A GENERATION AT RISK

When the baby boomers reach Golden Pond

A GENERATION AT RISK

When the baby boomers reach Golden Pond

by **Robert N. Butler, M.D.**

Reprinted from *Across the Board*,
a publication of The Conference Board,
845 Third Avenue, New York NY 10022. July/August 1983.

Hogg Foundation for Mental Health 1984
The University of Texas
Austin, Texas 78712

Robert N. Butler is chairman of the Ritter Department of Geriatrics and Adult Development at The Mount Sinai School of Medicine in New York City. He is the former director of the National Institute on Aging and author of the influential book, Why Survive? Being Old in America *(Harper & Row, 1975).*

A GENERATION AT RISK

When the baby boomers reach Golden Pond

The time is now to build into our personal and corporate behavior the realities of a long life ending not in the 60s and 70s but in the 80s and 90s. More and more of us are reaching these years. This is where some revolutionary trends of modern life are taking us as predecessors, successors, and members of the baby-boom generation.

We are relatively unprepared. Yes, we do worry about pensions and Social Security income and the costs of Medicare. Only beginning to sting are long-term care expenses and associated taxes affecting corporate, government, individual and family budgets. These costs are harbingers of a complex future that we must begin to plan for systematically, starting now.

The 20th century has seen average life expectancy in this country move from under 50 to over 70. Our society has become incredibly efficient at bringing children into maturity. Today's infant has a 50–50 chance of living more than the biblical three score and 10.

Converging with this expansion of average life expectancy is a second great trend: the aging of that enormous cohort of 76.4 million persons born in the 1946–1964 period. This baby-boom cohort will continue to stress our institutions: the schools were among the first to feel their impact, then the job market; next will be pension plans, Social Security, medical and social care, and other institutions concerned with later life.

The baby boomers constitute a generation at risk. The critical years of their retirement will start about 2010. By 2030, there will be over 50 million retirees, twice today's 65-and-over population. Where 1 in 9 Americans are elderly today, the ratio a half century hence may be 1 in 5, assuming that fertility stays at about the replacement level.

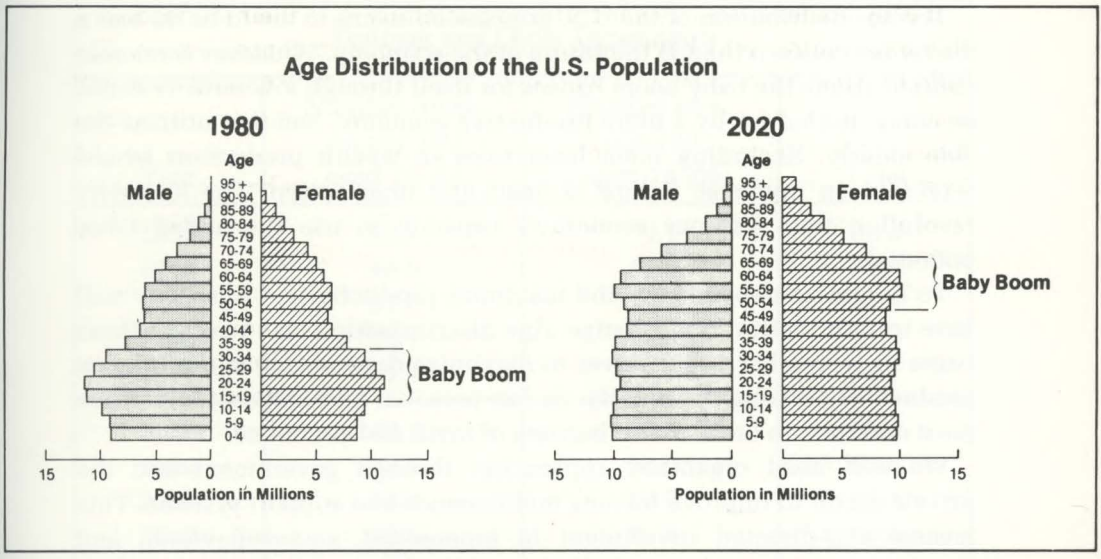
If baby boomers have fewer children per family than their predecessors, this expectation will have profound socioeconomic consequences. The ratio of Americans of typical working age to Americans 65-and-over will reach 2 to 1 as baby-boom retirements increase, considerably under today's 3 to 1. However, the total number of dependents—under 18 and over 65—per 100 working-age Americans will actually be fewer in 2030 than in 1970 or 1960. (See table on page 7.) Presumably, workers will spend less on children and will have more for the elderly.

I disagree with warnings that generational conflict will occur when younger workers are forced to support ever growing numbers of elderly. Not only does this line of argument ignore the decline projected in children per household, which will reduce the overall dependency costs of the baby boomers, it overlooks as well the income transfers that go on from elders to the young.

According to A. J. Jaffe in *The New York Statistician* for November–December 1982, the total dependency ratio in today's population is about 1 to 1, and in 2050 "about half of the total population will still be supporting the other half. . . . The change in the dependency burden is the shift from more younger to more older persons." Jaffe believes that the cost of raising and educating the child population about equals total retirement benefits. "It is evading the issue, if not outright misuse of statistics, only to compare the working force and the over 65," he says.

One of the most divisive measures for meeting costs of dependency would be government-enforced "filial responsibility"—that is, requiring children to help support their elderly parents. The Reagan Administration has announced a regulatory change in the Medicaid program to allow states to recover, when possible, nursing-home expenses from the children of poor patients. Experience with such policies has shown that they are administrative nightmares. Even when effective, they may result in family disruption, as resources are withdrawn from support of younger members of a family and given to older members. We have no need for coercive and disruptive measures in a society that can meet old-age needs humanely and efficiently with private or social insurance. Moreover, "filial responsibility" cannot help the 1 in 4 nursing-home patients who have no family.

On a scale no other birth cohort has confronted, the baby boomers will confront a double challenge. First, as they approach and enter retirement, they will have to balance their own needs with those of parents and even



The size of the baby-boom generation in 1980, and the projected size in 2020, compared with the rest of the population. The ratio of working-age Americans to those 65 + will decline to 2:1 as baby-boom retirements increase, considerably under today's 3:1. *(Source: The Social Security Administration)*

grandparents. This is illustrated by the 68-year-old daughter who oversees the care, at home or in an institution, of an 87-year-old mother while dealing with her own need for chronic care and that of her 72-year-old husband on a slender retirement income.

Second, as the baby boomers reach the oldest ages, they will have fewer family members to turn to for the same kind of help they gave in earlier years. Not only are more people living to the ages of highest sickness rates but family structure is changing: fewer children, more divorce, and more social isolation, especially because of widowhood. Given the continued emphasis on mobility and living independently, the elders of tomorrow may have to turn to strangers, particularly paid employees of social-service and health-care organizations.

This double challenge will grow rapidly as the population of the most frail elders increases: now one-third of all elders, they will comprise 40 percent in only 10 years. The challenge will spread faster among older women, blacks, and Hispanics, since these groups of elderly are growing faster than the total 65-and-over population. For older women, the challenge will be particularly intense; they outlive men and typically are the mainstays of long-term care within the family.

The age distribution of the U.S. population seems to me to be far less a matter for concern than is the future of the economy. Whatever economic complications the baby boom causes for itself through low fertility could be compensated for by a more productive economy, one that utilizes the able elderly. Excluding them from roles in wealth production would represent an immense failure of heart and imagination. The longevity revolution will test our economy's capacity to use the added labor potential.

To minimize dependency and maximize productivity, our society will have to spur institutional change. Age discrimination (as I wrote in these pages in November 1980) serves to maximize dependency and minimize productivity among the elderly. In our personal and corporate lives, we must continue to break down barriers of myth and prejudice.

We will need organized approaches through government and the private sector to improve income maintenance and support systems. This means well-directed investment in biomedical, sociobehavioral, and productivity-related gerontological research. We must originate, refine, and routinize programs to help preserve (and recover) health and productivity at any phase of the adult life cycle. Surely this is one of the best ways to reduce the dependency costs of the generation at risk.

Extending the Work Span

How shall we finance the added years of life? Assuming a life span of 85 years, we can imagine the working portion as about half, counting 20 years for retirement and 25 for maturation and education. A 40-year work span could easily accommodate two or more careers.

We could add to savings by extending the work span—by delaying retirement, by taking less leisure time during the working years, and banking the income, and by investing more in public and private pension programs. A delayed-retirement strategy implies a full-employment economy. Will our society have jobs for everyone as the baby boomers move toward old age? If we are evolving into a society that needs fewer people in the conventional work force, how will individuals build up reserves for retirement? Will automation drastically alter the education-work-retirement proportions of the life span?

Younger and Older Dependents			
Year	Number under 18 per 100 aged 18–64	Number 65+ per 100 aged 18–64	Total
1930	58.9	9.1	68.0
1940	48.9	11.0	59.9
1950	51.0	13.4	64.4
1960	65.1	16.8	81.9
1970	61.4	17.7	79.1
1980	47.2	18.6	65.8
1990	43.5	20.0	63.5
2000	43.2	19.9	63.1
2010	39.2	20.2	59.4
2020	41.2	26.0	67.2
2030	42.0	31.8	73.8
2040	41.2	30.6	71.8
2050	41.7	30.2	71.9

Projections of the numbers of "dependents" in the U.S. population, young and old (derived from U.S. Census figures by Herman B. Brotman, a consulting gerontologist). The table shows that while the proportion of those over 65 will steadily increase, the relative numbers of those under 18 is generally decreasing. Thus, the total "burden" on the working-age population of both young and old would not be unreasonable. In fact, the proportion of dependents may have been higher in 1960 and 1970.

These questions must be answered if we are serious about reducing risks for the baby-boom generation and its children. Likewise, we must ask hard questions about the solidity and efficiency of retirement-income programs, including Social Security, private pensions, and individual retirement accounts. Major evaluations should be made of the use of tax breaks to encourage people to plan for their own retirement. Should the goal be to encourage those who can to save more, allowing income to escape Federal taxation? Or should the goal be to assure an adequate basic income in retirement for all (for example, through higher Social Security benefits based on higher taxes and more income transferring)? Do we need a better balance between these goals than now exists?

Unfortunately, planning for population aging tends to occur in relatively narrow contexts, in response to perceived institutional crises. The recent deliberations of the National Commission on Social Security Reform extended gingerly into some of the issues of health and productivity. But the approach was to shore up the Social Security financing, and this necessarily limited the explorations. Nonetheless, the Commission's recommendations offer an entrée into some of the practical issues of planning for population aging.

The bipartisan panel dealt with short- and long-range problems. A deficit of somewhere between $150 billion and $200 billion in Social Security revenue was projected for the 1983–89 period. The panel recommended that this could be made up by a combination of taxes and benefit cuts. Some of these proposed actions would also reduce deficits expected after 2020, when the baby-boom retirees would reach a peak. However, an unresolved issue was how to meet fully the long-range gap.

Republican appointees on the Commission endorsed a gradual rise in the age of full entitlement, or indexing of that age to improvements in average life expectancy. They argued that postponing the age to 68 would be sufficient to keep the program sound through the mid-21st century.

Democratic appointees called the proposed age change a benefit cut for young workers confronting higher taxes over the proposed longer period until retirement. Such a step was unnecessary now, they argued, since the long-range deficit might well be made up through economic growth or additional tax increases.

The consensus recommendation of the Commission, however, omitted any call for an age change and instead advocated a policy of encouraging retirement at age 66, 67, or 68 by raising benefits by 8 percent for each year of delay. Congress was divided on the issue, and in the end prescribed a gradual rise to age 67 by the early 21st century. This provision is in the law signed by President Reagan.

Neither the Commission nor Congress directly raised the question of whether the United States spends enough on its Social Security program. Other advanced countries—with proportions of elderly the U.S. has yet to experience—seem able to manage a greater investment. Some devote twice the proportion of gross national product to benefits comparable to those offered under our Social Security system.

A major intent of proposals to raise the full-benefits age is clear: each year of delay means the individual will put more money into the system

and will take less out of it. Attempts to assure the system's soundness are praiseworthy, but we must consider some implications. Will jobs be available? Will they be open to older workers? Will employers or the government be willing to retrain them? Will they be healthy enough and willing to work? Or will they see delayed retirement as an unprofitable trade of healthy years for sick years?

Corporations in various fields have demonstrated ways of keeping older workers on the job, encouraging their re-entry into the work force, and developing part-time arrangements to meet retirees' needs for supplementary cash, as well as their own needs for their skills and for flexible scheduling. *Young Programs for Older Workers,* published by Work in America Institute in 1980, provides case studies of such programs.

Wm. Wrigley, Jr., Company has a long-standing practice of phased retirement for employees at age 65: The first year the employee takes a month off without pay, the second year, two months, and the third year, three months. For each year he works from age 65 to 70, the employee adds 8 percent to his base pension; $100 of pension income at age 65 thus becomes $147 at age 70. The term phased retirement, or flexible retirement, describes any program that allows the employee to gradually change the proportion of leisure time to work time, whether in the form of shorter days, shorter weeks, or months off.

There are various other arrangements to accommodate older workers. IBM fosters second careers to help individuals adjust to technologic and business changes and, when retirement is imminent, to develop new interests and skills. Tektronix Inc. employs a medical placement specialist to redesign jobs for better efficiency and improved job satisfaction on the part of workers who have physical limitations. A carpenter with a back injury can still saw and use the lathe but can't bend to trim moldings; that part of his job is eliminated, and instead he is given part of another job, say, driving a truck and delivering supplies. The Toro Company has a program that uses part-timers in two ways: some do regular part-time work and others are on call for overload periods.

Surveys show that many retirees want to work, that many workers in their 50s intend to extend their working careers, and that business recognition of older-worker productivity is increasing. Employment agencies for older workers have developed to serve these parties. In Los Angeles, a Second Careers Program—a nonprofit organization administered by the Los Angeles Voluntary Action Center—has been assisting companies since 1975 to begin or enlarge pre-retirement and retirement

programs and to identify opportunities for volunteer and paid second-career jobs. Mature Temps, formed by the Colonial Penn Group, provides jobs for people over age 50 through 14 offices around the country.

A lot more has to be done to provide options in employment and retirement for older workers. Robert W. Feagles, senior vice president of The Travelers Insurance Company, which two years ago eliminated mandatory retirement, points out that our society has built a system allowing more people to enjoy retirement but, at the same time, limits choices for older people. "In reality," he says, "most people over 65, whatever they may wish to do, face two stark alternatives: either full-time work or full-time retirement, with few options in between." Most private pension systems define retirement so strictly that even a short interval of paid work threatens loss of benefits. Social Security is a prime example of the earnings test.

We have to differentiate the expectations and conditions of tomorrow's older workers from those of today and yesterday. The fact is that two thirds of Social Security retirements occur before age 65. These individuals have actuarially reduced monthly benefits for the rest of their lives. Some early retirements are for reasons of health. Some of these persons are disabled but do not qualify for disability insurance and, through it, Medicare coverage. The disability definition of Social Security has been criticized as unduly severe: an individual must be unable to perform in any job no matter where it is in the nation; older workers cannot be expected to move thousands of miles to find a job they are able to do. (The commissioners who proposed a change in the full-benefits age also suggested provisions to assist sick early retirees. This group confronts reduced benefits at a time of above-average sickness costs—and no elibility for Medicare until age 65.)

The One-Hoss-Shay Issue

The Commission also considered the notion that people should be able to have longer work lives because improvements in longevity have been accompanied by improvements in health. In June 1982, as director of the National Institute on Aging, I discussed the point at the panel's request, along with Dr. Jacob Feldman of the National Center for Health Statistics.

The Commission wanted comments on a hypothesis set forth by Dr. James Fries of Stanford University that the natural limit of the human life span is about 85 years. Fries's policy-relevant point is that the period of morbidity in later life is shortening; people are likely to stay healthy longer, deteriorating much like the "one hoss shay" in the poem, almost all at once. If true, the trend might provide support for raising the Social Security full-benefit age beyond 65. In addition, the hypothesis offers the comforting prospect of moderation in the spiraling costs of Medicare and Medicaid as sickness diminishes in late life.

Trend data from the National Health Interview Survey do not support the Fries hypothesis. Sickness and disability rates by age bracket appear to have held steady over the last decade. Conceivably, this could change. However, applying current rates to the growing elderly population, we project a heavier load of sickness and disability in the 21st century.

Policymakers cannot reasonably ignore this projection, even though some anecdotal evidence suggests that the elders of today are in better health than their forebears. Some surely are. But some reach old age already sick, their lives preserved by medical care. Some live to the oldest ages despite great handicaps. And some maintain good health almost to the very end of life. How this mixed picture relates to ability to work is not precisely clear, since we lack objective criteria for assessing various physical and psychological factors in relation to different kinds of work.

This issue was made most clear to me when the National Institute on Aging, at Congressional behest, reviewed the Federal requirement for mandatory retirement of commercial airline pilots at age 60. Was it medically justified? This was hard to say, since there were no conclusive data on whether pilots were more or less like the general population, in which cardiovascular and other morbidity and mortality rates rise sharply in the 60s. Modern airliners are better staffed and powered than those of 1959 when the rule was imposed. But no one could say definitely that a fine record of passenger safety would be maintained. Undoubtedly, some pilots are mandatorily retired with unnecessary loss of their productivity.

The pilot issue is a special case. But it illustrates the shortcomings of our knowledge of aging and disease processes in relation to practical decisions important in population aging. Based on trends, our best guess is that the proportions of the population with disabilities will stay about the same. For the age bracket 65 to 74, which includes the years relevant to the benefits-age issue, the proportion with a limitation on activity due to a chronic illness or disability is projected to be about the same in 2020

as in 1980: about 35 percent. However, the number will double in that period to 10.7 million, reflecting the baby boom.

The activity limitations—joint stiffness, visual and hearing impairment, cardiovascular problems, and other handicaps—need not be so serious as to prevent employment. Policies could be adopted to promote employment of such people. The working day or week could be adjusted. Work environments and tasks might be modified. For instance, in regard to pilots, a report prepared for the National Institute on Aging notes: "Research on human factor engineering suggests that alterations in cockpit and equipment design can be made that will take into account decrements in performance, so that small changes in physical capability will not significantly affect a pilot's ability to fly safely."

Ways of making such changes for all kinds of jobs are being, and surely will be, researched and tested. The willingness of public and private sectors to pay their fair share for the accommodations would be an important issue. We are already seeing controversy between government and corporate interests over the recent law requiring job-based health insurance to supplant Medicare as the primary coverage for older workers. The companies oppose the law since private insurance costs more for older workers than for younger workers.

But we must also plan for persons with serious functional limitations who require considerable social support, including medical, hospital, nursing home, and at-home services. We must keep in mind that this group constitutes a sizable minority, but a minority nonetheless, of the elderly population. At any one time, only 1 person in 20 of the general elderly population is in a nursing home; the proportion after age 80 is 1 in 5. This is an important point in considering needs for both institutional and community-based services. According to some estimates, a population double the 1.3 million nursing-home residents is in need for long-term care services in the community. If true, the market for major long-term care services is probably about 4 million of the nation's 26 million elderly.

Because mortality and sickness rates accelerate markedly after age 75, the size of this population has implications for the development of health and social services. It is growing fast—over 9 million today, probably 14 million by 2000. The fastest growing segment of the entire U.S. population is the group aged 85 and older. In 1980, there were 2.6 million, or 1.1 percent of the U.S. population at this age. In 2020, there will be 7.6 million, or 2.5 percent.

Between 1980 and 2020, the 75-and-over population with activity limitations due to chronic conditions will increase 2.5 times to 10.7 million. The number of short-stay hospitalizations will rise to 104.6 million days from 45.8 million. Instead of 1.1 million in nursing homes, there will be 2.7 million. The number of physician visits will double. Personal expenditure for health care will more than double for the aged, while it rises by 50 percent for the entire U.S. population. Nursing-home expenditures will be in the forefront.

The Geriatrics Gap

Geriatric researchers seek ways to prevent a slow decline in various body systems and to help the patient adjust to changed conditions. They also study a variety of special problems of the elderly. The reactions of the older person to drugs, infection, pain, heart attacks, and other conditions may be different from the reactions of younger adults. For example, mental confusion, not chest pain, may be symptomatic of a heart attack in the older person. So-called senility, or senile dementia, may be reversible once the cause of confusion and memory loss is traced to a treatable cause, such as infection, malnutrition, alcoholism, drug abuse, or depression. Geriatric practice must be concerned with educating patients and families on the true nature of illness in old age, lest misconceptions like "it's just old age" delay treatment beyond the time when it can be most effective.

Unfortunately, the field of geriatrics is underdeveloped in this country. Scientific research into the processes of aging did not expand until recently, and some new conclusions are beginning to appear. Several studies have been done that show far less deterioration in information-processing and problem-solving abilities than investigators in the 1930s had thought.

Some of the most significant conclusions from recent gerontologic research are cautionary. First, what sometimes looks like psychological deterioration due to aging may in fact be more the result of a poor socioeconomic background or little education. For example, a 60-year-old born in 1910 may have greater ability than a 60-year-old born in 1880 simply because he has had a better education.

The enactment of Medicare in 1965 was not accompanied by major investments in research, manpower for service and for research, or by the organization and funding of geriatric services. Medicare was, and is, a benefit package based on what young adults need. It emphasizes short-term or acute care.

The Medicare nursing-home benefit, called "extended care" at first, was basically for convalescence after hospitalization. Because costs could not be forecast reliably, Congress omitted long-term care from the Medicare law. Administrative definitions of reimbursable illness costs exclude coverage of what is disparagingly called "custodial services," some of which are essential to the survival or functioning of patients who are not likely to get "better." For want of home care and other mundane assistance, sound geriatric principles cannot be applied, and some patients become expensive institutional cases.

The only large-scale program of long-term care benefits is found in Medicaid, the Federally aided program of state benefits for the poor. Medicaid money accounts for about half the annual $22 billion spent on nursing-home care. (The other half comes directly from patients or families.) The program's growth is threatening many state treasuries. Unless costs can be moderated, taxes will increase and the increases will cut into profits and wages. This is one reason why some forward-looking business groups are examining long-term care issues and their responsibilities for assisting in resolving them.

Private insurance has eschewed coverage of nursing-home and homemaker services. Reimbursement arrangements under conventional health insurance policies are ill suited to geriatric practice. Only grudgingly do they recognize time spent hearing out, examining, and counseling a patient, or the use of experts in medicine, nursing, and social work as a diagnostic and treatment team. The team approach, a cornerstone of geriatrics, disintegrates at the billing office and dies at the bank. A breakthrough in insurance coverage, through private or public approaches, or a combination of them, is sorely needed.

In addition, we will have to somehow meet the demand for more geriatric physicians—a prospect that now seems unlikely since only a small number of the nation's 127 medical schools have professors of geriatrics or required courses in geriatrics.

Organizing for Productive Aging

How may we organize our thinking for action in the interests of today's elderly and the generation at risk? Plans under way at the Mount Sinai Medical Center in New York City may provide one model.

In 1982, the Medical Center established the nation's first medical school department of geriatrics. The Gerald and May Ellen Ritter Foundation funded the department and the Brookdale Foundation supported the chair in geriatrics that I occupy. The department has six faculty members and eight postgraduate fellows. Wholehearted support by the trustees and administration assured substantial room for mandatory instruction in geriatrics in a crowded medical curriculum. A biomedical research program was authorized. Plans for inpatient and outpatient services for geriatric patients and their families were completed. In addition to providing the community with home care and a wellness clinic, the department is creating a geriatric assessment and referral unit to assist physicians, patients, and families in defining and carrying out programs of care. Special clinics will be devoted to patients with senile dementia, menopausal problems, incontinence, and mobility limitations.

Students and medical residents will be exposed to the well and ill elderly in the community at the hospital and at the Jewish Home and Hospital for Aged. The latter, a nationally recognized long-term care institution, will become a teaching nursing home—a counterpart of the teaching hospital.

To conduct policy-related research and analysis and to raise public and professional awareness of population aging, the department is creating an Institute for Studies of Health and Aging. Applying a broad conception of health, the Institute plans to organize these divisions as funds become available:

☐ The Center for Productive Aging, to study and offer consultation services on issues involved in enhancing the contributions of the older population to the economy and to family and civic life. The center will advise on such topics as: personnel policies and programs for long-term health and productivity; objective criteria for personal and corporate decisions on work and retirement, and adaptation of the elderly to work tasks and environments.

☐ The Center for Long-Term Care Systems, to focus particularly on long-term care insurance. The center will provide advice and information to corporations, labor unions, health-care organizations, senior citizen groups, and others concerned about long-term care and geriatrics.

☐ The Leadership Forum on Population Aging, to air the issues of population aging in seminars and other formats of practical use to public and private decision-makers. An Aging Information Service will serve the public and mass media as well as private clients.

☐ The Center for International Aging Studies, to bring policy specialists and social and health-care professionals together to examine population-aging issues of international significance. A program of regular exchange between U.S. and foreign teachers and practitioners is contemplated to accelerate the diffusion of geriatric knowledge and skills.

☐ The National Reference Center on Geriatric Education, to promote the development of geriatric training by collecting and disseminating innovative curricula and teaching materials and by advising schools on how to get started.

With well-conceived policies, later life will be a time of options. Even if impaired in some way, we will have opportunities to be productive, we will maintain our vigor for as long as possible, and we will not easily lose our personal autonomy. Supportive programs will exist, staffed by perceptive and humane practitioners, paid for by some contributory method that protects us against impoverishment and affirms our dignity. We will be proud of these accomplishments and leave them to our children. They will say we knew how to age well.


THE UNIVERSITY OF TEXAS