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ABSTRACT

In this paper, we develop a conceptual framework to describe an individual's preparations for later life. Situated in the life course perspective, this provides a framework that invites a more comprehensive and systematic study of preparations for later life. It describes a dynamic process that portrays the interplay between social structure and human agency. Through its consideration of collective preparations (the public protection programs offered by the state), individual preparations (financial and non-financial), and the interplay between the two, this framework provides fresh insight into the existing literature on retirement planning, the timing of retirement, savings, and consumption behaviour in later life. Moreover, the model may be used to structure research questions, to guide policy decision making and to point the direction for the design and content of future research studies. While the purpose of this paper is primarily the development of a conceptual model, we draw on empirical examples from the 1991 Survey of Aging and Independence (SAI) to illustrate some aspects of the model to Canada. We conclude by suggesting a number of research and questions that may be generated from the model.

Key words: retirement planning, financial security, savings, independence

INTRODUCTION

Within the context of rapid economic and social change, individuals are expected to make decisions about their everyday lives without benefit of full knowledge of the consequences of their decision (Beck ,1994). Decisions made thirty to forty years ago in drafting social security and health care policy have very different consequences today than anticipated by the policy makers of that time. The decisions made today may have very different consequences in the future than intended (Gee, 1995). The notion of 'risk" is central to our culture today (Beck, Giddens and Last, 1994). In many aspects of our lives, both individual and collective, we regularly construct potential futures and make decisions based on the probabilities of those futures. Youth plan what type and how much education they will obtain in anticipation of their job possibilities. Young adults also plan their career and family lives. They may save for and purchase a family home. And, beginning about mid-life, people begin to consider and plan for their independence and economic security in later life. The plans that they make are based on a whole set of assumptions about their future working lives, their health, and family lives as well as some notion of the quality of life they seek in later life. These plans are structured by the context of current social, economic and political institutions. Furthermore they are structured by gender, generation, social economic position, ethnicity, race and a host of other factors. Moreover, individual and collective life, is not static, but rather dynamic. The conditions of peoples' lives change as they age, as do the social institutions of the culture in which they live. Therefore, the decisions that are made in mid-life may have unintended consequences in later life.

To adequately prepare or plan for the future, people need to know what their needs will be. We cannot accurately foretell the future. There are too many unknowns, both for individuals in terms of their personal health and in terms of what our society will provide in the way of health care and income security. Three individuals may make the same financial preparations for later age but their needs may be different. One person may live in perfect health, wintering in Florida until he/she dies suddenly of a stroke at the age of 85. A second person may have a series of heart attacks and undergo open heart surgery. A third person may develop Alzheimer's disease and live in a chronic care hospital for ten years until death. Each scenario implies very different health care and everyday living costs. Being prepared does not depend solely, then, on an individual's financial preparations but also on how society meets their needs. It is an issue of what public protection programs are in place to meet the needs of individuals as they age. If the public protection programs are in place to provide the income for the necessities of life and the necessary health care, each of the individuals in the three scenarios will be financially prepared for later life. If the old age security system and the health care system no longer meet these needs, then two of them will not be prepared.

In this paper, we develop a conceptual framework to describe an individuals preparations for later life. Situated in the life course perspective, this model provides a framework that invites a more comprehensive and systematic study of preparations for later life. It describes a dynamic process that portrays the interplay between social structure and human agency. Through its consideration of collective preparations (the public protection programs offered by the state), individual preparations (financial and non-financial), and the interplay between the

two, this framework provides fresh insight into the existing literature on retirement planning, the timing of retirement, savings, and consumption behaviour in later life. Moreover, the model may be used to structure research questions, to guide policy decision making and to point the direction for the design and content of future research studies. While the purpose of this paper is primarily the development of a conceptual model, we illustrate the model with an application to Canada. We conclude by suggesting a number of research and questions that may be generated from the model.

A CONCEPTUAL FRAMEWORK: PREPARATIONS FOR LATER LIFE

Inspired by a classification of different insurance strategies suggested by Becker and Ehrlich (1972), we suggest that there are three types of preparations for later life. The first, *public protection*, includes state-provided pensions, income-related transfer programs designed to provide an element of income security, health services, and other public protection programs offered by the state. The second, *self- insurance* includes individual financial preparations, for example in the form of savings accounts, investments, contributions to individual pension and company pension accounts. The third, *self protection* includes non-financial preparations such as healthy lifestyle choices and the establishment and maintenance of social support networks.

The conceptual framework draws on a life course perspective in which individuals and cohorts move through time and space, interacting dynamically with their social and economic environments. The life course perspective is based on the premise that the life course can be divided into a sequence of transitions or stages, each with associated goals, tasks, norms and

roles and that adults pass sequentially through all stages. For example, some see the life course as a threefold model with each stage having a distinct function: youth for education, middle-age for work, and old age for retirement (Guillemard, 1997). Others argue that the life course is no longer standardized or has become "undone" due to changes in social structures that have changed the sequencing of the life course (Heinz, 1998). For example, education is no longer a privilege of youth in that people are going back to school or retraining at various stages of their life course.

Theorists view the life course as "structurally embedded" within a social structure composed of the major social, economic and political institutions which give structure to everyday lives (Jaffe and Miller, 1994). Social structure and existing patterns of inequality, power and resource distribution constrain the individual and limit his or her life chances. But, individuals have agency; they are rational beings who make creative decisions within the limits of structural constraints (Breytspraak, 1984). Marshall (1995) suggests that the individual and social structure are interrelated in a mutually influential, emerging process, such that individual decision making influences social structure over time.

Within the life course perspective, aging is not viewed as solely a biological process, but rather involves the interaction of the biological, the psychological as well as the social, and is shaped by economic, political and social events. Each age group is differentially affected by both cohort and historical factors such as "the great depression", world wars, increasing female labour force participation rates, higher unemployment rates or demographic change such as later age at first marriage and childbirth, increasing divorce rates and greater life expectancy

(Rosenthal, Martin-Matthews, Denton and French, forthcoming).

The conceptual model assumes that individuals differ in their ability to self-insure and self-protect their later life, in that their choices are constrained by the social structure, including existing distributions of resources and power. For example, low income earners may be less likely to self-insure their later life; or single individuals may be less likely to self-protect their later life. Moreover, the ability to self-insure or self-protect the future may vary over the life course, for example, people save more after their children leave home. Age cohorts may also differ in the types and extent of preparations they make for later life depending on the historical circumstances of their lives. For example, baby boomers who, over their life course, have occupied a 'privileged' position in the labour market may be better able to prepare for their future than younger cohorts (Foot and Stoffman, 1996).

The public protection system is constrained by economics, politics and demography. For example, changes in benefits or contributions are influenced by issues such as deficit financing, public debt and the associated rising health and social security expenditures, and the aging of the population. Self-insurance and self-protection preparations that individuals make are, in turn, structurally embedded in the social, economic and political environments. For example, in Canada the State determines the maximum level of contribution to individual and employer pension plans.

Whether conscious or not, individuals have a portfolio of financial and non-financial, collective and individual, mandatory and voluntary preparations for later life. Within these portfolios, some preparations are common to all individuals; others vary from individual to

individual. For example, public protection is common to all, while contributions to individual pension plans or social support are voluntary and vary from individual to individual. But individuals have "human agency", based on their preferences they exercise choice in the preparations that they choose. Some place more emphasis on building and maintaining strong networks of social support, while others place more emphasis on ensuring financial security in later age.

As noted earlier, the content of an individual's portfolio is constrained by their existing resources and obligations, and by the cohort and historical circumstances of their lives. Moreover, the content of the portfolio is dynamic and changes over the life course. Youths may not be actively preparing, those at mid life may begin to prepare depending on their economic and social resources, while many pre-seniors may be actively preparing for their retirement.

There is no one "optimal" mix of financial and non-financial preparations. The needs of individuals in later life vary and so what is "right" for one person may not be "right" for the next. Some preparations for latter life are complementary. Self-protection complements self-insurance. Self-insurance complements public protection and visa versa. Furthermore, some types of preparations substitute for others, some do not. Contributions to individual pension plans or savings and investments may substitute for the lack of a company pension plan. Social support in the form of informal caregiving may substitute for the lack of a publically funded nursing home bed. Formal services may provide instrumental assistance but cannot provide the intangible emotional support that may be obtained from long-standing close relationships. There is no substitute for love.

The model provides a framework that invites a more comprehensive and systematic study of preparations for later life. To illustrate the model we apply the framework to Canada.

AN APPLICATION OF THE CONCEPTUAL FRAMEWORK TO CANADA

Canadian society is in a period of rapid economic and social change as it struggles to adapt to free trade and the globalization of world economies. At the same time, the Canadian population is aging. Standing now at 12%, by the year 2021, the Canadian population age 65 and over is expected to reach 18% and, by 2041 it may almost double to 23% of the Canadian population (Denton and Spencer, 1995). This is an increase from 3.6 million to over seven million persons in this age group. As well, the average person is living into advanced age. Women and men, at birth, can expect to live until age 80 and 73 respectively (Statistics Canada, 1997).

The very nature of the Canadian social fabric has changed rapidly in the past 40 years. There has been a trend towards increasing labour force participation for women, especially for women with children and older women (Foot and Gibson, 1994). Along with this are trends towards higher unemployment rates (especially among the younger and older age groups) and earlier retirement (Lowe, 1991). In fact, McDonald (1996) argues that some of the trend towards early retirement is actually unemployment. And too, workers are more likely to be employed in a growing service sector, and less likely to be employed in the primary industries such as agriculture and natural resources (McDonald and Chen, 1994). Family life has also been changing. Compared to the older cohorts, younger cohorts are less likely to marry; those who do marry are likely to have fewer children, to have children at a later age, or to remain childless

(Beaujot, 1995). There has been a trend towards increasing divorce rates and a decline in widowhood in younger age groups (Martin Matthews, 1991). As well, with rising life spans, we are spending more time occupying the role of the child to an aging parent (Gee, 1990). As a result of these changes in the social fabric of our lives, there has been a fundamental alteration in the number of years that people spend in various life course stages with a trend toward more years in the "empty nest" and the declining primacy of traditional familial roles. Within this climate of change-- the changing nature of work and family life, the aging of the population and changes in the social welfare and health care systems, it is becoming more important that Canadians recognize the need to consider their own futures.

Public Protection

In Canada, government transfer programs are made up of the Old Age Security (OAS), the Guaranteed Income Supplement (GIS) and the Spouse's Allowance (SA) . The GIS is provided to Canadians with no income other than the OAS, while the SA goes to spouses between the age of 60 and 64 who are married to a GIS pensioner. These transfer programs are paid out of tax revenue and are meant to protect older people's incomes from falling below a specified level. Governments are concerned that they will not be able to afford to provide the same level of Old Age Security to future generations of older Canadians. Originally, the OAS was designed to be a universal benefit to all seniors, but, in 1989, the Federal Government announced an amendment commonly known as the "clawback" which required persons whose net income exceeded a specified threshold to repay OAS at the rate of 15% of the net income above the

threshold. In 1995, a draft amendment to the Income Tax Act proposed that, beginning in July 1996, all or part of the OAS not be paid to persons whose previous year's net income exceeds a specified threshold (approximately $53,000 per year)(Statistics Canada, 1996). In 1996, the new Seniors Benefit was announced in the Federal Budget. If it becomes law, it will consolidate the OAS and the GIS into one benefit beginning in 2001. This will not be a universal benefit, but is designed for those most in need. As well, eligibility for the Seniors Benefit will be based on family, rather than individual income, and will be lower for those whose incomes are over a specified threshold, reaching zero for the 9 percent of seniors with high incomes (singles with annual incomes over $52,000 and couples with combined incomes above $78,000). (Government of Canada, 1997).

The second tier of public protection is the Canada Pension Plan (CPP) and the Quebec Pension Plan (QPP), which is available to all Canadians who were in the paid labour force. The C/QPP is a mandatory “pay as you go” benefit with the contributions of those currently in paid employment financing the C/QPP of today’s seniors. Surpluses in the plan have been lent to the Provinces at very low interest rates over the years to help fund capital growth such as schools and hospitals. With the aging of the Canadian population, there is a growing concern that a smaller labour force will not be able to afford to provide the C/QPP at current levels to the baby boomers when they turn 65. The 1997 Federal Budget announced changes to the CPP to ensure that it remains sustainable in the future. Contributions will increase for those currently employed and future benefits may be reduced. Despite the recent announcement about the increase in contributions to the CPP, public confidence in the CPP has been seriously eroded.

As noted by Gee and McDaniel (1991), "Pension changes represent an attempt by federal governments to eliminate universal social benefits and to shift responsibility for pensions to individuals and employers and that this attempt represents a threat to the income security for Canadian elderly of the future" (p.469).

The Canadian health care system may also be seen as a social institution that protects the independence and economic security of older Canadians against the high costs of health care. Paid through the tax system, Canada's health care system provides universal access to physician services and acute hospital care. Health care is a provincial responsibility, but the federal government was instrumental in establishing and maintaining universal coverage to medical care through its command of monetary resources and the setting of national standards and priorities. Long-term care in nursing or retirement homes and community based programs such as home care or visiting nursing or homemaking services are not covered by any comprehensive national insurance scheme. They have tended to develop as add-ons to existing institutional medical care and there is a clear lack of uniformity from province to province (Havens, 1995; Greb, Chambers, Gafni, Goeree and Labelle, 1994).

Increasing age is associated with poorer health, greater likelihood of chronic diseases, increased disability, and a decrease in functional abilities associated with activities of daily living (Garfein and Herzog 1995; Mor, Wilcox, Rakowski and Hiris, 1994; Jagger, Spiers and Clark, 1993; Strawbridge, Kaplan, Camacho and Cohen, 1992; Forbes, Hayward and Agwani, 1991; Roos and Havens, 1991; Hirdes, Brown, Forbes, Vigoda and Crawford, 1986). This decline is most dramatic for older seniors, and women are generally more likely to be disabled

than men. With increasing age and the associated increase in disability and functional limitations, seniors place heavier demands on health care services (Mor et al., 1994; Roos and Havens, 1991; Roos, 1989; Wolinsky, Coe, Miller, Prendergast, Creel and Chavez, 1983; Stoller, 1982). And, given the aging of the Canadian population, there will be a corresponding demand on our health care system (Denton and Spencer, 1995). Concerned with the high cost of health care in Canada and the impact of an aging population on future health care costs, provincial governments are attempting to restructure the health care system and control its costs.

Initially, the federal government matched every dollar the provinces spent on approved health care services, but in the late 1970s this was changed to a system of cash grants or block funding (Chappell, 1993). In 1986, under Bill C-69, the legislation was amended to reduce the rate of growth of the amount of federal block funding and further reductions were announced in 1989 and the 1990s. The provinces' taxing powers have been increased in order to finance provincial health care. Bill C-69 removes much of the national ability to ensure comparable services from province to province and to prevent provinces from charging user fees or extra billing (Chappell, 1993). Provinces are scrambling to reduce or control their current health care expenditures by closing hospitals and hospital beds, moving health care back into the community, and reducing the number of nursing homes and extended and chronic care beds per capita (Havens, 1995). Drugs have been removed from the "covered list" and certain medical procedures are no longer covered by the medical insurance system. New procedures such as laser corrective eye surgery have not been added to the medical insurance system.

Public confidence in our universal health care system is deteriorating. Many see "health reform" as a code phrase for withdrawal of services and, consequently, there is concern about the viability of the system in the future (Canada National Forum on Health Care, 1997: 8). Some Canadians fear that their health care system “is headed towards an American-style, two-tier system with a private-pay system on one side and a public system with diminished quantity and accessibility on the other” (Southam News, March 23, 1997).

Beyond economic security and health care, other programs are in place to promote the independence and economic security of seniors. These include public housing or rent-geared-to-income housing for seniors, and seniors centres to promote leisure activities and social support.

Self-Insurance

In 1991, Statistics Canada conducted a national survey designed to measure a broad range of characteristics that contribute to the quality of life and independence of today’s and tomorrow’s seniors, known as the survey on Ageing and Independence (SAI) (Statistics Canada, 1992). The SAI collected information from 20,036 respondents 45 years of age and over, who were selected from the September, 1990—June 1991 Labour Force files (see The Survey of Ageing and Independence Microdata User’s Guide). We will use this data, along with some supplementary data, to describe what is known about the self-insurance and self-protection preparations that Canadians make for their later life. This illustration, however, is limited as we are using cross-sectional data to describe an on-going dynamic process.

Self insurance includes the financial preparations that individuals make such as savings,

investing, contributing to a registered retirement savings plan (RRSP), belonging to a registered or employer pension plan (RPP), or paying off debts. Registered retirement savings plans are important vehicles for saving for later life. They provide tax deferred savings as money is taxed at the time of withdrawal from the plan, rather than prior to investment. Individuals are constrained in terms of how much they can save using these plans as the Federal government sets the maximum allowable contribution which is currently set at $13,500 per year. As noted by Burbidge, Fretz and Veal (1997), many Canadians do not contribute to RRSPs and of those who do, most do not contribute at the maximum.

The 1991 Survey of Aging and Independence (SAI) included several questions on the preparations that people make or have made for their retirement (the unit of analysis was the household rather than a specific individual). The data show over their life-time, 49% of respondents aged 45 and over contributed to an RRSP; 58% built up their savings; 29% made other investments; 63% paid off or are avoiding debts; 17% made a major purchase; and 39% have an RPP. (Denton, Chambers, French, Gafni, Joshi, MacPherson, Raina and Rosenthal, forthcoming). With respect to age, findings are more complex. The percentage making or having made contributions to RRSPs and participating in an employer pension plan increases with age up to age 65 then decreases after age 65. This decrease may have more to do with the fact that many of these self-insurance strategies were not as readily available to the older cohorts at earlier ages as they are to the younger cohort**.**

How much do people contribute to registered retirement savings plans (RRSPs) and/or registered pension plans (RPPs), also known as employer pension plans? The RRSP room file

developed by Revenue Canada contains personal income tax information from 1991 onwards. This makes it possible, for the first time, to analyze the extent to which individuals have been saving for their retirement through RRSPs and RPPs (Frenken, 1995a 1995b; Statistics Canada, 1996). Maser (1995), using Revenue Canada data, estimates that in 1991, about one-third of tax filers contributed to RRSPs and about one-third contributed to RPPs. Over forty per cent of tax filers did not participate in either of these programs over the three years analyzed, 1991-93. Most workers belonging to an RPP participated each year, whereas almost half the participants from 1991 to 1993 contributed to an RRSP only one or two of the three years analyzed.

How much are people saving? Maser (1995) notes that for those participating in either an RRSP or an RPP, or both, average yearly savings for both plans was $4,049 in 1991 and $4,580 in 1993, up about 6%-- much more than the growth in total incomes. This represents about 10% of their incomes.

There is some research to show that factors such as age, gender, health, household income, marital and family status are related to the self-insurance preparations that people make. Schellenberg (1994) investigated factors associated with making preparations for retirement among retired and employed Canadians using data from the SAI. He notes a positive and consistent relationship between household income and the likelihood of making household financial preparations for retirement. Burbidge, Fretz and Veal (1997) show a positive relationship between income and making RRSP and RPP contributions using data from the Canadian Family Expenditure Survey (FAMEX). Statistics Canada, using Revenue Canada data found that the likelihood of making contributions to an RPP or RRSP increases with income

(Maser, 1995). Savings rates were higher at the higher income levels and were highest for those who belonged to an RPP and also contributed to an RRSP.

Men are more likely to save for retirement than women; overall, 47% of men reported saving at least once in the three year period compared to 36% of women (Maser, 1995). Denton et al. (forthcoming) show a positive association between having good health and making financial preparations for later life, with the exception of being a member of an employer sponsored pension plan.. Although research has begun to document the determinants of self-insurance for later age, much more needs to be done before researchers and policy makers will know who is preparing, how are they preparing and how effective their preparations will be

Self Protection

Self-protection includes the non-financial preparations that individuals make for their futures. A body of research is beginning to coalesce around the meaning of successful aging and factors that predict successful aging. Rowe and Kahn (1997) define successful aging as "multidimensional, encompassing three distinct domains: avoidance of disease and disability, maintenance of high physical and cognitive function, and sustained engagement in social and productive activities" (p. 439). They argue that successful aging is more than the absence of disease or the maintenance of functional capacities, rather "it is their combination with active engagement with life that represents the concept of successful aging more fully" (p. 433). We would add to this list the development of a positive attitude towards the aging process including self image, role definition and re-defining relationships.

Related to this concept of successful aging is the World Health Organization's definitions of health as "a state of complete physical, mental and social well-being, and not merely the absence of disease or injury" and later "as a resource for daily living". Operationalizing the WHO definition of health for later life is congruent with Rowe's successful aging concept.

The image portrayed in the media of a frail and dependent senior is giving way to seniors portrayed as active, healthy, independent, and interested in life. Literature or courses on retirement preparation speak of the non-financial preparations that people should make for their retirement such as developing hobbies and leisure activities. Media campaigns flood us with messages about "eating right" and "keeping fit" and reducing tobacco and alcohol consumption. Older Canadians are taking an active part in preparing for their own successful aging.

Recent evidence suggests that while genetics plays an important role in the onset of disease and disability and the loss of independence in later life, environmental and behavioural factors including elements of lifestyle are also important. Much of the recent focus on health promotion has attempted to persuade people to adopt healthier lifestyles by quitting smoking, reducing alcohol intake, eating healthy foods and staying physically fit and active. Evidence suggests that most people are attempting to incorporate healthy lifestyles into their everyday lives. For example, the SAI asked respondents about the types of things they did on a daily basis to stay healthy. In response, 88% reported eating a balanced diet; 90% getting enough rest and sleep; 86% keeping physically active; 94% brushing their teeth; 73% avoiding smoking, and 89% avoiding alcohol or drinking in moderation.

There are numerous ways in which people attempt to maximize their cognitive functions in later life. Education, including life-long intellectual activities (reading, crossword puzzles, etc.) may serve to maintain cognitive function in later life (Rowe and Kahn, 1997) For many, retirement from work is a gradual process, rather than an abrupt transition from work to non-work. It is estimated that somewhere between 30% to 50% of people move into their "final" retirement via part-time employment or using "bridge jobs" from their "career" jobs into retirement (McDonald, 1996:xvi). In the SAI, 15% of respondents (ie. either currently working or retired) changed their work pattern (for example, work part-time or work more hours) in preparation for retirement. And, approximately 21% of retired men and 11% of retired women reported that they worked after retirement. Of these, about one-half moved to a new employer, one-quarter stayed with a former employer and one-quarter started their own business.

Many Canadians engage in physical activities as a means of maintaining their physical functioning as they age. This includes activities such as walking, playing sports such as golf or tennis, attending exercise classes, gardening and so on. Thirty-one per cent of SAI respondents reported that they had developed physical activities in preparation for their retirement.

As we have noted earlier, aging is associated with a greater likelihood of chronic diseases and increased disability. For example, 36% of respondents to the SAI (age 45 and over) reported an activity limitation due to a long-term illness, physical condition or health problem. However, as many seniors have found, it is still possible to live a independent lifestyle with a moderate degree of disability. This is possible partly through changes in lifestyle including

modifications in the living environment. In the last third of life, many people may sell their family homes and move into a smaller retirement home or condominium which may entail less maintenance and or allow aging in place. This may be either for life style or health reasons. Findings from the SAI indicate that 22% of the respondents with an activity limitation had moved in the past 5 years. The two most common reasons for moving included: previous home too big or too small and a move because of a decline in health (of self or spouse/partner).

Those with chronic health problems and disabilities may also choose to make adaptations to their homes to allow for independent living. These respondents were asked if they had a number of health care features at home. Twenty-one per cent of those with a disability had bathroom modifications such as handrails; 7% had extra handrails throughout their home; and 19% had a street-level entrance. Very few had other modifications made to their home.

According to Rowe and Kahn (1997), continuing engagement with life has two major elements: maintenance of productive activities and interpersonal relations. Leisure is said to replace work and many seniors spend more time on leisure activities and hobbies after retirement. The SAI reports that 39% had developed other leisure activities and hobbies in preparation for their retirement.

Social support is an important determinant of health and well-being (Chappell, 1992). Moreover, social isolation has been found to be an important risk factor for health. Studies of the relationship of social support and well-being identify both a direct and indirect (or buffer) effect of social support. Direct effect refers to such things as being a member of a group, day-to-day interaction and the perception that others are supportive. The indirect effect refers to the buffer

effect that social support plays in mediating the effect of stress on quality of life in times of crisis (Chappell, 1992). Socio-emotional support (affection, friendship, confidants) appears to be more important than instrumental support for well-being (Chappell, 1992; Rowe and Kahn, 1997).

Social support may come from a number of sources including: spouse, children, siblings and, of course friends. Ninety per cent of those answering the SAI reported that they had family members that they felt close to (defined as family members you feel at ease with, can talk to about private matters or can call on for help), and most had several such family members. While 41% of these family members respondents felt closest to lived in the same household as the respondent, 13% lived in the same neighborhood; 22% lived within the same city or town, and 24% lived in another city or town.

Gee and Kimball (1987) argue that friends may be more important to overall well-being than kin. This is because it is the quality of relationships, particularly the confidant relationship, which contributes most importantly to well-being. Research suggests that activities with non-family are more satisfying than activities with family because friends share the same generational experiences and the relationships are voluntary rather than obligatory. Data from the SAI indicate that about 75% had close friends.

In this section of the paper we have attempted to illustrate the conceptual framework by applying it to Canada. While the conceptual model promises more, our illustration has been descriptive at best. Our review of the information currently available has allowed us to say little about the interplay between different forms of preparations for later life. The data do not allow

us to illustrate how social structure constrains individuals ability to self-insure and self-protect. Nor does it allow us to portray the model as a dynamic process which varies through time and space. The conceptual framework, however suggests a set of research questions. The task for researchers is to address these and other related research questions if we are to understand the process of preparing for later life and the adequacy of the preparations that individuals and government make in preparing for an aging population

RESEARCH QUESTIONS ARISING FROM THE CONCEPTUAL MODEL

This paper will now discuss a number of research questions suggested by the model.

1) **How do existing patterns of inequality, power and resource distribution constrain or limit the preparations that individuals make for their later life?**

Put another way, are preparations for later life structured by gender, socioeconomic position, race ethnicity, family status and other such factors? As documented earlier in this paper, the literature suggests that self-insurance is structured by gender, age, marital status, health and income. However, the research in this area is preliminary at best and further work on this important topic should be a priority. We know little about how self-protection varies by gender, age, marital status, health, income and other such factors.

2) **Are there separate age, period and cohort effects in preparations for later life?**

With respect to *age effects*, at what age do people begin preparing for later life, immediately before retirement, after they attend a course, or years in advance? Is there some event that triggers this such as the "empty nest" or an experience of ill health? Are people

consciously making preparation or simply responding to opportunities to save tax dollars or media campaigns on healthier life styles or both?

With respect to *period effects, a*re there specific historical events that influence the preparations that people make? Do sudden shifts in social welfare policy or shifts in the economy such as an economic downturn cause individuals to the re-evaluate their potential futures and the preparations they make for that future? For example, in Canada, have peoples' preparations for later life changed because of the recent proposal to introduce the Senior's Benefit, or changes to the CPP, RRSP tax contribution limits, limits to health care spending, and changes in the long-term care sector or the political agenda to convince Canadians that there are serious economic implications to an aging population?

With respect to *cohort effects*, do different age cohorts use different strategies to prepare for their later lives? Are cohorts who had fewer opportunities for self-insurance (i.e. the oldest old) more likely to rely on self-protection preparations?

3) **Are public protection, self insurance and self protection preparations for later life complementary or supplementary?**

Are there specific combinations of strategies that people use and does this vary by gender or other socio-demographic or some other characteristics? For example, do some people self-insure while others self-protect or do some do both while others do neither? Do others simply not prepare at all and count on the state to look after them in their old age. To what extent do self-insurance preparations substitute for public protection preparations; to what extent are they complementary? To what extent do self-protection preparations substitute for public protection

or self-insurance preparations; to what extent are they complementary?

4. **What is the interplay between the various forms of preparations for retirement?**

Policy analysts need a thorough understanding of the inter-relatedness of the various types of preparations before they make changes to state provided programs. What are the equity implications of (recent) changes in public protection measures? In Canada, will the introduction of the Seniors Benefit reduce the level of poverty among Canadian seniors? Another example, do RRSPs increase the amount that people save?

To answer these research questions and others, different research strategies are required. Qualitative methods, such as intensive interviews or focus groups will help answer the questions about how people think about their futures, whether they are making conscious plans, what strategies they use, events that might have triggered their plans and so on. Cross sectional studies may be useful for studying differences by age, gender, income and other background characteristics and for addressing the question about the complementary or supplementary nature of preparations. Longitudinal or trend data will allow us to test for cohort, period and age effects. Longitudinal data analysis permit researchers to capture the dynamics of social life which are shaped by economic, political and social events. People's lives are constantly changing as is the society in which they live. Individuals may face involuntary retirement in mid-life due to a layoffs, health may decline, family may move away. With changes in their lives, people re-evaluate their plans and make changes in their preparations. Longitudinal data will enable us to study the dynamics of peoples lives and what events trigger changes in their

preparations for the future.

Finally, we have suggested that the conceptual model may be used to address policy questions such as: Will tomorrow's seniors be prepared economically and socially for their futures? As we have argued, this is not a question that can be answered solely with information about self-insurance and self-protection preparations for later life, but rather must be approached from a consideration of the public protection available. It is an issue of what public protection programs are in place to meet the needs of individuals as they age. The public protection programs available in the future may look quite different from those in place today. Policy makers must ask: Will the public protection programs available meet the needs of all citizens in their later life?

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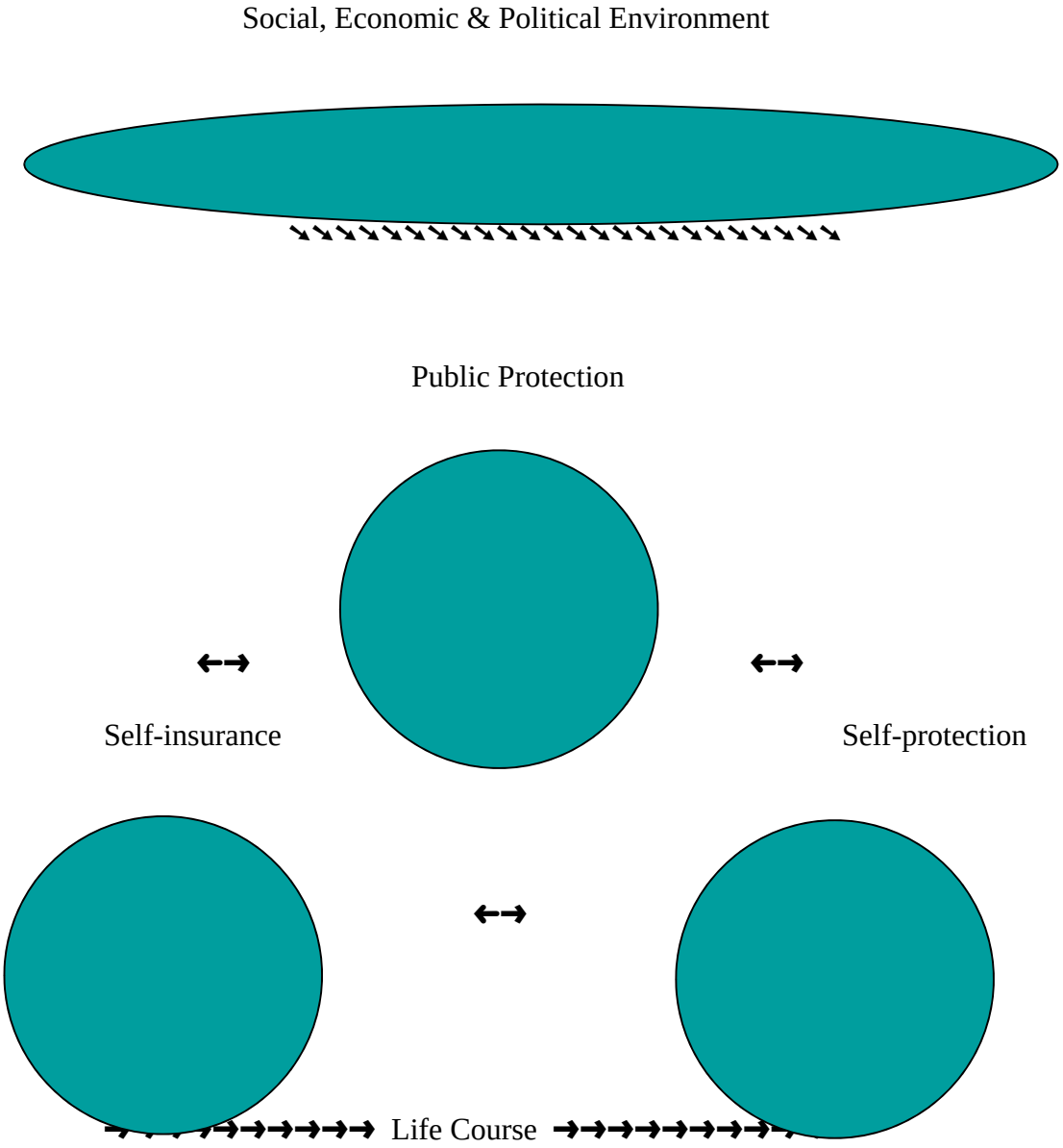
Figure 1

Preparations for Retirement: A Conceptual Framework



Features:

- Social Structure & Human Agency
- Dynamic
- Interconnected
- Discretion & Non-discretion
- Collective & Individual Preparations

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