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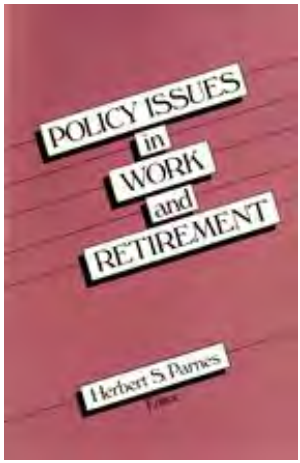
Health and Retirement, Retirement and Health: Background and Future Directions



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Chapter 4
Health and Retirement, Retirement and Health: Background and Future Directions

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Introduction

Contrary to what might be supposed, the relationship between health and retirement lends itself to no easy description. At the outset, it is important to recognize that health changes may be a cause as well as a result of retirement, that age of retirement is more flexible than often suspected, and that beliefs about health may be more important to functioning than are objective indices of health.

Age of retirement, often identified as the year of an individual's 65th birthday, has been changing dramatically. At the turn of the century, retirement as we know it, did not exist in the United States. Two out of three men aged 65 and older worked compared to one in five by 1980. In 1950, almost one-half of men aged 65 and older were in the labor force. Private pensions and social security benefits had made retirement possible for most people. Moreover, a long period of relatively stables prices and increased levels of post-retirement support under the Social Security Act and broader pension plan provisions began to encourage the exit of working people at age 65 and earlier. In the period 1950 to 1980, labor force participation of men 65 or older dropped from 45 percent to 19.1 percent. From 1960 to 1980, labor

force participation of men 55-64 dropped from 86.9 percent to 72.3 percent. For women the reverse trend has been occurring, with participation of those aged 55-64 rising from 37 percent to 43 percent during 1960-70.[1]

This trend for women leveled off in the 1970s, and in 1980, 42 percent of women 55-64 were in the labor force. If current trends continue it is estimated that four out of every ten older men and two out of every ten older women will be in the labor force.[2]

For much of the past decade it has been a case of more and more workers retiring at a younger age although the trend in favor of much earlier retirement has levelled out since 1979.[3] In 1978, 66 percent of male and female retirements occurred prior to age 65, but since 1977 the proportion of people retiring early has declined, reaching 64 percent by 1980.[4] It remains to be seen whether this is a reversal of the early retirement trend.

The significance of these data to the subject under consideration is simply that as the retirement age changes, either up or down, there is a relative shift in the importance of health as a co-variable. It is of some interest to note that in 1900, when the life expectancy of men was 48.2 years, two-thirds of the entire lifespan was spent at work, with retirement accounting for only 6.5 percent of total life expectancy. In 1980, with a life expectancy of 68.3 years for men, only 57 percent of total life expectancy was spent at work while 16.8 percent was spent in retirement. Thus, in 1980 the average man spent 11.5 years in retirement in contrast to approximately three years for the average male in 1900. Obviously, the data are distorted by the fact that proportionately fewer men reached retirement age in 1900. They nevertheless clearly indicate the impact on the total community of increased longevity and the consequent increase in years of retirement. It should also be noted, that these trends are expected to con-

tinue. Life expectancy of males is projected to be 68.5 years by 1990, at which time 55.8 percent of the average male's life will be spent at work and 17.2 percent in retirement.[5]

Since advancing age, especially beyond 75 years, is itself a predictor of health status, any modification in age of retirement may have a powerful influence upon the statistical relationship between retirement and health. With a longer work life, more workers will retire for health reasons; conversely, as work life becomes shorter, the number of workers who retire for health related reasons will diminish. Alternatively, since future cohorts of the aged are predicted to be healthier, health may be a less significant factor in retirement for the young-old (60-74 years). It is possible that workers who retire earlier than age 65 are likely to have higher rates of illness, while those who work beyond such an age will be healthier, other considerations relatively constant.

The continued competence and productivity of the individual with advancing age, and the limitations imposed on performance by health problems prior and subsequent to retirement are perennial issues in policy deliberations relating to the retirement and health of older workers. Much of the debate, however, has paid inadequate attention to research findings. The title assigned for this paper was "Health and Retirement; Retirement and Health." This topic clearly emphasizes some complex interrelationships, and implies at least two major questions:

- To what extent does health or functional disability influence retirement decisions?
- What is the impact of retirement upon health?

Before reviewing the empirical data on these issues, it is well to emphasize an important methodological point. The results of most studies in gerontology are based upon persons of specific ages at a specific point in time. The aged of the future, according to current projections, will be better

educated, will have received better health care, and thus will maintain their competence and health longer than the current generation of middle-aged and older workers. Furthermore, job-related competence of the middle-aged and older worker is a function of motivation, type of job, experience and training, as well as health.

Health in an abstract sense may or may not be relevant to an individual's occupation. The specific nature of a person's ill health, i.e., disease or dysfunction, is part of a complex of adaptive capacities relatable to the needs of the occupation as well as the symbiosis as it influences the future state of the employee. Clearly we have learned a powerful lesson in the employment of the handicapped. It is one's abilities rather than disabilities that are—or at least should be—at issue in judging the effect of health and disease upon propensity to retire.

Impact of Health on Retirement

How many people retire from various occupations because they are required to do so for reasons of health or functional disability? This question has at least two components: (1) certain occupations require medical examinations and/or proficiency evaluations intended to detect functional changes and disorders that have a negative impact on job performance; and (2) in other situations, the individual makes a personal and voluntary decision to retire because of perceived and/or objective health status.

Occupations Affecting Public Safety

Certain occupations affecting public safety require regular health certification, e.g., commercial airline pilots, flight officers, and FBI agents. On the basis of these regular physical examinations, the workers may be deemed unqualified for their job, and a change in job status or retirement may

result. The basis for the disqualification may be a demonstrable loss and inability to function, or it may be a more subjective opinion of the employer that the worker has suffered a limitation on occupational capacity.

Under the Age Discrimination in Employment Act, courts have sometimes considered age to be a bona fide occupational requirement (BFOQ). Age restrictions in a variety of settings are under challenge, and there is increasing controversy concerning the value and validity of age restrictions in employment. Historical arguments that advancing age is accompanied by progressive declines in physical and mental functions have unfortunately led to BFOQ decisions or arbitrary retirement restrictions in the absence of any empirical documentation that older workers are impaired on the job.

Certain occupations affecting public safety raise important concerns about the impact of specific health problems on decisions to retire. The commercial airline industry has required regular medical and proficiency examinations that successfully identify and ground those individuals who should not continue to fly an aircraft. In a study of more than 2,000 pilots employed by a major airline, 103 were found to have retired between 1938 and 1980 for medical problems occurring between age 45 and 60.[6] In a major analysis of more than 5,000 pilots in another major airline, 0.2 percent were grounded each year from 1938-1981 for medical reasons.[7]

The report on "Aging and Pilot Safety" of the Institute of Medicine (IOM) indicates that incapacitation and impairment were identified as causes of only 1.7 percent of general aviation accidents in 1978. Alcohol was identified as the most frequent physiological/psychological cause, accounting for about two-thirds of all accidents. These data do not apply to commercial pilots, but give a sense of the limited impact of health on this complex activity.

Statistics are available on health-related retirement decisions of uniformed state and municipal personnel, i.e., police officers and firefighters,[8] but to date there have been no carefully designed empirical investigations of health and retirement linkages for this group. It is interesting to note, however, that in a number of federal agencies where employees must pass specific endurance tests or certifying physical examinations, a substantial number of older workers remain employed. As of May 1976, 235 (14 percent) of the 1,650 Postal Inspectors were aged 50 or older. Only about six inspectors are assigned to desk jobs per year as the result of findings on the physical exam. In 1976, 1,578 (18 percent) of 8,521 FBI Agents were aged 50 or older, with only 100 agents of all ages assigned to limited duty on the basis of physical examinations. Of 35,943 workers in the Justice and Treasury Departments, as well as in the Postal and Forestry Services in 1976, 5,906 (16 percent) were aged 50 or older, had 30 or more years of service, and were still on the job.

Voluntary Decisions by Workers

The second view of the issue of health as a basis for retirement focuses on employee self-selection. These are cases in which individuals voluntarily withdraw from the labor force either because they believe themselves to be too sick to work or to perform the job, or because they have simply decided that the job is too difficult for them.

Retirement research in the 1950s and early 1960s established that poor health was the most prevalent reason for early voluntary retirement. A 1963 national survey of employment patterns of men aged 65 and older[9] showed that when wage and salary workers retired voluntarily, 35 percent cited poor health compared to only 6 percent in those cases where employers made the decision. Self-employed workers cited

poor health more frequently than other factors in explaining their retirement. Fifty-three percent mentioned poor health, compared with 29 percent who said they wanted more leisure time, 5 percent who cited business problems, and 13 percent who specified other reasons. Most investigators agree that the poor retirement benefits of that period created pressures against early retirement that only poor health could overcome.[10]

In a sample of 725 automobile workers who retired early in 1965, 25 percent identified poor health as the reason for early retirement, while 50 percent reported that they retired early because their retirement income was adequate, and 20 percent said they wanted more leisure time.[11] The remaining 5 percent explained their retirement in terms of dissatisfaction with their job.

The Social Security Administration's Longitudinal Retirement History Study initiated in 1969 has provided observations about the health and labor market activity of older Americans during the 1970s.[12]

The original sample included 11,153 individuals who were 58-63 in 1969. They were subsequently interviewed at 2-year intervals through 1979, by which time most of the people in the sample were retired.

Analysis of the baseline data showed a relationship between health and nonwork status. Of the 17 percent of the men and 41 percent of the women in the sample who were not working in 1969, 65 percent of the men and 38 percent of the women listed health as the reason for leaving their last job. Most of the nonworkers had not been employed for several years, but 10 percent of the nonworking men had terminated work as recently as the year before the survey. Of those persons still in the labor force who were working less than 35 hours per week, 14 percent indicated that poor health was the reason for their part-time status. Further-

more, of persons who had turned down job offers in the preceding two years, 21 percent cited poor health.

Despite these relationships between work and health, most individuals in the 58-63 year old group were approaching retirement with a conviction that they were as healthy or healthier than others their own age. Two-fifths considered their health to be about the same as others their age and 35 percent rated their health as better. Men who were living with their spouses and women who were not living with husbands had similar responses: 35 percent of each group described their health as better than that of their peers while 20 percent described it as worse. Of men without wives or living away from them, 28 percent felt healthier than their peers and 27 percent felt less healthy.

A majority of the people in the 1969 sample described themselves as having no limitations or handicaps affecting their mobility or capacity for work, but 35 percent reported work limitations. Over half the disabled reported that their disability had begun five or more years earlier; only 11 percent had become disabled in the year before the interview. Most of the disabled had continued working; two-thirds of the disabled married men considered themselves able to work, as compared with only 54 percent of the men without wives. This commitment to work by the disabled is consistent with a body of recent research, which documents that a considerable proportion of disabled individuals work despite severe disabilities. Among the disabled, age and severity of health problems predict who work part time compared to full time.[13]

One or more contacts with the health care system were reported by 90 percent of the sample. This included physician care (67 percent), prescription drugs (67 percent), hospital care (14 percent), dental care (40 percent), and other miscellaneous services (39 percent). Four-fifths of single men

reported getting one or more health services compared to 90 percent of men with wives and of women without husbands.

All respondents were asked whether there was some kind of health care need that they were postponing. Single women with the lowest incomes were the most frequent postponers of care. Dental treatment was the care most often postponed (39 percent) followed by diseases of the nervous system and sense organs (22 percent). The major reasons given for delaying health care were the cost of the care and fear.

In summary, about 75 percent of the baseline sample considered themselves at least as healthy as their peers. Three-fifths were free of disabling health conditions. Nine out of ten encountered the medical world and 25 percent were postponing medical care they felt they needed. A complete analysis of the cohort changes over the 10 years will provide valuable descriptive information, but analyses of interim data on selective problems have already proven to be useful. In 1980, Quinn examined the retirement patterns of self-employed workers in the 1969 interviews of the Social Security Study.[14] The self-employed workers were less likely than wage and salary workers to opt for early retirement, had more flexible work schedules, and were influenced in their retirement decisions by the same factors that influence everyone else, e.g., pension benefits, social security eligibility, and health.

Several other studies have identified the impact of poor health on participation in the workforce.[15] However, few studies have the complex interactions between the behavioral and social factors that affect both health status and retirement. Whereas the 1969-1979 Social Security Study will identify the effects of health on retirement in this cohort over a 10-year period, different generations of workers will "age" differently.

Continued investigations are needed to evaluate new factors that may affect future generations in the labor force. For example, studies of the occupational consequences of coronary bypass operations have yielded some fascinating statistical results.[16] An analysis of 1,165 patients under 60 years of age for periods up to 77 months after coronary bypass surgery revealed that 76 percent had returned to work. Preoperative unemployment, a preoperative job requiring strenuous effort, and low educational attainment respectively, were the strongest predictors of unemployment after the operation.[17] With future advances in medical technology, such as transplants and coronary operations, return to the workforce after serious illnesses should become more common.

Effects of Retirement on Health

The second major concern of this paper is the impact of retirement upon health. Little can be said with confidence on this subject.[18] The loss of the work role is a major event in anyone's life, and it can have powerful effects upon many factors, including interpersonal relationships, economic comfort, life satisfaction, and, of course, health. The health consequences of retirement may be physical or emotional and may compromise the individual's functional effectiveness. These changes may be major or minor as they affect daily activiies, life events, exercise and so on. However, the changes are not exclusively, nor indeed principally, negative, and changes in different factors are not necessarily in the same direction.

Retirement may affect health in different ways. In the classic study of Thompson and Streib, blue-collar workers reported improvement in health after retirement.[19] Since poor health is a reason for early retirement (although income levels may mediate that decision), it is clear that many individuals might welcome retirement as a relief. On the other

hand, Ellison has observed that retirees might perceive themselves to be in poorer health as a mechanism to deal with their new and less acceptable role in society.[20] Changing attitudes toward work, aging, and retirement may clearly alter such perceptions, although particular individuals are always exempt from group trends. Interestingly, Ostfeld's careful evaluation of older persons in Chicago indicated that the "older poor" report fewer serious medical problems than were disclosed by their physical exams, revealing that older persons often attribute functional incapacity to age rather than disease.[21]

In Ryser and Sheldon's study of 500 retirees between the ages of 60 and 70, 25 percent reported health improvement after retirement while only 10 percent reported a decline in health.[22] A substantial majority (85 percent) reported very good health, despite reports by 32 percent indicating some functional limitation as a consequence of a physical disorder. Mutran and Reitzes examined retirement and well-being as a result of what they refer to as the realignment of role relationships.[23] What is particularly interesting about this study of over 4,000 persons (conducted by the NCOA in 1974) is that retirement has a powerful but indirect effect upon a number of important factors related to psychological well-being. For example, whereas there is no significant relationship between health and well-being among working men, the relationship is strong in the case of retirees. A younger self-identity is associated with well-being in working men, while for most retired men such feelings of youthfulness are often irrelevant. Occupational prestige makes an important contribution to the well-being of workers; the prestige of an individual's former occupation is not as consequential. Thus, for men over age 55, employment has the advantage of maintaining a total involvement with the community along with age, health and friendship. While retirement *per se* does not lower a person's self-esteem, subsequent involvement in

community activities and the social environment may play a powerful role in how people perceive themselves after retirement. This once again emphasizes the importance of the old maxim that it matters less what you retire *from* than what you retire *to*.

New attitudes toward work and the relative decline of onerous physical labor have been operating to increase the probability that people will opt to continue to work if they can, part time or full time, after they reach normal retirement age. A survey of the attitudes of older Americans by Lou Harris (1981) indicates that four-fifths of workers between 55 and 64 years of age are opposed to stopping work completely when they retire.[24] Most wanted at least part-time paid work, and many wanted to continue in full-time employment. A report to the House Committee on Aging, indicates that 30 percent of retirees aged 62-67 are not healthy enough to work at all, 20 percent could work only part time, 14 percent are healthy but not interested in further work and 30 percent are potentially available for work (with 12 percent very interested and needing employment).[25]

The psychological impact of retirement has been described as a crisis, but the data on the incidence or prevalence of this crisis are lacking. Certain forms of psychopathology occur with increasing frequency in the aged, most of whom are not employed. Suicide and alcohol consumption increase with age. The aged account for 25 percent of all suicides in the United States; at the highest risk are white males over age 65 who live alone and consume moderate amounts of alcohol. Alcoholism shows a bimodal age distribution, with an early peak at age 45-54 and a second lower peak at ages 65-74.[26] The causes of this pattern of psychopathology are unclear. It has been proposed that much of the psychological impact of retirement is the consequence of modified life-style rather than in the event itself, and that retirement may actually

ameliorate pre-retirement anxiety for some who find suitable activities in their post-retirement life.[27]

For certain individuals retirement can be devastating, if they adversely identify themselves with their position and have no alternative life-style to move toward. At least one study has described the military forced retirement of officers who failed promotion to higher rank. This was preceded by a pre-retirement crisis of about two years duration in which alcohol abuse and gastrointestinal complaints emerged among this group of unhappy and angry officers. Thus, retirement may be seen as a failure rather than a reward.[28] With the aging of our population and the resulting intense competition between younger and older adults for jobs in the workplace, careful analysis of the unmet goals and aspirations of certain professionals and employees should lead to the implementation of flexible job and retirement options.

Qualitative as well as quantitative changes in the family support system and social networks after retirement may have a significant impact on an individual's mental health. Most evidence suggests that family members provide the strongest emotional support. Gore demonstrated that unemployed men who had supportive spouses had fewer physical and psychiatric problems than did unemployed men without supportive wives.[29] Whether support is derived from a spouse or a friend, a confidante is essential. As early as 1968 Lowenthal and Haven stated that older persons with confidants were able to adapt to gradual losses in social interaction as well as the more significant changes of death and retirement.[30] For most individuals, the social support systems that provide both emotional and instrumental support are described as concentric circles moving from the nuclear family in the center to relatives and friends in the middle circles, to work associates in the outer circumference.[31] Different parts of the network play various roles throughout the life span.

Women are more likely than men to have confidants. Therefore, significant life changes such as retirement may have a greater impact on health status and functional effectiveness of men than of women. Holahan surveyed 352 women in the Berkeley study of the gifted and reported that women who had had careers as well as those who ran households had greater life satisfaction and better health than women who had a history of working solely for income.

The Future

From a policy perspective, a number of issues face us. New cohorts of aging persons will be healthier, better educated, and more likely to be in jobs with less strenuous physical requirements. They will also be living longer. What is an appropriate employment policy? Do we face the challenge of creating new careers, flexible career patterns, a lattice career trajectory, or voluntary sabbaticals throughout the lifetime? Perhaps retirement should be delayed or perhaps retirement should be discouraged so we can die with our boots on at our desk at the computer terminal, that is to say, terminate at the terminal!

The economic impact of increasing the retiree population will not only pressure us to address the needs of the older worker, but also force us to attend to a number of other issues raised. What happens to options for the young within an aging workforce? Does management or do unions have a continued responsibility for the worker past retirement? If the private sector does not do it, will the government?

In summary, the two questions we asked at the outset require answers:

1) How does health influence retirement decisions?
Answer: It depends upon the individual's income, previous work experience, the demands of the present job, and the nature and severity of any health problems. The aged are

generally physically able and willing to work and interested in working if retirement income is not sufficient. Many older people indeed prefer a part-time occupation.

2) Does retirement influence health?
Answer: Yes, but the data are sketchy. For some there may be a crisis, for others an improvement in life satisfaction. Life-style at work and after retirement are key variables in predicting success during retirement and/or the impact of loss of work. Activity, both physical and social, is a key. The effect of part-time work on health has not been adequately assessed.

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Chapters 3 & 4
Discussion

Theodore Bernstein

Introduction

My comments will only indirectly relate to the two principal papers, because I believe that the employability and adaptability of the healthy older worker has been clearly and firmly established. Older workers can perform and do perform almost any job in a productive manner. The problem is not the health status or work potential of the older worker, nor is it the current Social Security design; rather, the basic issues relate to the economy and job availability.

A Profile of a Union, Its Workers and Retirees

"If we think that 76 is old, let's look at Rose Macaluso, who has actually been on the job that long." That statement was part of a tribute to garment worker Rose Macaluso by the late Lowell Thomas in a national broadcast a few days before his death. Rose Macaluso was born on August 6, 1887 in Palermo, Sicily. She came to Middletown, New York in 1911. After a 76-year work history, including a 56 year stint with one employer, lasting through 3 relocations, 20 foremen and 3 managers, she retired on her doctor's instructions in December 1981, at age 94. At retirement she announced that she was planning to go back to setting coat pockets as soon as her health returned. In the interim, she would make new drapes for the house and work on a quilt. Unfortunately, she succumbed to her illness six months later.

Dressmaker Celia Orlansky was born in Poland in 1891. She arrived in New York City in 1906 and commenced a lifetime of work at a sewing machine. Her retirement in July of 1981, at age 90, came as a shock. An April 1980 feature story in Justice, the ILGWU newspaper, entitled "Celia Orlansky—Still Going Strong At 90," portrayed this nimble ILGer as likely to sew throughout the 1980s. She worked a full day, commuting daily by subway to Eighth Avenue, Manhattan from her home in the Bronx; (her only concession to age being the half fare privilege accorded senior citizens). Her hands were still strong and sure, guiding fabric against needle in the same manner as when she started work some 75 years ago. However, during the last year, her shop closed. She found work at another shop, but it was slow. When her new employer took in pants for work, Celia Orlansky finally announced her retirement. It was dressmaking or nothing. What will she do in her retirement? "There is a limit to how many times I can clean my house in one week without going crazy," she joked. "I would love to work with children. I need advice on how to get started." If there were still dresses to be made, Celia would certainly be found working at her sewing machine.

It surely can be said that these profiles are atypical, representing two unique individual older workers. Perhaps such is the case. Yet these two remarkable women, while somewhat older, are but a few among the many thousands of garment workers who work beyond the normal retirement age of 65. Of the 111, 836 workers who retired with benefits from the ILGWU National Retirement Fund from January 1965 through September 1982, more than 13.5 percent, or 15,163 men and women, retired at age 70 or older; 3 percent or 3,265 workers, retired at age 75 or older, of whom 766 were at least 80. This experience covers almost an 18 year period; the more recent retirements would probably show a definite trend toward later retirements. Moreover, absent the

lingering recession, sharp import penetration, and the growth of non-union competition fostered by an underclass of undocumented workers, the statistics of delayed retirements no doubt would have been swelled by large numbers of older workers who have been compelled to retire earlier because of the lack of work opportunities.

What is the industrial and labor relations environment in which this experience takes place? The ILGWU represents workers producing ladies' and children's apparel in some 38 states and Puerto Rico. Eighty-five percent of its shrinking membership is composed of women. Most of the production in this labor intensive industry is based on a piece work system. Average earnings are $5.50 per hour exclusive of fringes. The average shop has some 40 machines and requires low capitalization. The application of technological changes is minimal. Work is generally seasonal with intense pressures to meet orders during peak periods. There is a high employer turnover and great worker mobility from shop to shop. Under the collective bargaining agreements, the basic work week is 35 hours. Usually there are no seniority provisions, as the principle of sharing of work prevails. There are no provisions for mandatory retirement.

The work force is covered by health benefit programs which typically include hospital, surgical, major medical, sick pay, prescription and eye glass benefits. The mail service prescription program fills almost two million prescriptions annually. Although retirees represent one-fourth of the eligible population they use more than one-half of the prescriptions. For active workers over age 65 Medicare supplements are provided. These benefits all end on retirement except for the prescription program and, in some cases, eye glass benefits. Workers and retirees in the New York area are covered for disagnostic procedures and ambulatory care at the Union Health Center first established in 1914. This institution serves 800 to 900 patients daily.

Retirement benefits are provided through a national multiemployer pension fund. The normal retirement age is 65 and the plan provides reduced benefits at age 62. Disability retirement is available at any age after 20 years of service. There are now more than 112,000 living retirees receiving monthly pension benefits. The worker-to-retiree ratio is just under 3-to-1 and is declining each year. Some 10 years ago, the ratio was 8 to 1. The current basic benefit is a modest $120 per month, ranging up to a maximum of $150 per month for higher wage earners. The Plan's benefits are not integrated with, but supplement, Social Security payments. For retirees who return to work in the industry, benefits are suspended in accordance with ERISA regulations.

The ILGWU maintains a Retiree Service Department staffed by social workers and part time retirees. Included among its activities are social work services, a visiting program, and cultural, education and travel programs, as well as a network of retiree clubs. A pre-retirement counseling program is operated in conjunction with the union's social service and education departments.

I believe that the ILGWU, through its collective bargaining agreements, health benefit programs, and pension plan design, has created an essentially age-neutral environment. This environment enables older workers to make their retirement decision based primarily on health, job characteristics, employment prospects, and retirement income, with age playing a secondary role. The only options absent from this picture are availability of jobs and training and employment programs for those older workers whose jobs have disappeared or who are unable to continue work because of the physical demands of their regular jobs. In the garment industry, as in other manufacturing jobs, "room at the top" is a nonissue!

Policy Considerations

Why at a conference on policy issues in work and retirement have I opened this presentation with a profile of a particular industry and its work force? Why this approach in a session on "Aging, Health and Work Performance," at which the major papers essentially deal with health issues? I do so because I believe that the ability and productivity of the older workers has been clearly established. I do so because I am concerned that the growing acceptance of the worthwhile goal of extending the labor force participation of the older worker has brought with it a host of proposed policies which are not as worthy as the goal they seek to achieve.

Given that the health of older workers is constantly improving, given that more older workers are capable and desirous of working additional years, given that our society can ill afford to waste the vast resources of skill and experience that reside in older workers, the work and retirement problems confronting older workers can be adequately addressed only through policies that lead to the expansion and revitalization of the national economy and to programs that provide full employment for all able-bodied citizens as well as economic security for those who can no longer work.

As workers become older, duration of unemployment rises sharply, and large numbers unwillingly withdraw from the labor force. On October 7, 1982, the House Select Committee on Aging reported that unemployment among workers over age 65 had risen 24 percent since January, contrasted to an overall increase of 16 percent. The disastrous rise in this unemployment level to 10.1 percent in September and 10.4 percent in October were not yet reflected in these figures. While age-neutral practices and policies, job-sharing, part-time work, job redesign, work incentives, and training and education programs all can extend the working lives of older

workers, the availability of jobs is a prerequisite to these policies. Older workers cannot be placed in jobs that do not exist; and the goal of extending the working years of older workers must not be achieved at the expense of other groups in and out of the work force.

In today's economy, characterized by a severely declining industrial base and low productivity growth, the false nostrums of increasing the retirement age, easing or eliminating the Social Security earnings test, and providing general tax credits to employers who hire older workers cannot be considered to be sound public policies. The employment problems of older workers are inseparable from the national problem of unemployment.

Increasing the Normal Retirement Age

In addition to altering the labor supply and affecting capital formation, raising the normal retirement age unnecessarily punishes older workers who are laid off for economic reasons or unable to work because of poor health or lack of job opportunities or skills. Raising the retirement age would merely be a form of benefit reduction for older workers. It is a policy which will do no more to create jobs than would the establishment of a sub-minimum age for young workers. A policy of raising the retirement age incorrectly assumes homogeneity of the older population. Despite increasing life expectancy, at age 65, there has not been a comparable improvement in health status. While a healthy older worker could possibly continue at work until retirement at full benefits at a later age, studies clearly show that a significant portion of early retirements are involuntary and relate to poor health, job conditions, chronic unemployment, or all of these. With higher rates of morbidity for blacks and other minorities as well as for older women, a policy of delaying full benefits would unfairly add to the burden of ill and disadvantaged workers. More positive

policies would include programs for economic growth and expansion, as well as work incentives and training for that group of older workers who can continue to work after age 65. The adoption of economic policies consistent with a commitment to full employment would result not only in more income for the Social Security trust funds but in more older workers remaining in or re-entering the labor force voluntarily rather than by virtue of economic necessity. Programs providing for options are necessary; however raising the retirement age would eliminate an existing option for a large number of workers.

Eliminating the Earnings Test

The elimination or liberalization of the earnings test is too costly a policy to delay retirement and increase labor force participation of older workers. From its inception, the Social Security program was intended to be an insurance program. It provides protection against the loss of income from work due to old age, death, or disability. Also, private pension plans are generally designed to provide income to non-working retirees. The purpose of these programs is not to pay benefits to full time workers. Past studies indicate that the elimination of the earnings test would result in little or no change in hours worked by males, currently receiving Social Security pensions, but would cause a substantial increase in benefit payments directed to men who currently choose to work full time, generally a group with above-average earnings. Thus, the removal of the earnings test would benefit primarily those who need the help least. The additional benefits that would be paid to the small percentage of retirees earnings more than $6,000 a year would be better spent for programs which encourage later retirement among lower wage earners.

General Tax Credits

Proposals for general tax credits to employers who hire older workers, which on the surface appear to be a reasonable approach, contain several serious drawbacks. In the first place many employers would receive windfalls for complying—as they are already required to do—with the Age Discrimination in Employment Act. Scarce federal revenues would be unnecessarily diverted from other important programs. Secondly, any policy of subsidized employment devoid of specific targets and controls could very well lead to the displacement of other groups of workers without the creation of a single new job. Targeted federal grants should be made available for limited periods of time only in those specific instances where an employer experiences demonstrable higher costs due to the employment or training of older workers. If general tax credits were ever implemented, pressures undoubtedly would build to expand the concept to encompass employment of other categories of workers experiencing similar employment problems (e.g., youth, minorities, displaced, disabled, etc.). If so, this approach would unfairly shift the burden of unemployment to those remaining groups not eligibile for subsidized jobs.

Conclusion

Serious tampering with the existing Social Security benefit scheme or granting general subsidies to employers are undesirable approaches to broadening work opportunities for older workers. The creation of a full employment economy is a mandatory first step in developing an environment for meaningful policies and programs which would enable older workers to continue working. Labor, industry and government must find a common ground in pursuit of this goal.

Chapters 3 & 4 Discussion

Anne Foner

As a sociologist, I should like to put forward a perspective for thinking about the issues before us. Over the last few decades there has been a good deal of research on age and aging in many different fields. As research has accumulated, certain principles have emerged as important for a full understanding of the complex issues related to age and aging, no matter what the field.[1] I shall focus on a few of these principles that I believe are particularly relevant for interpreting data about aging, health, and work performance.

Consider the fact that much of the work on aging and health focuses on old people only. These studies make a contribution and many are appropriate for particular research goals. But they do not tell us whether the pattern of behavior or attitudes observed is unique to old people. To understand whether or not we are dealing with an "Old People" problem, we need to compare older people with younger adults. When such comparisons *are* made, we learn that older people do not always do more poorly than younger adults. Even when the average performance of older persons is inferior to that of younger people, the differences are often small. Moreover, there is wide variability within the older population; there are some older persons who outperform some younger persons.

The general principle here is that older people are part of the whole age structure of a society. To fully comprehend the

position and capabilities of the old in society, the old must be viewed against the background of all other age strata.

Another aspect of this general principle is that older people coexist with younger people. Their interactions and relations with the young and the middle aged are part of their everyday living and can affect the way older people function. We know that there is an exchange of emotional and instrumental support between the old and their adult offspring in the family. But we know less about conflicts between the old and their children. And we know even less about the nature of the relations between young and older workers in the work place. As in the family, there may be reciprocity between old and young workers. But it is also likely that relations between young and old at work may give rise to stress—an occupational hazard somewhat different from the type mentioned in Dr. Eisdorfer's paper. There may be subtle or not-so-subtle pressures from younger co-workers or younger supervisors that create tensions among older workers affecting the older workers' health. Thus, it is not only the physical environment on the job that affects the way older workers function but the social environment, including the attitudes and behavior of younger workers.

A second set of principles for interpreting data on age and aging has to do with the aging process. I shall start off with several negative statements, suggesting what aging is not. It is not a process that begins only in the later years; it is not all downhill; and it is not only a physiological process. Put positively, aging is a process that begins at birth and ends with death. It involves accumulations and accretions as well as decrements. And in addition to biological changes and physical alterations, it involves social transformations such as changes in the individual's social roles, social status, and relations with age peers and age dissimilars. Moreover, the physiological, psychological, and social aging processes interact and affect each other.

Let me suggest a few implications of this perspective for the issues at hand. For one thing, the way people grow old is affected by the way they grew up and matured. We are only beginning to find out, for example, that exposure to environmental hazards in the work place and elsewhere when they were younger has damaged the health of many older workers. We have learned, too, that earlier patterns of nutrition and exercise can affect physical well-being in the later years. Let us not forget that the individual's social biography can also play a role.

A ten-year longitudinal study of men in the United States by Melvin L. Kohn and Carmi Schooler illustrates this last point.[2] Kohn and Schooler found a reciprocal relationship between people's occupational conditions and their psychological functioning. More specifically, intellectual flexibility affected the course of men's careers—leading to jobs with substance complexity. At the same time, the substantive complexity of the men's work affected their intellectual flexibility: being in a job with substantive complexity enhanced intellectual alertness and flexibility. In short, conditions of the jobs themselves affect the capacities of the individual.

It is not only the social environment of the family or work that has an impact on the way the individual ages. The larger social environment also plays a role. For example, we have been considering here a key life course transition—retirement from the labor force. We know that the older person's reaction to the loss of the work role is affected by such individual factors as his or her health and income. Important as these factors are, the societal context in which retirement takes place should not be disregarded. Societal attitudes that define retirement as a well-earned rest and as a reward for a lifetime of work, as well as the sheer number of fellow retirees—a sign that everyone else is doing it—serve to validate the retirement role. The stamp of public approval of

the retirement role helps to assure the retiree that he or she is doing the right thing.

As for aging being viewed as inevitable decline, research has demonstrated that such a view is an exaggeration. On some abilities there are minimal or no decrements for many years past age 65, on the average. One psychologist, K. Warner Schaie, claims that reliable decrements on all mental abilities for all individuals are not evident until advanced old age—the late 80s.[3] Other research indicates that the predominant trend for many characteristics is stability until the very later years. And, as Dr. Koyl suggests, certain abilities—like communication abilities—may actually improve with age.

The third principle I shall put forward is that aging, inevitable though it is, is not an immutable process. The way people grow up and grow older has changed historically. The cohort of people born before the turn of this century have had different experiences, have been exposed to a different social and physical environment as they aged, than people born decades later. Certainly the way the aged of the future will have grown older will not duplicate the way today's older population has aged. We already know some characteristics of the future aged—say the aged of the year 2020—that can affect the way they will function then. They will probably live longer, on the average, than earlier cohorts of the old. They will probably be healthier—not only because science has learned how to prevent some diseases, but also because there have been advances in learning how to prolong people's ability to function "normally." The old of the next century will be better educated than today's old. More of them will have been in jobs that involve substantive complexity. And more of the women will have been in the labor force for most of their adult lives.

In short, the early experiences of tomorrow's older population would seem to provide a solid basis for their con-

tinued ability to make contributions to societal activities in their later years. At the same time, there may be factors that work in an opposite direction. For example, more of the old of the next century will have experienced marital disruption because of divorce. We do not fully understand the effects of such disruption on people's ability to function. Nor do we now know about the possible deleterious effects of all the new chemicals being introduced. This cautionary note suggests the difficulties facing those who wish to shape social policies affecting the old of the next several decades. The future old will face old age in a different social and physical environment than the old of today. And they will have had different lifetime experiences, the effects of which we cannot now evaluate.

The fact that no two cohorts age in exactly the same way leads to my last point: definitions of old age and what are considered to be the problems related to old age are largely social phenomena. As Dr. Koyl notes, not too long ago a worker was considered old at age 40. Now in the United States age 60 or 65 is the magic number, a criterion of old age influenced by Social Security regulations. The very issues we are discussing arise from the unique circumstances of the advanced countries—an unprecedented number of older people in the population and retirement at around age 65 as the practice of the vast majority of older workers.

In earlier times in the United States and elsewhere, and even in many developing countries today, the work potential of the elderly was not an issue. It was assumed that older people would continue productive activity as long as they possibly could. Moreover, older people were thought to have special contributions they could make. Even in the relatively short time that retirement has been institutionalized in the United States, different concerns have come to the fore. Not too long ago people were concerned about mandatory retirement because they thought that workers were being forced to

retire—contrary to the workers' wishes. Recent studies indicate that only a small proportion of older workers retire because of the operation of mandatory retirement rules.[4] In the recent period most retirees have been retiring "early," that is, before age 65. And most retirees report satisfaction with retired life.

A major reason the work potential of old people is now of interest is undoubtedly the concern about the economic burden the country faces in supporting large numbers of retirees. However, in our eagerness to assess the "real" potential of older workers, we may well be building a new orthodoxy—that older workers *should* remain in the labor force well past age 65. Such a policy could have unfortunate and unforeseen consequences for both younger and older people. It could foreclose job openings and promotions for younger and middle-aged workers, and thereby exacerbate tensions between young and old. It would be unfair to the many older people who would not be fully capable of continuing to work. And it would be unfair to the many others—a large proportion of whom are blue-collar workers who started working before age 20—who have worked forty or more years in jobs that are unpleasant, monotonous, unhealthy, and physically demanding and who look forward to retirement as an earned right. In our concerns about easing one type of burden on the working population, we risk undertaking social policies that will put new burdens on both young and old.

NOTES

1. For a detailed discussion of these principles see, Matilda White Riley, Marilyn Johnson, Anne Foner. 1972. *Aging and Society. Volume 3. A Sociology of Age Stratification.* New York: Russell Sage.

2. Kohn, Melvin L. and Carmi Schooler. 1979. "The Reciprocal Effects of the Substantive Complexity of Work and Intellectual Flexibility: A Longitudinal Assessment." Pp. 47-75 in Matilda White Riley (ed), *Aging from Birth to Death: Interdisciplinary Perspectives.* Boulder, Colorado: Westview Press.

3. Schaie, K. Warner. 1979. "The Primary Mental Abilities in Adulthood: An Exploration in the Development of Psychometric Intelligence." Pp. 68-115 in Paul B. Baltes and Orville G. Brim, Jr., (eds.), *Life Span Development and Behavior.* Volume 2. New York: Academic Press.

4. Parnes, Herbert S. and Gilbert Nestel. 1979. "The Retirement Experience." Pp. 167-255 in H.S. Parnes, G. Nestel, T.H. Chirikos, T.N. Daymont, F.L. Mott, D.O. Parsons and Associates, *From the Middle to the Later Years: Longitudinal Studies of the Preretirement and Postretirement Experiences of Men.* Columbus, Ohio: Center for Human Resources, Ohio State University.

Chapters 3 & 4 Discussion

Elliot Liebow*

Dr. Koyl has given us a picture of older workers and the aging process that is at once comprehensive and marvelously detailed. Some of his assertions, however, are surprising. Is it really true, for example, that "there is no reason to suppose that any new cancer hazards have been introducted [into the environment] in the last few decades"; or that only 4 percent of all cancer deaths are work-related; or that, by implication, high estimates of work-related cancer are "politically motivated," while low estimates are scientific? These and other issues of fact and substance need to be dealt with, but for this discussion I want to focus instead on Dr. Koyl's approach to the problem of the work potential of the elderly and the relationship of the worker to the job.

The first point I want to make is that one cannot assess the work potential of the elderly by looking only at the elderly. To properly assess the work potential of the elderly or any other group, one must look equally hard at work itself and the organization of work, the politics and economics of work, and the social values that attach to it. To ignore these things and to assume that work potential resides wholly within the individual is to take the first big step toward blaming the victim. Less benignly, perhaps, this is precisely what we do when we make judgments about the work potential of low income, central city, black youth by looking only at the youths themselves, and their attitudes and values about

*The opinions expressed here are those of the author and do not necessarily reflect those of the National Institute of Mental Health.

work, without bothering to look at the other side of the equation, at their opportunities and rewards for work, and at what they have learned from their own work experiences and the experiences of those around them.

The point here, then, is that Dr. Koyl's carefully argued and unambiguous conclusion—that "most survivors to age 60, 65, 70, and even 75 are fit and able to work"—addresses an important factor, but only one factor, in the complex equation that describes the work potential of the elderly.

At the risk of faulting Dr. Koyl for not writing a different paper, I would argue that his conceptualization and presentation of the problem leads not only to locating the work potential of the elderly wholly within the elderly themselves, but to other problems as well. In this paper, the workforce is presented in all its rich and ever-changing variety of age, sex, race, health status, personal habits, personality types, varying physical and mental capacities, and so forth. Jobs, in contrast, are presented as a more or less static array of holes or job slots, each with its own particular shape. The problem, then, as Dr. Koyl seems to present it—except for a brief discussion of the potential contribution of ergonomics—is that of fitting a heterogeneous collection of ever-changing individuals to a fixed and finite set of holes or, more simply, to match the people to the jobs.

Such a model of work has profound implications for how we go about the business of organizing people for production. What should be done, for example, with the worker who doesn't fit a particular hold? Dr. Koyl would try to retailor the worker so that he does fit or, failing that, move him out and bring in another worker. Is the job a high-stress job? Exercise is a stress prophylactic. If the worker is still overstressed, he can use his bumping rights to move to a more suitable job, with perhaps a minor loss of salary. The overstressed manager can be "posted laterally out of line management into a consultant job."

What if the job slots are in industries that pose, say, a pulmonary hazard to their employees? Dr. Koyl suggests there is little need for concern because most such industries "are policed so that early signs of danger cause compulsory withdrawal from the workplace." And for those who escape early compulsory withdrawal, there is yet another line of defense: "most of the allergenic and irritative . . . dusts and solvents cause nose discomforts and shortness of breath to the 15 percent or more of the working population who are sensitive, and they withdraw from the workplace."

When we move from hazards to accidents, we find that here, too, many workers are simply not adaptable to the demands of the job. The "immediate trigger" for most industrial accidents, Koyl says, is the failure of the worker to pay sufficient attention to what he's doing. In older workers this inattention may signal the onset of disease, and such workers can then be posted to a safer job. Dr. Koyl does not tell us what to do about workers who have no such excuse, perhaps because inattention in a dangerous work environment sort of takes care of itself.

Once again, this model of fitting people to jobs has brought us back to blaming the victim. Is it really so—or rather, do we, as a society, want to make it so—that the primary responsibility for maintaining worker health and sanity in stressful and dangerous workplaces lies solely with the individual worker? Or that the employer's responsibility goes no further than propping up the employee in place or replacing him with the next person in line to face the exact same threats and difficulties? Is it always and only the worker who must change or move out and never the jobs or the work environment that need changing?

Dr. Koyl, I'm certain, would be the first to disavow such a position, but this is indeed the logic of his paper, and it is indeed the kind of thinking that is often found among

managers and personnel people, and all too often among labor economists and policy makers and even workers themselves as well. But even from the perspective of those who hold such a view, it is terribly short-sighted because it is so wasteful of the very people who do the jobs that need doing.

Moreover, if one states the problem narrowly in terms of matching people to a fixed and finite set of jobs, one is likely to overlook the intimate and powerful interaction between workers and jobs. In an important sense, our factories and offices produce not only particular goods and services but particular kinds of people as well. That is, workers are as much a product of the workplace as are goods and services. Quite apart from making it possible to support ourselves and our dependents, the workplace is an important crucible of personal identity and self-esteem, and our work experiences importantly determine our health, our skills, our values and attitudes, and even our personalities.

Despite the centrality of jobs to individual, family, and community well-being, however, we continue to stockpile the unemployed, and continue to face the problem of choosing who will have jobs and who will not. Dr. Koyl has given us hard and persuasive evidence that the elderly are able and willing to work. But so are young workers and middle-age workers, and so are whites and blacks and men and women and the skilled and unskilled. Given the importance of jobs to survival and self-hood, there is no moral basis on which to choose among them. Until we acknowledge the unconditional right to a job of every person able and willing to work, jobs will continue to go to those groups which can muster the political and social power to get them and an ever larger number of people will increasingly go without.

My comments on the paper by Eisdorfer and Cohen, "Health and Retirement, Retirement and Health," will be

especially brief and general because I have not yet seen the final version of the paper.

From a policy perspective, a major contribution of this paper is that it documents the complexity of the relationship between retirement and health and identifies the many different factors and influences that must be taken into account. Given this complexity, it is no wonder that the research in this area is often ambiguous and sometimes contradictory.

A major problem is that it is not simply the relationship itself that is complex; the central constructs, especially "retirement," are also complex. Retirement—whether viewed as an event, a status, or a process—involves different kinds of people in radically different circumstances, with different personal, social, and health histories, and equally different futures. The profound social, psychological, and economic changes often occasioned by retirement argue strongly for a powerful connection between retirement and health. But these powerful connections—good for Jones' health but bad for Smith's—will probably continue to wash out into ambiguity until we take a much closer look at Jones and Smith through the progressive disaggregation and specification of populations, occupations, circumstances, and histories.

Some things are already clear, however, and one of them is that money is important. Eisdorfer and Cohen tell us that, in the 1950s and 1960s, "poor health was the most prevalent reason for early voluntary retirement," and that "poor retirement benefits of that period created pressures against early retirement that only poor health could overcome." Here, and in most other research as well, money is deeply implicated in the relationship of health and retirement and retirement and health. Stanislav Kasl, for example, summarizes his excellent review and evaluation of the retirement

and health literature with the conclusion that "Financial considerations dominate the entire picture."[1] Although the arguments of Eisdorfer and Cohen are consistent with this view, one might wish that they make more use of money as a possible explanatory variable. For them, the fact that "a considerable proportion of disabled individuals work despite severe disabilities" is evidence of commitment to work. One wonders to what extent this commitment to work on the part of the disabled may be another way of saying they simply cannot afford to give up their jobs.

In addition to money, workplace safety and health are also central to the health outcomes of retirement. For most people, however, "money" in this context means "Social Security benefits" and "workplace safety and health" is largely a matter of standards and enforcement. In an important sense, then, the relationship between retirement and health is fundamentally political, and precisely because it is political, the consensus cited by the authors that future generations of the older workers will "maintain their competence and health longer than the current generation" is by no means a certainty. Quite apart from the larger issues of immigration, unemployment, recession, inflation, and health care, imminent changes in Social Security and recent changes in safety and health standards and practices in the workplace suggest that older and retired workers are headed for poorer health, not better.

Given the terms of discourse, for example, the current debate on Social Security must end up with reduced retirement income for the present generation of recipients, or the next two or three generations, or all of them. Similarly, recent political decisions around workplace safety and health have compromised the safety and health of all workers,

1. Kasl, Stanislav V., "The Impact of Retirement on Health and Well-being." Prepared for the National Institute on Aging, NIH, Order No. 263-78-M-2062, January 1978.

among whom the older workers are perhaps the most vulnerable. And to this one might add the unseemly tightening of the rules governing disability and the associated appeals process.

We can hope that Eisdorfer and Cohen are right about the future of retirement and health; we cannot count on it.