (the primary respondent and his or her spouse were interviewed). The primary original sample for the HRS consists of main respondents aged 51 to 61 years at wave 1 and their spouses, regardless of the spouse's age ($N = 12,652$ respondents; 7,702 households). Selection of households was based on a multistage area probability design oversampled for minorities and residents of Florida. HRS respondents were asked whether

they (or their spouses) provided help with basic personal needs like dressing, eating, and bathing to parents during the past year (wave 1) or since the last survey (waves 2–5). They were also asked whether any of their siblings provided such care. Note that the care variable reflects only help with basic needs and thus probably underestimates overall parent care to some extent. In addition, the HRS contains household rosters that provide information about all household members, including their gender, relationship to the HRS respondent, age, and marital status. From these rosters, we created variables reflecting the presence of dependent children, grandchildren, and any dependents in the household. Dependent household members are those aged 18 or younger. These variables (for the five waves) and parent care data for all waves were then merged. It should be noted that a substantial proportion (53.4%) of HRS respondents had no living parents at wave 1. Because respondents without any living parents cannot be at risk of care, these respondents were eliminated from further analyses. The analyses thus rely on respondents with living parents at wave 1 ($N = 6,271$). It cannot be ascertained whether care responsibilities among adult children whose parents had already died at the beginning of the HRS would differ in any significant way from those who still had living parents at time 1. Comparisons of these two groups on major demographic characteristics indicated that respondents with living parents at time 1 are younger and from higher socioeconomic status groups (based on household income) than those without living parents. However, they do not differ significantly in the number of living brothers and sisters. Furthermore, the proportions of respondents providing care to parents in individual waves of the HRS (which are based on respondents whose parents were either still living or had died since the previous wave) are quite similar (Table 16.6). Nevertheless, parents dying at younger ages may require different care than those dying later in life. Thus, the generalizability of the data to all adult-child care situations cannot be assured.

As far as other commitments are concerned, a noteworthy minority of HRS respondents had responsibility for dependents. Slightly over 10% of all HRS respondents had dependent children, and a similar proportion had dependent grandchildren in the household. Overall, a quarter of HRS had any dependents in the household (Table 16.6). These proportions differ considerably by race/ethnicity and to some extent by gender. Specifically, only about one-fifth of non-Hispanic Whites reported any dependents in their households compared with over two-fifths of Black and Hispanic women.

As reported in previous studies and by Hagestad and Uhlenberg, only a small proportion of adult children had care responsibilities for

TABLE 16.6 Caregiving and Dependents in Household by Gender and Race/Ethnicity

	Male			Female			
	Total	White	Black	Hispanic	White	Black	Hispanic
All Respondents:							
Has living parent at time 1 %	46.60	43.70	40.64	42.26	52.03	47.00	48.62
Has dependent children in household any wave %	14.25	12.07	19.06	28.05	11.70	16.41	26.35
Has dependent grandchildren in household any wave %	12.96	7.35	21.03	22.95	9.48	30.82	27.07
Has any dependents in household any wave %	25.76	18.93	36.69	45.36	20.38	44.44	48.03
Respondents With Living Parent Wave 1:							
Cares for parent wave 1 %	6.93	5.24	4.58	5.60	7.91	10.05	8.98
Cares for parent wave 2 %	8.43	6.55	6.47	3.88	9.69	13.63	8.38
Cares for parent wave 3 %	9.13	5.54	7.01	3.88	11.59	13.97	10.78
Cares for parent wave 4 %	8.64	6.60	4.31	4.31	11.09	11.07	7.78
Cares for parent wave 5 %	7.25	5.04	4.04	3.02	9.23	10.05	7.19
Cares for parent any wave %	25.94	19.95	17.52	16.81	31.14	34.58	26.65
Cares for parent or parent-in-law any wave %	33.00	31.03	23.72	29.74	36.49	36.63	29.34
Respondent or his/her siblings (in-law) care for parent or parent-in-law any wave %	54.77	53.50	47.44	67.67	53.97	56.90	65.87
Cares for parent any wave & has dependent children %	2.31	1.71	2.16	2.16	2.48	3.07	4.19
Cares for parent any wave & has dependent grandchildren %	1.85	0.65	2.96	0.86	1.28	6.13	4.79
Cares for parent any wave & has any dependents %	4.11	2.32	4.85	3.02	3.68	10.05	7.78
Cares for parent or parent-in-law any wave & has dependent children %	3.32	2.97	2.96	4.74	3.49	3.24	4.79
Cares for parent or parent-in-law any wave & has dependent grandchildren %	2.31	1.26	3.77	2.16	1.51	6.81	5.09
Cares for parent or parent-in-law any wave & has any dependents %	5.56	4.08	6.74	6.47	4.92	11.07	8.68

Respondent or his/her siblings (in-law) care for parent or parent-in-law any wave & has dependent children %	7.00	5.94	5.66	18.10	5.78	5.79	17.66
Respondent or his/her siblings (in-law) care for parent or parent-in-law any wave & has dependent grandchildren %	4.75	2.17	6.74	12.93	2.71	12.44	13.77
Respondent or his/her siblings (in-law) care for parent or parent-in-law any wave & has any dependents %	11.30	7.81	11.86	26.29	8.34	19.25	27.84
Respondents With Dependent Children: a)							
Cares for parent any wave %	12.50	11.04	10.13	7.14	14.99	14.88	12.28
Cares for parent or parent-in-law any wave %	17.93	19.16	13.92	15.71	21.08	15.70	14.04
Respondent or his/her siblings (in-law) care for parent or parent-in-law any wave %	37.84	38.31	26.58	60.00	34.89	28.10	51.75
Respondents Who Care for Their Parents: b)							
Has dependent children in household any wave %	8.91	8.59	12.31	12.82	7.97	8.87	15.73
Has dependent grandchildren in household any wave %	10.05	9.58	12.50	15.94	9.56	8.84	16.33
Has any dependents in household any wave %	12.78	11.11	11.93	26.75	10.70	10.18	26.82

Notes: The caregiving question pertained to care for basic needs by the family respondent or his/her spouse. a) Reflects the proportion of respondents with dependent children in specific waves who also cared for a parent, accumulated across waves. b) Reflects the proportion of respondents who cared for a parent in specific waves and also had dependent children, grandchildren, or dependents, accumulated across waves.

Source: Data based on the Health and Retirement Study waves 1-5, original HRS waves, own computations.

parents in any particular wave (Table 16.6). However, this picture changes dramatically when care over all waves is considered. Over one-quarter of adult children reported care responsibilities, and this proportion increased to over one-third for Black women. Because spouses often assist in the care of their partners' parents, an even higher proportion of respondents (33%) had care responsibilities for either a parent or a parent-in-law. Even more impressive is the percentage of adult children who are potentially at risk for becoming caregivers. Considering care provided by respondents' siblings to their parents, we find that over one-half of respondents were at potential risk for becoming caregivers (i.e., if they were asked to replace the caregiving sibling). Among Hispanics, this percentage rises to close to two-thirds. This suggests that with declining fertility and thus fewer siblings to take on care responsibilities, middle-aged and young-old children will be at considerable risk for becoming caregivers for their parents in the future.

As far as parallel care responsibilities for parents and dependent children are concerned, we find that only a minority of HRS respondents with living parents had dual care responsibilities. However, this proportion is much higher (up to 19% of Black and 28% of Hispanic women) if potential of care (care by the respondent or his or her siblings or siblings-in-law) to parents or parents-in-law is considered as well. Although the proportion of adult children with dependent children in the household who are caregivers is relatively small (under 15% for any racial/ethnic subgroup), this proportion rises considerably if potential care is considered as well. Specifically, over one-third of White women and over one-half of Hispanic women with dependent children were either providing care themselves or were at risk to be caregivers (i.e., they or their siblings currently provided care).

Looking at current caregivers in any wave, we find that 9% had dependent children in the household, a proportion that is much smaller than the 18% of adult-child caregivers with co-residing dependent children under age 15 reported in National Long-Term Care Survey (Wolff & Kasper, 2006). This discrepancy probably arises due to the age composition of the HRS. About 10% of White women caregivers and over one-quarter of Hispanic female caregivers reported any dependents in the household (Table 16.6).

Taken together, these data suggest considerable vulnerability in future intergenerational relations. Grandparents may experience limited access to grandchildren or be overburdened by care responsibilities for grandchildren. Limited access is more likely among Whites, whereas Blacks and Hispanics are more prone to have care responsibilities for

grandchildren. Individuals in need of care will probably have more restricted care networks in the future, either lacking support by adult children altogether or having to rely on smaller adult-child sibling networks. As far as caregiving adult children are concerned, reduced availability of siblings is likely to increase their burden as chances of sharing care among siblings decline and delays of parenthood are likely to raise the risk of dual care responsibilities for parents and dependents in the household.

CONCLUSION

What does the future hold for intergenerational relationships? Demographic trends, as well as the genealogical data presented by Fry (chapter 17, this volume), can tell us to what extent family structures offer opportunities for or place restrictions on intergenerational relationships. They thus present the structural framework within which families form intergenerational bonds, but these bonds also reflect numerous other contextual, family, and individual factors, ranging from subcultural variations (e.g., by race/ethnicity or rural–urban residence) in filial obligations to past family experiences and exchanges or other concurrent commitments of each family member (Davey, Janke, & Savla, 2005). It is also important to remember that families can respond to structural opportunities and restrictions through behavioral and attitudinal changes as illustrated by the adaptive family structures in poor Black neighborhoods (Stack, 1974).

Current demographic trends point to considerable heterogeneity in opportunity structures for future intergenerational bonds. The timing of parenthood, divorce rates, and especially fertility differ not only by race/ethnicity, by socioeconomic status, and by place of residence (Dye, 2005; Kreider, 2005), but they also show considerable variation within population subgroups. Generalizations across population subgroups fail to reflect this diversity and may thus divert attention from subgroups with special needs. For example, very little attention has been paid to childless minorities as they approach old age. Similarly, despite the vast literature on caregiving for frail and cognitively impaired elders, we know very little about the effect of caregiving on caregivers' co-resident children (Orel & Dupuy, 2002; Orel, Ford, & Brock, 2004; Szinovacz, 2003). However, these and other as yet marginal subgroups are likely to expand in the future. Recognition of heterogeneity is thus essential to develop programs and policies that are responsive to emerging social and family problems.

Full understanding of future intergenerational bonds also requires diversity of perspectives. Family structures that may be advantageous from the perspective of children or grandchildren may be problematic from the perspective of the older generation. One case in point is the impact of fertility on grandparent–grandchild relationships. Although fewer grandchildren will compete for their grandparents' attention, grandparents will have to compete for access to and attention from their grandchildren. Similarly, children with fewer siblings may enjoy more individual attention from their parents as they grow up, but they may face a heavier caregiver burden to aging parents in midlife. This suggests that changing demographic trends may bring about shifts in family problems from one generation to another generation or from family members in one stage of the life cycle to family members in another stage. A multiple-perspective approach is necessary to attend to the special circumstances and needs of all generations.

Given these caveats, it is still important to reflect on the combined effects of the multiple demographic trends that impinge on future intergenerational relationships. There can be little doubt that increased longevity offers opportunities for long-term intergenerational bonds. However, the quality of these bonds may be marred by high divorce rates and delayed parenthood. The former will have the foremost influence on father–child bonds and relationships between grandchildren and their paternal grandparents. The latter is likely to alter adolescents' and adult grandchildren's relationships to grandparents due to grandparents' age and declining health. Declines in fertility will enhance the attention individual children can receive from parents or grandparents, but it will also deprive many children of meaningful sibling ties. The lack of such sibling ties may prove particularly problematic as parents (or grandparents) require care. From the perspective of the older generation, childlessness and fewer children or grandchildren are likely to undermine the viability of social support networks and require increased reliance on formal supports.

The opportunities and restrictions for intergenerational relationships created by changing demographics will necessitate adaptations from individuals, families, and society. Alliances between individuals and families who lack intergenerational bonds and those who are overburdened by intergenerational responsibilities may alleviate the burden of care for grandchildren or for the elderly and promote nonfamilial age integration and relationships. At the societal level, programs and policies will have to be devised that facilitate such alliances and offer formal supports when intergenerational and other informal bonds are insufficient.

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Demographic Transitions, Age, and Culture (Commentary)

Christine L. Fry

Demographic change is a fact of life that humans have faced since the origin of our species. In our remote past, demography was even a more powerful force than it is today since humans lived in tiny populations of less than 500 individuals. Small increases in fertility and longevity could dramatically increase and alter the composition of a population. Likewise, a seemingly insignificant drop in fertility and a rise in mortality could annihilate a people. We know nothing of the consequences of demographic change for the vast majority of human history simply because it was not recorded. These humans lived in small-scaled, kin-based societies that did not have writing.

The earliest demographic transition we have any knowledge of happened after the ice receded. Some 9,000 years ago, humans abandoned a nomadic lifestyle for one that was more sedentary and based in domestication. Food production required more work, with work organized around the life cycles of plants and animals. A cultural response called for an increase in labor through a rise in fertility (Adams, 1988). The global effects of this demographic change was slow in coming because mortality also remained high since the positive effects of sedentism on fertility were offset by problems of sanitation and deteriorating diets. Nevertheless, over the next several millennia, human populations increased in size, but remained young.

Far more is known about what happened to these societies. Not only did they grow larger, but also the relationships between humans were drastically altered. The egalitarianism of the foraging life way vanished

to be replaced by hierarchy and stratification. Work was no longer the intermittent quest for food followed by periods of leisure. Because of the delayed return between planting and harvest, work had to be planned and managed across an annual cycle. Important and usually older males became the managers of the risks of food production. A dominance hierarchy based on wealth and wealth generation instead of physical strength and agonistic behavior created surpluses to get by during the periods of scarcity. Big men became chiefs and then rulers, and as a society got larger, it became urban and politically centralized in a state.

The demographic change we recognize as *the* demographic transition is far better known since the societies in which it is happening keep records and vital statistics. Through the monitoring of census taken every decade, we track the size and composition of a population. In the 20th century, the now-familiar decline in fertility and mortality created the aging populations of the 21st century. On the other hand, we know comparatively little about the ramifications upon social relationships in those societies. The chapter by Hagestad and Uhlenberg (chapter 15, this volume) raises important questions about fertility and longevity. They first consider relationships within families, especially the grandparent-grandchild relationship. Next, the transformation of the life course into one that can be characterized as age segregated is explored.

In this commentary, we will react to the ideas in the chapter by considering the following issues. First, we consider and use a data source that has been underutilized in gerontology, but which has considerable potential in investigating kinship and genealogical issues. Second, we look at the effects of declining fertility on sibling sets and age differentiation in families. Third, we consider the effects of fertility on an ego's core kindred. Fourthly, the potential of a marked increase in great-grandparents as a result of increased longevity will be explored. Finally, we raise a number of questions about the age-segregated life course.

A FOSSIL BED OF LIVES LIVED: GENEALOGICAL DATA

To investigate the transformations in a population through time, an ideal source of data would be a fossilized bed of ordinary lives. We could simply excavate back through time, tracking individuals and their families, and record variables related to their journey through time. Of course, the national census taken about every decade provides demographic snapshots of age and sex composition along with fertility and mortality. With fully indexed census records in the released census (1790–1930 for the United States), it is possible to track individuals and family groups

through time. However, these data are usually summarized at a population level because it is difficult to track related families beyond residential units. To get the data we need, one can construct a survey and ask respondents about their families. Alternatively, one can use genealogical records, which at minimum place individuals in family units and lineages with their birth and death dates (longevity) and reproductive histories (fertility) along with other information. Interestingly, genealogical data have not yet been discovered by the social and behavioral sciences.

Genealogy is both old and new. It is old in the sense that William Rivers invented the Genealogical Method in 1898 on the Torres Strait Expedition to the North of Australia (Rivers, 1900). He collected extensive genealogies of native people with the intent of linking psychological characteristics to family lines. Although his results were disappointing, his method proved very useful to anthropologists in the study of kinship in a wide variety of societies. Genealogy also tends to be old in the search for family roots it is definitely looking backward in time. On the other hand, genealogies are quite new as a product of the Internet revolution. The availability of genealogical records in the electronic world of the Internet has spawned America's number one hobby, genealogy. Family members search and reconstruct their family's past, and they make it available online for others to use in such repositories as Ancestry.com, FamilySearch.com, and many other Web sites. With questions about the consequences of declining fertility and increased longevity, these data are a potential gold mine, with a 500-year duration dating back to 1500 and sometimes beyond.

Genealogy is not the perfect data set, and one should be aware of its pitfalls and potentials before embracing it. The primary weakness of genealogical data is that they are a fossil record, and fossils are often fragmentary and incomplete. This is true of any historical information and the further in the past it is, the more patchy and disorganized it becomes. However, it often is quite complete, with portions of a pedigree and all associated families thoroughly known. Only when we ask questions that involve multiple and usually collateral linkages do we realize how fragmentary these data can be. More minor difficulties found in these data are that we are faced with temporal limits. Often, family lines end at 1700, and very few go beyond 1500 simply because surnames were not used and the records end. Likewise, as one gets close to the present, the lives involved are not yet finished, and privacy issues truncate information. Finally, the information contained in genealogical records is most often limited to information about births, deaths, marriages, and reproductive histories. Sometimes, there are data about residence, occupation, and net worth, and if one is lucky, an obituary or historical account may be

included for a few individuals. On the other hand, births, deaths, and reproductive histories are exactly the data we need to investigate the effects of declining fertility and increased longevity on families.

The main advantage of genealogical data is that they have been interpreted and put into software that permits an examination of entire families through time. Unlike census records, we are reasonably sure of how individuals are linked and what happened to them through time. Thus, we are able to study duration and the overlapping of lives. With the increased availability of historical documents and the indexing of the census, the quality of genealogies has steadily increased. Also, individuals interested in this kind of research make their results available online. It is a straightforward matter to devise sampling criteria to use these data in the investigation of families and demographic change.

In this commentary, I will use one genealogy of over 5,000 individuals to examine the effects of fertility and longevity on family relationships. The genealogy is that of the author. One could raise the question of how well this genealogy represents a larger population. From population genetics, we know that humans practice a mating pattern known as panmixia. Within a deme (a reproductive unit), mating is fairly random, with little preferential selection of partners. Thus, once into a genealogy, we can be assured that the individuals represent the larger deme. The deme represented here is White, of the northeastern United States, from 1620 to the present. A few lines extend back to Europe, to Saxony, Moravia, Austria, England, and Sweden. The people in this genealogy did what most Americans did. After the Revolutionary War, they settled in the Susquehanna Valley of New York and Pennsylvania and then, by the mid-1800s, they began moving west to Ohio, Indiana, Illinois, Iowa, and Kansas. Most were farmers until the 20th century, when they became wage laborers and a few merchants. We will use this data to examine how the demographic transition altered age differentiation, core kindreds, and grandparenting.

FERTILITY AND AGE DIFFERENTIATION IN FAMILIES

Undoubtedly, one of the most profound changes in the demographic transition is the impact on family composition in two generations. Diminished fertility dramatically altered the degree of age differentiation within them. The timing of family events was very different in Colonial America than it is today (Fischer, 1978; Haber, 1983). Although there are lots of ways of classifying families, when size of family membership

TABLE 17.1 Percentage of Family Types by the Birth Cohort of the Mother (50-Year Intervals)

Mother Born	Twig	Small	Large	Reconstituted	Truncated	Total
		Shrub	Shrub			
Before 1800 (44 families)	14	25	52	9	–	100
1800–1849 (70 families)	14	37	33	4	–	100
1850–1899 (72 families)	37.5	32.5	14	3.4	1	100
1900–1949 (72 families)	62.5	22	.03	.03	10	100
1950–2000 (40 families)	85	–	–	7.5	7.5	100

in a nuclear family is our window, the following five types have emerged in the literature:

1. The Twig Family consists of a parental generation and very few children, operationalized here as between one and three children. This is the symmetrical family discussed by Hagestad and Uhlenberg. This is also the bean pole family identified by Bengtson, Rosenthal, and Burton (1990) but in two generations.
2. The Small Shrub is identified here has a parental generation and between four and six children. This is the bottom-heavy family.
3. The Large Shrub is also identified here has a parental generation and a large set of siblings of at least seven or more. This is a really bottom-heavy family.
4. The Reconstituted Family is formed when the bond in the parental generation is broken by death or divorce. With remarriage, there is a potential for several half-sibling sets, which increases fertility.
5. The Truncated Family is a family created by marriage, but because no children have been born, there is only a parental generation.

We also should note that a significant number of individuals do not form families, do not marry, and do not have children.

The families in the genealogical data set have experienced a marked decline in fertility and a change in the types of families over the past 200 years (Table 17.1). Before 1800, over half of the families were large shrub families. In the 19th century, the large shrub family is replaced

by the small shrub family, and by the last half of the century, the twig family is becoming the predominant type by a slight margin. By the 20th century, the twig is by far almost the only type of family. How does this decline in fertility affect the age differentiation within a family? We will look at three lines of evidence. First, how long does it take to complete a sibling set? Second, we examine the reproductive behavior of the mother by examining her age at the birth of her oldest and her youngest child. Finally, we will consider the generation gap between the birth of the last child in a sibling set and the birth of the first grandchild to be produced by the older siblings in the set.

Because we are concerned with temporal variables, our results are not surprising. It simply takes time to grow a family. Smaller sibling sets take less time to complete. On average, the twig families took 4 years to complete, whereas the large shrub families took 19 years to complete (Table 17.2). Predictably, the mothers in large shrub families have longer reproductive histories by an average of 19 years. They start a little earlier at the age of 22 years and end a lot later at the age of 41 years. In comparison, the mothers in twig families start reproducing later at the age of 26 and conclude by the age of 30. The length of reproduction in the completion of a sibling set also affects the chronological gap between children and grandchildren. For twig families, grandchildren are born on an average of 24 years after the youngest child is born. In large shrub families, this gap is reduced to an average of 5 years after the youngest child is born. Interestingly, in this genealogical data set, nearly a sixth of the large shrub families had youngest children who were between 2 and 6 years younger than the oldest grandchild. This means that aunts and uncles are nearly the same age as or younger than nieces and nephews.

What are the sociological implications for families? In the larger families, the age differentiation or separation between generations becomes diffuse or blurred. The chronological gap between parents and oldest children remains at about 20 to 25 years. However, with the length of reproduction, younger children see older siblings as quasiparents and will report that an older sister was more like a mother than a sister. The parents are the oldest in a long line of family members that are always in the household. For the twig family, there is a period of an empty nest before the arrival of grandchildren. Where the most blurring of age differentiation occurs is in the grandchild generation. With grandchildren and youngest children nearly the same or very close in age, there is real confusion between genealogical generations and chronological generations. Because the large shrub family is the predominant family form

TABLE 17.2 Age Differentiation Within Families: Age Gap Between the Birth of First and Last Child in a Sibling Set, Age of Mother at Birth of First and Last Child, and Age Gap Between the Youngest Child and the Oldest Grandchild

Type of Family	Average Number of Years Between Oldest and Youngest Child	Average Age of Mother at Birth of Oldest Child	Average Age of Mother at Birth of Youngest Child	Average Number of Years Between the Birth of the Youngest Child and the Birth of the Oldest Grandchild in a Sibling Set
Twig	4 years (1–22 years) ^a	26 years (15–43 years)	30 years (17–49 years)	24 years (41–15 years younger)
	128 families	120 families	120 families	22 families
Small Shrub	13 years (4–23 years)	23 years (16–36 years)	36 years (24–45 years)	13 years (28–7 years younger)
	80 families	78 families	78 families	19 families
Large Shrub	19 years (9–28 years)	22 years (13–31 years)	41 years (34–48 years)	5 years (23 years younger to 6 years older)
	58 families	57 families	57 families	23 families

^aRange of years.

prior to 1800, the greatest transformation the demographic transition brought to family life is increased age differentiation. Chronological and genealogical generations are now congruent with one another. Children and parents are gapped between 20 and 25 years in age, as are children and grandchildren.

CONSEQUENCES OF FERTILITY ON CORE KINDREDS

Fertility and longevity certainly have effects on family size and duration of relationships. The question we answer here is: How is an ego's kindred shaped by family types and continuity and change between family types? Here, we look beyond an ego's immediate family to the kindred.

A kindred consists of the people an ego considers his/her relatives. The component parts of a kindred are: (1) the lineal relatives of the ascending (parents and grandparents) and descending (children and grandchildren), and (2) the collateral relatives or people who share a line of descent. The latter are marked by degree of collaterality, with siblings being the closest and aunts, uncles, nieces, and nephews being more distant. Cousins of different degrees are even more distant, as are great-aunts, great-uncles, grand-nieces and grand-nephews. Kindreds can become quite large if reckoned out to 4th and 5th cousins. In this analysis, we will look only at an ego's core kindred, consisting of five generations of lineal relatives, three generations of collaterals (aunts, uncles, siblings, nieces, nephews, and first cousins). We will also consider the relatives who were alive at any time during an ego's lifetime.

Table 17.3 contains two kinds of data for an ego's core kindred. The first are hypothetical egos, who are either born into kindreds in which everyone in the kindred had 10 children or kindreds in which everyone had 2 children. The second are real egos, who were either born into a shrub family or they themselves had a shrub family. Also, we include a real ego, who was born into a twig family and who had a twig family. The effects of high fertility are very apparent. If everyone had 10 children, the total number of relatives in the kindred would be 418, most of whom would be collaterals. If everyone had 2 children, the total number of relatives in the kindred would be 21, under half of whom would be collaterals. If everyone had 5 children, the total number of people in the kindred would be 103. Consistent with Malthus's observation, changes in fertility tend to have exponential consequences in terms of size. The collateral relatives are most affected. Only in the descending lineal generations of shrub families do we see the effects of high fertility, where with 10 children who have 10 children, one would end up with 100 grandchildren.

Mob scenes are not the normal state of affairs, and people in the real world fall far short of the hypothetical or can even go beyond. The real kindreds are in the table by way of example. However, the real kindreds do reflect the hypothetical in that (1) the ascending lineal relatives are fixed kin types and are not affected by fertility, and (2) the collaterals and the descending lineal relatives are increased or decreased by fertility. This, of course, leaves unanswered the duration of the overlapping lives and the meaning of the relationships between an ego and his/her lineal and collateral relatives. Although we often emphasize the age-heterogeneous nature of kinship, when we look at kindreds, we are reminded that kinship is also age homogenous. Siblings and cousins

TABLE 17.3 Number of Kin Types in Core Kindred by Family Type of an Ego's Family of Orientation and Family of Procreation

Type of Family in Three Generations	Overlapping Lineal Relatives			Overlapping Collaterals			Total
	Ascending Grandparents	Descending Children Grandchildren	Same Generation Siblings, First Cousins	Ascending Aunts, Uncles	Descending Nieces, Nephews	26 Total Kin Types	
Hypothetical: everyone has 10 children: shrub families	2 parents 4 grandparents	10 children 100 grandchildren	9 Siblings 180 first cousins	18 aunts & uncles	90 nieces & nephews	413 overlapping relatives during life time	
Hypothetical: everyone has 2 children: twig families	2 parents 4 grandchildren	2 children 4 grandchildren	1 sibling 4 first cousins	2 aunts & uncles	2 nieces & nephews	21 overlapping relatives during life time	
Real ego in shrub families in all generations	2 parents 4 grandparents	8 children 12 grandchildren	9 siblings 29 first cousins	11 aunts & uncles	43 nieces & nephews	107 overlapping relatives during life time	
Real ego in twig families in all generations	2 parents 4 grandchildren	3 children 6 grandchildren	0 siblings 2 first cousins	2 aunts & uncles	0 nieces & nephews	19 overlapping relatives during life time	

in age-differentiated families are usually of the same chronological and genealogical generations.

THE POTENTIAL OF GREAT-GRANDPARENTHOOD

Reduced mortality or the extension of the average life span is the second consequence associated with the demographic transition. Longer lives should mean more duration and more overlap in those lives. Children look upward to at least two ascending generations with nearly all grandparents alive, and a good many see one or two grandparents alive when they are age 30. Likewise, older adults look downward through two descending generations to see their grandchildren become adults. If grandchildren become adults in a grandparent's lifetime, will longevity make great-grandparenthood a common pattern? Hagestad and Uhlenberg provide data that suggests that longevity is increasing the frequency of four-generation lineages. Will this become the norm when we consider declines in fertility and delayed reproduction?

Most human families are of three generations, with one child and two adult generations (Harrell, 1997). This state of affairs is most likely to remain the statistical norm. Great-grandparenthood is more complicated than longevity. Indeed, if the genealogical generations are only 15 years, it is possible to become a parent at age 15, a grandparent at age 30, a great-grandparent at age 45, a great-great-grandparent at age 60, and great-great-great-grandparent by the age of 75. This never happens. Genealogical generations are between 20 and 25 years. Great-grandparenthood could happen in one's 60s but more likely later. In the genealogical data set of 5,000+ egos, great-grandparents are very rare, even in the late 20th century. In spite of considerable longevity, many of these egos miss their great-grandchildren by less than 5 years. Fertility plays a greater role in the creation of four-generation families than does longevity (Matthews & Sun, 2006). The reasons are linked to (1) the age of the parents at the birth of a child and (2) the reproductive behavior of two descending generations. The older the parents are at the time of birth, the less likely they will see great-grandchildren from that child. With reduced fertility, late marriages, truncated families, and never married in the child generation, the pool of grandchildren is reduced. If their reproduction is also reduced, then in spite of longevity, the number of great-grandchildren is considerably reduced. We may see an increase in families with a fourth and even a fifth generation, but they are not likely to become the statistical norm.

THE AGE-SEGREGATED LIFE COURSE

Age segregation of the life course is the most challenging issue raised by Uhlenberg and Hagestad. Is the tripartite life course a consequence of longevity and the aging of populations? Certainly, longer lives are more expectable. Demography at most contributes only marginally to age segregation. A more potent force is the economic organization of industrialized capitalism. Children and adolescents must be enculturated and prepared for participation in the labor market. Involvement in the labor force is coordinated through social policies related to education and retirement (Phillipson, 1982). States have rationalized their populations through legal age norms, which deny adolescents full adult status and privilege (driving, drinking, voting, marriage, working) and encourage older workers to leave the workforce or to remain in it until an older age to receive full benefits (Kohli, 1986; Mayer & Muller, 1986). Demography, however, has had an impact. Bismarck originally set the age of 65 for old age benefits because in the 1870s there were few survivors past that age. By the late 20th century, the increase in longevity means many more workers are surviving past the age of 65 to experiment with the possibilities of this new life stage and to give retirement an expanded cultural meaning.

Hagestad and Uhlenberg point to a number of negative consequences of an age-segregated life course, especially ageism. Others have also argued that this arrangement of the life course distributes resources and opportunities unequally to people of different ages. Education is for the young, work is for adults, and leisure is for the old (Riley, Kahn, & Foner, 1994; Settersten, 1999). If social scientists critique the problematic aspects of a tripartite life course, we also should ask about the positive features because this life course has been embraced in all the nations of the industrialized world. First, this life course defines a predictable long life. It is a road map for what individuals should be doing in different life stages as they look forward to old age. Second, it is a form of integration that links individuals to a larger social order as they pass through age-specific institutions. Because the state has set the age norms to define the age-segregated life course, we should examine how segregated it is and in what arenas of life.

When we look at the definition of this life course, we are dealing with fairly wide spans of time. Adolescence lasts for 20 years; adulthood 45 to 50 years, and old age possibly 20 to 30 years or more. Incidentally, this definition of the life course is a construct of social scientists and not the people who live these lives. In Project AGE (Keith et al., 1994),

people in the United States and Ireland saw 0 to 10 divisions of adult life (excluding adolescence) when asked about life stages. The majority divided up adulthood and old age into three to five stages. How does age segregation work out in ordinary life and the arenas of family, education, work, and community life?

Family

Vertical ties across the lineal relatives in kindreds render the family as one of the few face-to-face age-heterogeneous institutions in contemporary society. At least gerontologists emphasize this in our view of family life. Ironically, this masks the fact that kin units sort themselves out into remarkably age-homogeneous households. Only parents with dependent children or couples in a May–December marriage are age heterogeneous. Three-generation households are very rare. Given the reduced fertility and twig families, the temporal duration of age-heterogeneous households is around 25 years. Only related households in the same community are likely to maintain face-to-face interaction across generations. For households geographically distant, interaction is maintained but electronically mediated and through visiting. Kinship is marked by both the vertical age heterogeneity and the age homogeneity of co-residence and the collateral linkages of siblings and cousins.

Education

Ever since Eisenstadt (1956), we have been impressed with the rough parallels between the narrow age banding of grades in public education and the age sets to be found in age class societies. Although classes are age graded in public schools, they are not remotely a parallel to the age sets we find among the Nuer or the Maasai of Eastern Africa. For men in these societies, their stratified age groups function as corporate political units through which they ascend as they age. Schools, on the other hand, are adult-organized, state-mandated institutions that remove children from the care of their parents and place them under the supervision of other adults who are professional educators or teachers. The purpose is to standardize educational experiences to prepare students with necessary skills for their future participation in the labor force. Classes of only 1-year age-homogeneity are grounded in a psychological and educational theory that instruction is more effective if the students have the same abilities. Age is a proxy for ability until more is known of performance. Adults use the students' work to further

subdivide classes into honors and nonhonors sections and to make decisions about promotion between grades. What happens in formal classrooms and in extracurricular activities is under the supervision of adults.

Schools are not a segregating institution. To the contrary, they are one of the major points of integration in most communities. Because of the enforced participation of children, parents concerned about their children are brought into the school. Sports programs provide a rite of intensification by connecting a community with the school to cheer on a football or basketball team representing the district long after former students and their relatives have graduated.

Work

If work is the privilege of individuals between the ages of 15 and 65, we could call it segregated. But the range of age in this band is 50 or more years in a work life. That is almost too broad to call the work-force age stratified, much less age segregated. Most workplaces are age heterogeneous within the 50-year age band. Corporations cannot hire children, and older workers withdraw because of health issues or retirement. No company wants age homogeneity, only to face the near-simultaneous retirement of all its employees unless they are planning on downsizing.

Community

The more public aspects of communities consist of a variety of social groups and organizations. These are associations focused on political, religious, commercial, community service, recreation, or child issues. Are these groups age graded? The data reported by Hagestad and Uhlenberg on the age homogeneity of social networks would convincingly argue that groups are age graded and age segregated. However, if we ask people what groups they belong to, a somewhat different picture emerges. We did this in Project AGE, and from the data obtained in the town of Momence, we see very loose age grading. Younger people report more involvement with self-improvement (exercise classes), commercial (Chamber of Commerce), and child-oriented organizations. Older people report less involvement in political and recreational organizations. On the other hand, older people are more involved in veterans and fraternal organizations, along with voluntary and service organizations. Church membership is about the national average for all ages, but involvement increases substantially for the oldest ages.

In many respects, the type of community, its size, and social stratification affect what organizations are active. Small towns such as Momence (population, 3,400) may be more age integrated than large cities. Also, organizations such as churches, beyond the worship service, internally age stratify Sunday schools and use age and gender to form adult groups. Where there is continuity, people age together, and if they fail to recruit younger members, their organization will also age and become age homogenous.

SEGREGATION AND INTEGRATION

Segregation has taken on a negative connotation, especially after the political movements of the 1960s and civil rights activism. Segregation is, indeed, nasty when combined with race, class, and gender in the allocation of resources and opportunities. On the other hand, integration is seen as positive. Perhaps we should not look at integration as being the antonym of segregation when discussing sociological phenomena. If segregation takes a heterogeneous population and separates out relatively homogenous classes for special treatment, then a more profitable avenue is to look at the uses of heterogeneity and homogeneity in social life. According to Durkheim (1964/1893), both homogeneity (mechanical solidarity) and heterogeneity (organic solidarity) achieve an integration of social life. Hagestad and Uhlenberg argue that age homogeneity fosters age segregation and ageism. Is the age homogeneity of social networks simply a product of network formation, or is it a product of institutional and special age segregation?

Homogeneity is a very powerful force in social life. Value status homophily is a characteristic of social networks. People sort themselves out into groups and social networks along lines of similarity. Homogeneity in cultural background, social class, and geographic proximity along with other characteristics facilitate interpersonal bonding. Homogeneity erases barriers and boundaries so people can get to know each other and decide if they enjoy each other's company. Friendship is highly variable in disposition, maintenance, and duration, but it is notoriously a relationship of age peers (Adams & Bleiszner, 1989; Matthews, 1986). Cross-age friendships are likely not to be labeled as friends (Neugarten & Hagestad, 1967). Instead, mentor or parent substitutes are the terms of reference given from a younger perspective. Age-homogenous communities are created by institutional and special segregation. Age or absence of children is explicitly used to recruit new members, and price

of housing units homogenizes social class and race. Studies of these communities reveal a highly integrated world and not the geriatric ghettos that were predicted by urban planners such as Lewis Mumford (1956). Interestingly, the solidarity in these communities has very little to do with age. After the initial bonding, people sort themselves out into friendship cliques, factional divisions, neighbors, golf buddies, or along whatever interests they have in common.

Heterogeneity is also a very powerful force in social life. It would appear that integration through heterogeneity is a little more difficult to maintain since we/they boundaries have to be minimized or erased to permit acquaintance. As Durkheim (1964/1893) noted a long time ago, it is through the interdependency of the division of labor and the associated occupational structures that plural societies and urban societies are coalesced into a larger social order. Durkheim noted that integration through heterogeneity can be problematic in that some individuals and even entire social divisions may not be incorporated. Age-heterogeneous relationships certainly are to be found in kinship simply because of the interdependency between children and their adult parents, which usually endure as both grow older. We also find non-kin age-heterogeneous relationships in the division of labor. In preparing for the workforce, children bond with teachers. In the workforce, adults bond with coworkers and supervisors through the interdependence of a bureaucratic corporate structure. We also find age-heterogeneous connections in the groups and organizations that create the public culture of a community. Women's clubs, the Lions, the Rotarians, the Chambers of Commerce, and veterans organizations are usually age graded, with middle-aged and older men and women staffing their activities. However, if they wish to continue as an organization, they must reproduce their membership by recruiting younger members.

The issues raised by Hagestad and Uhlenberg are important and perhaps may initiate a new avenue of research. What is the impact of the tripartite life course on intergenerational relationships both kin and non-kin? What is the impact of population aging on social relationships? The contemporary life course is organized explicitly by age norms and thus should have considerable impact on both age-homogenous and age-heterogeneous relationships. If a consequence of the tripartite life course is the age segregation described in this chapter, then we should see sharp we/they boundaries between age grades. The evidence that individuals who have no downward-looking ties in kinship are less likely to participate in volunteerism and to support causes that will help younger generations is reasonable and convincing. The age homogeneity of

non-kin networks is expectable, but is only part of the story. Although we do not know the eliciting frame of the questions asked, the respondents are probably thinking of friends who are age peers.

It is the other part of the story that may lead to a new avenue of inquiry. Age-heterogeneous relationships are likely not to be labeled as friends and are apt to involve considerable interdependency in organizing social life. Beyond the division of labor and occupations, we should look at the arena of voluntary associations. In spite of their ubiquity, voluntary associations have not received much attention on the part of social scientists. They are extremely diverse. There are adult-organized organizations for children, such as Girl Scouts, Boy Scouts, or the Boys and Girls Clubs. Some are gender specific, such as Women's Clubs or the Lions. Some are organized at the national level with local chapters. Others are localized organizations. Some have explicit age norms, such as the Jaycees. Because these organizations are voluntary, they recruit members according to interest and identity. They range from religious, political, commercial, and professional to organizations focused on interests such as guns, cars, boats, crafts, music, art, and the like. Take any interest or hobby a human might have, and you will find an organization to meet those needs. It takes a foreign-born anthropologist to point out how important they are, as Francis L. K. Hsu did in his celebrated book *Clan, Caste, and Club* (1963).

Voluntary associations are beyond the scope of the chapter under discussion here, but do provide an interesting avenue for further research. Perhaps because we as researchers are members of voluntary associations, we do not look at them as an alien form of organization worthy of ethnographic observation. For instance, The Gerontological Society of America attracts members who have a professional interest in aging. Once initiated, individuals find an arena in which others pay attention to their work, and they learn from other members. Exchange takes place in sessions at annual meetings and through journals published by the society. Rites of intensification happen at award ceremonies and in the commensality of dining together. Name badges and tote bags promote the logo of the club and identity. Networks that are both age heterogeneous and homogenous are bonded by interest and profession, and age goes away.

Hagestad and Uhlenberg are raising interesting questions about age relationships in contemporary societies of Europe and North America. The answers are not simple. This chapter goes a long way in documenting those relationships and offering an interesting hypothesis about the consequences of age segregation. It is also refreshing to discuss a chapter

that asks questions about age and the organization of private and public life in contemporary societies.

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