Chapter 2
Aging in the United States

As we have shown in the Introduction, aging in the United States is not merely a reflection of the country's high level of economic development, because longevity gains in some ethnic groups are offset by continued poverty in other sectors of the population, and high fertility levels among specific immigrant groups, such as Hispanics. Due to these and other changes working through US society, the country is actually predicted to fall down the international aging table, from 23rd in 1975 to 50th by 2050, but nonetheless with 84 million people aged 65 years or more. Given that these 84 million live within the number one economy in the world (notwithstanding the rise of the Chinese and Indian economies) this means that many millions of people in the US are more likely to be able to access economic resources at a higher level than many of their counterparts in other parts of the globe. However, being part of the leading economy may also mean that their aspirations may also be unrealistically high, in that they may desire more second homes in sunny climes, more winter cruises, more expensive technological support systems, for instance, than may be feasible, whether in a strictly economic, social, political or environmental sense. In this chapter we explore a number of such issues, focusing on the many millions of US citizens who are growing old in such a wealthy society.

Towards a World of Silver Surfers and Golden Oldies

If you are 80 years old in 2010 then you were born in 1930, if 70 then 1940. What sort of events and experiences have impacted on your life and lifestyle? Well clearly growing up in the aftermath of the Great Depression would be one such major event and perhaps your parents were employed via President Roosevelt's New Deal, or perhaps your father was injured or killed in World War II. Later conflicts in Korea, Vietnam, Iraq and Afghanistan would have affected family or friends directly or indirectly, while the shock of the attack on the Twin Towers of 9/11 would have been significant, as was Pearl Harbor or the assassination of JFK. However, your

I.G. Cook and J. Halsall, *Aging in Comparative Perspective: Processes and Policies*, International Perspectives on Aging 1, DOI 10.1007/978-1-4614-1978-5_2,

family has probably prospered, despite or because of such conflicts and you have yourself have generally had a comfortable lifestyle notwithstanding economic setbacks such as the Global Recession of 2008–2010. You now live in a comfortable condo complex in the sunny South, and your son visits once or twice a year when he can get away from work and family demands on his time. You do worry sometimes about your savings, how long they will last, and you are concerned at some of the changes that you have seen in US society. You hanker back sometimes to your early life in the Village, and have the odd twinge of regret at leaving it all behind, but it was for the kids wasn't it? Now you laze by the pool, play a few hands of poker and surf the net—you're sure glad that you made the effort to learn how to use the Web, and you've got your webcam set up to communicate more easily with the family via Skype. Is this you? Or your mom or pop? Or your grandparents? Or their friends? Schulz and Binstock (2006, pp. 3–4) for instance note that the "vast majority" of older US citizens live:

- Reasonably healthy and active lives.
- Have generally adequate income.
- Significant wealth, for many.
- Independently.
- Have benefited from a dramatic rise in the number of years in retirement.
- Can access special agencies in every state, plus national facilities for older people.

But, in contrast, perhaps you are one of the minority who recently lost your home when Freddy Mac or Fannie May collapsed; you had to move back in with the kids and you rely on welfare handouts? Life has always been a struggle and it remains so, but thank goodness for Obama's health reforms; at least you don't have to worry about how those likely life-threatening diseases will be treated and paid for.

In other words, there is a need to avoid stereotypes of older people in the US, as for other countries. They are hard to pigeonhole, they vary considerably by income, ethnicity, location and life experiences. Further, the "baby-boomers" after World War II are probably younger in thought and perspective than were their predecessors at a similar age, influenced perhaps by the rise of the teenager in the 1950s and the "Swinging Sixties" and such happenings as Woodstock or "going to San Francisco" for the Summer of Love. In terms of aging trends, however, we can point to some salient facts drawn from key publications. LaPierre and Hughes (2009), for example, note that population aging in the US (and Canada) is not a new phenomenon, taking place "from the time the nations were established as independent states" (p. 192), and the change from being agricultural economies thru industrialization to become highly urbanised post-industrial economies which have undergone "profound transformations" in such spheres as technology, family structures, and the value of work. However, the US demographic transition actually began while the country was an agricultural society, with fertility decline beginning in the early nineteenth century, albeit from a far higher level than in Europe for example, befitting a new society. They present data and graphs which show a long-term decline punctuated only by the rise in fertility in the 1940s and 1950s (76 million births in

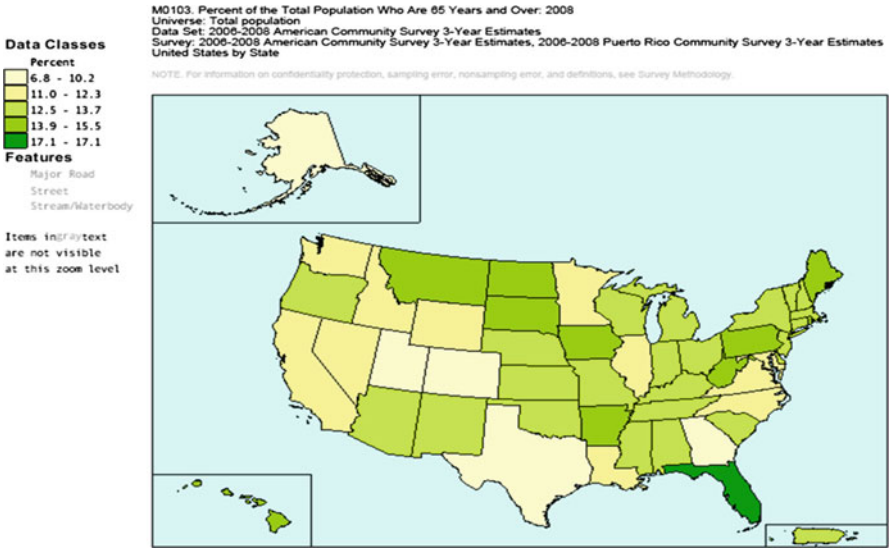

Fig. 2.1 Percent of the total population who are 65 years and over in America

the 18 years from 1946 to 1964 according to Schulz & Binstock, 2006, p. 1) before long-term trends reasserted themselves. By the early twenty first century US "fertility hovers just below replacement level at about two children per woman. This level is higher than that observed in most developed nations" (LaPierre & Hughes, 2009, pp. 193–4). In contrast, mortality decline is largely a twentieth century phenomenon, and mortality rates actually increased in the second half of the nineteenth century, perhaps in part as a result of high immigration levels due to the Irish potato famine and political upheavals in Europe—the fabled "huddled masses" being welcomed into the New World. The Nineteenth Century Civil War must also be factored in to these calculations, while "tropical diseases" in the Southern States could also be lethal, particularly to new arrivals.

The US Census Bureau provides data from community surveys 2006–2008, for the distribution of older people across the States. Figure 2.1 gives the percentage aged 65 or over, and it shows the spatial concentration to lie primarily in Florida, by far the State which contains the highest proportion of older people, plus a range of other States lying towards the East and/or North, such as Maine, West Virginia, North and South Dakota. In contrast those States with lower percentages are Alaska, Utah, Texas, Georgia, California and Nevada for example. Several of the latter have relatively low proportions of white populations, while the former are more likely to have the reverse, but it is a complex picture, and Florida with its Cuban links has a relatively low proportion of whites, whereas at the bottom of the aging table, Utah has 90% white population (Table 2.1).

Across the country, the complexity of US population composition due to immigration means that we must focus more closely on different cohorts within US society. It was estimated by 2007, for example, that there were 38 million foreign-born

Table 2.1 US aging data, by state

Area	Percent 65 or over	Percent 85 or over	Percent white	Dependency ratio
United States	12.9	1.8	74.3	20.5
Florida	17.2	2.8	76.7	28.3
West Virginia	15.8	2.1	94.4	25.1
Maine	15.6	2.2	95.3	24.4
Pennsylvania	15.4	2.5	83.8	24.7
Iowa	14.8	2.5	92.7	24
North Dakota	14.7	2.7	90.7	23.3
Montana	14.6	2.1	89.6	23.1
Hawaii	14.5	2.5	26.8	23
South Dakota	14.5	2.5	87.1	23.8
Vermont	14.5	2	96.1	22.2
Arkansas	14.3	2	78.6	23.4
Delaware	14.3	1.8	72.6	23
Rhode Island	14.3	2.4	82.8	22.3
Connecticut	13.9	2.2	79.9	22
Ohio	13.9	2	84	22.2
Alabama	13.8	1.7	70.4	22.2
Missouri	13.7	2	83.9	22
South Carolina	13.7	1.7	67.5	21.8
Massachusetts	13.6	2.1	82.7	21
New Hampshire	13.5	1.9	94.9	20.9
New Jersey	13.5	2	70.1	21.4
Oklahoma	13.5	1.9	75.4	21.8
Oregon	13.5	1.9	86.2	21.2
Wisconsin	13.5	2	87.6	21.2
Michigan	13.4	1.8	79.6	21.3
Nebraska	13.4	2.2	88.8	21.8
New York	13.4	2	66.7	21
Tennessee	13.4	1.7	79.3	21.2
Kentucky	13.2	1.7	89.2	21
Arizona	13.1	1.8	77.7	21.7
Kansas	13	2.1	85.7	21
New Mexico	13	1.7	70.1	21.1
Indiana	12.9	1.8	85.7	20.9
Mississippi	12.8	1.7	60	20.9
Minnesota	12.7	2	88	20.1
North Carolina	12.7	1.6	70.3	20.2
Illinois	12.4	1.8	71.4	19.6
Louisiana	12.3	1.6	64.3	19.7
Wyoming	12.3	1.6	91.6	19.4
Maryland	12.2	1.6	61.2	19
Virginia	12.2	1.5	70.7	18.9
Idaho	12.1	1.6	92.4	20
Washington	12.1	1.7	80.5	18.8
District of Columbia	11.7	1.6	36.1	16.9
Nevada	11.6	1.2	74.9	18.5
California	11.2	1.6	60.9	17.7
Colorado	10.6	1.3	83.7	16.4
Georgia	10.3	1.2	62.2	16.3
Texas	10.2	1.3	71.4	16.5
Utah	9	1.2	90	15.1
Alaska	7.6	0.7	68.6	11.4

Source: US Census Bureau (2010)

living in the US, with more than 10 million of these (29%) being illegal immigrants. Migrants, both legal and illegal were spatially clustered into five main States, such as California or Florida, States which thus bear a related welfare burden, and for which taxation is thus a controversial issue. Further Keating and Wetle (2008, p. 99), for example, point out that:

> In the US, life expectancy at age 65 differs by gender and race. For white women and men it is 19 years and 16 years respectively; for Black women and men it is 17 years and 15 years.

There is also the challenge of socio-economic inequalities, and these authors note that 13% of older women live in poverty compared to 7% men, but for older Black or Hispanic women the proportion in poverty reaches 40% (ibid., p. 100). Poverty is not an exact predictor of longevity but the lack of it is a key factor in ensuring that people not only reach an old age but also that they can live a more active life once they have reached it. But the picture is complex (Fig. 2.1):

> Thus, members of minority groups are likely to enter old age with poorer health and fewer resources than majority whites, especially in the U.S. However, minorities are not always disadvantaged: U.S. Hispanics are advantaged relative to whites on some dimensions of health and Asian-Americans economic achievement outstrips that of whites. Members of various groups bring these advantages and disadvantages to old age where they help to shape how they age and the needs they experience (LaPierre & Hughes, 2009, p. 205).

Think of contrasting diets for example; in Europe the "Mediterranean" diet with high proportions of pasta, olive oil, fish and tomatoes for instance is now considered preferable to the high meat and potato diet of Northern Europe, while a traditional Asian rice-based diet would also be seen to be advantageous in comparison to the wheat-based nutrition system traditional in the West. But as migrants adapt to new host societies they can be drawn into less healthy junk food and processed food systems as their lifestyle changes so, once more, the outcome is complex and highly variable, while diets of the host group are not static when faced by the opportunities for a "Mexican" or a "Chinese" that new migrants provide.

Pension Provision in a Deregulated Society

Although there are those in the US who view their own society as over-regulated, to European eyes at least, the US is a relatively deregulated society, in which welfare provision for older people is more likely to be provided via the Market rather than the State, via private pension and saving schemes. As in other societies, the main area of debate is how far State provision should go in order to provide a minimum level of income for older people, and to what extent taxpayers should fund this floor level of provision. In the US "older adults with little or no income or assets can apply for Supplemental Security Income (SSI)…available to the blind, the disabled and the elderly" (LaPierre & Hughes, 2009, p. 210). Despite the costs involved, these authors note that "government forecasters predict only a small increase in the proportion of the U.S. population who will receive SSI benefits over the next 25 years" (ibid.), in large part because those aged 65 or over comprise only 20% of SSI

recipients, and many qualified older people never apply for these benefits. Indeed, it is forecast that SSI payments "will actually decline from 0.285% of GDP in 2005 to 0.243% of GDP in 2031" (ibid.). Even if we assume some element of error or over-optimism in this forecast, it is highly likely that there is considerable validity in this estimate.

However, it is another form of support, namely Social Security (comprising two elements, Federal Old-Age Survivors Insurance (OASI) and Disability Insurance (DI), together known as OASDI) for which the outlook is "troublesome" and despite an increase in eligibility for full payments to 67 years compared to 65 previously "the long-term solvency of the Social Security program is still in jeopardy" (ibid., p. 211). These payments are taxed, and earmarked for the Social Security program and Medicare, the government health insurance for older people, but a 2008 report suggests that by 2017 the annual costs of this program will exceed taxation income. Currently, there is a surplus income that has given rise to the Social Security Trust Funds for each element, effectively "an IOU from the U.S. government, which has been using these excess funds for other programs" (ibid), but these Trust Funds will be completely used up by 2041, meaning:

> At that time the government will have no choice but to either increase taxes, or restrict or reduce benefits, as income from tax revenue will only cover 75-78 per cent of promised benefits between 2041 and 2082 (ibid.).

The US Government has been given warnings by the Social Security Board of Trustees about this growing problem "for decades" and since 1991 the Trustees have recommended action, for fear that the longer the situation is left unaddressed, the more drastic will be the eventual outcomes via increased taxation, decreased benefits or a combination of the two.

The third stream of pension support is via the private sector, via defined benefit plans or defined contribution plans. The former is based on final salary for each year of service and is paid annually as a lifetime annuity, while the latter is based on contributions to a retirement savings account that is invested, with the employer deciding "how and when to withdraw the funds" (ibid., p. 213). For the past 30 years or so a steady 52% of US retirees take such a pension income but with a shift towards the contribution plans rather than benefit plans. Those who utilise such private provisions "are more likely to be male, older, non-Hispanic, white, married and high-income earners" (ibid), thus there is a link back to comments at the end of the previous section, whereby certain cohorts are at a higher risk of not having the income that may might wish or need upon retirement.

One of the reasons why some commentators and analysts become so agitated about the potential costs of older people to society is that dependency ratios for people aged 65 or over compared to those aged 16–64 are set to increase considerably in the twenty first century. However (and as one of the authors has pointed out in his ongoing analysis of gerontological issues in China, e.g. Cook & Powell, 2005, 2007), dependency ratios for those aged 15 or less are on the decline too, while in any case there can be unemployment among those that young and old are dependent upon, or older people may not be "dependent" at all. Addressing the first of these points LaPierre and Hughes (2009, p. 221) present a highly informative table of past

Table 2.2 Changing dependency ratios, 1870–2050

Year	65 or over	0–15 years	Total
1870	0.05	0.68	0.73
1900	0.07	0.56	0.63
1930	0.08	0.47	0.56
1960	0.15	0.52	0.68
1990	0.19	0.33	0.52
2020	0.26	0.31	0.57
2050	0.35	0.33	0.68

Source: LaPierre and Hughes (2009), Table 10.6, p. 221. Final column may vary due to rounding

and projected dependency rates for the US, from which we have selected those at 30 year intervals for Table 2.2, as shown. Because the US had high fertility levels, as noted above, dependency ratios in 1870 were higher than for today due to the high number of children being born, and then the gradual decline in the birth rate led to a reduction in total dependency ratios until the combined impact of the baby-boomers with the increase in numbers of older people sparked an increase by 1960. Further falls in the birth rate led to further decrease thru 1990, and then an increase once more thru to 2050. Even by 2050, however, their projection is still less, in total, than for 1870. This is an encouraging sign, and although concerns over too high proportions of older people will not disappear, the prognosis is certainly not all doom and gloom as some would have it (Table 2.2).

Taking Stock in the Aftermath of the Banking Crisis

The previous sections make full use of the excellent chapter by LaPierre and Hughes, a chapter that is based on a wealth of references and a deep coverage of the key concerns posed by aging in the US (and Canada). However, although published recently in 2009, the time lag to publication plus recent events means that we must take stock of the aftermath of the ongoing banking crisis and also President Obama's healthcare reforms, reforms that are proving to be highly controversial. Ongoing debates in the US have become more intense, with those who are worried about the country's high level of debt being particularly concerned to reduce State expenditure. Some have even accused the Social Security system of being a Ponzi scheme, after the fraudster Carlo (Charles) Ponzi (and more recently Bernie Madoffs, who emulated him successfully for many years before being caught) who introduced a pyramid plan that provided huge returns to investors—as long as new investors were continually brought into the scheme. As Skidmore (2010, p. 162) notes:

> Profits to the early investors came from amounts paid in by subsequent investors, but the promised returns were so great that paying each wave of investors required a geometric increase in the number of investors in the next wave. If every investor remained in the scheme, the successive requirements for new investors to keep the system going would fairly quickly exceed the population of the earth. Obviously, this is unsustainable. Ponzi schemes inevitably collapse.

Some analysts such as those associated with the Cato Institute or the Tea Party worry that the Social Security system is based on a similarly false premise, placing an intolerable burden on future generations. Skidmore, author of a recent book on U.S. Social Security (2008), and editor of Berkeley's journal *Poverty & Public Policy* refutes these concerns, noting that the program "has operated efficiently and economically since its first regular benefits were issued in 1940…has become an integral part of the fabric of American life, and is probably the most popular government program in the country's history" (ibid., p. 164).

Health Threats or Active Aging?

Anyone can become ill, at any age, but the expectation is that older people, especially the oldest old aged 85 years or over, will become more dependent on healthcare provision. President Obama successfully passed his healthcare reform bill in the House of Representatives on 21st March 2010, arguing that the reforms were necessary in order to make health care more affordable and health insurers more accountable. However, some of his own supporters in the Democrat Party opposed the bill, and no Republicans voted in favour of it. Buoyed by their success in the mid-term elections of November 2010 the Republican Party, aided by such allies as the Tea Party Patriots, have vowed to continue their opposition at every stage of the legislation in order to block or reverse the progress of this bill. At the time of writing, however, a key debate in the House has been postponed due to the horrific shooting of Congresswoman Gabrielle Giffords and others in Tucson Arizona in January 2011, in which 6 died, including a 9-year old child, while the congresswoman was shot in the head and is seriously ill. Many politicians are blaming the shootings by a young man, Jared Loughrin, on the vitriolic level of debate on these reforms, which Giffords supports (Sarah Palin for instance had placed Giffords in the crosshairs of a rifle sight on her website, along with other supporters of the reforms). Claims and counter-claims are now being made, but many outside the US do find the high level of political abuse rather strange, going beyond the bounds of normal political discourse in democratic society.

So, why the high level of concerns both pro and anti the healthcare reforms? It is clear that the polarisation reflects two broadly contrasting views of US society. Those who oppose the reforms prefer the individualist approach to society, in which individual freedom from government and governance is a central feature. Such people believe that citizens should be left alone by government, which should "butt out" from things that do not concern it. There is a real worry among such opponents that the reforms will be too costly and too bureaucratic, and they see the National Health Service in Britain for example, as an organisation that is "socialist" in its operation, leading to unnecessary expenditure and over-staffing. In contrast, those in as the Tea Party for instance would prefer private sector provision in health care, continuing as at present via private health insurance. The private sector can keep costs down in a way that government cannot, and offers a more effective and efficient means of catering for the needs of people in general, and older people in particular, in the twenty first century.

Table 2.3 Public-sector healthcare provision, 2007

Per cent public provision	Type
57.2	Medicare: government-funded for over-65 s
24.7	Medicaid: government-funded for those on low incomes
4.5	Military veterans: government-run scheme
4.2	Military currently serving: government-run scheme
9.5	"Other" including state children's health insurance policy for children whose parents do not qualify for Medicaid and Uninsured who receive treatment in emergency rooms only

Source: Editor's Choice (2010)

[a] Total cost of this public sector provision in 2007: $754 billion

Those who support President Obama's initiative generally represent those who do not trust the private sector sufficiently to keep costs down. They point to the recent failure of the banks as a warning as to what might happen in the healthcare industry too, and are concerned that too many Americans at present have no health insurance at all, or have too low a level of insurance to be able to afford big healthcare bills should major surgery or care provision become necessary. They wish to see a system that caters for the less well off as well as the better-off, and believe that public-sector provision is the best way forward. The US census, for example noted that in 2008, 46.3 million Americans were uninsured, out of 300 million, although this figure included 9.2 million non-citizens plus 18 million people who earn over $50,000 per annum, and who presumably feel that they have access to sufficient financial resources should health concerns escalate. The authoritative BBC website contains a very effective summary of these key issues as well as useful data to assist our understanding of this difficult issue (Editor's Choice, 2010). Table 2.3 summarises healthcare provision in 2007, with the per cent cost of public-sector provision

Despite the high cost of this provision ($754 billion in 2007), this is less than one third of total costs, which reached $2.2 trillion that year, 16.2% of GPD, which is twice the average of OECD countries. Mechanic and McAlpine (2010) note that this share of GDP rose to 18% in 2009 and is forecast to rise to 34% by 2040 unless costs can be curbed. It is the private sector expenditure that forms the vast bulk of these costs, being roughly of the order of $1.2 trillion in 2007, compared to $0.5 trillion in 1990. Employer-funded health insurance, paid for by salary deductions make up the main element of this, in which those insured can also be liable to "a deductible" of part of the cost of treatment in addition to that for which they are insured (ibid.). It is this high cost, allied to what Weissert and Weissert (2010) call the "mediocre" quality of health care in the US that means that the Obama reforms, although controversial and contributing to high Democrat losses in the mid-term elections of November 2010 (Saldin, 2010), may not be able to address these major problems, because the Reform Bill has plumped for a system in which there is a universal mandate in which everyone must have health insurance even if the employer does not provide this, and for the less well off this will be subsidised. This move placated the powerful health insurance lobby but does not address the cost dimension, although Obama argued that the scheme would be affordable via making Medicare less wasteful. The aim is to reduce the federal deficit by $100 billion over the next decade, but this is likely to be very difficult to achieve in practice, to say the least.

Is there an alternative perspective on these seemingly intractable problems? One possibility is to reduce the stereotyping of older people, and to recognise that many will not be as dependent on welfare support in the future as may currently be thought. To paraphrase and build upon Cook & Powell, 2007, who refered to older people in China, some will be illderly, some wellderly, some Han, some-nonHan, some wealthy, some poor, some with family support, some not, some will be vulnerable and some will be active. In other words, growing old in the US as elsewhere contains a myriad of individual possibilities, and is not necessarily as gloomy a prognosis as some would have it. For example, the first Active Aging Week in the US for those aged 50 or over was held September 29 to October 5, 2003. In this first attempt, the emphasis was on fitness, with Jazzercise (http://www.jazzercise.com), the world's leading dance-fitness program, with 5,000 instructors worldwide and the International Council on Active Aging (ICAA, http://www.icaa.cc) coming together to launch that Active Aging Week (http://www.seniorjournal.com, 2003). They offered free "Simply Lite" fitness classes across a range of cities, including Washington DC, Miami, Chicago, Dallas and New York. At the time of writing, the latest (8th) Active Aging Week was held September 20–26th 2010. Now, however, the focus was more sophisticated. As the Journal on Active Aging (2010) noted prior to the event:

> Because wellness is a multidimensional model – one that encompasses physical, spiritual, vocational, intellectual, social, emotional and environmental wellness – a myriad of activities can enhance health and well-being.

The key is to find the right activities for the individual and so there was a wide range of activities made available, including health fairs, lectures, concerts, dances and others, organised on the theme of how to "be active your way", the theme of Active Aging Week 2010. The journal contained a planning guide to the event, with the aim being for people to organise their own week within a self-help program.

This feature, co-operation assisted by an umbrella organisation such as the ICAA in this case, also helps point towards future alternatives. As Mechanic and McAlpine (2010) point out in their analysis of healthcare reforms, there has been an erosion of trust in recent years, such as trust in government, trust in healthcare professionals and trust in experts more generally. But despite this erosion there remains a high level of trust in one's personal physician, who is more likely to be viewed as acting in one's interest, to a greater extent than for many other professionals or interest groups. It will not be easy but somehow such trust must first of all be sustained in the face of difficulties such as the high cost of health care, then it must be built upon and then extended to other groups also, if this is indeed possible. To be possible, the extreme top rhetoric would have to be toned down, albeit without removing the recognition that strong disagreements do exist, and that these disagreements have to be faced, discussed and worked through. As Mechanic and McAlpine (2010), conclude:

> There are many thoughtful proposals for a more rational health care system, but the challenge is in our politics, not in our imagination. The health reform legislation passed in 2010 is a massive change with many important advances and opportunities. These modifications are not fully comprehensive or efficient, but we will have to muddle through as we go and iteratively build coalitions to implement further needed changes in covering the uninsured, cost control, reimbursement, and regulatory processes (Mechanic 2006). While at this time polarization and distrust are at high levels, building the needed organizational structures and norms will require renewal of more trustful and cooperative efforts.

http://www.springer.com/978-1-4614-1977-8

Aging in Comparative Perspective
Processes and Policies
Cook, I.G.; Halsall, J.P.
2012, VIII, 96 p., Hardcover
ISBN: 978-1-4614-1977-8