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LIVING LONGER, LIVING BETTER: THE CHALLENGE TO POLICYMAKERS

FORUM

BEFORE THE

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UNITED STATES SENATE

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LIVING LONGER, LIVING BETTER: THE CHALLENGE TO POLICYMAKERS

TUESDAY, NOVEMBER 21, 2000

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The forum convened, pursuant to notice, at 10:29 a.m., in room SH–216, Hart Senate Office Building, Fay Lomax Cook, Moderator.

OPENING STATEMENT OF FAY LOMAX COOK, MODERATOR

Ms. COOK. I am Fay Lomax Cook, President of the Gerontological Society of America and Director of the Institute for Policy Research at Northwestern University, and I want to welcome you to this hearing.

The title of this congressional briefing is "Living Longer, Living Better: The Challenge to Policymakers." What exactly is the challenge to policymakers? In my view, it is not to add more years to the long lives that Americans will already be living in the 21st century, but to add better years. To do that, it is important to take a hard look at four of the major domains in which the U.S. Congress develops policies to affect the lives of older Americans: work, income, health, and family.

We need to assess where we are and where we need to go within each of these policy domains and then, to examine the connections between the domains. As we stand at the beginning of the 21st century and look forward, I do not think it is hard to predict that the same four domains of life that were central to aging well in the 20th century will continue to be important. Maintaining an adequate income, having access to good health care, being able to make choices about work and having the support of family and family like friends and neighbors are important throughout adult life, and especially in old age.

In the 20th century, as this group well knows, we saw the role of government in the areas of work, income, health and family expand. From the Social Security Act of 1935 to the legislation in 1965 enacting Medicare and Medicaid to the most recent legislation repealing the earnings limit on Social Security, the U.S. Congress has developed policies that improve the lives of older people.

We have seen that government programs can do much to decrease poverty and inequality, and to increase economic and physical well-being. Nonetheless, there remains much more that can and should be done. To make further progress requires recognizing where we have been, where we are, and where we need to go. That is the goal of the discussions that follow by Dr. Burtless, Dr.

Smeeding, Dr. Moon, and Dr. Kutza. In those presentations, we are going to learn a lot about these four separate domains.

The next challenge, I think, for policymakers and for those of us who are researchers in the audience is to understand more about how policies in each of these domains interact to produce opportunities or constraints in the lives of older people. Currently, we have separate legislation focusing on these different domains, but in the real world of lives as lived, legislation is connected in the individual lives of older people who receive social programs, and it is this integrated perspective on how policies and programs are interconnected in people's lives that we need to begin to understand more about.

This figure presents a framework which we can use to begin to develop this integrated perspective. At the very center of our interest should be the older person. Revolving in overlapping circles around this person are the four domains that affect the quality of his or her life: family, health, work, and income. Policymakers and researchers need to understand the operations and effects of these policies and programs and the nexus where the person copes within the domains as they overlap in the real world of his or her life. Finally, affecting policies and programs about work, income, health, and family are those macrosocietal factors of the demographics of an aging society, history, and the economy.

At the bottom of the figure, a timeline represents the simple fact that we have to envision aging as a continuum over time in the 21st century. In the next figure, this framework is taken apart, and in the presentations you are going to hear today, these domains will be examined separately. Nonetheless, policymakers and researchers should envision, as you hear these presentations, the effects of aging policies as a product of the interaction of the policies operating in these multiple domains.

I just want to give you some examples of the kind of interaction that I mean, and we can think more about these later. For example, the domains of health and income are intimately related. The high cost of prescription drugs takes income from many older people who cannot afford it. This impoverishes some, while it causes others to forego medicine that they need because they simply do not have the money to spend. Still others borrow money from adult children or other relatives who can ill afford it. Adding some form of prescription drug coverage to Medicare would be a policy in the health domain that would have have an effect on the domain of income and family, as well as health.

So, too, targeting a policy on the domain of family can have an impact on work, income and health. For example, adult and children often want to care for their elderly parents, but when health crises occur, adult children face a big work, income, family dilemma. The Family and Medical Leave Act enables them to take time off from their jobs, but it does not require employers to pay for such time, nor does it provide any caregiving assistance. If we enlarged the scope and coverage of the Family and Medical Leave Act, this would have ripple effects for health, income, and work, as well as for family.

In the four presentations that follow, Dr. Burtless, Dr. Smeeding, Dr. Moon, and Dr. Kutza take a hard look at each of these do-

mains. The challenge to policymakers is, I think, to add better years to the long lives Americans will be living in the 21st century. I have argued they can do this by becoming more and more aware of the effects of policies across domains, and know that by targeting a policy in one domain, it can have ripple effects to increase the well-being of other domains.

First, we are going to focus on the domain of work, and Gary Burtless will be presenting that. Dr. Burtless is a Senior Fellow at the Brookings Institution.

[The prepared statement of Fay Lomax Cook follows:]

Living Longer, Living Better: The Challenge to Policy Makers
An Overview

Presentation for the
Special Committee on Aging
United States Senate

November 21, 2000
Hart Building, Room 216
10:00 AM – 12:00 PM

by

Fay Lomax Cook
Director, Institute for Policy Research
Northwestern University
Evaston, IL 60208-4100

Living Longer, Living Better: The Challenge to Policy Makers
An Overview

Fay Lomax Cook[1]

The title of this Congressional Briefing is *Living Longer, Living Better: The Challenge to Policy Makers*. What exactly *is* the challenge to policy makers? It is not to add more years to the long lives Americans will be living in the 21st century but to add better years. To do that, it is important to take a hard look at the four major domains in which the U.S. Congress develops policies to affect the lives of older Americans -- work, income, health, and family. We need to assess where we are and where we need to go within each policy domain and then to examine the connections between these domains.

As we stand at the beginning of the 21st century and look forward, it is not hard to predict that the same four domains of life that were central to aging well in the 20th century will continue to be important. Maintaining an adequate income, having access to good health care, being able to make choices about work, and having the support of family or family-like friends and neighbors are important throughout adult life and especially in old age.

In the 20th century, we saw the role of government increase in the areas of work, income, health, and family. From the Social Security Act in 1935 authorizing Old Age Insurance to the legislation in 1965 enacting Medicare and Medicaid to the most recent legislation repealing the earnings limit on Social Security, the U.S. Congress has developed policies that improved the lives of older people. We have seen that government programs can do much to decrease poverty and inequality and to increase economic and physical well-being. Nonetheless, there remains much more that can and should be done. To make further progress requires recognizing where we've been, where we are, and where we need to go. That is the goal of the discussions that follow by Doctors Burtless, Smeeding, Moon, and Kutza.

In those presentations, we will learn much about four separate domains. The next challenge for policy makers and for researchers is to understand how policies in each of these domains interact to produce opportunities or constraints in the lives of older people. Currently we have separate legislation focussing on these different domains, but in the real world of "lives as lived," legislation is connected in the individual lives of older people who receive social programs. It is this *integrated* perspective on how policies and programs are interconnected in people's lives that we need to begin to understand more about.

Figure 1 provides a framework from which to begin to develop an integrated perspective. At the very center of our interest should be the older person. Revolving in overlapping circles around the person are the four domains that affect the quality of his or her life –

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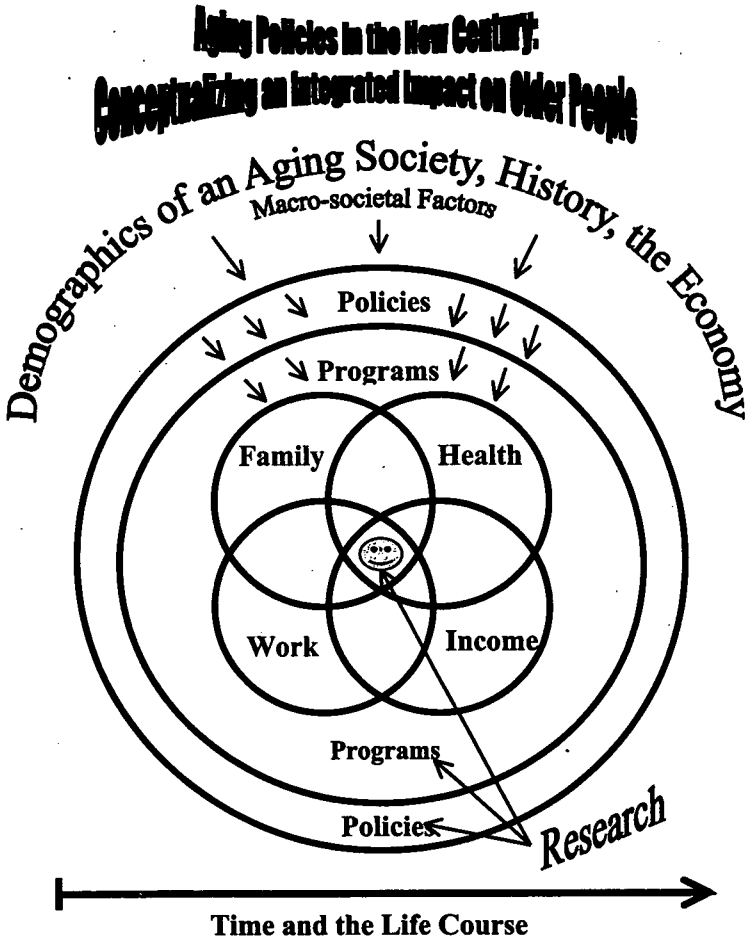
Figure 1



family, health, work, and income. Policy makers and researchers need to understand the operations and effects of policies, programs, and the nexus where the person copes within the domains as they overlap in the real world in his or her life. Finally, affecting policies and programs about family, health, work, and income are macro societal factors of the demographics of an aging society, history, and the economy. At the bottom of the figure, a time line represents the simple fact that we must envision aging as a continuum over time in the 21st century.

[Insert Figure 1 about here]

In the next figure, this framework is taken apart. The past, of course, is a guide to the future, and we know we can expect both continuity and change in these four major domains that are so crucial to people across the life course.

Work. For decades, successive cohorts of men retired at younger and younger ages. In 1950, 72 percent of men aged 65 were in the labor force. In 1995, 30 percent of men aged 65 were in the labor force – a quite dramatic decline. Some men retired due to health factors; others due to a sense of financial security; still others were encouraged by retirement plans through their jobs. For women, the story was different. Whereas the proportion of men aged 55 to 64 in the work force dropped between 1960 and 1997 by 20 percent, the proportion of women aged 55 to 64 in the labor force increased by 14 percent from 37 percent to 51 percent. Between 1960 and 1997, the proportion of women aged 65 to 69 in the labor force ranged between 14 and 18 percent and is now at its highest level of about 18 percent.

What will work in the new century look like? The trend toward early retirement appears to be tapering off in the last few years, and both men and women are choosing to remain in the work force longer. More significantly, over 70 percent of baby boomers report they plan to continue working at least part time after age 65. Will they?

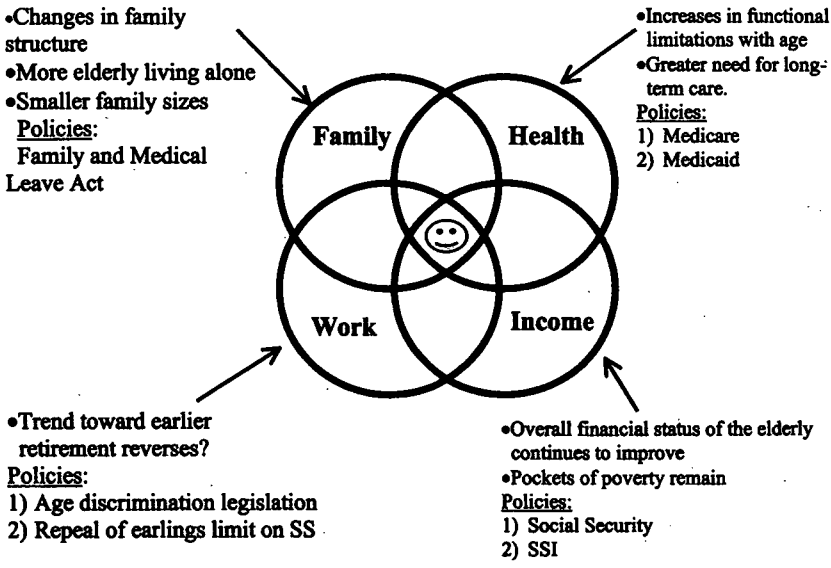
They will certainly have a new incentive to work longer. The U.S. House and Senate voted unanimously in Spring, 2000, to remove limits on how much money most Social Security recipients can earn without losing part of their retirement benefits. This legislation repealed the Depression era policy of discouraging the elderly from working. According to interviews reported in the *New York Times*, members of both parties said the earnings limit might have made sense at the time that Social Security was established in the Depression when the employment rate was 25 percent, many jobs entailed hard physical labor , and life expectancies were much lower than they are today. But they said it makes no sense now, with employment so low that companies cannot find enough workers, jobs are generally less physically strenuous, and actuarial tables lead people to plan for long lives after age 65.

[Insert Figure 2 about here]

Income. In terms of income, older adults in the 21st century will be better off on average than the elderly of past generations in the 20th century. The trend toward improved financial status is clear. In 1965, a third of all elderly persons had incomes below the

Figure 2

Key Domains for Aging Policy in the New Century*



*This is not intended to be an inclusive look at relevant domains of all relevant policies. It is simply illustrative.

poverty line. In 1998, 10.5 percent of all elderly persons were poor – a dramatic and significant decrease. We will probably not see such dramatic changes in the 21st century if the United States does not tackle the problem of child poverty more vigorously. In 1998, 19 percent of all children under age 18 lived in poor families. Seventeen percent of young people aged 18 to 22 are poor. To affect meaningful changes in the aged of the 21st century, we need to mount a campaign to reduce childhood poverty *now*.

The improvement of the financial status of the elderly in the 20th century was due to a number of factors, perhaps the most important of which were the increases in Social Security benefits and adding the cost of living adjustments (COLAs), Medicare and Medicaid, and the conversion of Old Age Assistance to Supplemental Security Income (SSI) in 1972. The vast majority of the elderly now receive Social Security – 91 percent compared with only 69 percent in 1962.

But it is only part of the story to talk about the fact that conditions for the elderly as a whole have improved over the 20th century and that this trend is likely to continue. Some groups are still very vulnerable. If the total dollar income of the elderly population is divided into equal quintiles or 20 percent shares, we learn that the top 20 percent of all the elderly income is shared among just six percent of the elderly. The bottom 20 percent of elderly income is shared among 34 percent of the elderly.

What does the future hold for programs that help to insure that the elderly continue to fare well in the income domain? Much will depend on the fate of Social Security and the changes that Congress and the President choose to make. Under one scenario, Social Security will be partially privatized, and thus the strength of the stock market will become linked to levels of economic well-being the elderly can expect. Under a second scenario, Social Security will continue much as it is, strengthened by using the surplus to pay down the $3.5 trillion national debt by 2012 and then devoting the savings in interest payments ($200 billion annually) to Social Security.

Health. The major factor that determines whether older people are able to lead independent and active lives is their health. Functional limitations increase as people age. Only five percent of older people aged 65 to 74 living in the community have a need for assistance with one activity of daily living compared to 9 percent of people aged 75 to 84 and 18 percent of those aged 85 and over. Considering assistance with three or more activities of daily living, only two percent of persons aged 65 to 74 need assistance as compared to four percent of those aged 74 to 84 and 12 percent of those aged 85 and over.

What can we expect in the 21st century? It is hard to predict. Younger people today – the baby boomers and the generations that follow them – know more than ever before about the importance of good nutrition and exercise, and many will experience healthier old ages because they have put that knowledge into practice. But we also know that people do not always do what they know is good for them and that obesity is a worse problem now than previously.

In terms of policies in the health domain, Medicare and Medicaid are key. As with Social Security, two quite different options have been proposed. In the one scenario, Medicare would be turned into a kind of insurance subsidy, giving seniors money for private insurance and prescription drug coverage. In the other scenario, the current contours of Medicare remain in place with the addition of a prescription drug benefit.

Family. Family structure has changed considerably in the 20th century, and in the 21st century these trends are likely to continue. Specifically, roughly 25 percent of elderly persons lived with other relatives in 1960 whereas the 1990 Census showed only 13 percent living with other relatives. Conversely, the proportion of elderly people living alone increased by 12 percent – from 19 percent in 1960 to 31 percent in 1990. These changes are in part due to the elderly's success in the domains of income and health, for as more older people have had greater financial security, they felt that financial independence could result in independent living.

Throughout the 20th century, families have been the primary source of care. In 1997, 31 percent of informal caregivers to the elderly were sons or daughters and 28 percent were other relatives. In the future, this trend is likely to continue, but predictions are that the pool of potential caregivers will grow smaller. The reasons are well known: due to increased mobility, adult children are less likely to live nearby; smaller family sizes mean fewer children are available to help; more women are in the work force.

One piece of legislation that has some potential to help on the caregiving and family front is the Family and Medical Leave Act of 1992. This legislation allows workers to take time off to care for children, parents, or spouses without risk of losing their jobs, thus acknowledging the importance of the family caregiving role. The problem is that as currently structured, it leaves the caregiver in the difficult position of having the opportunity to take time off work with no guarantee that salary will be paid while the care giving occurs. For the FMLA Act to truly enable caregiving, employers need to have some obligation to maintain the salaries of caregivers. Further, in cases where the care recipient needs long term assistance, the act needs to be expanded to allow caregivers to draw on in-home, long term care providers such as home nurses and nurses' aides.

Integration. We usually look at each of these domains one by one and develop policies and programs to deal with problems separately in each domain. In this new century, we should envision the effects of aging policies as a product of the interaction of the policies operating in multiple domains of work, income, health, and family. As we make policies and develop programs in one area, it is important to examine their effects on other domains. For example, the domains of health and income are intimately related. The high cost of prescription drugs takes income from many older people who cannot afford it. This impoverishes some, while it causes others to forego medicine that they need because they simply do not have the money to spend. Still others borrow money from adult children or other relatives who can ill afford it. Adding some form of prescription drug coverage to Medicare would be a policy in the health domain that would have an effect in the domain of income.

So, too, the domains of family, work, income, and health are linked. For example, adult children often want to care for their elderly parents, but when health crises occur, adult children face a work-income-family dilemma. The Family and Medical Leave Act enables them to take time off from their jobs but does not require employers to pay them for such time nor does it provide any caregiving assistance. Enlarging the scope and coverage of the Family and Medical Leave Act would have ripple effects for health, income, and work as well as for family.

In the four presentations that follow, Doctors Burtless, Smeeding, Moon, and Kutza take a hard look at the domains of work, income, health, and family. The challenge to policy makers is to add better years to the long lives Americans will be living in the 21st century. They can do this by working to develop policies that, while targeted in one domain, have ripple effects that increase well being in other domains as well.

STATEMENT OF GARY BURTLESS, SENIOR FELLOW, BROOKINGS INSTITUTION

Dr. BURTLESS. Good morning. I want to talk briefly about the labor market aspects of an aging population. My analysis is based on joint research that I have conducted with Joe Quinn, who, like me, is an economist. Unlike me, however, he has real responsibilities. He is the Dean of Boston College.

I want to make three basic points this morning. First of all, after a decline in the average age at which Americans left the labor force, which lasted almost a century, the trend toward earlier and earlier retirement came to a stop in this country about 15 years ago. There is growing evidence that the typical age of retirement may now be edging upwards.

Second, we understand many of the reasons behind the long-term trend toward earlier retirement that lasted until about 1985. I think we also understand a lot of the reasons behind the recent reversal in that trend, or at least the halt in the long-term trend toward earlier retirement. And I am going to briefly describe those in a minute.

Third, the natural question that policymakers and citizens want answered is this. Should the country adopt new policies to encourage even later withdrawal from the labor force? Most of us recognize that lengthening lifespans and the low population growth rate, as a result of low birth rates, will make our existing retirement programs a lot more costly in the future. Should we limit future cost increases in these programs by implementing policies that push workers to retire much later than they do today?

My answer to this question depends on how quickly productivity in this country grows. If productivity climbs very strongly in the future, we will have plenty of resources to retire at the same age as we do today or even earlier than we do today. If productivity grows very anemically, I think policymakers and workers are going to want to think very hard about ways that might discourage workers from retiring early.

Let me turn to these points in a little bit more detail. The formal statement that is available to you on the table outside gives statistics on labor force participation and retirement rates over the past century. You can see that Americans who spent most of their lives working outside of the home tended to retire at an earlier and earlier age, as the 20th century moved on. In 1910, more than 60 percent of American men who were 70 years old were labor force participants. By 1985, the percentage of 70-year-olds who were labor force participants had dropped below 20 percent. There were similar or even larger drops in participation at ages somewhat below age 70.

That long-term trend toward earlier retirement came to an abrupt halt around 1985. Participation rates of older men have held steady or even edged upwards since about 15 years ago. Participation rates of older women have clearly trended upwards since that time.

I think we know why workers tended to retire earlier as the 20th century progressed. The basic reason is they grew much wealthier over time. Rising productivity, rising wages, made workers much better off. They used some of their additional wealth to leave the

workforce in their 60's or even in their 50's. They used the rest of it to consume more and better consumption goods. They lived in bigger houses, they took more and longer vacations, they drove bigger and fancier cars and they consumed a better class of food.

Even as the workers devoted a smaller percentage of their life to full-time work, they still had plenty of resources left over to enjoy higher and better consumption.

Another reason workers left the labor force earlier is that our country established a number of institutions that made that possible or made it easier. Social Security is probably the most important one. Medicare is another, but employers also set up retirement plans and retiree health plans that allowed their employees to live comfortably in old age without working. Do not get me wrong. Workers probably would have retired at younger ages even if there were no Social Security program, even if there were no Medicare, even if there were no company health plans and retirement plans.

By establishing these institutions, our country made it easier for workers to do something they clearly wanted to do anyway, which is devote more of their years in old age to years of leisure, rather than work. Some of the institutions also provided strong financial incentives for workers to leave work at a particular age. Everyone is familiar with the normal retirement age in Social Security and the retirement earnings test in Social Security. Both of these tended to give people incentives to leave the workforce when they attained the normal retirement age, and some even gave major financial incentives for some workers to leave when they reached the early retirement age.

Private retirement plans often created even bigger inducements for company workers to leave their jobs at a specified age. There used to be mandatory retirement rules in a lot of companies that just pushed people off the job. In the old days, too, a lot of workers were enrolled in traditional or defined-benefit company pension plans, which created big financial incentives to leave work at the normal and sometimes the early retirement age under the plan. Even if the company did not literally push people out of the door because of mandatory retirement rules, those big bonuses that they offered to workers, if they chose to retire at the early or normal retirement age, gave lots of workers a good reason to leave the workforce.

We also have a pretty clear idea why the trend toward early retirement might have slowed down after 1980. Mandatory retirement has been eliminated under law, except in a handful of jobs. The Social Security earnings test was liberalized, and then it was eliminated altogether for workers reaching age 65. Social Security pensions stopped growing more generous, both in absolute terms and relative to workers' lifetime wages, sometime around 1980. The benefit formula has also been reformed to give workers a bigger financial payoff if they delay their retirement past the normal retirement age.

Changes in company retirement plans have been just as impressive and have tended to work in exactly the same direction. First of all, fewer employers are establishing new pension plans to cover new groups of workers. The percentage of the workforce covered by a company pension plan stopped growing in the early 1980's, and

the type of plan that companies are enrolling workers into has also changed. In the old days, a great majority of workers were enrolled in traditional defined benefit plans that offered big prizes to workers if they retired at the normal or early retirement age. Nowadays, far more workers who are covered by a company pension plan are covered by one that is a defined-contribution plan, and these plans typically do not offer big financial rewards if you leave work at a particular age. Our retirement institutions are gradually shifting to create weaker incentives to retire and stronger financial rewards to people who prolong their careers.

Should we adopt reforms that push workers to retire later than they currently do? For example, should we raise the Social Security and Medicare retirement ages? Most elected officials recognize that these kinds of reforms are extremely unpopular. In the last Presidential campaign, every single candidate, except George W. Bush, promised at one stage of the primary season that he would never allow an increase in the Social Security retirement age. Only Governor Bush did not go that far, but he promised he would not raise that age for people who were now nearing retirement.

The cost of our government programs will surely increase as lifespans increase, especially if birth rates remain as low as they have been for the last 30 years. If workers do not want to face high contribution rates for their retirement benefits, a later retirement age might be unavoidable.

Should we do everything we can to encourage workers to retire later than they presently do? This is a very reasonable question, a very sensible one, but let me offer an answer that some of you will find surprising.

There is no purely economic reason for adopting policies that encourage workers to retire later than they do at present. There may be a good political case to do that, and I will return to that in a minute, but there is no convincing economic case to do that. The main reason today's workers retire at a younger age than their grandparents and great-grandparents is that they are a lot better off than their grandparents and great-grandparents were. Their greater wealth means they can retire younger, and at the same time, they can live in bigger houses, take longer vacations, go to Disney World more frequently, and enjoy foi gras occasionally.

If our children, grandchildren, and great-grandchildren are wealthier than we are today, then they too can live more comfortably than we do, even if that involves retiring at a younger age than we do. This will be true, even if tomorrow's population is significantly older than the population today. The fact is, all of the improvements in our living standards, including our longer and better fed retirements, can be traced to higher worker productivity. The gain in productivity makes us wealthier. We can spend that gain in a number of ways, including by spending a bigger percentage of our potential work lives as retired senior citizens.

I do not think everyone wants a longer retirement. Many of us like to participate in the workforce and enjoy our work, and would like to do so as long as we can. A lot of workers certainly do enjoy their retirement, and my guess is they comprise the majority of American workers. So long as workers are willing to give bigger contributions to support their longer retirement, there is no purely

economic case to adopt a policy that essentially forces healthy, older Americans to stay on the job as long as they can.

Let me mention one last fact. Even though American workers retire much earlier today than their great-grandparents did at the turn of the last century, a much larger percentage of non-aged Americans is now in the paid workforce. A century ago, women worked primarily in the home or on the farm. They did not work outside the home for a paycheck. Today, a rising percentage of 20- to 65-year-old women, including women with very small children, are in jobs and those jobs are paying wages that are the same as those received by men.

If more non-aged American adults are working for pay, we surely are making it possible for aged Americans to spend a bigger percentage of their golden years in a comfortable retirement. As I show in my formal statement, today's Americans are typically spending more of their lives in paid jobs, in spite of the fact that career workers tend to retire younger than workers did a generation or more ago. The explanation, quite simply, is that the gains in paid work hours among non-aged women have had much bigger effects on the lifetime paid employment of Americans than has the loss of work hours associated with early retirement of workers who have career jobs.

Let me repeat, if American productivity continues to rise, there is a gain in American wealth that can be divided in any way that Americans choose. If they choose to spend that gain by devoting more of a longer lifespan to retirement, there is no economic case against that choice. Thanks.

[The prepared statement of Dr. Burtless follows:]

Second draft

LIVING LONGER, LIVING BETTER: The Policy Challenge of an Aging Workforce

Presentation for the
Special Committee on Aging
United States Senate

Sponsored by the Gerontological Society of America

November 21, 2000
Hart Building, Room 216
10:00 am - 12:00 pm

by
GARY BURTLESS *and* JOSEPH F. QUINN*

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* Burtless is Senior Fellow, The Brookings Institution, 1775 Massachusetts Avenue, N.W., Washington, D.C., 20036; Quinn is Dean, College of Arts and Sciences, Boston College, Gasson Hall 103, Chestnut Hill, MA 02467. Much of this discussion is taken from Burtless and Quinn, "Retirement Trends and Policies to Encourage Work among Older Americans," prepared for the annual conference of the National Academy of Social Insurance, Washington, DC, January 26-27, 2000. The views expressed are solely our own and should not be ascribed to the Brookings Institution, Boston College, or to the Gerontological Society of America.

LIVING LONGER, LIVING BETTER:
The Policy Challenge of an Aging Workforce

by
GARY BURTLESS

Summary

THE UNITED STATES and other industrial nations face key challenges associated with a graying population. Depressed birth rates and rising longevity have increased the dependency ratio throughout the industrialized world. Population projections of the Social Security Trustees suggest the U.S. aged-dependency ratio -- the ratio of Americans older than 64 to Americans aged 20 to 64 -- will increase almost 70 percent between 2000 and 2030. The increase will be even larger in some other rich countries. As the American population grows older, the cost of paying for pension and health benefits must rise, boosting tax burdens and impairing the nation's ability to pay for other government obligations. The burden imposed by an aging population would rise more gradually if workers could be persuaded to delay their retirements and continue contributing to the health and pension systems.

Many people may be surprised to learn that the typical age at retirement is now increasing–slowly in the case of American men and more rapidly in the case of women. The trend toward earlier and earlier retirement was an important labor market development during most of the twentieth century. The trend was evident in all the major industrialized countries. In the United States, however, the trend toward earlier retirement came to at least a temporary halt in the mid-1980s. Male participation rates at older ages have stabilized or even increased slightly. Older women's participation rates are clearly rising. Several changes in the economic environment and in public policy contributed to the long-term decline in the U.S. retirement age as well as to the recent reversal.

The main cause of earlier retirement in the first 85 years of the twentieth century was the increase in Americans' wealth, which permitted workers to enjoy rising living standards even as they spent a growing percentage of their lives outside the paid work force. The expansion of Social Security pensions and of employer-sponsored pension plans and the introduction of mandatory retirement rules also encouraged earlier retirement over much of the last century.

Many public policies and private institutions that encouraged early retirement were modified in the past two decades, however. Mandatory retirement has been outlawed in most jobs. Social Security is no longer growing more generous. Worker coverage under company pension plans has stopped rising. Both Social Security and many private pensions have become more "age neutral" with respect to retirement. Public and private pension programs now provide weaker financial incentives for workers to retire at particular ages, such as age 62 or age 65. They offer stronger incentives for older workers to remain in the work force. Other public policies could encourage later retirement. An open question is whether such policies are needed. Rising labor productivity and increased work effort during the pre-retirement years mean that Americans can continue to enjoy higher living standards, even as improved longevity adds to the number of years that workers spend in retirement. If opinion polls are to be believed, most Americans favor protecting the institutions that allow early retirement even if it means these institutions will require heavier contributions from active workers.

Retirement trends

At the beginning of the last century, retirement was relatively uncommon but not unknown. Two out of three American men past age 65 were employed, but one-third were not.[1] By the middle of the twentieth century male retirement was much more common. Fewer than half of men 65 and older held a job in 1950. By 1985 the proportion at work fell still further. Just 16 percent of men over 65 were employed or actively seeking a job. Eighty-four percent were outside the active labor force. The percentage of women past 65 who were employed or looking for work also shrank during the first four decades after World War II, though this was mainly because the average age of women past 65 was rising. The reduction in women's employment was far smaller than among men because the percentage of older women who worked outside the home had never been high.

The decline in labor force participation at older ages has not been confined to the United States. It is characteristic of all rich industrialized countries. In most European countries employment rates among the elderly are now significantly below those in the United States. Along with a shrinking work week and rising paid employment among married women, earlier retirement among men has been a distinctive feature of economic progress in all the developed countries.

The pattern of declining work among older men is clearly evident in Figure 1. Each line in the figure traces the labor force participation rate of older American men, by age, in a different year of the past century. (A person is considered to be a labor force participant if he or she holds a job or is actively seeking work.) The top line shows age-specific participation rates of older men in 1910. Note that there is a clear pattern of labor market withdrawal with advancing age. Even at age 72, however, the male participation rate in 1910 was over 50 percent. Participation rates in 1940, 1970, 1984-85, and 1998-99 are displayed in the lower four lines. Each of these lines shows a characteristic pattern of labor market withdrawal as men grow older. The crucial difference between 1910 and later years is that the fall-off in labor force participation begins at an earlier age and proceeds at a faster pace.

The decline in male participation was neither smooth nor uniform over the century. By far the largest proportionate declines in participation occurred among men past the age of 65. In 1998-99, for example, the participation rate among 72-year-olds was only one-quarter the equivalent rate in 1910. The fall-off in participation was smaller at younger ages. In general, large declines in participation occurred in the early and middle parts of the century for the oldest age groups; major declines occurred after 1960 among younger men. The largest percentage declines among men older than 70 occurred between 1910 and 1940. The fastest declines among 65-to-69 year-olds took place between 1940 and 1970. The biggest declines among men under 65 did not occur until after 1960, after the earliest age of eligibility for Social Security benefits was reduced to 62. A striking feature of Figure 1 is that there has been *no* decline in older men's participation rates since the mid-1980s. After a long period of decline, the participation rates of older men stabilized or even increased slightly after 1985.

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[1] Historical changes in retirement patterns are more difficult to measure among women. During much of the twentieth century, most women worked primarily within the home (and without pay) for most of their adult lives. It is harder to detect when retirement occurs for people who work mainly in the home or without any regular pay.

The story for older American women is different. Older women's participation rates in the post-World-War-II era have reflected two partially offsetting phenomena – the early retirement trend of older workers in general and the increasing labor force participation of married women. As a result of the latter, the participation rates of older women did not exhibit the dramatic post-war declines seen among men. Instead, as shown in lower panel of Table 1, age-specific labor force participation rates generally increased among women. Between 1950 and 1998-99, the female participation rate rose 39 percentage points at age 55, 26 points at age 60, 8 points at age 65, and 7 points at age 70.

What is similar to the male experience is the shift in trends after 1985. As with men, there is a noticeable break from the earlier trend in older women's labor force participation. Between 1970 and 1985 older women's labor force participation rate barely increased at all and even declined among people past age 62. In contrast, female participation rates surged in the 15 years after 1985. Figure 2 shows the annual percentage-point change in participation at selected ages in the two different periods. The lighter bars show changes between 1970 and 1985; the darker bars show changes between 1985 and 1999. The top panel shows trends in the participation rate of older men, and the lower panel shows trends at the same five ages for women. At age 62, the male participation rate fell 1.5 percentage points a year from 1970 to 1985. The rate among 62-year-old women declined 0.2 points a year over the same period. Between 1985 and 1999, the male participation rate at age 62 rose 0.3 percentage points a year; the female rate increased 0.7 points a year. At each age the rate of increase in participation rates accelerated, the rate of decline in participation rates shrank, or a decline in participation rates was reversed. The similarity of the break points in the male and female time series is striking. Women's participation rates at older ages have risen strongly over the past 15 years, while among older men the long-term decline in participation rates has ended and may even have reversed.

Historical information about participation rates can be used to trace out the long-term trend in retirement. Figure 3 shows the trend in the "average" male retirement age if we define that age as the youngest age at which fewer than half the men in the age group remain in the work force. Under this definition, the average male retirement age fell from 74 years in 1910 to 63 years in 1998-99, a drop of about 1.2 years per decade. The tabulations in Figure 3 also indicate, however, that the trend toward earlier male retirement has recently slowed and may even have ceased.

The decline in the average retirement age has occurred in an environment of rising life expectancy among older Americans, especially in the period since 1940. Falling mortality rates among the elderly added almost four years to the expected life span of a 65-year-old man and more than 5½ years to the life expectancy of a 65-year-old woman after 1940. Since expected male life spans increased about 0.8 years per decade during a period in which the retirement age dropped 1.2 years per decade, the amount of the male life span devoted to retirement climbed about 2 years per decade, adding almost 12 years to the amount of time men spend in retirement. Retirement now represents a substantial fraction of a typical worker's life. For many workers, retirement will last longer than the period from birth until full-time entry into the job market.

Explaining the trends

Research by economists and other social scientists has shed light on the evolution of retirement in the United States. In the 1940s and early 1950s, fewer than 5 percent of new retirees reported leaving work because they wanted to retire or enjoy more leisure. About 90 percent left because of poor health or a layoff. These explanations for retirement dominated survey responses and the research literature from the 1940s through the early 1970s. Only a very small percentage of retired men reported leaving work because they wanted to retire.

In recent surveys of new Social Security beneficiaries, a larger percentage of pensioners reports leaving work because of a desire to enjoy additional leisure or to retire. By the early 1980s, the desire to leave work explained nearly half of all retirements among men 65 or older, while poor health accounted for only a little over a fifth and involuntary layoff about 15 percent of retirements. The percentage of workers who say they have retired for purely voluntary reasons has dramatically increased.

Wealth. The survey responses just mentioned make it plain that the long-term trend toward earlier male retirement had an important *voluntary* component. A growing body of research evidence also supports this inference. The simplest and probably most powerful explanation for earlier retirement is rising wealth. The United States has grown richer over time. Real per capita GDP in the United States has more than doubled since 1960, increasing about 2 percent a year. Some of this increased wealth has been used to purchase more leisure. Americans stay in school longer than they once did, enter the workforce later, work fewer hours per year, and leave the labor force earlier.

Social Security and Medicare. For many of today's retired workers, the increases in wealth flowing from greater national prosperity have been augmented by windfall gains from a generous Social Security system. Because Social Security was historically very generous, most generations retiring up to the present have received larger pensions than their contributions alone could have paid for if the contributions had been invested in safe assets. Workers who retired under Social Security before the mid-1980s received pensions well in excess of the benefits they would have received if Social Security offered normal returns on their contributions. Retired Americans continue to receive Medicare benefits that are vastly larger than those that could be financed solely out of their contributions and the interest earnings on those contributions. This fact is well known to students of social insurance, who recognize that most early contributors to a pay-as-you-go retirement system obtain exceptional returns on their contributions. The exceptional returns on Social Security and Medicare taxes have increased the amount of consumption that older Americans can afford. One way workers have used these windfall gains is to retire at a younger age.

While some researchers have attributed most of the post-war decline in male labor force participation to the introduction and liberalization of Social Security, most specialists think the impact on retirement has been considerably smaller. Because of the long-term rise in productivity, workers are much wealthier today than they were at the beginning of the twentieth century. This would have led workers to retire earlier than previous generations, even in the absence of Social Security and Medicare. Social Security, Medicare, and employer-sponsored retirement plans were established and expanded in part to help workers achieve the goal of living comfortably without

work in old age. If these programs had not been developed, it is likely that workers and employers would have found other ways to achieve the same goal.

Older workers' health and the health requirements of jobs. Of all the explanations advanced for earlier retirement, two of the least persuasive are declining health and the changing physical requirements of work. While nearly all good retirement studies find that health plays an important role in the timing of retirement, there is no convincing evidence that the health of 60-year-olds or 65-year-olds was declining over the period in which older Americans' labor force participation was falling. Declining mortality rates as well as recent evidence about the trend in the physical disabilities of the aged suggest instead that the health of Americans is improving, at least in early old age. Moreover, analyses of the growth of different kinds of occupations and in their physical requirements imply that the physical demands of work are now easier to meet than they were in the past. A much smaller proportion of jobs requires strenuous physical effort; a larger percentage requires only moderate or light physical exertion. Of course, within every generation there will be workers who are in poor health and who work in physically demanding jobs. These workers will be among the first to retire. But it cannot be true that a general deterioration in health or widespread increases in the physical demands of employment explain the tendency for recent generations to retire earlier than workers in the past.

Financial incentives. Besides increasing most current retirees' lifetime wealth, the Social Security system also affects the financial attractiveness of remaining at work. Most workers can choose to collect Social Security starting at age 62, and many do.

One reason that many people must retire in order to collect a Social Security check is that the program imposes an earnings test in calculating the annual pension. Workers who are between 62 and 64 and who earn more than $10,800 a year lose $1 in annual benefits for every $2 in earnings they receive in excess of $10,800. Until this year, workers between 65 and 69 lost $1 in benefits for every $3 in annual earnings in excess of $17,000. (Pensioners age 70 and older did not face an earnings test.) At one time the earnings limits were much lower, discouraging pensioners from work and possibly encouraging them to postpone claiming a pension until they were confident their earnings would remain low.

Many employer-sponsored pension plans are structured similarly to Social Security pensions. Workers who are covered under an old-fashioned defined-benefit plan earn pension credits for as long as they work for the employer that sponsors the plan (sometimes up to a maximum number of years). The longer they work under the plan, the higher their monthly pension. Most defined-benefit plans are structured to encourage workers to remain with the employer for a minimal period – say, 10 years – or until a critical age – say, age 55. Workers who stay for shorter periods may receive very little under the plan. On the other hand, workers who stay in the job too long may see the value of their pension accumulation shrink. This would happen if the plan offered benefits to workers starting at age 55 but then failed to significantly increase the monthly benefit for workers who delayed retirement after age 55. If a 55-year-old worker can collect a monthly pension of $1,000 when he retires immediately and a monthly check of $1,001 if he delays his retirement one year, he will clearly lose a substantial amount of lifetime benefits – nearly $12,000 – for each year he postpones receipt. The worker essentially suffers a pay cut when he reaches age 55, and the cut is equal to the loss in lifetime benefits he suffers by postponing retirement. Such a pay cut might seem illegal under

U.S. age discrimination laws, but it is perfectly legal as long as the pay cut is reflected in reduced lifetime pensions rather than reduced money wages. Many employers find this kind of pension formula to be an effective prod in pushing workers into early retirement.

This explanation of the financial incentives in Social Security and employer-sponsored pensions sheds some light on the retirement trends discussed earlier. Social Security is now the main source of cash income of households headed by someone 65 or older. The program provides slightly more than 40 percent of the total cash income received by the aged. Among aged households in the bottom 60 percent of the elderly income distribution, Social Security provides over three-quarters of cash income. Until 1941, Social Security provided no income at all to the aged. Today the program replaces about 42 percent of the final wage earned by a full-career single worker who earns the average wage and claims a pension at age 65. If the worker has a non-working dependent spouse, the benefit replaces 63 percent of the worker's final wage. Benefits are clearly large enough so they can be economically significant in influencing the choice of retirement age.

The change in retirement trends after 1985. There are two types of explanation for the slowdown or reversal of retirement trends in recent years. One hypothesis is that permanent changes in the retirement environment have encouraged additional work by older Americans. Under this interpretation, the long-term trend toward earlier retirement is over. Another view is that temporary cyclical factors are responsible for a pause in the historical retirement trend. When these cyclical factors are behind us, the historical trend toward earlier retirement will resume. Although it will be many years before we can be sure of the relative importance of these explanations, it is possible to assess some of the permanent and temporary factors that have influenced recent retirement trends.

Although a strong economy has contributed to the recent rise in older Americans' participation rates, it is probably not a big part of the story. The economy also grew strongly and unemployment reached very low levels in the 1960s, yet older men's labor force participation rates fell in the decade and older women's participation rates changed very little (see Table 1). Joseph Quinn estimated the impact of the business cycle on older workers' participation rates, and found that changes in the overall unemployment rate account for a relatively small proportion of the change in participation trends since 1985. Most of the change in participation trends since 1985 is probably due to factors other than the cyclical movement in economy-wide unemployment.

Social Security's impact. It is easier to point to factors in the retirement environment that have permanently changed in a way that encourages later withdrawal from the job market. One important change is that the nation's main pension program, Social Security, is no longer growing more generous. Workers who retired between 1950 and 1980 retired in an environment in which Social Security benefits were rising, both absolutely and in relation to the average earnings of typical American workers. Most workers received pensions that were higher than those they would have obtained if their Social Security contributions had been invested in safe assets. The maturation of the Social Security program meant that fewer workers who retired after 1985 received windfalls from the program. The Social Security amendments of 1977 and 1983 brought an end to a four-decade expansion and liberalization of benefits. In fact, the amendments trimmed retirement benefits modestly in order to keep the program solvent.

Congress has changed Social Security rules and the pension formula to make work late in life more attractive. The amount of income a recipient can earn without losing any Social Security benefits has been increased, and the benefit loss for each dollar earned over the exempt amount has been reduced. For pensioners between 65 and 69, the earnings test has been eliminated altogether. In the 1977 and 1983 Social Security amendments, Congress also increased the reward that workers receive for delaying initial benefit receipt past the normal retirement age (NRA). Instead of penalizing work after the NRA, Social Security is becoming more age-neutral. When this formula change is fully implemented, for workers attaining age 62 after 2004, the adjustment for delayed benefit receipt will be approximately fair for retirements up through age 70. It is nearly so today. There will be no retirement penalty for delaying retirement beyond the normal retirement age.

Employer-provided pensions. Important changes have also occurred in the private sector. There has been a sharp increase in the relative importance of defined-contribution pension plans and a continuing decline in the importance of old-fashioned defined-benefit plans. Defined-contribution plans are age-neutral by design, and therefore they have none of the age-specific work disincentives that are common in traditional defined-benefit plans. As a growing percentage of workers reaches retirement age under defined-contribution plans, there will be less reason for workers to leave their jobs to avoid a loss in lifetime retirement benefits.

Eliminating mandatory retirement. Some changes in the environment are the result of policy initiatives aimed specifically at encouraging more work at older ages. For example, mandatory retirement has been nearly eliminated in the United States. In the early 1970s about half of all American workers were covered by mandatory retirement provisions that required them to leave their jobs no later than a particular age, usually age 65. In 1978 the earliest legal age of mandatory retirement was raised from 65 to 70, and in 1986 mandatory retirement provisions were outlawed altogether for the vast majority of workers. The increase and eventual elimination of mandatory retirement ages not only increased the options open to older employees who wanted to remain on their jobs, but also sent an important message to Americans about the appropriate age to retire.

This message was reinforced by a provision of the 1983 Social Security amendments that is gradually raising the normal retirement age in Social Security from 65 to 67. The higher NRA will become fully effective for workers who reach age 62 in 2022. So far as I know, the United States was the first industrial nation to pass a law lifting the retirement age under its main public pension program. Although few workers may be aware of the higher retirement age, many are affected by it already. Workers reaching age 62 in 2000 face a normal retirement age of 65 years and 2 months, which means that they will qualify for age-62 pensions that are 1 percent smaller than age-62 benefits under the traditional NRA. The delay in the eligibility age for unreduced pensions has an effect on benefit levels that is almost identical to across-the-board benefit cuts.

These changes in the retirement environment suggest that the future will not look like the past. The relative attractiveness of work and retirement at older ages has been altered in favor of work, though the changes may have produced only modest effects so far. The break in the early retirement trend that occurred in the mid-1980s suggests that changes in the retirement environment are having an impact in the expected direction.

Should we encourage later retirement?

Even if the trend toward earlier retirement has stopped, it is natural to ask whether the nation should take further steps to encourage later retirement. One reason often mentioned to induce later retirement is concern over public finances. Social Security is the largest item in the federal budget, and when the Baby Boom generation retires after 2010 it will become even more costly. Restoring both Medicare and Social Security to long-term solvency will be painful. The federal budgetary cost of achieving solvency would obviously be smaller if workers' eligibility for benefits under the two programs were delayed.

A large part of Social Security's long-term funding problem arises because of good news about longevity.[2] Americans now live longer than their parents and grandparents did. Their children and grandchildren can be expected to live longer than we do. The improvements in longevity mean that living Americans will survive much longer past age 65 than was true when Social Security was established in the Great Depression. The longevity increases provide the equivalent of a benefit increase to Social Security recipients. The benefit increase must be paid for if the system is to remain solvent.

While it might seem logical to raise the retirement age in Social Security to reflect improvements in longevity, most workers do not accept the logic of a later retirement age. American voters and workers routinely reject the idea of a higher retirement age when it is suggested as a solution to Social Security's problems. With rare exceptions, solid majorities of poll respondents reject any proposed hike in the retirement age. Most political leaders take their cue from the polling numbers. Nearly all of the presidential candidates in both political parties expressed strong opposition to the idea of a higher Social Security retirement age sometime during the past presidential campaign, for example.

Americans' hostility to a higher retirement age does not provide much guidance to policymakers, however. Big majorities also oppose other basic steps that would solve Social Security's funding problem. Most poll respondents are against higher payroll taxes, lower monthly benefits, and investment of Social Security reserves in stocks, where they could earn a higher return. Many workers' may oppose a higher retirement age in Social Security because they intend (or at least hope) to retire several years before attaining the *early* eligibility age for Social Security benefits. If the Social Security retirement age is increased, early retirement would become a less affordable dream.

Other options. There is no compelling reason to raise either the Social Security retirement age or the average retirement age, of course. If Americans' incomes continue to grow 1 or 2 percent a year, some fraction of the increase can be used to finance comfortable incomes during longer spells of retirement. This means, however, that more of the income earned by active workers must be set

[2] Much of the future funding problem is due to the maturation of the program (most future retirees will reach the retirement age with enough earnings credits to receive a full pension), slow growth in the future working population, and a long-term slowdown in the rate of real wage growth (which has deprived the system of anticipated revenues). Increased longevity explains only part of the system's funding shortfall.

aside to pay for longer retirements. This could take the form of higher payroll or income taxes to pay for Social Security benefits to the currently retired or higher personal saving to make up for the loss of monthly Social Security benefits if Social Security pensions are trimmed to preserve solvency.

There is some evidence that workers understand this trade-off. When forced to choose between the option of making larger contributions to pay for retirement or accepting smaller pensions after they retire, most workers opt to make larger contributions. By a 2-to-1 majority, workers favor higher payroll taxes over reduced Social Security pensions (Employee Benefit Research Institute, 1997, "The 1997 Retirement Confidence Survey: Summary of Findings." Washington, D.C., Chart 6). This suggests a simple conclusion: Americans would rather set aside more of their wages for retirement than postpone their retirement.

More work before retirement. Workers can offset the effect of higher retirement contributions by working longer hours during their prime working years. There is some evidence this is occurring. American work patterns have changed slowly but significantly over the past generation. Since the 1960s three major trends have affected adults' use of time. Women have joined the paid work force in record numbers; men have retired from their jobs at younger ages; and both men and women have devoted more years to formal schooling. The effects of these trends on average work effort can be seen in Figure 4, which shows changes in weekly hours of paid work between 1968 and 1998. The darker bars show average hours on a job during the second week of March 1968; the lighter bars, average hours exactly 30 years later in March 1998. The weekly average is calculated as the total hours of work during the survey week divided by the total number of men and women in the indicated age group. People who do not work are included in these estimates. (The estimates would show higher average hours if they reflected the work effort only of people who held jobs.)

In spite of the trend toward earlier male retirement since 1968, the figure shows a sizable jump in the total amount of time that Americans spend at work. The increase in hours was driven almost entirely by the surge in women's employment. The CPS interviews show only a small change in average weekly hours among men and women who actually hold a job. Averaging across all ages, women worked 49 percent more hours in March 1998 than they did in March 1968 (20.3 hours a week in 1968 versus 13.6 hours in 1968). The rise was due to a 45 percent jump in the fraction of women holding jobs. Partly offsetting the rise in women's employment was the dip in men's paid work. Most of the drop occurred as a result of sinking employment among men past age 54. Across all age groups, the male employment rate slid 6 percentage points (or 8 percent) between 1968 and 1998, but it fell 15 percentage points among men between 55 and 64 and 9 points among men past 64.

The combined effects of the shifts in male and female work patterns are displayed Figure 4. Averaging the trends of both men and women, we see that hours spent on the job increased for people 18 to 54 years old and declined for people past age 54. Older Americans clearly enjoyed more free time in 1998 than their counterparts in 1968, mainly because of earlier male retirement. For adults between 25 and 54, however, the estimates imply that paid employment consumes a much bigger percentage of available time. The employment rate of people in their prime working years jumped 11 percentage points – almost 17 percent – between March 1968 and March 1998, boosting the average amount of time spent in jobs from 28 hours to 32 hours a week. This increase is equivalent to five extra 40-hour work weeks a year for adults between 25 and 54. In short, Americans

are working longer hours between 25 and 54. The increase in hours should help them pay for shorter hours and longer retirements when they are older than 55.

Conclusion

After a long period of decline, the trend toward earlier retirement came to at least a temporary halt in the mid-1980s. Labor force participation rates of American men past age 60 leveled off, and in the past few years they have actually increased slightly. Participation rates among older women have risen significantly since 1985, though this trend may be the result of the historic shift in women's attitudes toward career employment rather than to a change in their retirement behavior *per se.* Along with workers in Japan and Scandinavia, Americans now leave the paid work force later than workers almost anywhere else in the industrialized world.

The question is, do Americans retire at an age that will ultimately prove unaffordable? As life spans increase, the fraction of life spent in retirement will rise unless we delay workers' exit from paid employment. Improved longevity places heavier burdens on active workers if retirees are supported by contributions from current payrolls. Even without any further improvement in longevity, the long-term decline in birth rates has slowed labor force growth and will eventually increase the ratio of retired to active workers. This will place extra pressure on retirement programs like Social Security and Medicare that depend on payroll taxes for most of their funding. To reduce this pressure, the country could adjust the age of eligibility for early and/or normal retirement benefits and take other measures to encourage workers to postpone their exit from the labor market. These steps would directly improve the finances of Social Security and Medicare. They would encourage some workers to delay their departure from career jobs and induce others to find bridge jobs to tide them over until full retirement benefits begin. The United States has already taken several steps in this direction, and these steps have contributed to the recent growth of employment among older Americans.

Although most workers today claim that they expect to keep working after age 65, or "retirement," most oppose additional changes in the retirement system that would push them to retire at a later age. A majority resists the idea that a higher retirement age is needed to protect Social Security. The United States is a rich country and will become wealthier in the future. It can certainly afford to maintain current retirement patterns if its citizens choose to spend their additional wealth in this way. The important public policy issue is the importance of this goal in comparison with other legitimate uses of the rise in wealth.

Proponents of a higher retirement age often focus on the long-term trend in older people's employment rates without considering what has happened to work effort and productivity among people before they reach the retirement age. They worry about the budget cost of retirement at age 62 without reflecting on the fact that younger workers may be paying for their longer and healthier retirements by working harder and more productively in their pre-retirement careers. As long as productivity continues to improve, American society and individual workers can choose how they want to allocate the income gains that flow from higher productivity. The evidence of the twentieth century suggests they will use at least part of it to pay for a longer retirement.

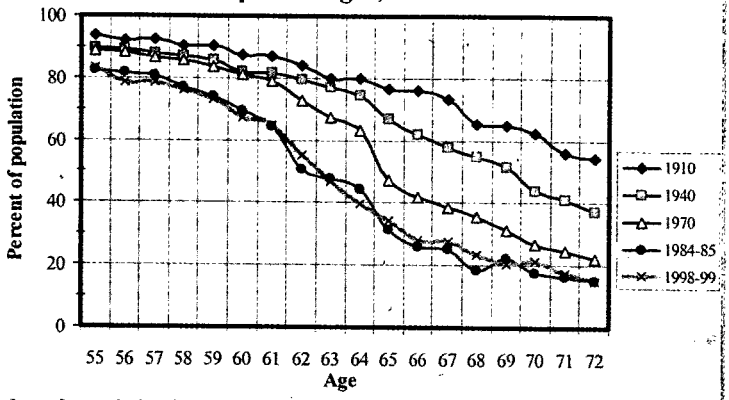
Table 1. Labor Force Participation Rates at Selected Ages by Sex, 1940-1999

Percent of population

Year	Age 55	60	62	65	70
Men --					
1940	90	82	80	67	44
1950	88	82	80	68	45
1960	90	83	79	54	33
1970	89	81	73	47	27
1984-85	83	69	50	32	17
1998-99	83	68	55	34	21
Women --					
1940	20	17	15	12	6
1950	28	23	21	16	8
1960	43	35	29	20	12
1970	50	43	36	22	11
1984-85	52	44	32	17	10
1998-99	67	49	43	24	15

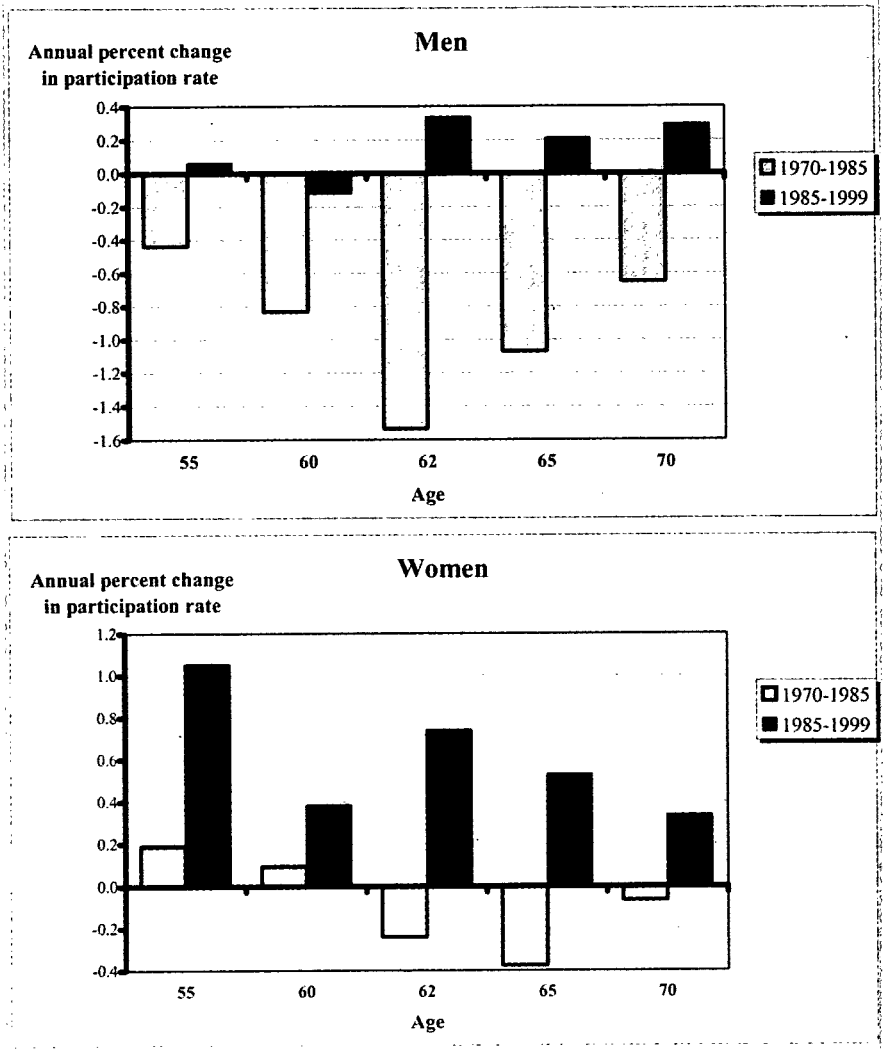
Source: Munnell (1977), p. 70, and authors' tabulations of March CPS files for 1984, 1985, 1998, and 1999.

Figure 1. Labor Force Participation of Men at Specific Ages, 1910-1999



Source: Ransom, Sutch, and Williamson (1991); Munnell (1977); and authors' tabulations of March Current Population Survey files for 1984-85 and 1998-99.

Figure 2. Annual Change in Labor Force Participation Rate at Selected Ages, 1970-1985 and 1985-1999



Source: Authors' tabulations based on Mumell (1977), p. 70, and March CPS files for 1984, 1985, 1998, and 1999.

Figure 3. Average Retirement Age of American Men, 1910-1999

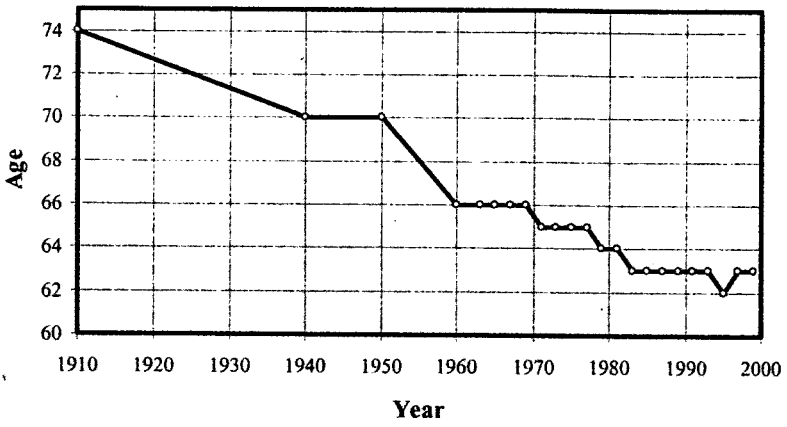
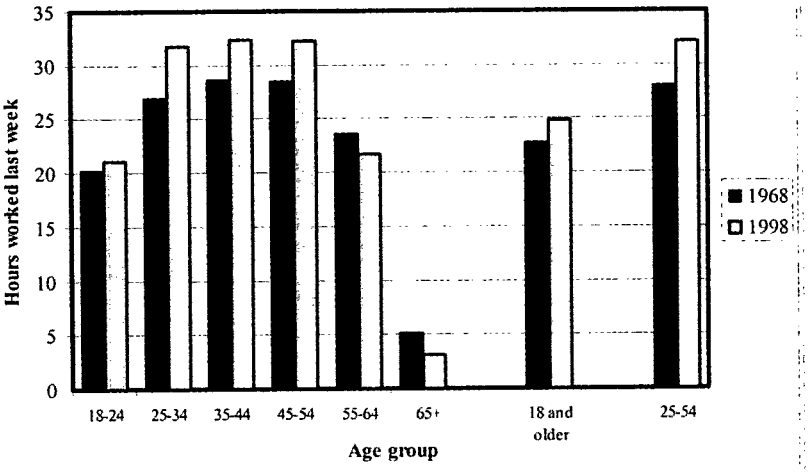


Figure 4. Average Hours of Work, by Age Group, in the U.S. Population, 1968 and 1998



Source: Authors' tabulations of March 1968 and March 1998 CPS files.

Ms. COOK. Our next speaker is Tim Smeeding, who will focus on income. Professor Smeeding is Maxwell Professor of Public Policy and Director of the Center for Policy Research at the Maxwell School at Syracuse University.

STATEMENT OF TIM SMEEDING, PROFESSOR OF ECONOMICS AND PUBLIC ADMINISTRATION, CENTER FOR POLICY RESEARCH, SYRACUSE UNIVERSITY

Dr. SMEEDING. Thank you, Fay. It is really nice to have all you folks out here today. For those of you who did not get all the material, I have some handouts and that just outline what I am about to speak on. You do not need this if you were here early and got a copy of the printed statement.

The title of this forum is Living Longer, Living Better and I have a big question mark after the title, not a colon like the rest, but a question mark. This is because not everyone may be living better in the future and I think public policy ought to pay some attention to that. We can afford to make everybody live a better, poverty-free, life in old age but it is not clear that we will do so. I also have a small disclaimer. Jim Smith from Rand and I wrote part of this testimony for the Democratic Leadership Council/Progressive Policy Institute, which was called "The Economic Status of the Elderly on the Eve of Social Security Reform," and you never met two stranger bed-fellows, politically, than Jim Smith and I. We ended up agreeing enough that we could forge a consensus on how to reform social security. I am not sure that is going to happen over the next 4 years in this building, but it might.

I want to talk about economic well-being now and in the future, including briefly talking about provision for health care, knowing that Marilyn Moon is following me to talk about that exact topic. In particular, I want to focus on the most at risk group among the elderly, and that is very elderly women. Old age looks very differently if you view it from age 62 or 64 with two pensions, two jobs, good savings, a house, maybe a second house, a car, and all that, or if you view it from 90, looking backwards, having outlived your spouse for 15 or 16 years, being alone, in poor health, dependent only on Social Security and so forth. I do not want policy makers to forget that latter group.

First of all, I am going to look at the economic status of everybody, then focus in on older women, and then I am actually going to read the last paragraph or so from my written statement to make sure I am clearly understood here. I am willing to cut a bargain with the incoming administration to have a mandatory savings, defined contribution, privatized savings plans for older Americans, as long as that risk is compensated for by guaranteeing that by 2020, no elderly person in America will be poor or will spend their way into poverty for health care. That is the bargain I want to cut.

First of all, some of the facts—we have done pretty well in this country with Social Security in fighting poverty among the elderly. About 35 percent of the elderly were poor in 1959. In 1999, 40 years later, is just under 10 percent, which is pretty darn good. On the other hand, understand that this poverty notion may be little far-fetched, $6,000 or $7,000 per year is the poverty level for a sin-

gle person. We still have 17 percent of the elderly today living on less than $10,000 per year, 17–19 percent of all older people living on less than $10,000 per year, less than $1,000 per month. There is a big chunk of them between the poverty level $7,000 and $10,000 and they are mainly little old ladies.

If you look at wealth as well as income and if you really want to measure the well-being of the elderly, you have to take a number of things into account, not just their income. You would also like to look at their wealth, their housing and, particularly, their liquid assets and their health status. When we do, you find an even bigger variance. Do you know that your average elderly person today has about $6,500 in financial wealth? That is all—$6,500, your average, median elderly person. Sure, the upper quintile has got pension plans and retirement plans, and second homes and all that. On the other hand, there are a number of people below the median who really think hard about whether they ought to go buy those prescription drugs, or fix their roofs because they are spending into what little bit they have left.

You have to also understand that the lower you go on that income distribution, the more people rely on Social Security. It is the only inflation protected thing you can really count on. For little old ladies, you find that it matters that your husband did not select a survivor's benefit, for his company pensions. Increasingly more are selecting this benefit, but a lot do not because they rely on survivor's benefits from Social Security. You also know that Social Security is inflation protected. Every year, it will go up with the cost of living and so on, while private pensions do not.

The older you get, the more female you get, the more minority you get, the larger the reliance on Social Security. Among people with $10,000 a year or under, 80 percent of their income comes from Social Security.

That is where we are today. Is it going to change in the future? Let's focus a little more on older women, since that is a group I really want to talk about, and then see if the situation will change for them in the future.

You have to understand, when you are talking about old, you are talking about women. Three-quarters of the people 85 years and older are women. Three-quarters of all poor persons in America over age sixty-five are women. Your average widow lives fifteen years in widowhood in old age. Thus I am talking about the people who really need help now. You have to understand, when we look at Social Security, when we designed it in the 1930's, we designed it for Ozzie and Harriet. I can say that to you, but my students do not know who Ozzie and Harriet were. I know you do. The Simpsons? Okay the Simpsons then, a married couple where one works and the other stays home with the kids.

There is a huge change that is going to take place in the next 20 years in the composition of elderly women and it is something that policy has to spend some time on. What is going to happen is the fraction of older women who are divorced and never married is going to go way up and those are among the most at risk groups. In fact, if you just flip over my handout and look at the back, look at this one little chart. This really captures a lot.

What that chart says is that according to the Social Security Administration's projections using their MINT model, there are going to be just as many poor older women in 2020 as there were in 1991, 12 percent. How can that be? Most of the women in this room have jobs, they have pensions, they are going to be better off. If you are married, you will do a little better by 2020. Even if you are widowed, you do a little better by 2020. But divorcees and never married, which are today only about 10 percent of older women, will be 25 percent of older women by 2020. And never married, we mean increasingly minority women, women of color, as well as white Anglo women, and women who may have never married, may have been single parents their whole life, may have worked in informal jobs instead of working in formal jobs, and so on. And the poverty rates for these groups are above-average, so they are pulling up the poverty rates for the rest of us, leaving the overall poverty rate the same.

There are all sorts of solutions to this problem. I have suggested a number of them. We can find a way to deal specifically with widowed women. Virtually everyone wants to do that, to do something for divorced women, such as sharing Social Security as an asset at divorce the same way you would other assets in the family, and even for the never married. At the same time, we are going to have to have some Social Security reform to go on top of this.

The election is almost over, and when it is over, the newly elected President will wake up and will say what all of us have been saying all along, about the bad news along with the good news of Social Security. Somebody is going to have to cut benefits somehow, maybe raising the retirement age. We will probably end up raising taxes a little bit. We certainly will have to raise taxes to pay for Medicare, I think. In any case, I will be done as soon as I read this last paragraph in my testimony.

Social Security reform must ensure against old age poverty and poor health status by means of a more solid and generous lower tier to the Social Security and old age security system. At the same time, we need to further strengthen incentives to save and keep on saving, particularly among lower and middle income households, if we want them to enjoy a three-legged stool to have something besides Social Security and if you passed a mandatory add-on, defined contribution pension plan, a lot of low income people will have something besides Social Security.

I, for one, am willing to assume some risks of an expanded and in some ways privatized, Social Security system if we were, at the same time, to guarantee that no elderly woman or man would ever live in poverty or spend herself into poverty for health care needs. I am willing to make that bargain.

There are many ways to make it, too. While these changes are not costless, the gains to the system estimated by privatization advocates should be more than enough to pay for these changes and, at the same time, modestly increase the well-being of low-income older women. I strongly urge Congress to make just such a bargain for the well-being of all of our wives, mothers, grandmothers and daughters, the most important beneficiaries of the Social Security system. Thank you.

[The prepared statement of Mr. Smeeding follows:]

Living Longer, Living Better? Economic Status in Old Age

Presentation for the
Special Committee on Aging
United States Senate

Sponsored by the Gerontological Society of America

November 21, 2000
Hart Building, Room 216
10:00 am – 12:00 pm

by
Timothy M. Smeeding*

*Maxwell Professor of Public Policy and Director, Center for Policy Research, The Maxwell School, Syracuse University. Much of this discussion is taken from CPR Policy Brief #16 and Smeeding and Smith (1998). The views expressed are solely my own and should not be ascribed to Jim Smith, Syracuse University, the Progressive Policy Institute, or anybody other than the author.

Introduction

This testimony concerns the economic status—income, wealth, and poverty—among the elderly as we enter the 21st century. The testimony is derived from two recent surveys of the literature (Smeeding 1999; Smeeding and Smith 1998), with some updating based on recent developments in income, wealth, and the cost of health care, and in light of the upcoming debate over the inevitable Social Security and Medicare reform efforts which this country must face early in this century. I begin with a summary of the current and projected incomes and wealth status of the aged. I then turn to the most at-risk group among the elderly (older women). Throughout, and particularly in closing, I discuss the relevance of these trends and projections for Social Security and Medicare reform.

Economic Status of the Aged

The first thing to stress is the theme of economic heterogeneity among the aged. While "averages" (means, medians) are used to describe economic well-being, they are often a poor indicator because of the wide disparity among various subgroups of the aged classified by gender, race, ethnicity, and health status. This diversity often makes it difficult to adequately describe the economic well-being of such different groups as 60-something retired couples and 90-year-old single women by any one dimension, much less well-being more generally.

That is, the economic condition of the aged is a story of both change and variance. While many Americans are enjoying very comfortable retirement years, many others age under the significant threat of economic deprivation. There have been dramatic improvements in the average economic well-being of older Americans over the last several decades, but many still

subsist near or below the poverty line. Using both income and wealth as measures of economic well-being, one can draw a picture of old age filled with both the bright lights of economic security and the dark tones of economic distress. Moreover, if one goes beyond descriptions of current older Americans to consider the likely economic well-being of the next century's older population, one finds even greater expected diversity.

Income and Poverty

Poverty rates among the old is an example of this diversity. Over the past four decades the economic status of the aged has improved considerably and their poverty rates have been cut by two-thirds, from 35 percent to 10 percent. Still minorities and older women living alone have poverty rates in excess of 20 to 25 percent. Moreover, a much larger fraction of the aged than of the non-aged live right above poverty (between 100 and 125 percent of the poverty line), and are therefore living on less than $10,000 of cash income per year. And, if we were to follow a National Academy of Sciences recommendation and subtract out-of-pocket health care expenses from the incomes of the elderly in determining their poverty status, the fraction counted as poor would be 14 percent, not 10 percent.

The average economic status of the aged also differs sharply depending on marital status, minority status, and age. In fact, disparities in economic in economic well-being are greater among the elderly than among the non-elderly. The three-legged stool of Social Security, income from financial assets, and pensions works well only among the top 20 percent of the aged; the bottom 20 percent rely on Social Security for over 80 percent of their income. This dependence is particularly large for older women, minorities, and those in poor health. And for the most part the level of Social Security benefits alone for these groups is too low to escape poverty.

Over the next half-century, Social Security will contribute a decreasing share of the income needed for a secure retirement. The demographic and fiscal crunch facing the system

rules out large, across-the-board increases in benefits. As Social Security transfers decline in relative importance, personal savings, job-related pensions and earned income from working longer will assume a larger rule in guaranteeing economic security for older Americans. But these other sources of economic well-being are considerably less secure and reliable than is Social Security among the very old, particularly among older women.

Wealth

Income is not the only measure of well-being among the old; wealth also matters, and here we find even more variance. Inequality in wealth holdings is much greater among the aged than is income inequality. Many older households have extremely modest levels of accumulated savings, especially financial assets. For example, the *median*, i.e., the "average" older (aged 70 and older) household has less than $6,500 in financial assets, enough to get by for less than half a year. A measure of well-being that takes account of this would show greater inequality than one based on income alone. Hence, income inequality *understates* overall economic inequality among the aged. Wealth inequality among the elderly is largely the consequence of past savings decisions. In addition to income, savings are influenced by past health shocks, a desire to leave bequests to one's heirs, and disincentives to private savings provided by asset-tested transfer programs, like SSI.

Many features of Social Security (OASI) have changed little since they were designed in the 1930s and 1940s. Back then, life expectancy was much shorter, couples stayed married and wives, most of whom were also mothers, did not work outside the home. While society has changed, Social Security's basic distributional scheme has remained the same, and this has produced results that are not easy to understand or defend at the turn of the century. They will be even harder to defend in the future, particularly as we face a sea of change in the economic well-being of older women, the most at-risk group among older Social Security recipients.

Older Women

The Social Security program was designed over 60 years ago for a world in which women married, stayed home and raised children, and were widowed at a relatively young age; where fathers worked in industrial settings; and where both men and women had much shorter life expectancies at older ages than those of succeeding generations. Back in 1935 the founders of Social Security did not anticipate that women would become the major beneficiaries of the program. Increasingly, women rely on Social Security as the major source of their economic security at older ages, much more so than do men. Therefore, women are the group with the most to gain or lose from reform of the Social Security system and modification of its benefit formulae.

Future women beneficiaries will be different than today's beneficiaries, since as women's lives are changing rapidly in many ways. More women work outside the home today, and about one-half of all current marriages will end in divorce. Increasing numbers of children grow up in a single-parent family, typically that of the mother. The higher future benefits expected for married women with their own careers in the labor market need to be balanced against the potentially bleak economic situation in old age for a large and growing number of divorced and never married women.

Older Women Today

Benefit adequacy and economic security for women in old age should be our primary concerns. Social Security is the only guaranteed, inflation-protected, lifetime benefit for older people. More than two in three persons aged 75 and over are women, and almost three in four persons aged 85 and older are women (Social Security Administration 1998). Since the population aged 85 and over is the fastest growing group among the old, their economic and

health care needs are of particular importance For instance, at least one member of the average couple who retires today and begins receiving Social Security benefits will live an average of 25 years (Social Security Administration 1998). Women at age 65 are expected to live an average 3.3 years longer than men, and because most women marry older men, women are three times more likely to be widowed in old age than are men (Anderson 1998). This produces an expectation of over 15 years that the average older female survivor spends as a widow (Schoen and Weinick 1993).

One might ask, how do these older women fare? In fact, three of every four poor elderly people are women. Poverty rates for the elderly are highest among divorced, never married, and widowed women—all about 20 percent—compared to a poverty rate of below 5 percent for married women. And older United States women have poverty rates 1.5 to 20 times higher than those found in other rich western nations in the Organization for Economic Cooperation and Development (OECD) nations (Smeeding 1998; Burkhauser and Smeeding 1994), even before accounting for their higher out-of-pocket health care costs.

The importance of Social Security to older women cannot be overestimated. If there were no Social Security, and barring any behavioral change, more than one-half of all older women would be poor today (Social Security Administration 1998). Women are far less likely than men to qualify for private pensions (30 percent vs. 48 percent in 1994). And even when women do receive their own pensions, they qualify for benefits that are only about one-half the median benefit received by men. Finally, about one-third of husbands still do not elect joint and survivor options for their private pensions upon retirement, despite federal legislation to encourage that choice.

On average, unmarried women receive 72 percent of their incomes from Social Security. The percentage of income that comes from Social Security rises with age, rises among older

women living alone, and rises as overall income declines. For instance, widows aged 80 to 84 with below-median incomes rely on Social Security for more than 80 percent of their income (Macunovich 1999).

Finally, while poverty rates for older women are high, Social Security keeps many more older women out of poverty. In 1998, Social Security reduced the poverty rate among older women from 53 to 14 percent (among men the rate was reduced from 41 percent to 8 percent). For elderly widows, as well as for women aged 85 and over, Social Security plays an even larger role, reducing the poverty rate from more than 60 percent to about 20 percent (Porter, Larin, and Primus 1999).

Older Women Tomorrow

While more women will have greater lifetime earnings in the future, they will be increasingly likely to be unmarried and will be at greater risk, due to higher rates of divorce and greater periods of single parenthood, than were previous generations of elders. For black women, the numbers will be much higher due to higher divorce and never married rates. More women, both black and white, will choose to have families outside of marriage, and the number of women who are predicted never to marry will also increase (Iams and Butrica 1999). These changes will lessen the level of social and familial support, as well as economic support, that we can expect in the future.

The net outcome of these changes in earnings, pensions, and marital status is very difficult to predict with any degree of certainly. However, the Social Security Administration's Office of Policy has developed a model to predict the distribution of retirement income for future Social Security beneficiaries. Figure 1 presents some results based on this model (Iams and Butrica 1999; Smith and Toder 1999; Butrica, Cohen, and Iams 1999).

The broad picture in Figure 1 shows that the poverty rate for older women receiving Social Security benefits in 2020 will be exactly the same as it was in 1991, 12 percent. In fact, the official overall poverty rate for older women in 1999 in 11.8 percent (U.S. Bureau of the Census, 2000, Table 2). While poverty rates will be a bit lower for married, divorced, and widowed women in 2020, they will stay high among divorced women (22 percent) and widowed women (15 percent). Poverty among never-married women, many of whom will be never-married mothers in 2020, will increase from 23 to 35 percent. Finally, poverty among married women, which was only 4 percent in 1991, is expected to decline to 3 percent in 2020. These results are driven by the fact that the fraction of older women who are divorced and never married will rise from 10 percent in 1991 to 25 percent in 2020 (see bottom of Figure 1). These results suggest that many of tomorrow's female Social Security recipients will be no better off than today's, and that poverty and insecurity will be as much a problem of older women in 2020 as in 1991 or 1999.

Despite the "good news" of greater labor force participation of women, which will increase the number of women with pensions and long earnings careers at higher earnings levels, there is also the "bad news" that divorce, never marrying, and the poor earnings futures of low-skilled women will yield poverty outcomes that mirror those we find today. Therefore, Social Security reformers should be wary of reform elements that put benefit adequacy or insurance protection at risk, and should pay special attention to provisions for widows, the never-married, and women who are divorced. Lower income older women will need Social Security just as much or more in the future as they do today.

Economic and social change will have both positive and negative effects on the economic security of tomorrow's women in old age. One can hope that women's earnings, Social Security benefits, and private pensions will grow to mirror those of men, but we must realize that

tomorrow's women will experience many of the same insecurities and risks due to their social roles and career work and family patterns as do those of today (Iams and Sandell 1998). If we as a society want to reduce poverty among older women, we must take precautions now to provide even better levels of benefit adequacy and economic security through the reformed Social Security system. In particular, we should better protect those individual women who will lose more than is gained overall from these ongoing and tumultuous social and economic changes.

Conclusions

In summary, the legs of the traditional retirement income stool are increasingly unequal. Social Security (OASI) will continue to play a very important role in the incomes of many current and future elderly at the same time that a large number of well-to-do Americans will find that Social Security is becoming an increasingly smaller source of their economic well-being in old age. The growth of two-earner households, the rise in women's careers, and uncertain factors such as the recent growth in the return to retirement investments will ensure this change, even if there is no change in Social Security. But there will be a change; in fact there must be one, to preserve the system's integrity. And the sooner the change is made the easier will be the adjustment costs and the adjustments themselves.

The upcoming reform of the pay-as-you-go OASI system may involve different investment regimes for the trust fund or for individual participants in the system. But even if we follow some sort of privatization strategy, there still must be benefit reductions or tax increases to cover projected future revenue shortfalls. Benefit reductions to remedy the deficit in the pay-as-you-go OASI system and to maintain current benefits should not compromise the program's ability to provide a decent non-poverty level standard of living to the low-income elderly. In particular, given that three out of every four poor aged persons are women, these changes should,

if anything, be designed to strengthen the anti-poverty effect of the system on older women, particularly surviving spouses, divorcees, and never-married older women.

We will have a new President and a new Congress in a few weeks. Many Congressmen and Governor George W. Bush are wedded to some form of privatization of the Social Security system. Such a change introduces the possibility of higher returns on Social Security investments, but also the risk of poorer outcomes due to the volatility of the stock market. But, as stated by *all* serious analysts, there must also be some pain in higher taxes and/or lower benefits as the system pays off its unfunded liabilities. However, there is little talk among the President's advisors of strengthening benefits among those most at risk due to divorce, widowhood, or being a never-married woman.

Social Security reform must insure against old age poverty and poor health status by means of a more solid and generous "lower tier" to the Social Security and old age income security system. At the same time, we need to further strengthen incentives to save and keep on saving, particularly among lower- and middle-income households, if we want them to enjoy a solid three-legged stool of pensions, savings, and OASI in old age. I for one, might be willing to assume the risks of an expanded and privatized Social Security system, if we were, at the same time, to guarantee that no elderly woman (or man) would ever live in poverty or spend herself into poverty for health care needs. There are a large number of ways to make such a guarantee (e.g., Smeeding 1999). While these changes are not costless, the gains to the system estimated by privatization advocates should be more than enough to pay for these changes and at the same time modestly increase the well-being of low income older women. I strongly urge Congress to make just such a bargain for the well-being of all of our wives, mothers, grandmothers, and daughters—the most important beneficiaries of the Social Security system and the ones most threatened by future Social Security Reform.

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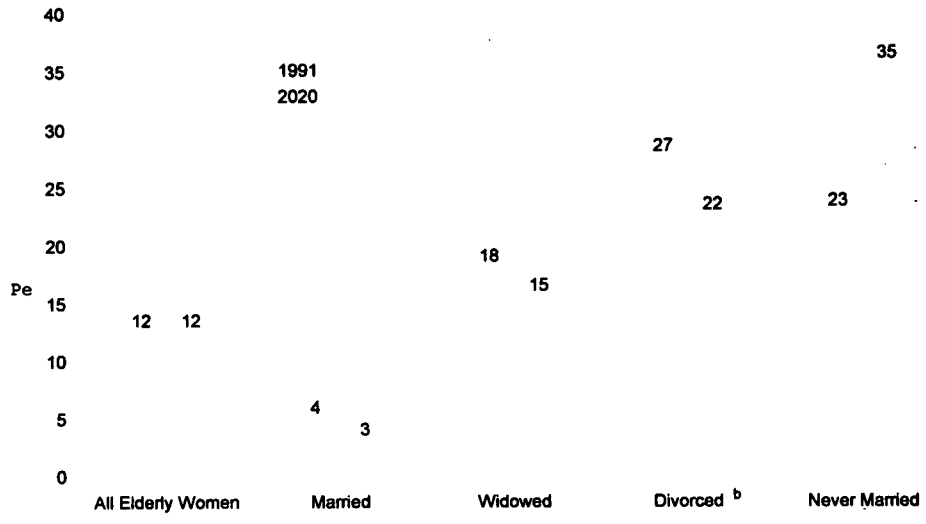
Figure 1.

Poverty Rates of Elderly Women Beneficiaries by Marital Status, 1991 and 2020[a]



(Distribution of Older Women Receiving Social Security by Marital Status)

1991	(100.0)	(48)	(42)	(6)	(4)
2020	(100.0)	(44)	(31)	(19)	(6)

Source: SSA MINT Model.

Notes:

[a] Output presented by H. Iams and B. Butrica to the SSA Technical Panel, April 1999.

[b] "Divorced" includes separated and divorced women.

Ms. COOK. We now turn to the issue of and the domain of health. Marilyn Moon is the Senior Fellow at the Urban Institute here in Washington, and she will discuss health.

STATEMENT OF MARILYN MOON, SENIOR FELLOW, THE URBAN INSTITUTE

Ms. MOON. Thank you, Fay. I would like to remind Tim, that the Simpsons actually are Ozzie and Harriet. They are a family with a husband and wife, and the wife stays home as a homemaker and has three kids. Tim is making himself look a little old by not watching it, as I do religiously.

I might actually go along with some of Tim's bargain, as well, because health is a critical issue. We are talking about increasing risks to individuals and individuals taking more responsibilities, because we all have defined contribution plans instead of defined benefit pension plans, or many of us do, because we are talking about potentially reducing Social Security in ways that would have us shift more of what used to be a very stable base into areas that carry higher risk, in order to try to get higher returns. Therefore, we should be very careful before adding to risks for people through the health care system. Unfortunately, that is where many of the proposals on the table would go.

Health care raises interesting issues in terms of living longer and living better. Ironically, living longer is touted as a problem for the Medicare program, because it means more years of coverage and hence higher costs. And living better requires more resources in health care, also raising costs. There are some difficulties facing the Medicare and Medicaid programs, the public programs that fund this care, and even if there are cutbacks, society is going to have to deal with these costs since people have to get care somewhere. That is what I mean about the problem of increasing risks on the older population.

Despite claims that the Medicare program, which I am mostly going to talk about today, although a lot of what I have to say refers to Medicaid, as well. Despite claims that the Medicare program is unsustainable in its current form, this program has achieved major successes, and we should keep those in mind as we think about what are likely to be necessary changes.

First, Medicare has achieved near universal coverage. Although only about half of all people were without insurance, before Medicare within a year-and-a-half Medicare covered about 97 percent of all the elderly and it has remained at about that level ever since. Largely, the other 3 percent are folks who do not qualify for Social Security benefits, usually because they are legal immigrants who have not accumulated enough quarters of coverage.

Medicare also gives people access to mainstream care, although there was worry that when Medicare was passed in 1965, that it would be boycotted by physicians and that hospitals would turn people away. It has proved to be a very good program in terms of getting people access to mainstream care. For example, the diffusion of new technologies often occurs at a faster rate for people over the age of 65 than under the age of 65. Although some people have criticized Medicare's coverage delays for new technology, in large measure, that has not been a problem, because people in the Medi-

care program have gotten care with much of the new "gee whiz" technology as fast as anyone else.

Third, Medicare was very important to the desegregation of hospitals, and has been a very important reason why a lot of minority people have achieved access to care that they were denied before Medicare, a major and important change. Again, Medicare plays a social insurance rule, not just an insurance role.

Fourth, financial burdens fell for beneficiaries who were covered by the program, even though Medicare does not cover all health care costs. It covers only about a little over half of the acute care costs that seniors and disabled persons face. Financial burdens fell for seniors from 19 percent of their income in 1965 to 11 percent in the years immediately after Medicare came on board, although ironically, we are now up to over 20 percent of individuals' incomes going to health care cost, not counting long-term care.

If projections that we have just recently done, and will be out in a paper very soon, come to fruition, my last year's projection of 28 percent of people's incomes by 2025 will not only be wrong, they will be higher. It will be over 30 percent, largely because of prescription drug costs.

Medicare has also been relatively successful in holding down the cost of care. Despite a lot of rhetoric the costs per person of Medicare have actually grown slower between the years of 1970 into the late 1990's than the costs per capita for private health insurance. There are some ways in which additional adjustments should be made for this comparison, but even after you do those, Medicare certainly does not come out any worse than private insurance. It still comes out a little bit better.

Finally, Medicare now offers people access to private HMOs and other private health insurance plans, although they are largely HMO-based. Although this, I would argue, has been the least successful part of the program, largely because Medicare has not found a good way to pay reasonably on behalf of these folks. Medicare initially paid too much to plan, which meant that people were getting lots of extra benefits, loving it. Now that we are trying to pay a little less, there are a lot of very unhappy beneficiaries and very unhappy of HMOs out there who like their windfall and want to keep it.

Sorting out payments to private plans is going to be a big challenge, and one that overshadows the future of the Medicare program, in terms of the kinds of reforms people may consider.

Projections are for costs to rise in the Medicare program in 2025 to almost 4 percent of GDP, from 2.29 percent in 2000. This would be a 72.5 percent increase in cost as a share of our economic well-being. But the number of people covered by the program will grow 78.5 percent. In many ways, the question is how much do we think we can reasonably ratchet down the program, in order to accommodate, instead of one in every eight Americans, one in every five Americans in the future?

I would argue that efficiency and fraud and abuse efforts are not going to get us there. They are not going to allow us to keep the share of GDP at the current level, which means, as Tim mentioned, additional financing is going to be necessary for this program. We would be well-served to come to grips with that pretty quickly.

Rising wages will make people better off. Even relatively modest increases in productivity will mean future generations will be substantially better off, and could afford to help pay for care for seniors and disabled persons. One of the questions is, will people be willing to pay through the public sector. If we decide we want to reduce efforts in the public sector and rely more on private initiative and private activities, then we will have to forego an ability to redistribute resources and hence care to beneficiaries.

I believe it is necessary to improve benefits over time, for a number of reasons. First of all, because the share of what people are paying out-of-pocket and through purchasing insurance policies is quite high, they bear the risk of higher costs for much of their care. Medigap premiums are getting to be out of sight, and are not particularly a good deal for many people who want to buy insurance to protect themselves.

Risk means that today Medigap premiums are often much higher for the very old then the young old, for example. We do not community rate or share resources for these private supplemental plans, for the simple reason that they are out there to make money and to provide services for these folks. They are not in it for social insurance reasons. Again, this means a lack of redistribution. Further, it also means that it is very difficult to find a way to expand coverage, for example, for prescription drugs, or to improve the cost-sharing of the current program without taking away business from private insurers.

Recently I made the argument for expanded coverage, I got a very nasty letter from a lady who said she and her husband received free prescription drugs because he was a veteran, and she did not want to have to pay for anybody else to get less expensive prescription drugs. Within the beneficiary population, there will be people who do not want to see the rules change, because they are well-off now. But we have, however, an extremely messy and inefficient system. For grounds of both risk and efficiency, I would argue it would be important to expand and improve benefits.

In terms of the older women that Tim worries about, in the new projections we have been doing, we look at cohorts, and older women could be spending well over 60 percent of their income, for health care in 2025 if nothing changes. That is up from just a small 35 percent of their income right now.

In terms of solutions to Medicare's problems, we do need to work on coordinating care. But unlike many people, I do not believe that we suddenly turn to the private sector for answers. HMOs have been successful in managing care for the rest of the population so why should we think they will do just fine for seniors.

We are going to have to have new models on both the fee-for-service part of Medicare, which will be around as the default option for a very long time and private plans. We ought to spend some time getting much better at managing care in fee-for-service, in a cooperative way with beneficiaries, and we ought to encourage the private sector to continue to find ways that work. Reform needs to go forward with a double-barreled strategy, rather than turning it all over to the private sector.

Finally, let me say a little bit about financing of the program. I have already mentioned that we will have to ask taxpayers, young-

er taxpayers, to pay more, but I believe we will also have to ask beneficiaries to pay more. One way to do that is through higher cost-sharing or, for example, through making people more at risk by raising the premiums if they choose higher cost plans. These are not the preferable ways to go. If we are going to ask beneficiaries to pay substantially more, we should consider, for example, taxing the actuarial value of medical benefits. This is not a wildly popular idea, but certainly a fairer idea than many others.

We should also think very carefully before raising the age of eligibility which many people offer as a panacea. I do not think it will do very well. Because, if you raise eligibility for people 66 and 67, that is about 5 percent of the Medicare population. If you think about how much they cost the Medicare program, it is about 2 to 3 percent of the cost of the Medicare program, because those are the cheap people.

We would keep on the eligibility roles these who are disabled and who age into that age group. These are the expensive people in that age group. We would not save nearly as much as many people think when they talk about raising the age of eligibility. We would move the cheap people out of Medicare into the private market, where they will raise the rates for everybody else, the 63-year-olds, who are not going to be very happy about this. Unless we have very good insurance reforms, we would have a mess.

Then, finally, we will also tick-off current beneficiaries, because current premiums are related to the average costs of Medicare. Raising eligibility age will cause those average costs to go up and premiums will go up for seniors. It is a real lose-lose proposition when you begin to look at this option. I am surprised that anybody ever talks about raising the age of eligibility, but then I am one of those dinosaurs that lives in a world that believes that social insurance is important, that Medicare and Medicaid contribute to the lives of seniors and disabled persons. We need to find ways to keep Medicare a vital and vibrant program, to expand coverage a little bit to make it a more rational system, and to recognize that we are going to need to put a crowbar into our wallets to get there. Thank you.

[The prepared statement of Ms. Moon follows:]

Health Issues in Living Longer and Living Better

Marilyn Moon[1]

Health care for older Americans plays a critical role in determining whether Americans are living longer and living better; and in turn, longer lives pose challenges for the public programs that serve this population. Medicare and Medicaid represent success stories in improving access to health care for seniors. Without these programs, some of the progress in life expectancy and lower morbidity would not have occurred. And because health care costs are likely to continue to grow as a share of our economy, affording care in the future will also mean an important role for public policy.

The aging of the baby boom generation will clearly have a major impact on the numbers of persons over the age of 65 in the United States. But also important is increasing life expectancy. As a result, the population profile for the future is not the infamous "pig in a python" that people used to discuss, but rather a "python in a python." We are facing not just a period of time in which older persons will increase as a share of the population, but a permanent shift to a society with a large number of senior citizens. This will place increased demands on all public sources of expenditure for older Americans.

Rather than looking forward to ways to improve Medicare and Medicaid for the future, however, much of the rhetoric since the 1980s has been of Medicare as an "unsustainable" program that must be dramatically overhauled as we move into the 21st century. Spending on

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the program of $213 billion in 1999 certainly represents a large commitment of resources and one that is projected to rise substantially over time. But calls for major reform to "save" Medicare could lead to changes that would undermine the program's basic strengths. Implicitly, such efforts could place a greater burden on Medicaid to fill in the gaps, or effectively replace it if Medicare were also to become an income-related program. This brief paper focuses mainly on Medicare since it is likely to be in the front lines initially. Medicaid, on the other hand, has not nearly been as much in the public eye, although it too will likely face greater demands as the population ages.

The Accomplishments of Medicare and Medicaid

Before examining the issues facing these program in the future, it is appropriate to review the improvements in the lives of older Americans that these two health insurance programs have achieved. As the larger and primary source of insurance for this population, Medicare receives more attention, but Medicaid plays an important role both in covering the gaps that Medicare leaves for those with low incomes and offering the primary source of long term care support for older Americans.

When Medicare began in 1966, it almost immediately doubled the share of persons aged 65 and over covered by insurance. Before Medicare, only about half of persons in this age group had insurance (Andersen, Lion, and Anderson, 1976). By 1970, 97 percent of older Americans were enrolled, and that proportion has remained about the same ever since (Moon 1996).

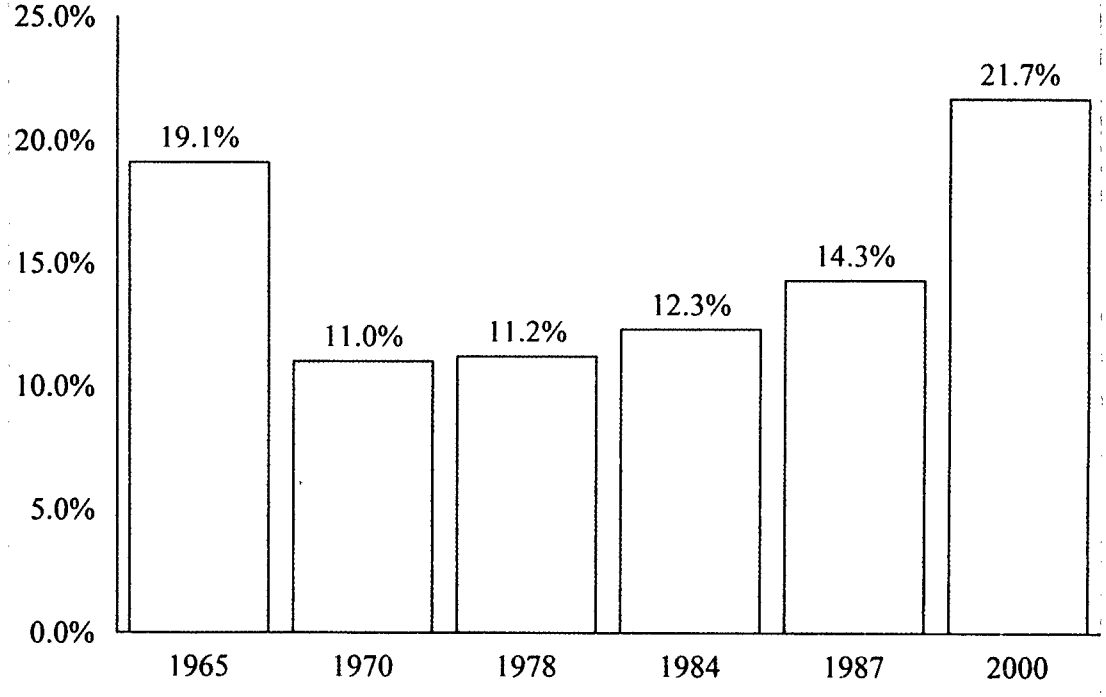
Two effects followed immediately: use of services by the population grew and financial burdens on older Americans and their families declined. Thus, access increased, particularly for

those who previously lacked the resources to obtain services. Although Medicare's benefit package has changed little since 1965, in those areas where services are covered, the program has kept up with the times. Many surgeries are now performed on an outpatient basis, for example. Today, even the oldest old have access to mainstream medical care. New technology is available to beneficiaries and in some cases, the dissemination of new procedures occurs at a faster pace for the old than for the young (Moon 1999).

Perhaps even more important, Medicare played a crucial role in speeding the desegregation of hospitals and other medical facilities, ensuring not only that minority seniors would receive care but that minorities of all ages would have access to health care services. It is easy to forget that in 1965, for example, many black Americans could not go to the best hospitals, particularly in the south (Height 1996; Stevens 1996).

Financial burdens for seniors also fell nearly in half as a result of Medicare and Medicaid. Over time, the share of income that seniors spend on health care has crept back up, but the burdens would be much greater if these programs were not there. In 1965, the typical elderly person spent about 19 percent of her income on health care. That share fell to about 11 percent in 1968. Today it is nearly 22 percent (see Figure 1). Medicare's contribution to the costs of health care for seniors totals over $5300, nearly 40 percent of the median income of persons aged 65 and older. So, without Medicare, most of those now covered would pay more for their care, and many people would likely have to cut back on the amount of care they receive. Medicaid has also played an important role in filling in the gaps in spending for low income persons. It not only pays for the cost sharing and premiums that Medicare requires, but adds other services as well including prescription drugs and long term care. Participation remains a problem, however,

Figure 1
Acute Health Care Spending by Elderly as Share of Income



Source: Author's calculations from National Health Expenditure and Current Population Survey data.

with many low income persons who do not enroll facing very high out-of-pocket costs. The welfare nature of the program remains an important barrier to participation -- a fact that should not be lost in discussions about additional reforms to both programs.

In the area of the costs of care, Medicare can also point to substantial accomplishments. It was a leader in cost containment activities in the 1980s, improving upon payment to hospitals and doctors by shifting from a cost-based system to one in which payments are known and, in the case of hospitals, do not encourage excess use of services. Both of these systems have since been adopted by a number of other insurers. Further, these and other changes helped moderate the growth of Medicare spending such that, on a per capita basis, Medicare payments have grown more slowly than private insurance costs in most years (Levit et al 1999). Moreover, on a cumulative basis, Medicare has performed better than private insurance from 1970 to 1997 despite increased efforts in the 1990s by private insurance to limit costs by moving to managed care (Moon 1999).

Medicare has also changed over time to allow beneficiaries to choose to be served by private plans instead of remaining in the traditional fee-for-service part of the program. In 1997, this option was modified to allow plans other than health maintenance organizations (HMOs) to participate and to reform the payment system which, on average, costs Medicare more for each enrollee than if they remained in the traditional program (Riley et al 1997). This new Medicare + Choice benefit has been one of the least successful changes in Medicare. The limits imposed on payments have been strongly criticized by the private sector, creating an impasse in the program that will be difficult to overcome. Plans will likely continue to withdraw from participation and there will be efforts to increase payments to plans even if this means a less efficient Medicare

program. Coordination with Medicaid programs that seek to enroll individuals in managed care is also an outstanding issue that needs attention.

Finally, improvements in life expectancy since 1965 have occurred at a faster pace for persons aged 65 and over than for the population as a whole. In 1960, women faced a life expectancy at age 65 of 15.8 years; by 1998, that figure was up to 19.2 years. For men, the increase in life expectancy over the same period was from 12.8 to 16 years (NCHS 2000). Some of this improvement is undoubtedly a by-product of Medicare and Medicaid. Improvements in disability also seem to be occurring, suggesting that these longer lives may often be healthier lives. But before we celebrate that such improvements will reduce future costs, it is important to note that the aging of the population will likely overshadow some of the disability improvements. Seniors in the 21st century will still need long term care as well as acute care services.

Projections of Medicare's Future Costs

One way to look at the future costs of Medicare is to focus on the share of the gross domestic product (GDP) that the program would reach if no changes in policy were to take place (the so-called baseline numbers). Spending as a share of GDP is a useful measure because the projected dollars of spending get to be so large over time that they are hard to put in context. Moreover, this measure is relevant for assessing the combined costs of Parts A and B of the program (rather than just focusing on the status of the Part A trust fund).

Projections from the 2000 Trustees Report indicate that Medicare's share of the Gross Domestic Product (GDP) from both parts of the program will reach 3.95 percent in 2025, up from 2.29 percent in 1999 (Board of Trustees 2000). While the outlook has improved in the last

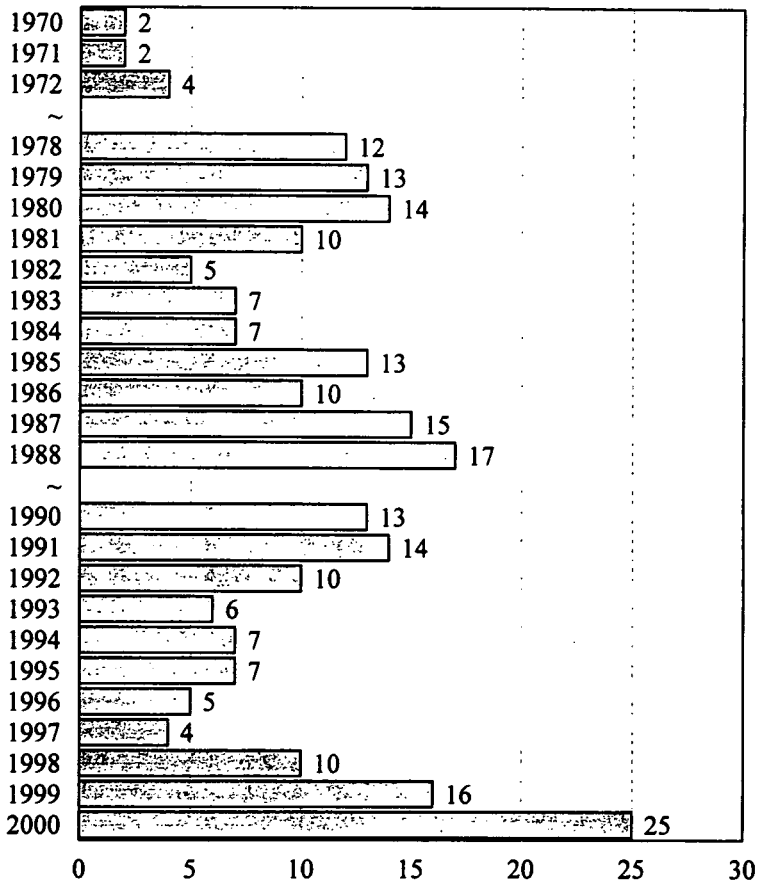
few years, a substantial increase in the share of GDP devoted to care will occur over the next 25 years -- a 72.5 percent rise -- but the number of persons projected to be served will increase over the same period by 78.5 percent. At that time, Medicare will serve about one in every five Americans, up from one in eight today. Thus, a legitimate concern is to what extent it is desirable to drive spending lower, and if so, by how much?

Improved efficiency in the delivery of care ought to be a major goal, but it cannot and will not be the only solution to Medicare's financing problem given the challenges of a large older population. Further, a growing economy can absorb at least some higher spending on Medicare even if the same share of GDP is devoted to the program. That's because GDP is assumed to grow about 2.1 percent a year in real terms over time. But this is not fast enough to absorb both growth in the number of beneficiaries and per capita costs of care that rise faster than the general Consumer Price Index (CPI).

Over the years, the payroll tax contribution for Part A has been increased periodically. Even so, Part A financing has tended to lag behind growth in the costs of the program. For example, as early as 1970, the Part A trust fund was projected to be insolvent within just 2 years (see Figure 2). Further, the payroll tax rate for Part A of Medicare has not increased since 1986, when it was set at 1.45 percent each for employers and employees. Since that time, the number of beneficiaries covered by Part A of Medicare has grown from 32.4 million in 1986 to 39 million in 1998, and the share of the U.S. population covered by Medicare has also increased. The payroll tax rate currently is not scheduled to rise in the future.

Promising no new taxes to serve a population that will double over the next 30 years and in which the share of the population will also rise is more wishful thinking than good policy. As

Figure 2
Number of Years Before HI Trust Fund Projected to be Exhausted



~ Missing Data for Years 1973-1977 and 1989
Source: CRS 1995 and Medicare Trustees Report

a society, we will be substantially better off in the future, but it is likely that the fruits of economic growth will not be shared with seniors unless there are explicit policy efforts to do so. If wages rise just 1 percent a year in real terms, on average, income will be 40 percent higher for a worker in 2025 than today. We will be able to afford substantially more goods and services; the question is how we will share our resources in the future.

Further, Medicare does not offer a comprehensive package of benefits; in fact, this is the way in which Medicare has most failed to remain mainstream insurance. Thus, in addition to pressures to finance the current program, there will likely be a need for improvements in coverage as well.

Improved Benefits

It is hard to imagine a "reformed" Medicare program that does not address two key areas of coverage: prescription drugs and a limit on the out-of-pocket costs that any individual beneficiary must pay. When Medicare was passed in 1965, the benefit package was reasonable as compared to other available private insurance. But over time, private insurance has expanded upon what is covered, while Medicare has changed little.

Critics of Medicare rightly point out that the inadequacy of the benefit package has led to the development of a variety of supplemental insurance arrangements, which in turn creates an inefficient system with most beneficiaries relying on two sources of insurance to meet their needs. Medicaid and employer-sponsored retiree benefits do a pretty good job of comprehensively filling in the gaps. But private supplemental (Medigap) plans -- which serve about one-fourth of all beneficiaries -- are becoming unaffordable for those with average

incomes. Costs of policies have risen rapidly as the risk pool becomes more heavily weighted with less healthy beneficiaries (Alexcih et al 1997). Moreover, plans have moved away from community-rated premiums to arrangements where premiums rise dramatically with age. Consequently, these experience-rated Medigap plans shift costs onto those beneficiaries least able to pay.

Further, without a comprehensive benefit package that includes those elements of care that naturally attract sicker patients, viable competition without risk selection among private plans (either in the current Medicare + Choice or its successor) will be difficult to attain. For example, the problems with the current Medicare + Choice system relate more to affording the rising costs of the additional benefits they add to the basic package than to the costs of Medicare-covered benefits. In particular, private managed care plans that have been offering prescription drug benefits find that they attract sicker patients and consequently they have been cutting back on these benefits (Gold et al 1999). If all plans had to offer a basic prescription drug benefit, for example, and payments from Medicare to these plans increased to reflect that new benefit, competition might actually improve.

Thus, a concerted effort to expand benefits is necessary if Medicare is to be an efficient and effective program. The most straightforward approach would be to revise the Medicare package. Alternatively, to make such an expansion to work as a voluntary add-on, a subsidy sufficient to entice even healthy beneficiaries to sign up would be needed.

Prescription Drugs. Prescription drug coverage is a logical expansion of Medicare. Drugs are now, more than ever, a critical part of a comprehensive health care delivery system. Lack of compliance with prescribed medications can lead to higher costs of health care over time.

And for many who need multiple prescriptions, the costs can be beyond their reach. The private sector, both through Medigap and Medicare + Choice, is failing to fill in the gaps and making coverage less available each year. Thus, to assure future availability, prescription drugs are a crucial -- but expensive -- piece of an expanded benefit package.

Cost Sharing Changes. Expansion of coverage to drugs alone is unlikely to be enough to entice enrollees in traditional Medicare to forego supplemental plans since cost sharing under the current program rules can be very high. In particular, the lack of an upper bound limit on what people can owe causes problems. Adopting a more rational Medicare cost sharing package would not have to be extraordinarily expensive if it increased cost sharing in areas that are low now as compared to private plans, while reducing the unusually high hospital deductible and adding stop loss protection (Moon 1996; Gluck and Moon 2000). Medicare's cost sharing could be brought more in line with what the rest of the population faces without resorting to full first dollar coverage. The difficulty with this approach is that liabilities for cost sharing would rise for many beneficiaries, while the protections would apply to a more limited group (although the amount protected would be substantial), creating more "losers" than "winners." Many of those who would pay more to Medicare could still come out ahead of the current system, however, by not paying the $1000 or more per year they now spend on Medigap. And as Medigap becomes more expensive, this type of change will become more attractive over time.

Low Income Issues. The need to provide protections for low-income beneficiaries has still not been well met by the current system. Income cutoff levels for eligibility for special benefits offered through Medicaid are restrictive, excluding many modest income beneficiaries. Participation in this program is low, in part because it is housed in the Medicaid program and is

thus tainted by its association with a "welfare" program. Further, states, which pay part of the costs, tend to be unenthusiastic about it and likely also discourage participation. Beneficiaries alike in all ways except state of residence may face very different levels of protection.

One advantage of expanding Medicare's benefit package would be an easing of burdens on Medicaid. That might in turn help states that will be struggling to meet the costs of long term care for this population in the future. Improvements in long term care, particularly in home and community-based services are overdue, but likely will only be examined once changes in Medicare have been established.

Savings Through Greater Efficiency/Competition

Efforts to find ways to reduce spending on Medicare have been a high priority for politicians for several years. The urgency behind various reform efforts has diminished, however, as projections of spending growth moderated at the end of the 1990s. And over the long run, Medicare changes in the delivery of care will likely move in tandem with the rest of the health care system, placing limits on what can and should be accomplished with this mechanism.

Nonetheless, several competing approaches to reform remain under discussion. They usually focus on reducing per capita spending and range from incremental changes to major structural reforms to shift Medicare more under the control of private plans. Incremental approaches usually seek to modernize the existing Medicare program, largely by changing payment policies for services and for private plans. Critics of this approach worry that it focuses more on prices charged for services and less on controlling the amount of care being used.

The principal option to restructure Medicare being discussed is a variant of the 1999 plan

of the co-chairmen of the National Bipartisan Commission on Medicare's Future. It has since been offered in an amended form by Senators John Breaux (D-LA) and Bill Frist (R-TN). Termed "premium support," this approach would require that beneficiaries choose among an array of private plans (with traditional Medicare being just one choice); if the plan chosen was more expensive than the national average, the beneficiary would have to pay a higher premium. This would presumably result in greater awareness by beneficiaries of the costs of health care and a greater incentive for private plans to hold the line on costs so as to be competitive. Traditional Medicare, which is now effectively the default plan for most persons, would become much more expensive and perhaps would be eliminated over time. This and other proposals to expand competition in Medicare are controversial because they are based more on theory than on practice and many supporters of Medicare are skeptical of the level of savings likely to be generated and fearful of what protections for beneficiaries might be lost if private plans take over.

Recent experience with the Medicare + Choice plan also suggests that we are a long way from being able to rely on the market. Even with payments that should be high enough to cover costs in the traditional program, private plans have pulled out of markets, changed the benefits offered substantially, and have resisted efforts to provide data on quality and to accept adjustments for differences in the risk profiles of beneficiaries. These are not promising trends and suggest that reforms will need to be done at a much slower pace than many would like.

Changes will need to be made in Medicare to keep it up to date, but given the dissatisfaction of many with managed care and the current flux in the delivery system, does putting Medicare beneficiaries in managed care mean keeping up with the times or subjecting beneficiaries to the problem-plagued system the rest of us face? Does managed care in its

present form represent an improvement in the delivery of care? Even those who are most enthusiastic about this approach usually admit that it alone cannot solve the financing problems facing Medicare.

Other Reform Issues

Although most of the current policy attention focuses on proposals to reform the structure of the program and the benefit package, other key issues will also arise as approaches to assure Medicare's future, including age of eligibility, beneficiary contributions, and the need for more general financing. Even after accounting for changes that may improve the efficiency of the Medicare program through either structural or incremental reforms, the costs of health care for this population group will still likely grow as a share of GDP. That will mean that the important issue of who will pay for this health care--beneficiaries, taxpayers, or a combination of the two--must ultimately be addressed. The answer to that question will directly affect whether older Americans will truly be living better in the future.

Age of Eligibility. Proposals to raise the age of eligibility for Medicare are offered to reduce the size of the beneficiary population. Life expectancy has increased by over three years since Medicare's passage in 1965, offering one justification for delaying eligibility (NCHS 2000). And if people begin to work longer, delaying their retirement, this option becomes more viable.

About 5 percent of Medicare beneficiaries are aged 65 and 66. If the age of eligibility were increased to 67, however, savings would be substantially less -- likely in the range of 2 to 3 percent of Medicare's overall spending -- since persons in these age groups have lower Medicare

costs than other beneficiaries. This is particularly the case since those aged 65 and 66 who became eligible as disabled beneficiaries would stay on the Medicare roles (Waidmann 1998).

But this approach also has disadvantages. Without private insurance reform, those out of the labor force might find it difficult to obtain insurance. Employers will face higher insurance costs if they provide retiree benefits to fill in the gaps of a rising age of eligibility. Alternatively, they might cut back on coverage, increasing the numbers of persons who would have to pay on their own or go uninsured. As a consequence, if the number of uninsured rise placing burdens on public hospitals, if the costs of producing goods and services rise to pay greater retiree health benefits, if the number of young families supporting their older relatives increase, we will be just as burdened as a society. Thus, we will not have solved anything, although the balance on the federal government's ledgers will improve.

Beneficiaries' Contributions. Some piece of a long-term solution probably will (and should) include further increases in contributions from beneficiaries beyond what is already scheduled to go into place. The question is how to do so fairly. Options for passing more costs of the program onto beneficiaries, either directly through new premiums or cost sharing, or indirectly through options that place them at risk for health care costs over time, need to be carefully balanced against beneficiaries' ability to pay. Just as Medicare's costs will rise to unprecedented levels in the future, so will the burdens on beneficiaries and their families. Even under current law, Medicare beneficiaries will be paying a larger share of the overall costs of the program and more of their incomes in meeting these health care expenses (Moon 1999).

One option is an income-related premium where higher income persons pay a greater share of Medicare's costs. Tying premiums to income makes sense on grounds of equity, but

may be difficult to achieve in practice. Administrative costs would have to rise substantially. But more important, such approaches generate only limited new revenues unless the income thresholds are set very low. There simply are not enough high income elderly persons for this option to "solve" the problem.

An alternative income-related approach would treat Medicare benefits--all or in part--as income and subject to the federal personal income tax. This is analogous to taxing Social Security, although more complicated because these benefits are received "in-kind" and are not traditionally viewed as income. Taxation of benefits would not only raise revenue, but also make beneficiaries more aware of the "value" of Medicare benefits. However, this option would add considerably to Medicare's complexity, and critics argue that it is unfair to tax some in-kind benefits and not others.

Additional Public Financing for Medicare. Ultimately, the issue of who will pay must be divided between beneficiaries and taxpayers. Even with higher beneficiary contributions and more efforts at improving the efficiency of the program, the long run costs of Medicare will require additional public funds (Gluck and Moon 2000). Since the population currently served by Medicare will grow to more than one in every five Americans, as a society we will need to face up to the costs of financing health care, either through the Medicare program or privately. Reducing Medicare's population or benefits will shrink government liabilities, but do little to change the liabilities that society must face.

Conclusion

Americans living longer will place financial challenges on Medicare and Medicaid to continue to meet the needs of the population. And if seniors are to live better as well, they cannot be expected to bear the full brunt of higher spending requirements for a good health care package. Several steps will be needed in the near future: 1) continuing efforts to improve the efficiency and delivery of care, but probably in incremental steps as the rest of the delivery system evolves, 2) improvements in the benefit package to lead to a situation in which most beneficiaries need only one insurance plan, and 3) expanded financing for the program that asks both beneficiaries and taxpayers to contribute, with the amounts adjusted over time to reflect what each group can afford to pay.

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Ms. COOK. We now turn to the fourth domain, family, and we will hear from Elizabeth Kutza. She is Professor of Urban Studies and Planning and Director at the Institute on Aging at Portland State University.

STATEMENT OF ELIZABETH KUTZA, DIRECTOR, INSTITUTE ON AGING, PORTLAND STATE UNIVERSITY

Dr. KUTZA. Good morning and thank you for the opportunity to talk with you today about American families. The other day, I was talking with my friend Jane, who was telling me about a recent marriage of her stepdaughter. Jane described how her husband, David, sat companionably between her and his former wife, the mother of the bride. The groom in his toast, warmly acknowledged the bride's ex-husband, the father of her son, who was there with his longtime partner. The bride's sister, a part of a lesbian couple, was there with her new baby. The new husband of David's ex-wife introduced Jane and David to his daughters from two previous marriages. To add to the complications, the groom decided to take Jane and David's, that is, the bride's, surname, since he was abandoned early in his life by his biological father and felt a closer parental bond with his soon-to-be in-laws. Are you still with me?

In fact, this scenario represents an all too typical post-modern family; one typical of Republicans, as well as Democrats; conservatives, as well as liberals; rich, as well as poor. I have to tell you that I am simply not creative enough to have made that up. I blended stories from two separate colleagues of mine, one who had a marriage of a stepson and one who had a marriage of a stepdaughter, just in the past few months. Public policies, as mechanisms for social problem solving and social support, are slow to respond to changing social conditions, such as those I have just described.

In addition, policies often embody a normative view of social institutions, a view that expresses how we would like things to be, rather than how they are. One area in modern American society that is firmly rooted in normative assumptions is "the family." The prominence of the concept of family values in policy debates gives evidence to such normative assumptions. How policymakers view family, their structure, roles, strengths and weaknesses will shape the programs they develop.

We all know what the typical American family is supposed to look like. Our image presumes several things. It presumes that, to be a family, everybody in the family lives together. It presumes that family involves children. It presumes that adults are only bound as a family by blood or marriage, and in many ways, there is an implicit assumption that the functions traditionally performed by families for individuals; that is, emotional support, nuturance, financial support, protection, caring; cannot truly, nor perhaps legitimately, be filled by other social networks or by formal service providers.

What I would like to share with you today is, first, how the structure of families is changing; second, how that changing structure is impacting on social roles; and third, what this means for policies, especially long-term care policy.

While in 1960, 88 percent of children lived in the ideal family that is, husband and wife living together with their children; by 1998, only 68 percent did. Of the remaining 32 percent, four-fifths lived with only one parent, usually the mother, and in 56 percent of these households, no other adult was present. In 1970, only 3 percent of all children under 18 lived with a grandparent. By 1998, that figure had doubled to 6 percent.

The traditional image of family as husband, wife and children is also being challenged by the rise in the number of childless couples. About 42 percent of today's families are married couples without children. The percentage of U.S. women not having children has doubled since the late 1970's to about one in five, according to the Census Bureau. I am one of those childless women, and I frequently tell my students that, in retrospect, I did very poor planning for my old age.

Increased longevity has led to more four and five generation families, where 70-year-old children are caring for 90-year-old parents.

Finally, the growing number of people living on their own, from young adults to older widows, results in fewer families of any kind than there used to be. Thus, in the last century, we have seen family structures that diverge from the ideal. Fewer families consist of a husband and wife and their biological children living together. There are now more single-parent families, blended families, childless families and fewer families altogether.

Broader changes in the social environment also have affected family life. The widespread availability of contraceptives, for example, has resulted in the ability to control the size of family and the spacing of children. The fertility rate for Baby Boom cohorts is generally less than two children, compared with a rate between 2.4 and 3.6 children in their parents' cohort.

More women, both with and without children, are now in the workforce, as Gary has said, which also affects family patterns and roles. In 1970, 42.6 percent of women over the age of 16 were in the labor force. By 2006, it is anticipated that 61.7 percent will be employed.

Only about one in seven families fit the earlier norm, or maybe the Simpson norm, of a bread-winning husband, full-time, stay-at-home wife and their children. The majority of married couples have both spouses in the workforce. Labor force participation rates for married women with children under the age of six, rose from 18.6 percent to 63.7 percent, between 1960 and 1998. And 59 percent of mothers with infants under a year are employed.

Widowed, divorced, separated and single mothers have always had high labor force participation rates. In 1960 over one-half of them were in the labor force, now it is about three-quarters.

Analysts at the Census Bureau report there is no sign that the movement of women into the workforce has peaked, and they continue to expect it to rise. What are the implications of changing family structures and roles in an aging society? They are several and important.

Historically, the family has been an important institution in both the care of children and in the care of adult family members who are infirm or disabled. American society has a stronger expectation about parents' responsibility to children than it does about adult

children responsibility to their parents. With the availability of Social Security and Medicare benefits, adult children no longer retain primary financial responsibility for their elderly parents, and few older people actually live with their children.

When infirmity or disability strikes, the family, whether proximate or remote, still is regarded as the primary source of care. In addition, the family is assumed to be the appropriate surrogate for decisionmaking as regards long-term care placement or end-of-life decisions.

While gerontological research attests to the persistence of family involvement in caregiving, that family involvement may be changing in intensity and consistency. Data from the National Long-term Care Survey found in 1984 that more than half of the chronically disabled elderly relied solely on family care, while another 19 percent used both formal and informal care. By 1994, sole reliance on informal care dropped to about 40 percent, while use of both types of care rose to just over one quarter.

Some researchers suggest this trend is likely to continue, given the increasing diversity of families in modern society combined with the modern Western emphasis on self-over family. One researcher has noted the ascension of what she calls the opportune family, in which individuals exercise options regarding their household, their mutual responsibilities, and their significant relationships.

Several trends I have noted above, may contribute to the declining ability of families to provide intensive caregiving services to elderly relatives. First, widespread marital dissolution and smaller families result in fewer kin upon whom to rely. Second, some argue that increased labor force participation by women will reduce the amount of uncompensated care they can provide to older relatives. Third, as women delay childbearing, the proportion that faces the dual responsibility of caring for an elderly parent and a minor child may increase.

These changing social trends, in the context of an expanding older population, suggest a scenario wherein the needs of the old for care may far exceed the capacity of the family to fulfill. Thus, the balance between family care and formal care must shift. The challenge is how to do it.

I do not think that social policies have yet reflected the changes that have occurred in family structure or roles in modern America. Current policies embody an either/or choice; that is, either the family is sufficient or other institutions must step in to fill the deficit. This view is clearly based on the existence of traditional family forms, rather than on these emerging opportune family forms.

Research over the last several decades has shown there is little substance to the substitution theory; that is, that expanding formal services will result in the total withdrawal of families from caregiving. At the margins, formal services supplement in those cases where the needs are so high that, without help, families could no longer continue to support their relatives. No existing long-term care policies actually require that families take on caregiving responsibility, but they do factor such care into the development of service packages.

I realize that policies such as these are unlikely to be abandoned. Given scarce resources, Congressional and state policymakers will always want to stretch public funding through shared public/private responsibility for caregiving. Given the changing nature of families, the reduction in potential caregivers, and the changing age structure of society, policies will have to remain flexible as regards their expectations regarding family involvement and caregiving. Providing informal care should be viewed as a purely voluntary activity that may enhance the person's quality of life, but not a necessity for the person to continue to stay within the community.

If we continue our current implicit policy practices of expecting families to be the first recourse of care, then we should do all that is possible to help families through training, technical support, counseling and respite care. Fay mentioned the Family Medical Leave Act, and certainly the recently passed National Family Caregiver Support Program, which was part of the reauthorization of the Older Americans Act, are starts in the right direction.

I was a family caregiver. My 91-year-old father moved in with my husband and I, and we cared for him until his death at 95.5. I can tell you the difficulty of juggling work and caregiving responsibilities, of trying to find suitable supplemental care for him when we were at work, and of the emotional strains that are put on a marital couple or a family in these caregiving roles.

In conclusion, I want to again suggest to you that there is currently a policy lag that exists between the image of family that is in policy and the reality of changing family structures and norms, and it needs particular attention. As more Americans live into late old age, their needs of care will increase, and we can no longer assume that family members will be available and/or willing to be primary caregivers.

Baby Boom cohorts, who have grown up on the values of self-sufficiency and independence from family, may even refuse to be cared for by their children, preferring a stranger rather than burdening their children with caregiving responsibilities. It is, therefore, critically important that the Congress attend to national long-term care policy considerations, and carefully and explicitly look at what families can perform, do perform, and should be expected to perform for our frail and dependent senior citizens. Most importantly, perhaps, they should refrain from romanticizing family relationships, especially if this leads to a greater transfer of responsibility for the support of the elderly back to the family.

While on the one hand, families will be the same as they have always been, because as individuals we continue to need the intimate connectedness that family brings. On the other hand, as the story of my friend's stepdaughter's wedding illustrates, families will never be the same again. Thank you very much.

[The prepared statement of Ms. Kutza follows:]

LIVING LONGER, LIVING BETTER:

Policy Presumptions and New Family Structures

Presentation for the
Special Committee on Aging
United States Senate

November 21, 2000
Hart Building, Room 216
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by

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LIVING LONGER, LIVING BETTER:
Policy Presumptions and New Family Structures

By

Elizabeth A. Kutza, Ph.D.

Introduction

Public policies, as mechanisms for social problem solving and social support, are slow to respond to changing social conditions. Policies are uniquely temporal, and when enacted, presume a state of the world that remains relatively fixed. It takes a long time for new facts and changing realities to be reflected in our public policies. The end result is a growing divergence between what *is* in society and what is needed in social policy. In addition, policies often embody a normative view of social institutions, a view that expresses how we would like things to be rather than how they are.

One area in modern American society that is firmly rooted in normative assumptions is "the family." The prominence of the concept of "family values" in policy debates gives evidence to such normative assumptions. How policymakers view families—their structure, roles, strengths and weaknesses—will shape the programs they develop.

New family structures

Every social institution, be it church, neighborhood, a community, or government, carries with it a symbolic meaning that sometimes is more powerful than its reality. And because being a member of a family is a universal human experience, no institution has more such symbolic meaning for individuals than "family." "The family" evokes a visual impression, a mental picture of two parents, living together with their children, providing both physical and emotional support and nurturance. We all know that this is what the typical American family is *suppose to* look like. This image presumes several things. It presumes that to be a family, there must be co-residence, that is, everyone in the family lives together. It presumes that "family" involves children. It presumes that adults are only bound as a "family" by blood or marriage. And, in many ways, there is an implicit assumption that the functions traditionally performed by families for individuals—emotional support, nurturance, financial support, protection, caring—cannot truly (nor perhaps legitimately) be filled by other social networks.

But social institutions are not static; they are dynamic. And, they come in diverse forms. There is no one, typical family structure or type in the U.S. today. The definition of family varies by historical period and social context. For example, there can be no denying that the number of families that represent the "ideal type" of family consisting of husband, wife and children living together has declined in the past half century. In 1960, 88 percent of children lived in a two-parent household; in 1998, only 68 percent did. Of

the remaining 32 percent, four-fifths lived with only one parent (usually a mother), and in 56 percent of these households, no other adult was present.

A greater number of children today than 20 years ago are living in the homes of their grandparents. In 1970, only 3 percent of all children under 18 lived with a grandparent; by 1998, that figure had doubled to 6 percent. In 1998, to a larger extent than in 1970, however, the grandparent was also providing shelter and support to one or both parents.

These data from the Census Bureau, which provide a cross-sectional snapshot of marital status and family composition, mask much of the diversity of these family arrangements with children. For example, children in two parent families may be living with both of their biological or adoptive parents, or with one biological and one step-parent. Children living in single-parent households may, in fact, be living with another "parent." The family may consist of a heterosexual couple living together but not legally married (one of twenty households headed by a couple are a cohabiting household), or may consist of a lesbian or gay person and his or her life partner.

Even in those single-parent households where no other adult is present, a child may retain a strong relationship with the biological or adoptive parent who lives elsewhere. To assume that a child living in a household with an "absent parent" is really absent that parent is a faulty assumption. A significant number of divorced and separated couples strive to share parenting duties so that both parties continue with their caregiving responsibilities. Thus, for today's child, family can take many forms.

The traditional image of family as husband, wife and children is also being challenged by the rise in the number of childless couples. About 42 percent of today's families are married couples without children. The percentage of U.S. woman not having children has doubled since the late 1970s, to about one in five according to the Census Bureau. In 1998, 19 percent of women aged 40 to 44 had not given birth to a child compared to 10 percent two decades earlier. For some of these women, childlessness is a deliberate choice. Others find themselves unmarried in their forties because they concentrated on their education or careers only now to be unable to find a suitable mate. But roughly one-half of these women are married and would like to have a child, but have been unable to conceive because of age-related fertility problems. Increasingly, then, family may be characterized as two adults who have no children.

Increased longevity has led to more four and five generation families, where 70 year-old "children" have 90 year-old parents. Finally, the growing number of people living on their own, from young adults to older widows, result in fewer families of any kind than there used to be.

As Stephanie Coontz has observed in her book, *The Way We Really Are: Coming to Terms with America's Changing Families*, "Marriage was once the primary way of organizing work along lines of age and sex. It determined the roles that men and women played at home and in public. It was the main vehicle for redistributing resources to old

and young, and it served as the most important marker of adulthood and respectable status....All this is no longer the case. Marriage has become an option rather than a necessity for men and women, even during the child-raising years."

Thus, in the last century, we have seen family structures that diverge from the "ideal." Fewer families consist of a husband, wife and their biological children living together. There are now more single-parent families, blended families, childless families, and fewer families all together.

Social roles

Broader changes in the social environment also have affected family life. The widespread availability of contraceptives, for example, has resulted in an ability to control the size of families and spacing of children and hence the number of years that adults are engaged in child-rearing activities. The fertility rate for Baby Boom cohorts is generally less than two children, compared with a rate of between 2.4 and 3.6 children in their parents' cohorts.

More women, both with and without children, are now in the workforce which also affects family patterns and roles. In 1970, 42.6 percent of women over the age of 16 were in the labor force; by 2006, it is anticipated that 61.7 percent will be employed. Only about one in seven families fit the earlier norm of a breadwinning husband, a full-time stay-at-home wife, and their children. The majority of married couples have both spouses in the work force. In 1960, 30.5 percent of married women were in the labor force; by 1998, that figure had doubled to 61.8 percent. A greater increase was seen among married women with children, with labor force participation rates increasing from 27.6 percent to 70.6 percent between 1960 and 1998. Even in families with preschool children at home, the majority of mothers work. Labor force participation rates for married women with children under the age of six rose from 18.6 percent to 63.7 percent between 1960 and 1998.

Widowed, divorced, separated or single mothers have always had high labor force participation rates. In 1960, over one-half of them were in the labor force. In 1998, 72.5 of single mothers and 79.7 widowed, divorced or separated women with children were in the labor force. One factor contributing in the steep increase in labor force participation of these single parents may be recent workfare policies that require poor, single mothers to secure work in order to maintain welfare benefit status.

Implications for an aging society

What are the implications of changing family structures and roles in an aging society? They are several and important.

Historically, the family has been an important institution in both the care of their children and in the care of adult family members who may be infirm or disabled. This function of family is not limited to the household. Caregivers may live in the next block,

the next town, or 1,000 miles away. However, if someone has no family or if the family fails to function this way, then the individual must be able to take care of himself or herself or the state, through its public policies, takes over the responsibility.

American society has a stronger expectation about parents' responsibility to their children than it does about adult childrens' responsibility toward their parents. With the availability of social security and Medicare benefits, adult children no longer retain primary financial responsibility for their elderly parents, and few older persons actually live with their children. (Contrary to popular beliefs, American households and families always have been nuclear in structure. An earlier generation may have lived near their children, but even in the 17th and 18th centuries, they typically lived in separate households. And given the age structure of American society even at the beginning of the 19th century when life expectancy was 47 years, extended caregiving responsibility for adult children was rare.)

But when infirmity or disability strikes, the family, whether proximate or remote, still is regarded as a primary source of care. Current long-term care policies presume this primacy. Families are expected not only to provide hands-on assistance with personal care activities (i.e., bathing, dressing, toileting, feeding, transferring), but also to provide assistance with instrumental activities such as cleaning the house, transportation to doctor's appointments, and paying bills. In addition, the family is assumed to be the appropriate surrogate for decision making as regards long-term care placement or end-of-life decisions.

Yet relations of mutual support are formed over a lifetime of family interactions that may or may not be positive. Attitudes toward the *obligation* of familial support also changes with each new cohort. In the early part of this century, parents often discouraged the younger daughter from leaving home and marrying so that she could continue to support them. An expectation such as this would be met with disbelief and derision by any young modern American woman. The cohorts that are currently aged, especially the oldest-old, come from an immigrant experience and often retain the historical and traditional attitudes of "the old country." Future cohorts may not have the same strong familial interdependence.

Although some of the intensive historical patterns of family support have survived among first generation immigrant, African-American and working-class families, a gradual weakening of mutual assistance over time has occurred. Gerontological research attests to the persistence of family involvement in caregiving, but that family involvement may be changing in intensity and consistency. Data from the National Long-Term Care Survey found that in 1984, more than half of the chronically disabled elderly relied solely on family care while another 19 percent used both formal and informal care. By 1994, sole reliance on informal care dropped to about 40 percent while use of both types of care rose to just over one-quarter. Some researchers argue that this trend is likely to continue given the increasing diversity of families in modern society combined with the modern western emphasis on self over family. Professor Colleen Johnson, a Professor of Medical Anthropology at UCSF, has noted the ascension of what

she calls "the opportune family," in which individuals exercise options regarding their households, their mutual responsibilities, and their significant relationships.

Several trends noted above may contribute to the declining ability of families to continue to provide intensive caregiving services to their elderly relatives. First, widespread marital dissolution and smaller families result in fewer kin upon whom to rely. Surveys have identified a hierarchy of caregivers. When available, a spouse provides the majority of care. (Nearly one-half of primary caregivers are over the age of 65, most being the spouse of an even older care receiver.) In the absence of a spouse, a daughter is called upon, followed by a son (who usually transfers such tasks to his wife.) If an older person is childless or has outlived his or her children, more distant kinship networks come into play such as grandchildren, nieces or nephews.

Second, some argue that increased labor force participation by women will reduce the amount of uncompensated care they can provide to their older relatives. Research to date, however, has not found that women's employment outside the home has severely limited the supply of informal caregivers. Some analysts have attributed this to women's traditional "ethic of care" which may still strongly influence women's behavior with regard to eldercare. The National Long-Term Care Survey found that even employed women who were caring for severely disabled elders provided, on average, between 32 and 39 hours of care per week. And between 1984 and 1994, the percent of women who were primary caregivers and also full-time workers actually rose from 23 to 27.5 percent.

Third, as women delay childbearing, the proportion that faces the dual responsibility of caring for an elderly parent and a minor child may increase. In 1994, nearly 3.5 million persons were in this so-called "sandwich generation." Of these, nearly 325,000 were actively providing care to a disabled elderly spouse or parent. Such dual responsibilities may put enough stress on a caregiver that they withdraw from their eldercare responsibilities and turn to more formal providers.

These changing social trends, in the context of an expanding older population, suggest a scenario wherein the needs of the old for care can far exceed the capacity of the family to fulfill. Thus, the balance between family care and formal care must shift. The challenge is how to do it.

Implications for policy

Social policies have not yet reflected the changes that have occurred in family structure and roles in modern America. Current policies embody an "either/or" choice, that is, either the family is sufficient or other institutions must step in to make up the deficit. This view is clearly based upon the existence of traditional family forms, rather on emerging "opportune family" forms. Since the 1970s, policymakers have resisted expanding public long-term care services because of the fear that attractive (but costly) formal services would substitute for informal, family (i.e., unpaid) caregiving.

Research over the last several decades has shown that there is little substance to this "substitution theory." That is, expanded formal services do not result in the total withdrawal of families from caregiving. At the margins, formal services supplement care in those cases where the care needs are so high, that without help, families could no longer continue to support their older relatives in the community.

No existing long-term care policies actually require that families take on caregiving responsibilities for their elderly relatives, but they do factor in such care when developing a service package. In my state of Oregon, for example, eligibility for home and community-based services under the Medicaid waiver, as well as home care services under our state-funded Oregon Project Independence, explicitly includes an assessment of the extent to which relatives, friends, and neighbors can meet a client's needs. Many other states include similar assessment criteria.

Such policies are unlikely to be abandoned. Given scarce resources, Congressional and state policymakers will always want to stretch public funding through shared public/private responsibility for caregiving. These policies are also consistent with the American policy preference of government services as residual, that is, available only to those who have no other options. But given the changing nature of families, the reduction in potential caregivers and the changing age structure of society, policies will have to remain flexible as regards their expectations regarding family involvement in caregiving. Providing informal care should be viewed as a purely voluntary activity that may enhance the person's quality of life, but is not necessary for the person to continue to stay at home.

Professor Rosalie Kane, who with her husband Dr. Robert Kane, have contributed significantly to research in long-term care policy, recently set out three criteria of a "good long-term care policy" related to family caregivers. Such a policy would achieve the following goals:

- It should provide a minimum floor of adequate care for each person needing long-term care.
- It should maintain any self-selected mutually agreeable caregiving relationships between adults and elderly family members needing care.
- It should not force any family members to provide care to elderly relatives in the absence of such agreement.

However, Professor Kane acknowledges that moving to a more explicit family caregiving policy might not be politically feasible. She urges that if we continue our current implicit policy practices of expecting families to be the first recourse for care, then we should do all possible to help families through training, technical support, counseling and respite care.

Another area of policy that is related to family also bears review. Under law, when a dependent person lacks decisional capacity, family caretakers are looked to as surrogate decision makers. It is assumed that families know the preferences and values of their incapacitated family members, and that they will act in the best interest of these family members. It is in this arena that the question of "who is family" becomes important. In our modern, mobile society in which relationships and family ties fluctuate over time, and in which alternative life styles are becoming more common, our policies need to allow for surrogate decision makers who are related neither by blood nor marriage. Only then can we be assured that the "best interests" of the dependent party are served.

Concluding remarks

The policy lag that now exists between the image of family extant in policy and the reality of changing family structures and norms need special attention in our aging society. As more Americans live into late old age and their needs for care increase, we can no longer assume that family members will be available and/or willing to be primary caretakers. Baby Boom cohorts who have grown up on the values of self-sufficiency and independence from family, may even refuse to be cared for by their children, preferring a stranger rather than burdening their children

It is therefore critically important that you who make our nation's long-term care policy consider carefully and explicitly what caregiving role families can perform, do perform, and should be expected to perform for our frail and dependent older citizens. Most importantly, perhaps, is that you must refrain from romanticizing family relationships especially if this leads to a greater transfer of responsibility for the support of the elderly back to the family.

Ms. COOK. We are fortunate to have a very, very special person provide a synthesis and an integration of these presentations. Dr. Robert Butler is President and CEO of the International Longevity Center and Professor of Geriatrics and Adult Development at the Mount Sinai School of Medicine.

STATEMENT OF ROBERT BUTLER, FOUNDING DIRECTOR OF THE NATIONAL INSTITUTE ON AGING AND PRESIDENT OF THE INTERNATIONAL LONGEVITY CENTER-USA

Dr. BUTLER. Thank you, Dr. Cook. I really welcome this opportunity to comment on the concept of research being brought to policymakers, and I congratulate Dr. Cook for undertaking that theme. In olden times, there used to be a general category of membership within the GSA, which was terrific from the point of view of those of us who were devoted to interdisciplinary research, the perspective, the work and the data. I really wish we might move back to having a general membership, because I think the integration of policy across the wonderful diagram that Dr. Cook created of family, work, income and health was, I think, very, very important. I really think that was terrific.

I have to say I agree basically with everything the participants have said, with a possible exception of Gary, because I am afraid that new class of food, this great, good class of food that you referred to, which is a very toxic environment in terms of McDonald's and Wendy's, has helped bring us Type II diabetes in 10-year-old children in the United States. That is about the only disagreement that I might have.

My colleagues have described the key domains for aging in a new century: family, health, work and income, put together in that wonderful diagram by Professor Cook. Dr. Gary Burtless described the policy changes of an aging workforce, noting that mandatory retirement has been outlawed in most jobs, that Social Security is no longer growing more generous, the worker coverage under company pension plans have stopped rising, and that Social Security and many private pensions have become more age neutral with respect to retirement. He notes, also, the beginning of the reversal of the trend toward earlier retirement.

To me, that is reasonable on a number of grounds, not only economic. It really is hard for me to imagine 70 million wonderful Baby Boomers, with all their talents, experience and knowledge, sitting by idlely for up to three decades in retirement, collecting Social Security and using Medicare. We knew from studies we were involved in the 1950's and 1960's at NIH, how important having a goal-in-life, purpose-in-life structure to your everyday life, actually contributed measurably to the quality of life and to the length of life, really somewhat to our surprise.

Of course, as Dr. Burtless observes, many retired to enjoy additional leisure and increased wealth has been used to purchase more leisure. He further notes that two of the least persuasive explanations for earlier retirements are declining health and the changing physical requirements of work, which are already under change. The physical demands of work are declining, and the older population is growing healthier, and by the way, the disability rate

decline reported by Kenneth Madden and others at Duke University, are really now being seen throughout Europe and Japan.

Workers in Japan, Scandinavia and the United States leave the workforce later than almost anywhere else in the industrialized world. Dr. Burtless also correctly observes that raising the retirement age under Social Security would constitute a reduction in benefits. There are advantages in utilizing the continuing productivity of older persons in my judgment.

There will be changing patterns in the productive workforce as we move into the next century. We will not always have the productivity and prosperity we have enjoyed. We will probably see experiments, involuntary or mandated community service of young people, and their later entry into the workforce. We will probably see intermittent training. Some of the programs being considered, for example, by the Norwegian parliament today are already operative to a degree in the extended work leave efforts within Australia. We will probably see people upgrading their skills and knowledge throughout life, and undoubtedly a later exit from the workforce.

Marilyn Moon has described the success stories of Medicare and Medicaid and improving access to health care for older persons. She is absolutely correct. I believe without these programs, some of the progress in life expectancy and lower morbidity, including the disability rate fall, would not have occurred. Along with Social Security, Medicare constitutes one of the great legislative triumphs of the 20th century. Despite pressure for financial changes in Medicare, Moon also correctly observes that Medicare payments have grown more slowly than private insurance costs in most years. Moreover, on a cumulative basis, Medicare has performed better than private insurance from 1970 to 1977, despite increased efforts in the 1990's by private insurance to limit cost by moving to managed care.

She also points out that the Gross National Product is "assumed to grow about 2.1 percent per year in real terms, over time, but this is not fast enough to absorb both growth in the number of beneficiaries and in per capita costs that rise faster than the general Consumer Price Index." Marilyn Moon's fine paper provides me the opening to discuss the importance of Medicare reforms that would go beyond finances, however important they are to changes in the very system of delivery of care, the advancement of research and the importance of training health providers in geriatrics.

There has been, after all, an extraordinary mismatch between Medicare and the needs of older persons. Yes, it has certainly helped to deal with the finances. Yes, it has brought some relief to financial worry. But, when Medicare was created in 1965, there were no geriatricians at the table. There was a monumental struggle involving the insurance industry, the American Hospital Association, the American Medical Association, consumers and legislators, out of which came a program whose model was the employer-based, acute medical care system. The original Medicare did not include prevention—the original system—outpatient medications, long-term care, part of the Presidential debates this year, so vital to older persons and their families.

Some changes since 1965 have brought coverage of preventive strategies, but still minimal support of long-term care and no outpatient medications. Medicare still does not meet fully the needs of older persons. Indeed, cutbacks resulting from the Balanced Budget Act of 1997 and the Reforms of 1999, for which we proudly announced the great surplus, has resulted in dramatic reductions in home health care, for example, some 45 percent, one of the most desired features of Medicare by older persons and their families. Moreover, although $6.2 billion is devoted to graduate medical education for the training of residents in medicine, ironically it has contributed little to developing the field of geriatrics.

While there has been some fellowship money, what is really necessary is the creation of a cadre of academic geriatricians in each of our 145 allopathic and osteopathic schools of medicine, so that no one, but no one, graduates from medical school or from a residency program, whether they go into to primary care or specialty medicine, without adequate knowledge, and I would add, the appropriate attitude with respect to the care of older people. American families and older persons deserve this. It may be hoped in the next several years there will be basic reforms in Medicare that improve the system of care, a continuum from assessment to hospice, and comprehensive training of those who deliver it, not only doctors, nurses and social workers.

One example of why adequate training is essential, and this is Merck-Medco data, in any given year, 35 percent of everybody over 65 years of age has an adverse drug reaction, and in any given year, Merck-Medco data, 17 percent of people over 65 have an adverse drug reaction that winds up with a hospitalization.

A truly reformed Medicare system will also be more affordable. Indeed, there is a great deal of money in the American health care system, one-seventh of the nation's economy. My own sense is we probably do not need new money, if we were to reform it, to tip the scales away from institutional and hospital care to a more broad-based community-based care.

Elizabeth Kutza has offered a valuable portrait of the changing American family. As she observes, there is no one typical family structure or type in the United States today. This is not to say that family loyalties have been lost, but it does make clear "the reality of the changing structures and norms need special attention in an aging society."

One salient point she makes is again worthy of quotation, "research over the last several decades has shown that there is little substance to the substitution theory; that is, expanded formal services do not result in the total withdrawal of families in caregiving. At the margins, formal services supplement care in those cases where the care needs are so high that without help, families could no longer continue to support their older relatives in the community." Indeed, families might give up and then institutionalization might occur.

It is also evident from Kutza's paper and from a variety of other sources that the caregiving burden largely falls upon women. But more women are in the workforce and the strain is becoming increasingly unbearable. What is necessary, clearly, is a program and policies that provide not substitutes, but supplements to the won-

derful strength of the American family to serve its older family members.

Timothy Smeeding reminds us vividly of the economic status of older Americans. He considers the economic status; income, wealth and poverty, among older Americans as we enter the 21st century. He stresses, in particular, subgroups among older persons, notably older women. Smeeding reminds us of the dangers of thinking of older persons as homogeneous and of depending upon averages, means and medians, used to describe economic well-being. They are not altogether good indicators, for there is wide disparity among various subgroups classified by gender, race, ethnicity and health status.

He also reminds us that while many Americans do enjoy comfortable retirement years, many exist near or below the poverty line. Minorities and older women living alone, in particular, have poverty rates in excess of 20 to 25 percent. Moreover, a much larger fraction of the aged than the non-aged live right above the poverty line, between 100 percent 125 percent of the poverty line. They live on less than $10,000 of cash income per year. Let me restate that, $10,000 cash income per year.

Smeeding believes that Social Security "will contribute a decreasing share of the income needed for a secure retirement. The demographic and fiscal crunch facing the system rules out large, across-the-board increases in benefits." Smeeding also notes that "inequality in wealth holdings is much greater among the aged than is income inequality."

Just as I emphasized this mismatch between Medicare, as originally conceived and built 35 years ago, the remarks of Kutza and of Smeeding emphasizes a mismatch between Social Security, designed some 60 years ago, when women then married, stayed home and raised children, and were widowed at a relatively early age. Observe that many of the issues of aging are issues of older women, often alone and poor. Eighty percent of nursing home residents are older women, and older women are the most frequent victims of elder abuse, meaning financial, as well as physical.

As Smeeding notes, older women in the United States have poverty rates 1.5 to 20 times higher than those found in other rich, Western nations, the OECD nations. Smeeding correctly observes people's anxieties over the prospects of privatizations, benefit reductions and tax increases to cover projected future benefits. He emphasizes "Social Security reform must insure against old age poverty and poor health status, by means of a more solid and generous lower tier Social Security and old age income security system." In striking language, he notes the importance of "well-being of all of our wives, mothers, grandmothers and daughters, the most important beneficiaries of the Social Security system and the ones most threatened by future Social Security reform."

In conclusion, let me note that what we have discussed here reflects the 20th-century gains in life expectancy. But what might the 21st century bring; the astonishing possibilities of gene-based research, regenerative or spare parts medicine, nano-technology, and the results of other biomedical and aging research. There will be interesting and great surprises. Already we know we will have nearly a million centenarians by mid-century, and five million by

the end of the century. And I have to say that all of the predictions in the last century by all government bureaus always turned out to be underestimates.

There may be other astonishing breakthroughs in health and new patterns in the work lives and the family life, certainly the basic elements in our discussion today relevant to policymakers. Soon, in 2011, the first baby boomers will arrive at Golden Pond. They are likely to be a major transformative generation, altering the culture and experience of aging forever.

All sectors of society will be involved; the marketplace, surely, the civil society, the individual, the family, as well as the economic enterprise, meaning both business and labor. All players have a responsibility of effectively adapting to this unprecedented revolution in longevity. In my judgment, we have already made remarkable adjustments and, with considerable rapidity, throughout the last century. Of course, there is an urgency to move quickly, before the baby boomers reach old age.

We need to provide them appropriate social, economic and cultural roles. We need to systematically reform Medicare into a health care system and contribute to the evolution of the finest of geriatric care. We must have reforms in the Social Security system, which help overcome the gross inequalities of income and wealth. We must appreciate, also, the rich and wonderful diversity of the American family. Thank you very much.

[The prepared statement of Mr. Butler follows:]

U.S. SENATE
SPECIAL COMMITTEE ON AGING

CONGRESSIONAL BRIEFING

Living Longer, Living Better: The Challenge to Policy Makers

November 21, 2000

By

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My assignment is to offer a synthesis, defined as organizing various elements into a coherent whole. I will allow myself some poetic license in order to meet the larger purposes suggested by the title "Living Longer, Living Better: The Challenge to Policy Makers."

The title summarizes well a universal goal of humanity, to both live longer and to enjoy a high quality late life.

That is precisely what has been happening in the industrialized world – a dramatic increase in life expectancy, some 30 years since 1900, and over the last several decades, significant declines in disability rates in the United States, Europe and Japan. In addition, as Bloom and Canning described in an article in *Science*[*] this year with the growth of longevity and health has come the expansion of wealth in the industrialized world.

This contrasts with the gloomy view of some pundits who see the growing population of older persons as a virtual calamity and growing crisis.

While not the focus of the discussion today, the extraordinary longevity divide in the world should be noted. I am referring to the inequality in life expectancy from Uganda to Japan. The short lives of the developing world are also associated with reduced health

[*] February 18, 2000.

throughout life. As we experience globalization and contemplate future markets for our products and services it must be kept in mind that free enterprise ultimately depends upon healthy, productive consumers who can therefore afford to buy our products and services. To this extent, longevity – ~~or~~ perhaps we should say shortgevity – is a geopolitical factor of a profound nature. Indeed, the great diseases of the world from tuberculosis to malaria along with other re-emergent or emergent infections can also affect the developed world – for within any 36 hours an infection can be brought from one locale in the world to another. Further, we have seen the loss of the life expectancy in former Soviet Union and Soviet Bloc Countries with the destabilization of health care systems and economies.

We enjoy here in the United States and in the developed world an extraordinary longevity dividend. There was much discussion in the past concerning the "peace dividend" and many have wondered how wisely it was used. One might now ask, will humanity profitably use or squander this surplus of longevity – a surplus that was actually unanticipated and, indeed, most projections by governmental agencies during the 20th century underestimated – the growing numbers of older persons.

J.R. Wilmoth, using Swedish data, some of our finest Family Registration Data, reported in *Science** magazine that the 70% gain in additional life over nearly one and fifty years occurred after age 65. The revolution in longevity is not only due to welcome reductions in maternal, childhood and infant mortality rates.

This gain in the numbers of older people has led to five concerns which I have observed in my travels – both official and personal - in some fifty countries:

1) Will societies be able to afford the growing numbers of older persons?

2) Will population aging result in the stagnation of economies?

* September 29, 2000

3) Will population aging generate intergenerational conflicts?

4) Since population is growing at both ends of the life course, will planetary over-population be further complicated?

5) Will societies be controlled by gerontocracies?

We do not have time here to fully answer these concerns. Let it be said that, happily, there is already evidence of varied successful adaptations to population aging that have been made by industrialized societies over the 20th century. Already mentioned is the finding that the growth of the additional life has led to wealth. See the "Health and Wealth of Nations." It is clear that older people are increasingly recognized as a massive new market, called by the Japanese the "Silver Industries," for example, financial services, health care, pharmaceuticals, living arrangements, etc. Indeed, it has been argued that the recent growth of the stock market is a function of "providence," that is, the deliberate action of people to invest in mutual funds, 401Ks and IRAs to protect their late life and retirement.

Polls taken in the United States and France do not support the idea of intergenerational conflicts. Rather young people remain supportive of the older generation and wish Social Security, Medicare and other entitlements to be protected – although some fear such resources will not be available for them – not a likely scenario given the fact that with their rising numbers they will constitute an even more massive and significant vote than older people do today. For example, when the Baby Boomers all reach Golden Pond and constitute 20% of the population - 1 out of 5 Americans – 2020 to 2030 - they will account for 30 to 35% of the vote.

With respect to the fear of over-population it may be noted that in those societies where population growth and longevity have increased, birthrates have decisively fallen. This is true in all of Europe, for example, with the exceptions of Ireland and Turkey. This is true in Japan

and, were it not for immigration, there would be a fall in the birthrate in the United States, below replacement levels.

Finally, while we have gained additional life and soon all the industrialized societies will have some 20% of their populations over 65, it should be noted that over 75% will be under 65. It is difficult to imagine gerontocracies under those demographic circumstances.

My colleagues have described remarkably the key "domains for aging in the new century" – the family, health, work, income – put together in a Venn diagram so nicely by Professor Fay Lomax Cook. Dr. Gary Burtless described the policy challenge of an aging workforce, noting that mandatory retirement has been outlawed in most jobs, that Social Security is no longer growing more generous, that worker coverage under company pension plans has stopped rising, and that Social Security and many private pensions have become more "age neutral" with respect to retirement. He notes we are beginning to see a reversal in the trend toward earlier retirement. This is reasonable on a number of grounds – economic, that is to say, for example, it is hard to imagine some 70 million Baby Boomers with all their skill, talent and knowledge remaining idle while collecting Social Security and using Medicare, for up to three decades of retirement. We know from studies at the National Institutes of Health in the 1950s and 60s that having a sense of purpose and constructive productivity advances both length and quality of life. Here, therefore, we have a situation in which both the individual and social good are served by continuing productivity. Doubtless, the 21st century will see great changes in patterns of the productive work life.

Of course, as Dr. Burtless observes, many retire to enjoy additional leisure, and increased wealth has been used to purchase more leisure. He further notes that two of the least persuasive explanations for earlier retirements are declining health and the changing physical requirements of work, already under change. The physical demands of work are

declining and the older population is healthier. Already workers in Japan, Scandinavia and the U.S.A. leave the workforce later than almost anywhere else in the industrialized world. Dr. Burtless also correctly observes that raising the retirement age constitutes a benefit reduction under Social Security.

There are advantages in utilizing the continuing productivity of older people. There will be changing patterns in the productive work life. We will probably see experiments in voluntary or mandated community service of young people and their later entry into the workforce, intermittent training to upgrade knowledge and skills throughout the life course and later exit from the workforce.

One matter I think worthy of brief discussion is the often cited "dependency ratio" one definition of which we believe is inappropriate. It compares the number of persons age 65 and over with those 18-64 (the so-called working population). As the size of the aged population increases, some suggest the younger workers will have to shoulder the burden of supporting dependent older people as well as themselves.

However, if we look at the total dependency ratio (which calculates dependents at both ends of life), then declining birth rates offset the growing proportion of older persons. In fact, if we divide the total number of persons under 18 and over 65 by the number of persons in the traditional workforce we arrive at the same dependency ratio in 2050 as existed in 1900.

Most children in the United States are not significant wage earners, whereas many persons over 65 are economically independent, either through continuing employment or as a result of a lifetime accumulation of resources. Moreover, the cost of raising a child to age 18 is estimated conservatively at $200,000 ($300,000 if the child goes to college). By comparison the average annual cost of maintaining an aged person in a nursing home is about $40,000 per year with the average stay being three years.

Some believe that if more babies are born the dependency ratio will improve. However, Nobel Prize winner Robert Solow has pointed out: "the initial effect (of an increase in the birthrate) would be to increase the dependency ratio. Second if the birthrate eventually reverts to the maintenance level, the end result will have been a second Baby Boom; the new Boomers will, for a while, lower the dependency rate when they are all working; they will then worsen it again when they retire, and eventually disappear... Faster population growth brings with it increased pollution, loss of open land, and pressure on food and water supplies," (On Golden Pond, *The New York Review of Books*, May 6, 1999).

Thanks to the technology revolution, productivity is a more important measure of a nation's economic well-being than the size of its workforce. For example, food is far more plentiful now than it was a century ago, even though 37% of Americans in 1900 were in engaged in agriculture compared with 2% today.

Increasing longevity is being matched by increasing productivity. It is therefore reasonable to predict that the Baby Boomers will contribute to the nation's economy well into the 21st century.

Marilyn Moon has described the, "success stories" of Medicare and Medicaid in improving access to health care for older persons. She is quite correct, I believe, that without these programs some of the progress in life expectancy and lower morbidity would not have occurred. Along with Social Security, Medicare is one of the great legislative triumphs of the 20th century.

Despite pressure for financial changes in Medicare, Moon also correctly notes that "Medicare payments have grown more slowly than private insurance costs in most years .... Moreover, on a cumulative basis Medicare has performed better than private insurance from 1970 to 1977, despite increased efforts in the 1990s by private insurance to limit cost by moving to managed care." She also points out that the gross domestic product is "assumed to

grow about 2.1% a year in real terms over time but this is not fast enough to absorb both growth in the number of beneficiaries and per capita costs of care that rise faster than the general Consumer Price Index."

Marilyn Moon's fine paper provides me the opening to discuss the importance of Medicare reforms that would go beyond finances, however important, to changes in the system of delivery of care, the advancement or research and the importance of training health providers in geriatrics.

There has been extraordinary mismatch between Medicare and the needs of older persons. When Medicare was created in 1965, there were no geriatricians at the table. There was a monumental struggle involving the insurance industry, the American Hospital Association, the American Medical Association, consumers and legislators, out of which came a program whose model was the employer-based, acute medical care system. The original Medicare did not include prevention, out-patient medications, long-term care, etc. – all vital to older persons and their families. Some changes since 1965 have brought coverage of some preventive strategies but still minimal support of long-term care and not out-patients medications. Medicare still does not meet fully the needs of older persons. Indeed, cutbacks resulting from the Balanced Budget Act of 1997 and the "reforms" of 1999 resulted in dramatic reductions in home health care, one of the most desired features of Medicare by older persons and their families.

Moreover, although $6.2 billion is devoted to Graduate Medical Education for the training of residents in medicine, ironically it has contributed little to developing the field of geriatrics. While there has been some fellowship money, what is really necessary is the creation of a cadre of academic geriatricians in each of our 145 allopathic and osteopathic medical schools so that no one, but no one, graduates from medical school or a residency

program, whether in primary care or any specialty, without adequate knowledge, skills and, I must add the appropriate attitude of respect to the care of older people. American families and their older members deserve this. It may be hoped that in the next several years there will be basic reforms in Medicare that improve the system of care – a continuum from assessment to hospice - and comprehensive training of those who deliver it.

One example of why adequate training is essential: In any given year, 35% of all persons over 65 develop adverse drug reactions. Further, in any given year, 17% of all persons over 65 develop an adverse drug reaction that leads to hospitalization. Older people and the nation cannot afford this.

A truly reformed Medicare system will also be more affordable. Indeed, there is so much money in the health care system that I believe systematic reforms could be undertaken with virtually no new money.

Elizabeth Kutza has offered a valuable portrait of the changing American family. As she observes "there is no one, typical family structure or type in the U.S. today." This is not to say that family loyalties have been lost but it does make clear "the reality of the changing structures and norms need special attention in our aging society."

One salient point she makes is again worthy of quotation "research over the last several decades has shown that there is little substance to .. 'the substitution theory' that is, expanded formal services do not result in the total withdrawal of families in caregiving. At the margins formal services supplement care in those cases where the care needs are so high that without help families could no longer continue to support their older relatives in the community." It is evident from Kutza's papers and from a variety of other sources that the caregiving burden largely falls upon women. But more women are in the workforce and the strain is becoming increasingly unbearable. What is necessary, clearly, is a program and policies that provide not

substitutes but supplements to the wonderful strength of the American family to serve its older family members.

Timothy Smeeding reminds us vividly of the economic status of older Americans. He considers the economic status – income, wealth and poverty – among older Americans as we enter the 21st century. He stresses, in particular, sub-groups among older persons, notably older women. Smeeding reminds us of the dangers of thinking of older people as homogenous and of depending upon averages – means, medians - used to described economic well-being. They are poor indicators. For there is wide disparity among various sub-groups classified by gender, race, ethnicity and health status. He also reminds that while many Americans do enjoy comfortable retirement years many exist near or below the poverty line. Minorities and older women living alone in particular have poverty rates in excess of 20% to 25%. Moreover, a much larger fraction of the aged than the non-aged live right above the poverty line (between 100 and 125% of the poverty line). They live on less than $10,000 of cash income per year. Let us re-emphasize, less than $10,000 of cash income per year. Smeeding believes that Social Security "will contribute a decreasing share of the income needed for a secure retirement. The demographic and fiscal crunch facing the system rules out large, across-the-board increases in benefits." Smeeding also notes that "inequality in wealth holdings is much greater among the aged than is income inequality."

Just as I emphasized the mismatch between Medicare as originally conceived and built 35 years ago, so, too, Smeeding emphasizes the mismatch of Social Security designed some 60 years ago, when women married, stayed home and raised children and were widowed at a relatively young age.

Observe that many of the issues of aging are issues of older women, often alone and poor. Eight percent of nursing home residents are older women and older women are the most frequent victims of elder abuse, that is, financial, physical and emotional abuse.

As Smeeding notes older women in the United States have "poverty rates 1.5 to twenty times higher than those found in other rich western nations in the Organization for Economic Cooperation and Development [redacted] (OECD), even before accounting for their higher out-of-pocket health care costs.

Smeeding correctly suggests anxiety over the prospects of privatization, benefit reductions and tax increases to cover projected future revenue shortfalls.

He emphasizes, "Social Security reform must ensure against old age poverty and poor health status by means of a more solid and generous 'lower tier' Social Security and old age income security system." In striking language, he notes the importance of "well-being of all of our wives, mothers, grandmothers and daughters – the most important beneficiaries of the Social Security system and the ones most threatened by future Social Security reform."

* * *

What we have discussed here reflects the 20th century gains in life expectancy. But what might the 21st century bring us? The astonishing possibilities of gene-based medicine, regenerative or "spare parts" medicine, nano-technology and the results of other biomedical and aging research. There will be interesting and great surprises. Already we know that we will have nearly a million centenarians by mid-century and a projected 5 million by the end. Thus, we will do well to continue to invest in biomedical research to ensure the reduction of disease to generate greater health and robust vitality. There may be astonishing breakthroughs in health and new patterns in work and family - the basic elements essential to our discussion and to policymakers in a society growing older.

Soon in 2011 the first Baby Boomers will arrive at Golden Pond. They are likely to be a major transformative generation altering the culture and experience of aging forever. All sectors of society will be involved - the marketplace, surely, the civil society, the individual – him or herself and the family – as well as the economic enterprise, that is business and labor. All players have a responsibility in effectively adapting to the unprecedented revolution in longevity. In my judgement we have already made remarkable adjustments and with considerable rapidity. Of course, there is urgency to move quickly before the Baby Boomers reach old age. We need to provide these appropriate social, economic and cultural roles. We need to systematically reform Medicare into a health care system and contribute to the evolution of geriatrics. Reforms in the Social Security system would tend to a growing inequality of income and wealth. And there will be a growing appreciation of the rich diversity of the family.

Thank you very much.

Ms. COOK. Each of you have been given a little card. If you have any questions, you should have written down your question, and Bob Shepler is picking them up. Thanks.

Marilyn Moon, why is it that the most prosperous country in the world has 44 million people who have no health insurance?

Ms. MOON. Beats me. I think that a combination of thinking about uninsurance for younger families and the quality of the Medicare program makes a lot of sense to do together, because I do not want to see a world in which we put one side against the other. That can happen in talking about improvements here. One of the great myths of America is that the uninsured get fine care just by showing up at hospitals. There are many, many studies now that show that the quality of care they get is not as good. The uninsured do not get care as early as they should. It costs us all in terms of productivity. It costs us in terms of intangible things.

The hardest kind of briefing I ever do is to talk to health care experts from other countries, who listen very politely while you describe the system for about 5 minutes, and then they say, how on earth can you tolerate this terrible system. And my answer is always, beats me.

Ms. COOK. Professor Kutza, what do you think of paying family members to provide in-home long-term care, as is done in Germany, and passing legislation to this effect?

Dr. KUTZA. Well, I think it is complicated. There is some evidence that some people—the ones who do not want to provide care—even if you paid them, may not want to provide care. It is not a surefire kind of solution to getting people into the caregiving area.

Clearly, there are burdens some of them financial burdens that affect people. Historically, the Congress has always looked at that and said those costs are much too high for us to entertain, because those now unpaid caregivers are going to be getting paid care. However, we have some illustrations within various states where they have moved toward paying family caregivers. And we have not necessarily seen budgets bust, and we have seen some good outcomes in that.

It is an area where there is enormous fear and some resistance, culturally, I think, to wanting to pay caregivers in this country. There is still an expectation that it should be kind of a familial obligation, rather than a paid activity. Yet, as I say, there has been some progressive activity on the level of some states where they have been able to both control cost and, as I say, have some good outcomes with caregiving.

The debate is not yet resolved, certainly at the national level, and I do not know where it is going to end up or come out.

Ms. COOK. Professor Smeeding and/or Professor Burtless, what will be the impact of increased labor force participation by women on the poverty status of older women? In other words, how long might it take for older women not to be poor?

Dr. SMEEDING. For a number of older women, it will probably work out just fine. The people who you are most concerned about are divorcees or mothers who spent most of their time working in their home. If we had earning-sharing, if you divided the Social Se-

curity benefit over the work life of couples, you just add it all up, split it in half and gave each credit, that would really help.

The thing that is just the scariest part is to have reform that increases the number of years that need to be counted to get a minimum benefit from 35 to 38. While more women will be working longer in the market, and that is good, we find married women, in particular, have many more "zero years" now. If you look at the number of years that are zeros of earnings, many more women than men are hurt.

Personally, I hope all working women get what they deserve and we do not have to worry about a minimum benefit guarantee at some point in the future. That would be really nice. The way I like to pose it is after that I sit and listen to a whole panel of people talk about how everyone is going to be better off under privatization, I say that it should be really inexpensive to guarantee that no little old ladies will be poor out there, so let's do it. Well the response is "Oh, no that's going to be expensive." But, I say, wait a minute, you just told me we are all going to be so much better off, so let's cut this half of the bargain too.

Personally, I think women's labor force participation probably has peaked. And I think as the demand for labor continues to grow in this country over time, there are going to be many more opportunities provided by employers for older workers, that they are going to become a valued commodity. Employers are going to start to pay more attention to what it is the older worker wants and needs. This may be based in part on a Pollyanna view of continuing good times in the economy. But, I think, in general, the demand for labor is going to increase by more than the supply, and that is going to open jobs and pull up wages. Gary probably has something to say about this, too, right.

Dr. BURTLESS. No.

Dr. SMEEDING. No? He will wait for another one.

Ms. COOK. The next question is for Gary Burtless. Dr. Burtless, do you consider there to be a looming aging crisis?

Dr. BURTLESS. If you told someone in 1900 or in 1800 that women could expect to live past 77 and past men 72, that during most of those additional years of life, most people would be in excellent health, that their diet could be so rich, that they are in danger of getting diabetes, that their energy levels during most of their lives will permit them to do much, much more active work, than the generation alive in 1800 and 1900, and that on top of that, their lifetime incomes would be several times greater, I think you would have a tough time persuading the person in 1800 or in 1900 that people in the year 2000 face an aging crisis.

What is the nature of the crisis? The crisis is that people live longer than they did in the past, No. 1, and No. 2, that they have fewer children than they did in the past, assuring that the population will not grow very fast and may actually shrink in many of the rich countries. I would like someone to describe to me why those trends constitutes a special burden on people now alive. It does not strike me that it is a very painful problem that we face.

There is a public budget problem. There is no doubt about it. There is a problem for public budgets in the rich nations that have rich and generous retirement programs, to help support the con-

sumption of the aged. That is true, but let's take the green eyeshade off and not focus so much just on what the government's budget problem is. Let's instead look at what the modern economy, and population aging, and the decline in birth rates mean for the average well-being during most of our lives. Let's consider this for people who are currently alive and for our own children and grandchildren in the future. It is not a crisis.

Ms. COOK. Another person has written a very similar question for Dr. Butler. Dr. Butler is there an aging crisis specifically in the area of health care, or is there going to become one in the 21st century?

Dr. BUTLER. Well, I basically concur with Gary. I think, as I mentioned in my remarks, I do think that we could so greatly improve the health care of older persons by having better informed physicians, nurses, social workers, in a comprehensive program that would avoid—I happened to mention the medications, but mention could be made also of the delay in diagnosis of Alzheimer's Disease, the failure to recognize hyperthyroidism, which often presents in an apathetic manner in older person. There are many very specific issues that really should be addressed if you are going to talk about a crisis in health care.

It would be certainly in the quality of that care. I really concur with Dr. Moon, in terms of the financing. There are certainly issues to be dealt with. I like Gary's point very much, and I am reminded here in this great city, CSIS, I guess that is the Center Strategic International Something—now that the cold war is over it has decided it has another crisis, and that is the aging crisis. And my friend, Pete Peterson, who wrote the book, "The Gray Dawn," that he himself says it is a book if you put it down, it is very hard to ever pick it back up, thinks the sky is falling in, when, in fact, this is an enormous human achievement, and we have made enormous strides already and adjustments throughout the last century, and we are only going to get better at it as we move into the next.

I think there is nothing that is not manageable within both the health and the financing aspects of a growing, healthier, older America.

Ms. COOK. This next question is directed to both Dr. Moon and Dr. Kutza. I am not sure which one of you would like to answer this. Is there any hope for raising the social status and the income of formal caregivers of the elderly?

Ms. MOON. I think there is a chance, because when those jobs get to be unfillable at the rates that people are paying, then the wages will rise, and a higher wage always means higher status for that job. As long as you pay people about the same to flip burgers at McDonald's as to care for older people, flipping burgers is more fun. What you have to hope for right now is that you get lots of dedicated, caring people, which happens in many cases, but that is not going to be enough. I think we will see wages increase from natural pressures.

Dr. KUTZA. I think we have already begun seeing that. At least in my State, in Oregon, which a has a very expansive home and community-based program. Nobody can fill the slots for homemakers, for health aides, for certified nurse assistants. They are

crying in need and that, from an economist point of view, will naturally push up the wages.

On this point, I would just say that I think one of the areas that we, as researchers, have done a very poor job is understanding these manpower needs, and understanding what it takes to keep people doing this kind of care, because I am still firmly convinced it is not just money. It is not just poor pay. It has something to do the nature of the work, it has something to do with organization and delivery of the way that we do it. As I look around and try to find research that has been done by colleagues about this issue, I find little.

Here is where I would use the word crisis. It could be a looming crisis down the road, as the population ages, and yet we know very little about what explains how one nursing home, who pays the same, can have a stable workforce, little turnover, people feeling good about what they are doing, while another one has 100 percent turnover in a year, or in 3 months, and has lousy quality and is not providing the care they needed. It is not just money and we do not know all the answers to that. I would encourage any of you who have students or are doing research to say, "Here is an area of growth for your research endeavors."

Ms. COOK. Someone has written a question asking, "Dr. Cook, could you let us know which Congress people are represented here today?"

No members of the Senate are with us today, because the Senate is not in session, and Senator Grassley and Senator Breaux could not be here. However, we do have staff people from the different committees. I just want to make sure we all get introduced to two people, right now, and perhaps they will introduce us to others, on the Special Committee On Aging. Ted Totman and Bob Shepler. Here is Bob Shepler who was just wonderful. Ted Totman asked him to organize this, and get invitations out to staff people. Bob, I want to give a lot of credit to you, and thank you for putting all of this together. Are there other staff people here from different committees that perhaps you might want to recognize, or perhaps those people could stand up if you are here from the various staff?

Dr. SMEEDING. It is really too bad, because this is one of the best testification opportunities that I have heard. We all learned things today. Thank you Bob, for that little gem about adverse drug reactions. We all wrote that down. This has been a good set of speakers and I am glad we can all share in their thoughts. We could have done it back at the other hotel, but what the hell, they were not using this room anyway.

Dr. BURTLESS. Thank you for the testification, Professor George W. Smeeding.

Dr. SMEEDING. Is this about Social Security? Those Democrats want to make it a Federal program, you know. I am telling you. We are going to stop them.

Ms. COOK. The next question is for Dr. Butler. What are the barriers to integrating geriatrics and gerontology content into the curriculum of health care professionals, and, second, what strategies to you recommend to overcome these barriers?

Dr. BUTLER. I am so glad you asked. The barriers are many. Part of it, frankly, within Medicine, has been the opposition of internal

medicine to a further fragmentation of the field, and it gets down to dollars and cents. I would point out that before the 1920's, when pediatrics was born, there was opposition also to pediatrics, because after all they are just miniature adults. I think there is that opposition.

Part of my new effort, which we will be undertaking this coming year, is a campaign to try to have a modest amount of money from GME, the Graduate Medical Education, for the support of training really bypasses the opposition of internal medicine, because what we are saying is, if you just want academic geriatrics and no one graduates from a medical school or a residency program without proper training, there is no reason you and I should be turned over arbitrarily to some new person called a geriatrician at some arbitrary age, 60, 65, 70. And we also want our gynecologists, our urologists, our neurologists, everyone, to have proper training. That is one area I think we can overcome.

The second is, on average, medical students graduate with about $100,000 in debt. It is extremely attractive to enter a procedure specialty which brings more money. Part of an effort by a new foundation relatively new to the world of geriatrics, named the Donald W. Reynolds Foundation—not aluminum, not tobacco, which is offering a major program of some $80 million to strengthen geriatrics in American medical schools, and has established two new departments of geriatrics in the United States. More money than has ever gone into the field. Part of the package is some debt reduction money to help with regard to medical students, because there are those who really do want to be part of the process of caring for older people.

Third, is the fact that it has not been required within medical schools. It is so frightening and disturbing—depression, despair, dementia—that not many volunteer to take the electives which are offered in only 45 of the 125 allopathic medical schools, and then only 2 to 3 percent take it. We found when it is mandated and they get over the transom, they are amazed to find what can be accomplished by even modest interventions by nurses, doctors, social workers.

I do not want to go on too long, except also reimbursement does have something to do with it. I am not talking about big dollars. I am just talking about the time, the time involved in evaluation, just getting the patient up on the examination table, the complexity, the multiplicity, the interacting aspects of the many diseases that are likely to occur in a person seventy-five, eighty and above, particularly a woman, are really time-consuming. It is very difficult to finance a practice under those circumstances.

Ms. COOK. We have only time for one more question. This is the final question and I am sorry we have not been able to go through all the questions here. What is the likelihood—I guess this is Marilyn Moon, but I think Gary Burtless could also help address it, because it is an inside the Beltway question. What is the likelihood there will be a serious debate about government's role in providing health care, especially long-term care, in the upcoming Congress? What are the odds that any policies will result, if there is a debate? Who is ultimately responsible for the care of the elderly? Marilyn, do you want to take a crack at that first?

Ms. MOON. Since both sides of the political isle have argued strongly that there should be prescription drug benefits for seniors, and because there was, a rather surprising interest in the uninsured by both candidates, both sides, may come together in a reasonable way. I think there will at least be discussion of this in the next Congress, although they have a long way to go to come to agreements.

The real question is, can people decide to work together for things that they agree are good things and find some common ground? I would like to be optimistic, but we do not have a very good track record with that in the last few years. I am hopeful that, rather than hold things hostage, since everyone knows there is such a split Congress, and there is likely to be a rather controversial president, that it may be the case that there is a decision to go ahead and try to get something done. I hope that is true.

Ms. COOK. Do you want to add anything?

Dr. BURTLESS. It is a mistake to believe that because one lives inside the Beltway, one knows anything more about what is going on inside the Beltway then a person who lives in Peoria, IL, or Salem, OR. I really do not have any special insight on what makes the Congress tick.

In the last Congress, people in both parties said that they believed in some kind of extension of rights to people who are participants in HMOs. As far as I can tell, nothing got done, because it was more important to people in both parties that their disagreement result in more votes for the people who hold office, then it was that they actually achieve a compromise. That may be true in the next Congress, as well.

Ms. COOK. Elizabeth Kutza.

Dr. KUTZA. I just want to add—Marilyn talked about health care or about the attention that has been paid to health care issues. I would like to address the lack of optimism I have, because of recent history, about attention to the long-term care arena. I think that is a forgotten stepchild of this whole health care debate.

Earlier, before I came to Washington for the GSA meetings, a couple of staff people from OMB, from the Office of Management and Budget, came to my office to talk about long-term care. The representative from the long-term care section was asking me if I knew about all of the Clinton initiatives. I looked at him and I said "What initiatives?" "What is there?" For the last decade, the only initiatives have been insurance-based—how to get people to buy more long-term care insurance, how to give tax credits so that one would buy more long-term care insurance. Only recently there is a little bit of money coming through the Older Americans Act around caregiving.

To really have a serious and broad discussion around long-term care issues, around the issues of caregiving, around the issue of who pays, all of that has devolved to the states and all the action, now, on long-term care is at the state level. I do not think we have had a serious national debate about this. As I said to the OMB representative, even when Clinton put forward the National Health Security Act, you would never know from reading the newspapers and all the discussion that went on, that it had a piece on long-term care in it. It was all about acute health care. So I think that

long term care is the stepchild of the Congress, and I do not, frankly, see any hope that there will be even discussion about it until we really get in trouble with it.

Ms. COOK. This has been a wonderful session. All of you are terrific to attend. Thank you very much.

[Whereupon, at 12 p.m., the forum was adjourned.]

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