

**DIFFERING PROSPECTS FOR WOMEN AND MEN: YOUNG OLD-AGE,
OLD OLD-AGE, AND ELDERCARE**

Lois B. Shaw

Institute for Women's Policy Research

Washington, DC

April 21, 2006

Acknowledgments: I thank Brittany Stalsburg and Erica Williams of the Institute for Women's Policy Research for their assistance with references and tables, My daughter Sarah Shaw Tatoun for her expert assistance in preparing the final editing and my daughter Rachel Shaw for her careful reading and encouragement.

I have been asked to address the question of government spending on the elderly from a woman's perspective. The perspective I bring is that of an **old woman**, a semi-retired feminist economist, who is a participant observer of the process of growing old. I live in a continuing care retirement community and so am well situated to observe my neighbors and friends growing old as well as myself. In this paper, I will comment on the some of the policies being advocated or adopted that may affect women and men in different ways.

Although Social Security has received the most attention, expenditures for Medicare and Medicaid are projected to increase even more rapidly than Social Security spending. Some of the policies advocated for these programs may interact in unexpected ways. Regarding Social Security reform, increasing ages of eligibility to promote longer working lives has often been advocated. At the same time proposals are made to constrain Medicaid spending by shifting more of the care of the disabled elderly to unpaid caregivers, primarily women, but also some men, many at the ages when more paid work is to be expected.

The elderly are conventionally defined as the population age 65 and over, but this is a very broad age range that covers a very wide range of capabilities. When we think about work and retirement we tend to be thinking about young old-age, when most people are physically active and able to care for themselves. There is less research, at least by economists, on old old-age when disabilities increase, most of the elderly begin to need some assistance, and many require extensive help with the most basic activities of daily living.

Although elderly men and women encounter many of the same problems as they age, their lives are likely to follow different patterns. Men are less likely than women to live into extreme old age; women are, therefore, an increasing majority of the elderly at older ages (see Table 1). Men are also likely to have married women younger than themselves. As a result, while the majority of both men and women ages 65-74 are married, by ages 85 and over approximately 59 percent of men are married compared with only 14 percent of women. If they become ill or disabled, men are thus much more likely than women to have spouses available as caregivers whereas women are more likely to depend on adult children. These patterns will certainly change with health improvements and different marital patterns as the baby boom generation ages, a topic I will return to later.

YOUNG OLD-AGE: PAID WORK, UNPAID WORK, OR LEISURE?

Paid Work: Working longer

Retirement often occurs even before age 65, most commonly at age 62 when eligibility for Social Security begins. As life expectancy increases, encouraging people to work longer seems a reasonable policy. Most commonly proposed is to make further increases in the age when full Social Security benefits are available, currently being increased from 65 to 67 years. Further increases could be made as life expectancy increases. Another proposal is to gradually increase the age of first eligibility for Social Security benefits beyond the current age of 62 years. Proposals of this kind would in effect be benefit cuts for anyone who cannot work past age 62. Either proposal would cause the greatest hardship for some of the most vulnerable elderly, especially minorities,

who cannot continue to work because of poor health, inability to find work, or conflicting responsibilities for family members.

Proposals for later retirement would have the greatest impact on workers in physically demanding jobs, which are held more commonly by men than women. However, some occupations that are not especially demanding for younger workers become more difficult as people age. These include many service occupations and some retail sales jobs that require standing or walking for long periods. According to data from the Health and Retirement Survey (HRS), slightly more than half of workers in service occupations and about one quarter of those in sales reported that their jobs involved much physical effort all or most of the time (GAO, 2005b). These kinds of jobs are often held by women. Increasing the early or normal retirement age should be accompanied by changes that make disability benefits more readily available for people who cannot continue to work because of the physical demands of their jobs.

Working longer will only be possible if employers are willing to hire older workers. At present companies that are downsizing often encourage their older workers to retire even before age 62. Studies show that although unemployment is generally low at older ages, older workers who do lose their jobs are unemployed for longer periods and often stop trying to find work (Flipper and Tienda, 2000). Many workers believe that if they wanted to work to older ages, either their own lack of up-to-date skills or employers' discrimination against older workers would prevent them from working (GAO, 2005b).

If labor shortages develop as the baby boom generation retires, perhaps more employers will be interested in providing options such as phased retirement, allowing for

part-time or part-year employment which few employers now offer (GAO, 2005b, p.29). A slight trend toward more employment at older ages appears to have already begun. For example, labor force participation rates at ages 65-69 were 33.6 percent for men and 23.7 percent for women in 2005, up from 24.4 percent and 13.5 percent in 1985. These trends could reflect better job opportunities or they could be due to many people feeling the need for more income than they had anticipated as the cost of medical care increases more rapidly than inflation.

Unpaid work: Care-giving responsibilities

One problem of a longer working life that is often not recognized is that many women and some men in their 50s and 60s may find it difficult to continue working because they are needed as caregivers for their spouses, parents or other relatives. Research suggests that informal care by spouses or adult children delays the use of nursing home care and reduces the use of formal paid home care (Van Houtman and Norton, 2004; Charles and Sevak, 2005). Consequently, encouraging care by family members is a frequently mentioned option for reducing pressures on public programs (Wolf, 1999). Reducing Medicaid availability, as is happening at both state and federal levels, may well force families to assume this responsibility.

Relatively small amounts of assistance can usually be combined with paid employment, and when the family relationship is good, may be very satisfying to the caregiver. Sometime elderly parents who do not need too much assistance themselves can reciprocate by occasionally or even regularly taking care of grandchildren. However, caring for those who require considerable help with the so-called instrumental activities

of daily living (IADL) may be quite time-consuming.¹ Even more difficult to combine with paid work is the more intensive care required for those who need assistance with the activities of daily living (ADL) such as dressing, bathing, eating, moving around indoors, and using the toilet.

This country appears to be following the path taken by some European countries: encouraging more paid work and increased unpaid eldercare (Stark, 2005; OECD, 2005). Women are more likely than men to feel the impact of these conflicting demands. In the U.S. spouses and daughters are the most common caregivers; wives are approximately 60 percent of spouse caregivers, but husbands also play a significant role, in part because they are so much more likely than women to be married. Among adult children, daughters (or daughters-in law) are much more likely to provide extensive care than are sons, sons-in-law, or other relatives or friends (Johnson and Wiener, 2006; Wolf, 2004).²

Nearly all spouse caregivers are over age 55 and approximately one third are in the 55-69 age range, the ages when more paid employment is being advocated (Johnson and Wiener, Table 5.6). Nearly one-quarter of daughter caregivers are age 60 and over, approximately one third are in their fifties, and another third are in their forties; many of them are employed (Johnson and Wiener, Table 5.5). Thus the conflict between paid employment and care-giving may arise for women and some men not only when they are raising children but also at older ages when they must provide care for spouses or elderly parents (Gross, 2006). Some of the younger caregivers may be caring for both parents and children.

¹ IADLs include being able to manage medications, use the telephone, shop, manage money, cook and do light housework.

² Estimates of the characteristics of caregivers of the elderly vary across years, source of the data, and the kind and amount of care being provided. The estimates shown are for those helping with ADLs.

When increased family care is recommended as a way to reduce dependence on expensive nursing home care, it is the most intensive kind of care that is implied, and co-residency is often required. Wolf (1999) argues that care by family members, specifically adult children, can be more efficient than paid care. Co-resident care can indeed offer economies of scale. In some cases, a parent's retirement income can also make a substantial contribution to the family's welfare.

On the other hand, the potential stress for both the recipient and the caregiver should not be ignored. Bringing a parent into the home of an adult child can be a difficult adjustment and for both parent and child. A Canadian study finds that providing care for a parent living in the household is far more stressful than the same amount of child care (MacDonald, Phipps, and Lethbridge, 2005). Intensive caregiving, especially for an elderly person with dementia can put enormous strains on the caregiver. Those who have to give up their jobs or reduce their hours of paid work may also be jeopardizing their own retirement incomes.

The value of caregiving to society may well exceed its value to the caregiver; therefore, public support to encourage caregiving by family members is warranted (Wolf, 1999; Folbre, 2005.) In some communities, adult daycare facilities are available, but they are not cheap, nor always available. Some states permit Medicaid to pay for this service. The use of adult daycare can allow the caregiver some respite to do necessary shopping and other tasks. In some cases, such an arrangement can even allow caregivers to continue with their regular jobs.

Countries such as Australia, Canada, Sweden and the United Kingdom have tried to ameliorate the eldercare problem by providing allowances to support caregivers

(OECD, 2005). Some of these countries have also provided social insurance benefits for caregivers. Proposals for caregiver tax credits or added years of Social Security coverage have been made in Congress in the U.S., but have not been enacted (Wolf, 2004).

Leisure?

If we make adequate provisions for those who are not able to work because of disability, care responsibilities, or inability to find a suitable job, then it should be possible to encourage longer working lives for those in young old-age who are able and willing to work. Shouldn't we also allow a place for leisure at some point before old old-age? Policies to encourage more paid work even past age 70 sometimes take on a rather puritanical tone that reminds me of the old hymn, "Work for the night is coming when man's work is done." This hymn enjoins us in successive verses to work though the morning hours, through the sunny noon, and while the night is darkening; the work ethic indeed.³ Perhaps we are a bit influenced by the media view of the wealthy young-old people living in retirement communities with golf courses and going on cruises and other exotic vacations.

This picture may apply to some upper-middle class people, but for most the reality is very different. Many are caring for aging spouses or even still working, at least at part-time paid jobs. Leisure is more likely to consist of simpler pleasures like gardening, visiting with neighbors, napping, and playing with grandchildren. Even this last activity, for women especially, sometimes becomes part or even full-time caregiving to help their daughters hold paid jobs. In low-income communities, grandmothers are sometimes raising their grandchildren alone (Joslin and Brouard, 1995).

³. For the complete hymn see www.cgmusic.com/cghymnalothers/workforthenight.htm.

OLD OLD-AGE AND THE NEEDED FOR CARE

At the same time that life expectancy has been increasing, disability among the elderly has decreased (Cutler, 2001). Many women and men who live into old old-age remain in relatively good health, but as Table 2 shows, as they reach their late 70s and into their 80s, more of them develop problems that may interfere with their ability to live independently.⁴ Low vision becomes an increasing problem, and many old people lose some of their independence when they can no longer drive a car.

Although women are more likely to live to older ages, they are also more likely than men to have mobility problems at each age. Women are more likely than men to be disabled because of arthritis or osteoporosis or after a fall, conditions that are usually not fatal, but can lead to long periods of disability. Men, on the other hand, are more often disabled because of heart disease or strokes with shorter life-expectancies (Guralnick et al, 1997). The risk of dementia, probably the most disabling and most feared disability, rises rapidly with age for both men and women, reaching approximately 17 percent of women and 21 percent of men by age 80 and more than 30 percent of both men and women who are 85 or over (Federal Agencies, 2004, p.90.)⁵

Among married couples, caring for an ailing spouse is common. Approximately 45 percent of spouse caregivers are in their seventies and some are in their eighties, when their own health may be a constraining factor (Johnson and Weiner, 2006). Although most eldercare is provided by spouses or other unpaid caregivers in the community, many of those needing care, women especially, live alone and have no relative who can assist

⁴ Some part of these age differences could, of course, be due to cohort effects.

⁵ These figures are underestimates because they include only the non-institutional population.

them. After age 75, the majority of women are not married (Table1) and nearly half live alone (Shaw and Lee, 2005).

Among the elderly residing in the community, about 20 percent of those who need assistance with either ADLs or IADLs rely on paid caregivers who come to their homes (Wolf, 2004). The majority of paid caregivers are women, predominately African-Americans or Hispanics (Wiener and Tilly, 2002.) The work is usually low-paid and often provides no benefits. Turnover is high, leading to a high level of insecurity for those relying on this kind of care. More women than men rely on paid care, even though they have less income and assets than men.

Formal long-term care is most commonly provided in nursing homes but can also be provided in small room and board facilities that offer complete care. Residence in nursing homes increases rapidly with age. In 1999, approximately 3 percent of men and 5 percent of women lived in nursing homes at ages 75-84, and the percentages increased to 11 percent of men and 20 percent of women age 85 and over (see Table 2). About three-quarters of nursing home residents are women. About 72 percent of nursing homes are operated for profit, and the quality of care is often poor (Eaton, 2005).

The average cost of a year in a nursing home is \$70,000 (Metlife Mature Market Institute, 2004), while median net worth of married couple households age 65 and over was \$170,000 in 2000, median net worth of female householders at this age was \$75,275, barely enough to cover one year in a nursing home (U.S. Census, 2000). Many nursing home residents exhaust their savings within a year or two of entry, and then become eligible for Medicaid. Nursing homes may be reluctant to take people on Medicaid,

making it more difficult for lower-income people to find accommodations in nursing homes. (Harrington Meyer, 2001).

Paying for Long-Term Care

For women, especially, paying for the care they need is often a major problem of old old-age whether they remain in their homes or go into nursing homes. Over half of long-term care for the elderly is paid for by federal and state governments: Medicaid paid for 35 percent and Medicare 25 percent in 2004 (CBO, 2004). Only 4 percent was paid for by insurance; the rest (36 percent) was paid for out-of-pocket by the recipients, their families, or other sources such as charitable funds. These figures include both nursing home and home-based care. Nursing home care involves much higher Medicaid expenditures than home-based care. In 2004, Medicaid covered nearly 40 percent of nursing home expenses compared with 25 percent of home-based care expenses (CBO, 2004, Table 1-2).

These figures do not take into account the value of unpaid care. Depending on the value assigned to unpaid care, the amount paid by families for long-term care is much larger. The CBO estimates the value of unpaid care as accounting for 36 percent of long-care expenses, bringing the total amount from private sources both paid and unpaid to over 60 percent of total costs.⁶

Medicare plays an essential role in paying for long-term care, but it is strictly limited to paying for short-term stays in skilled nursing care facilities after hospitalization and to skilled nursing care that is provided at home or elsewhere on a daily basis.

Medicaid is not an entitlement and is administered by the states, which can determine

⁶ Wolf (2004) explains some of the different ways of valuing unpaid care, and some of the sources of both over and under-estimation.

eligibility within limits set by federal law. Medicaid has been described as insurance in which the deductible is your life savings and the co-payment is your annual income (Quoted in Clark, Burkhauser, Moon, Quinn, and Smeeding, 2004, p.326). More stringent rules for Medicaid eligibility is a favorite recommendation for curbing government expenditures on the elderly (CBO, 2004). Women are not only the primary recipients of Medicaid, but also the primary caregivers who will be under pressure to provide more unpaid care.

As previously mentioned, private spending by the care recipient or her/his family represents a major source of payment for long-term care. Out-of-pocket medical expenditures of all kinds are usually largest in the last years of life, reaching approximately one quarter of annual income for the median couple and over one-half of annual income for 20 percent of elderly couples (McGarry and Schoeni, 2005). If assets are drawn down to pay for medical expenses, the surviving spouse, most commonly the wife, will be less likely to be able to pay for her own expenses in her last years.

Long-term care insurance is relatively new, but it is likely to become a more important way of paying for long-term care in the future, as I will discuss later. Premiums at age 65 average approximately \$2,000 per year for a guarantee of an inflation-adjusted payment of a stated amount for 3-6 years (CBO, 2004, Table 1-3). Purchase of life-time coverage is even more expensive. Premiums increase rapidly with age, and are considerably lower if purchased before age 65. However, Consumer Reports does not recommend earlier purchase because of the risk of having to drop the insurance if income should decrease or premiums should be increased enough to make them unaffordable

(Consumer Reports, 2003).⁷ An estimated 15 percent of those applying for policies are turned down for health reasons. Some purchasers have also found it difficult to get companies to pay when long-term care is needed.

ELDERCARE IN THE FUTURE

In 20 years, the large baby boom generation (born in 1946-1964) will all be in what is now the usual retirement ages, and the oldest will have reached age 80. The future I will discuss here is based on current trends. It is by no means impossible that abrupt climate change, wars over energy sources, epidemics or other disasters could completely change this picture.

Although the baby boom generation will probably be healthier than today's elderly, it is unlikely that continuing medical advances will be large enough to offset their large numbers (Wiener and Tilly, 2002.). The decrease in disabilities that has occurred in recent years has been greatest for those with more education and higher incomes (Schoeni, Martin, Andreski, and Freedman, 2002). It is possible that increasing income inequality, a larger immigrant population, and reports of increases in disability at younger ages portend smaller decreases in old-age disability than in the past. In any event both Medicare and Medicaid are likely to be under great pressure because of the size of the baby boom generation (GAO, 2005a). A likely outcome is that, as at present, eligibility or payments are likely to be reduced, putting more of the burden on families for unpaid care.

⁷ While premiums are supposed to be fixed at the age of purchase, insurance companies have sometimes been successful in getting grants from state regulators for large increases in premiums if they find their premiums are not covering costs (Johnson and Uccello, 2005). Over a long period of years, there are also more risks of company bankruptcies as well.

However, family care is likely to be less available than at present. Whether as much spouse care will be available for either women or men is uncertain. On the one hand, fewer of those in their 40s and 50s are married than was the case for the current elderly population. On the other hand, increasing life expectancy may reduce the percentage of women who are widowed. In any case a larger percentage of the younger generation is predicted to be divorced or never married (Butrica, Iams, and Smith, 2003).

Another important difference between today's elderly and baby boomers is that the latter have had far fewer children than their parents. Nearly 60 percent of women who are now in their 70s had had three or more children by ages 40-44, compared with only about 30 percent of women born in 1956-60. Similarly only 10 percent of the older women had no children by their early forties, compared with 19 percent of the younger group (US Census, 2005). Therefore, care by daughters, which is now such an important source of eldercare for women, will also become much less common.

Additional sources of eldercare may be necessary in the future. Sons and sons-in-law may need to provide more care than at present. Siblings, friends, and perhaps nieces and nephews may also become more important sources of care. In any event, it is probable that an increased reliance on paid care will be necessary. In the past, nurse shortages have often been filled by recruiting nurses and other care workers from the developing world (Callahan, 2001.) In all probability, the United States will continue to depend on immigrants, including Hispanics who are the subject of so much controversy at present. Higher wages and better working conditions may also be necessary to retain high-quality workers.

Higher rates of saving are always advised as part of the solution for reducing the need for higher government spending on eldercare when the large baby boom generation retires. Although members of the baby boom generation are expected to have higher incomes than the current elderly generation and could probably benefit from saving more, many of them can probably not save enough before retirement age to finance long-term care if they need it (Van Derhie and Copeland, 2003). Families with below-average incomes and the majority of unmarried women are not likely to have adequate savings to finance their old age.

In addition, fewer workers in the future will have income from defined benefit pension plans, and the defined contribution plans that replace them are usually taken as lump-sum benefits rather than annuities (Shaw and Hill, 2002). This not only exposes retirement income to investment risk, but also requires careful long-term management of assets (Copeland, 2005). The risk of out-living assets may very well increase for this generation.

Long-term care insurance will probably become a more important part of paying for long-term care. Federal employees, for example, now have the option of including long-term care insurance as a fringe benefit. Use of home equity to buy long-term care insurance through reverse mortgages has been suggested, but is not yet widely practiced. Long-term care premiums are at present deductible as a medical expense once total medical expenses exceed the required percentage of income. Reverse mortgages could also be used to pay for long-term care directly (Rich and Porter, 2006).

In the past ten years Germany, Japan, Austria and Luxembourg have instituted state-provided long-term care insurance systems (OECD, 2005). These systems should be

studied carefully. Adding long-term care insurance to Medicare might be a good option for the US as well. This could be accomplished by increasing the payroll tax, but might also be accomplished in a less regressive way by reinstituting the estate tax at higher levels and dedicating the proceeds to universal long-term care insurance.

An important strategy to reduce long-term care expenditures is to delay the need for full-time care by helping the individual to remain active longer. Assistive devices such as walkers and motorized scooters with seats allow old people to move about more easily. These and other assistive devices have been found to reduce the number of hours of personal assistance needed (Hoenig, Taylor, and Sloan, 2003). Medical advances such as cataract surgery, hip and knee replacement, and various treatments for heart conditions have allowed people to live longer active lives. Here as in other aspects of government spending, increased (decreased) spending of one type (Medicare) may lead to reduced (increased) need for other spending (Medicaid).

Retirement communities with services are a growing source of support for the elderly with mild disabilities or those who anticipate that they may need services in the future. About 7 percent of the population age 85 and over at present lives in one of these kinds of senior communities. Because providing care at home or in communities with services is less expensive than nursing home care, some states are attempting to shift funds for seniors in this direction. Senior low rent housing may be provided in communities that offer some services such as transportation to shopping. Congregate housing facilities usually offer individual apartments with common dining facilities and other common areas. Assisted living facilities usually offer meals and other services such as laundry, housecleaning, and assistance with medications for those who need

considerable help, but are still able to do many things for themselves. Assisted living usually costs considerably less than nursing home care.

Continuing care retirement communities offer a range of services including independent living, assisted living, and full nursing home care.⁸ Communities of this kind provide settings in which it is easy for elderly people to assist each other with small amounts of care. Such assistance can delay the time when more expensive formal care is needed and can thus reduce government expenditures on Medicaid. It is my hope that the baby boom generation, which includes my own children, will be able to think of still other ways to help themselves and each other in old age.

⁸ The Appendix describes the continuing care community in which I live in some detail.

Table 1. Percent Married, Probability of Surviving to Next Age, and Percent Female by Age					
	Percent Married^a		Probability of Surviving to the Next Age^b		Percent Female^c
Ages	Men	Women	Men	Women	
65-74	77.6	56.1	0.747	0.828	54.2
75-84	72.8	36.6	0.485	0.606	59.2
85 and over	59.4	13.9	N/A	N/A	66.3
^a Source: U.S. Census Bureau, Current Population Survey, as reported in Federal Interagency Forum on Aging-Related Statistics, 2004, Table 3. ^b Calculated from Life Tables for Males and Life Tables for Females, National Vital Statistics Reports, 2002. ^c Calculated from Current Population Survey, 2004; excludes population in nursing homes.					

Table 2. Disabilities and Nursing Home Residence by Age and Gender			
Ages	Trouble Seeing^a	Impaired Mobility^b	Nursing Home Residence^c
(Percentages)			
MEN			
65-74	13.3	13.0	1.0
75-84	16.2	21.3	3.1
85 and over	29.2	35.1	11.7
WOMEN			
65-74	15.5	26.0	1.1
75-84	19.1	32.9	5.1
85 and over	34.7	59.5	21.1
^a Source: Federal Interagency Forum on Aging Related Statistics. Older Americans 2004: Key Indicators of Well-Being. Table 16a, Non-institutionalized civilian populations, 2002. ^b Table 19c, Medicare enrollees, 2002. ^c Table 35a, Percent of age group, 1999			

References

Butrica, Barbara A., Howard M. Iams, and Karen E. Smith. 2003. "It's All Relative: Understanding the Retirement Prospects of Baby Boomers." Washington, DC: The Urban Institute.

Callahan, James J., Jr. 2001. "Policy Perspectives on Workforce Issues and Care of Older People." *Generations* XXV (2).

Charles, Kerwin K. and Purvi Sevak. 2005. "Can family caregiving substitute for nursing home care?" *Journal of Health Economics* 24 (November): 1174-1190.

Clark, Robert L., Richard V. Burkhauser, Marilyn Moon, Joseph F. Quinn, and Timothy M. Smeeding. 2004. *The Economics of an Aging Society*. Chapter 11, pp. 326. Malden, MA, Oxford, and Melbourne: Blackwell.

Congressional Budget Office. 2004. *Financing Long-Term Care for the Elderly*. Washington D.C.: Congressional Budget Office.

Consumer Reports. 2003. "Do You Need Long-term-care Insurance?" 68 (3) November.

Copeland, Craig. "Changes in Wealth for Americans Reaching or Just Past Normal Retirement Age." 2005. Employee Benefit Research Institute No. 277.

Cutler, David M. 2001. "The Reduction in Disability among the Elderly." *Proceedings of the National Academy of Sciences* 98(12).

Eaton, Susan E. 2005. "Eldercare in the United States: Inadequate, Inequitable, but Not a Lost Cause." *Feminist Economics* 11 (July): 37-52.

Federal Interagency Forum on Aging-Related Statistics. 2004. *Older Americans 2004: Key Indicators of Well-Being*. Federal Interagency Forum on Aging-Related Statistics, Washington, DC: U.S. Government Printing Office.

Flippen, Chenoa and Marta Tienda. 2000. "Pathways to retirement: patterns of labor force participation and labor market exit among the pre-retirement population by race, Hispanic origin, and sex." *Journals of Gerontology: Series B: Psychological Sciences and Social Sciences* 55B (January): S14-S27.

Folbre, Nancy. 2004. "A Theory of the Misallocation of Time" in Nancy Folbre and Michael Bittman, eds. *Family Time: the Social Organization of Care*, pp.7-24, London and New York: Routledge.

Gross, Jane. 2006. "As Parents Age, Baby Boomers and Business Struggle to Cope." *New York Times*, March 25.

Guralnik, Jack M., Suzanne G. Leveille, Rosemarie Hirsch, Luigi Ferrucci, and Linda P. Fried. 1997. "The Impact of Disability in Older Women." *Journal of the American Medical Women's Association* 52 (Summer): 113-120.

Harrington Meyer, Madonna. 2001. "Medicaid Reimbursement Rates and Access to Nursing Homes: Implications for Gender, Race, and Marital Status." *Research on Aging* 23 (September): 532-551.

Hoenig, H., D.H. Taylor, Jr., and F.A. Sloan. 2003. "Does Assistive Technology Substitute for Personal Assistance among the Disabled Elderly?" *American Journal of Public Health* 93(2) February: 330-7.

Johnson, Richard W. and Cori E. Uccello. 2005. *Is Private Long-Term Care Insurance the Answer?* Center for Retirement Research at Boston College. Issue Brief.

Johnson, Richard W. and Joshua M. Wiener. 2006. "A Profile of Frail Older Americans and Their Caregivers." Urban Institute. The Retirement Project, Occasional Paper No. 8.

Joslin, Daphne and Anne Brouard. 1995. "The Prevalence of Grandmothers as Primary Caregivers in a Poor Pediatric Population." *Journal of Community Health* 20(5): 383-401.

MacDonald, Martha, Shelley Phipps and Lynn Lethbridge. 2005. "Taking Its Toll: The Influence of Paid and Unpaid Work on Women's Well-Being." *Feminist Economics* 17 (March): 63-94.

McGarry, Kathleen and Robert F. Schoeni. 2005. "Medicare Gaps and Widow Poverty." *Social Security Bulletin* 66(1): 58-74.

MetLife Mature Market Institute. 2004. *The MetLife Market Survey of Nursing Home and Home Care Costs: September 2004*. Westport, CT: MetLife Mature Market Institute.

Organization for Economic Cooperation and Development. 2005. *Long-Term Care for Older People*. Paris: OECD.

Rich, Motoko and Eduardo Porter. 2006. "Increasingly, the Home is Paying for Retirement." *International Herald Tribune*, February 26.

Schoeni, Robert F., Linda G. Martin, Patricia M. Andreski, and Vicki A. Freedman. 2005. "Persistent and Growing Socioeconomic Disparities in Disability Among the Elderly: 1982-2002." *American Journal of Public Health* 95 (November): 2065-2070.

Shaw, Lois B. and Sunhwa Lee. 2005. "Growing Old in the US: Gender and Income Adequacy." *Feminist Economics* 11 (July): 163-198.

Shaw, Lois and Catherine Hill. 2002. *The Gender Gap in Pension Coverage: What Does the Future Hold?* Washington, DC: Institute for Women's Policy Research.

Stark, Agneta. 2005. "On the Need of a New World Order of Care." 2005. *Feminist Economics* 11 (July): 7-36.

U.S. Census Bureau. 2000. *Wealth and Asset Ownership*.
http://www.census.gov/hhes/www/wealth/1998_2000/wlth00-1.htm (accessed April 2006).

U.S. Census Bureau. 2005. "Fertility of American Women, June 2004." *Current Population Reports*, December 2005.

U.S. Government Accountability Office. 2005a. *Long-Term-Care Financing: growing Demand and Cost Are Straining Federal and State Governments*. GAO-05-546T.

U.S. Government Accountability Office. 2005b. *Labor Can Help Employers and Employees Plan Better for Their Future*. GAO-06-80.

VanDerhei, Jack and Craig Copeland. 2003. *Can America Afford Tomorrow's Retirees: Results from the EBRI-ERF Retirement Security Projection Model*. EBRI Issue Brief No. 263. Employee Benefits Research Institute. <http://www.ebri.org>.

Van Houtven, Harold and Edward C. Norton. 2004. "Informal care and health care use of older adults." *Journal of Health Economics* 23 (November): 1159-1180.

Wiener, Joshua M. and Jane Tilly. 2002. "Population Aging in the United States of America: Implications for Public Programs." *International Journal of Epidemiology* 31: 776-781.

Wolf, Douglas A. 1999. "The Family as Provider of Long-Term Care: Efficiency, Equity, and Externalities." *Journal of Aging and Health* 11 (August): 360-382.

Wolf, Douglas A. 2004. "Valuing Informal Eldercare." in Nancy Folbre and Michael Bittman, eds. *Family Time: the Social Organization of Care*, pp. 110-129. London and New York: Routledge.

Appendix: An Example of a Continuing Care Retirement Community (CCRC)

The CCRC I live in has features that allow the elderly, especially women living alone, to delay the time when they will need the full care of a nursing home. We are a not-for-profit community with over 1,000 residents, the majority living in independent living apartments. One meal a day is provided, but breakfast and lunch are available if desired. A small grocery store, beauty salons, doctor's offices, and a pharmacy are on the premises. About three-quarters of the residents are women, the majority of whom are widowed, divorced or never-married. According to a recent survey, only 2 percent are in their 60s, about 35 percent are in their 70s, over half are in their 80s, and 10 percent are 90 or over. (These figures may under-represent those in their late 80s and beyond as they are probably less likely to respond to written surveys.)

Although the population is definitely middle class, it is not limited to such a high-income population as some have supposed. Our friends are retired teachers, librarians, and housewives. Most of the men were civil servants, but one we particularly enjoy talking to was a train conductor. We continually meet people who have lived here for more than 10 years, some more than 20 years. People who need daily help usually move into assisted living, but a few hire their own helpers. A nursing home provides after-hospital care and physical therapy for those recovering from hip or knee surgery. Full long-term care is also available, including a special wing for Alzheimer care. There is also an adult day-care unit used as respite care by spouses of residents with early-stage Alzheimer's and by people in the surrounding community.

People offer each other help of various kinds. Those who still drive may take others shopping or to doctor's appointments. People who are becoming forgetful will

have friends to remind them to come to meals. People in the nursing home unit after surgery usually have well-wishers who send cards or flowers and visit them when they are well enough. This kind of friendly environment is particularly desirable for women who have no family or friends living nearby.

Although the nursing home unit does depend partly on Medicare and Medicaid funding, there is also a benevolent fund to help those whose income and assets fail to cover all their costs. Many residents contribute to this fund as do people in the surrounding community. No one has ever been asked to leave because of insufficient funds. In an area with lower housing costs than the one in which we are located, this kind of non-profit community, organized by religious or other voluntary groups, could offer a retirement alternative to a broader income-range of older people living alone.