AGEING IN THE UNITED STATES AT THE END OF THE CENTURY*

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The belief that America is a "young" nation is widely held by many individuals in the United States. Historically, individualism, self-reliance, and an orientation towards youth have been cherished values reflecting of our national heritage and tradition dating from the 18th through the mid-20th Century. However, America is no longer a "young" nation. Rather, we are an "aging" population, as we show in our analysis of demographic transitions reviewed in this paper. The phenomenon of "cultural (or structural) lag" is discussed in two different contexts: first—the context of the aging family; and second—the context of ethnic/racial minority groups. Finally, some of the relevant public policy responses to aging are described. We look at government programs in four major categories, namely, 1) income; 2) health care; 3) social services; and 4) housing.

INTRODUCTION

Many consider the United States to be a "youthful" nation. Americans give high priority to values such as independence, individualism, innovation, and vigor—values associated with the young—and the United States has always been a land of immigrants—mostly young adults and families. In fact, however, the U.S. population is aging. Almost one in six Americans are above the age of 60. One-quarter of the adult population is outside the paid workforce, in or approaching retirement. Teenage Americans today can look forward to spending well over half of their remaining years of life as grandparents, and most may become great-grandparents.

Demographic facts such as these reflect only some of the contexts and

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contradictions concerning aging in the United States at the end of the 20th Century. In this chapter we first present an overview of population aging in the U.S., noting the vast changes that have occurred since 1900 and emphasizing the remarkable diversity of American's older population. Second we discuss social structures and aging, emphasizing the phenomenon of "cultural (or structural) lag" in two social contexts: aging in families and aging in ethnic/racial minority groups. Third we describe recent public policy responses to aging in the United States, looking at government programs in four major categories: income, health, care, social services, and housing. We conclude with some observations about the future of aging in the United States.

THE DEMOGRAPHIC CONTEXT OF AGING IN THE UNITED STATES.

"The elderly" and "senior citizens" are terms often used to describe Americans aged 65 and over, as if they were a homogeneous group within the population. However, diversity—not homogeneity—is a more accurate way to characterize the older population in the United States (Bengtson, Rosenthal, & Burton, 1990; Treas, 1992). Because our social and economic diversities are so broad and so complex, it is often difficult to make valid generalizations about the U.S. elderly populations (see U.S. bureau of the Census, 1993a). For example, while many American retired couples in their 60s are enjoying their leisure with ample financial and/or family support, at the same time we have many widows in their 90s living in poverty or who are too frail to get into and out of bed without assistance each day (Treas, 1992). America's older population is growing, and America's elders are living longer into retirement; the United States has begun to experience the cultural changes that accompany an aging society.

Demographic Transitions and Population Aging

As with most societies, population aging in the U.S. is an historically recent phenomenon. The demographic factors which influence population aging are well-known: low fertility, low mortality, and to some extent, migration. In the 1930s, during the Great Depression period, demographers first began to express concern about population aging as fertility declines predicted future changes in the age structure of the population (Myers, 1990). It was then that the concept of demographic transition was proposed to characterize the joint effects of fertility and mortality on population age structures over time. As shown in Figure 1, there are four stages in the
demographic transition from a relatively "young" to an "aged" population. The first is characterized by high rates of both fertility and mortality, with the net result being a "young" and stable population (neither increasing nor decreasing in size). In the second stage fertility remains high, while mortality begins to decline; this combination results in gradual population growth over time. Stage three is characterized by declines in fertility as well as declines in mortality, with the result a slower rate of population growth and a net increase in population aging. The age structure of the population begins to resemble more of a "column" or a "beanpole" than a "pyramid" (which represents more young people at the Base, with fewer old people at the Apex), and the age structures of families show the same trend, with fewer vertical levels of generations and more growth horizontally within generations (Bengtson, Rosenthal & Burton, 1990; Bengtson & Silverstein, 1993). In the final stage of demographic transition, fertility and mortality are both low and population growth is almost zero; the population structure is stable with high proportions of older people (see Meyers, 1990). This is the four-stage course of "population aging" over time. Nation-states can be categorized as young, mature, or aged depending on the percentage of elderly relative to members of younger birth cohorts in the population.

How do trends of population aging in the U.S. compare with those in other parts of the globe? Table 1 shows contrasts in the percentage of older persons among major nations and regions of the world from 1970 through 2025 (projections). The definition of a "young" country or region is that less than 4% of the population is above the age of 65. One example of a "young"
population would be Mexico, which in 1990 had only 3.4% of the population elderly. In a "mature" population the elderly constitute at least 4% but less than 7% of the total population. The Republic of Korea is an


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example, with 4.8% of its total population being elderly in 1990. In an "aged" society more than 7% of the population are elderly individuals. Sweden now has 18%; England almost 16%; and the U.S., nearly 13%. Considering the demographic transition process and the percentage of the population aged 65+, it appears that America is presently in stage three of the demographic transition and already has achieved an "aged" population structure (see Maddox, 1987; U.S. Department of Commerce, 1993). By the middle of the 21st Century, most industrialized societies across the globe will be "aged" populations, as can be seen by the last column in Table 1.

Profiles and Projections of America's Older Population

An historical review of America’s population aging since 1900 helps to illustrate the changes occurring in industrialized nations. It is commonly believed that, at the beginning of the Twentieth Century, America was "young" population. The median age in 1900 was 23 years, with an average life expectancy of 47 years. In 1900, there were 3.1 million older persons in the U.S. and one out of every 25 Americans was aged 65 and over, representing 4.1% of the total population (Treas, 1995). What this means is that, even in 1900, the U.S. represented a "mature" population rather than a "young" one, in terms of the categorization of population aging described above. Figure 2 portrays the age distribution of our country from 1900 to 2030 (projection).

The "Baby Boom" which began at the end of World War II resulted in 75 million births during the period between 1946-1964. In Figure 2 the effects of the Baby Boom can be seen as a bulge in the age-population distribution that has been described as the "hour glass" curve or the "pig-in-a-python" phenomenon moving through historical time. These Baby Boomers, who in 1995 are between 31-49 years old, will contribute to a large expansion of the U.S. elderly population after the year 2011, when the first of them will reach retirement age. By the year 2030 the last of the "Baby Boom" cohorts will have become age 65 and older, and they will constitute 18% of the population. After 2030 the rate of increase in the older population will fall sharply as the smaller "Baby Bust" birth cohorts begin to turn age 65.

Over 31.1 million people age 65+ were counted in the 1990 U.S. Census, which was ten times more elderly than were alive in 1900. As of 1990, the median age in the United States was 34 years, while the average life expectancy of Americans was about 79 years for women and 72 years for men (Treas, 1995). For those who have already reached 65, women can expect to live on average another 20 years; men, another 15 years (Atchley,
Almost one in eight Americans were aged 65+ as of 1990, representing almost 13 percent of the total population—certainly classifying America as an "aged" society in demographic terms. Between 1990 to 2020, the U.S. older population is projected to increase to some 54 million people. By 2020 one in six Americans will be elderly, representing 17% of the total population (Treas, 1995). These projections assumed that present mortality rates will persist. However, if people continued to live longer and healthier lives, the projected number of elderly will increase even more (Crimmins, 1989; Fries, 1993).

In 1990 the oldest-old, those 85 and over, constituted about three million


persons and 1.2% of the total U.S. population. These "oldest-old" represent the fastest growing age segment of the American population. By 2020 it is projected that the oldest-old will increase to about 6.5 million (see Figure 3) and by 2050, they will have more than doubled, to 17.7 million (U.S. Bureau of the Census, 1993a). The total U.S. elderly population will have grown to about 80 million, which is more than twice the size of the present U.S. elderly population. One of every five, or 20%, of all Americans will be elderly in 2050.

**Diversity within American's Older Population**

One of the major characteristics of American society is its racial and ethnic diversity. Our older population will become more racially and ethnically diverse with each future decade. This is shown in the projections of Table 2. In 1990, 87% of the 31.1 million older Americans were Whites of non-Hispanic origins. This group is projected to decrease to 78% in 2020, and further decline to 67% of those aged 65 and over by 2050. Black elderly were the second largest elderly group in 1990, with 2.5 million persons 65+ comprising about 8% of the elderly population. The proportion of Black elderly will increase slightly over the years to about 10% of the elderly population by 2050. Hispanic elderly—the third largest category in 1990—
<table>
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<tr>
<th>Year</th>
<th>Total 65+ population</th>
<th>White</th>
<th>Black</th>
<th>American Indian, Eskimo, and Aleut</th>
<th>Asian and Pacific Inlander</th>
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<tr>
<td></td>
<td>Number</td>
<td>Total</td>
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<td>20,021</td>
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<td>26,952</td>
<td>66.7</td>
<td>2,492</td>
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<td>2000</td>
<td>35,322</td>
<td>31,357</td>
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<td>29,575</td>
<td>63.7</td>
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<td>2010</td>
<td>40,104</td>
<td>34,967</td>
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<td>32,205</td>
<td>60.6</td>
<td>3,435</td>
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<td>2020</td>
<td>63,340</td>
<td>45,740</td>
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<td>41,405</td>
<td>77.8</td>
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<td>2030</td>
<td>70,175</td>
<td>59,295</td>
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<td>52,333</td>
<td>74.6</td>
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<td>2040</td>
<td>77,014</td>
<td>63,858</td>
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<td>64,509</td>
<td>70.6</td>
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<td>2050</td>
<td>80,109</td>
<td>84,982</td>
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<td>53,597</td>
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Source:
The proportion of elderly Hispanics will increase to about 9 percent, and by 2050 they will make up about 15.5% of elderly Americans, more than 12.5 million people. The fourth racial/ethnic group, elderly Americans of Asian and Pacific Island origins, represented in 1990 a half-million persons, about 1.4% of the U.S. elderly population. This group will grow dramatically: by 2050 they will comprise 7.4% of the American aged population, numbering 6.2 million. Finally, about 100,000 American Indian, Eskimo, and Aleut persons 65+ were counted in the 1990 U.S. Census, 0.3% of the population; by 2050 their numbers will double (U.S. Bureau of the Census, 1993b).

A second aspect of diversity is reflected in marital status (Treas, 1995). As of 1994 approximately half (48%) of elderly women in the U.S. were widowed, compared to only 15% of elderly men. This can partially be explained by the fact that in the U.S. women have on average married men who were several years older than themselves. In addition, women have higher life expectancies than men, and a smaller percentage of women than men remarry following widowhood or divorce. In the future, gender differences in marital status are expected to continue.

We also see considerable diversity in terms of living arrangements. The majority of U.S. elderly lived with their spouse in 1992, but this generalization is not true for Black elderly. Only 37 percent of Black elderly lived with a spouse compared to 56 percent of elderly Whites, 54 percent of Asians, and 49% of elderly Hispanics (U.S. Census Bureau, 1993c). Differences in living arrangements among racial/ethnic groups can be partially explained by differences in marital status. Elderly Blacks are less likely to be married than the other groups. Asian and Hispanic elderly were not as likely to live alone as either Whites or Blacks. Only 16% of elderly Asians and 19% of elderly Hispanics lived alone, compared to 31% of Whites and 36% of elderly Blacks.

A common misconception about American elderly is that a large proportion are living in nursing homes, having been "put away" by their families into institutionalized living arrangements. In fact, the percentage of elderly who live in nursing homes is very small: in 1990 it was 5.1%, only one in 20 older Americans. However, the likelihood of living in a nursing home increases sharply with age. Although little more than 1% of those age 65 to 74 lived in nursing homes in 1990, almost half of those aged 95 and over were in hospitals or nursing homes (Figure 4). Over the past decade, the percentage of nursing home residents 85 and over has grown rapidly (42% in 1990 compared to 34% in 1980; U.S. Bureau of the Census, 1993c). The expansion of the oldest-old population—the percent of those 85+
almost doubled between 1980 and 1990—is the factor most contributing to the change in institutional living arrangements.

SOCIAL STRUCTURAL CONTEXTS OF AGING IN THE US

Changes in population characteristics over time have implications for social structures and social relationships over time. William Ogburn (1922/50) first suggested the term “Cultural lag” to reflect a pattern he observed in social history: that cultures—institutionalized patterns of behavior—change less quickly than do the population characteristics of human groups. Recently this idea has been applied as an explanation for some of the problems societies have encountered as a result of population aging during the last century. The concept of structural lag has evolved from the basic model of “age stratification” set forth 25 years ago by Matilda White Riley and her colleagues (Riley, Foner, Moore, Hess, & Roth, 1968; Riley, Foner, & Waring, 1988; Riley, Johnson, & Foner, 1972) in their Aging and Society. This model postulates a continuing interplay between two dynamisms as societies and their members move through historical time: Changing social structures and changing human lives over time.

Structural lag occurs when population members’ lives change faster than social structures—when there is a mismatch between people’s capacities, behaviors, and beliefs (as reflected in population aging, where by individuals are living longer, in better health, than in previous decades) and
the surrounding societal structures of role opportunities and constraints. The concept has proved useful in thinking about social change and aging in widely varied domains—ranging from the nation state to dying, and from work to leisure (as addressed in Riley's [1994] recent book on Age and Structural Lag). We will comment on two of these structural settings: aging within the multigenerational family and aging within ethnic/racial minority groups.

American Families and Their Elders

Many in the mass media and politics have claimed that the family is no longer the important institution it once was in American society (see Bengtson, Rosenthal & Burton, 1995). That many elderly Americans today are isolated from, or abandoned by, the families they have created is a frequent corollary to this view.

The most prominent sociological proponent of the "American family decline" argument today is David Popenoe (1988, 1993). He argues that "the family has been stripped down to its bare essentials—just two adults and two main functions: childbearing and the provision of affection and companionship to its members" (1993, p.540). The result, he claims, is that Americans today are less willing than ever before to invest time, money, and energy in family life, and are turning more to other groups and activities in an age of the "me-generation." "Adults for their own good purposes, most recently self-fulfillment, have stripped the family down to its nucleus. But any further reduction—either in functions or in number of members—will likely have adverse consequences for children, and thus for generations to come" (p.540).

Among family sociologists, Popenoe's views have touched off spirited debate by those who question a "decline" in the importance of families in America (Cowan, 1993; Skolnick, 1991; Stacey, 1993). Critics have argued, for example, that: (1) Popenoe's definition of "family" rests on an outmoded and conservative structural-functionalist interpretation of what families are, or should be; this minimizes and in fact scapegoats non-nuclear families, such as those with single parents, those without children, or those "unconventional" in other ways; (2) Popenoe's attribution of change in family structure and function to "a decline in family values" is misplaced; the growth of functions taken over by other societal institutions such as the state and formal education—rather than a lessening in family values—is the principal cause for nuclear family change; and (3) the most important is the fact that Popenoe confuses families with households. His definition of
family is a "relatively small domestic group of kin (or people in a kin-like relationship) consisting of at least one adult and one dependent child" (Popenoe, 1993, p.545), and this ignores many of the cross-generational kinship support structures evident in today's multigenerational families.

Are American elders victims of declining family structures and functions? A growing body of recent research evidence suggests not. These studies indicate that intergenerational bonds are perceived as remarkably strong by most family members in contemporary American society; that this is true for both emotional and instrumental connections involving family elders; and that there are positive consequences for both older and younger generations of such linkages (see reviews of current research by Bengtson, Rosenthal, & Burton, 1990; Bengtson & Silverstein, 1993; Blieszner & Bedford, 1995; Goldscheider, 1990; Marshall, Matthews, & Rosenthal, 1993; Ryf & Seltzer, 1995).

Several important studies published recently document these conclusions. Rossi and Rossi (1990) have demonstrated the extensiveness of intergenerational cohesion (in terms of affect, interaction, and help exchange between generations) in their Boston-area study—providing a model for the complexities of activities "bonding" involving older and younger generational kin. Bengtson and Harootyan (1994) report data from a nationally representative AARP survey that indicate extensive linkages across generations involving older family members. Elder, Rudkin, and Conger (1994) demonstrate the strength of intergenerational ties even during economic catastrophe—their sample represents multigeneration Iowa families who lost the "family farm" during the economic downturn of the 1980s. Soldo and Hill (1994) document the extensive nature of intergenerational transfers in the recently completed Health and Retirement Survey, as do Eggebeen and Hogan (1990) in the National Study of Households and Families. Silverstein and Bengtson (1991, 1994) report the long-term consequences of parent-child solidarity over time in the Longitudinal Study of Generations, and find that close ties enhance not only the psychological well-being of aging parents but also decrease their mortality risks—in particular, that widows with high intergenerational solidarity live longer. Roberts and Bengtson (1993) demonstrate that close relationships with parents in late adolescence is related to their self-esteem and psychological well-being far into middle age.

Research concerning the long-term caregiving needs of frail elders in American society suggests one principal conclusion: that families are their primary and most effective source of support. Family members provide 60-80% of long-term care for dependent elderly members, and formal or
institutional mechanisms become activated only after family caregiving resources are expended. This is documented in extensive research reviews by Abel (1990), Brody (1985), Dwyer (1995), Gatz, Bengtson, and Blum (1990), Maddox and Lawton (1993) and Matthews (1988).

It is becoming clear that large numbers of American family elders are involved in kinship roles beyond that of the traditional grandparent. Many are "surrogate parents," primary caregivers to their grandchildren (or great-grandchildren) following the divorce or incapacity (through disease, drugs, AIDS or incarceration) of the middle generation. Chalfie (1994) has documented that an increasing number of American grandparents are assuming full-time responsibility for their grandchildren: the number of youngsters living in households headed by grandparents has increased by over 50% since 1970, to more than 3 million, and in 33% of these families, neither parent of the grandchild resides in the household. Troll (1985) suggests that grandparents are often the "family watchdog," keeping a low profile until a crisis threatens the younger generations, when they spring into action to protect and to serve; Johnson (1987) documents increased involvement with grandchildren following divorce; Burton (1992) describes the activities of both grandparents and great-grandparents raising children of drug-addicted parents. And finally there is great-grandparenthood. Doka and Mertz (1988) and Wentowski (1985) note that, as a social role, great-grandparenthood was virtually unknown only a few decades ago, but it is becoming increasingly common today. These kinship functions of elders have been ignored in the "American family decline" arguments to date.

Norms and values supporting intergenerational connections appear to have high salience for most Americans today—contrary to conventional wisdom about the detachment of "Generation X" (the "Baby Busters," born after 1965) from such linkages (Bengtson & Parrott, 1994). Recent data from national and cross-national surveys (see Bengtson & Harootyan, 1994; Hogan & Farkas, 1995) provide evidence for strong normative support of cross-generational linkages, reflecting equally strong values about the desirability of such connections.

The concept of structural lag is useful in explaining what appears to be a paradox concerning intergenerational family relationships in America at the dawn of the 21st Century. On the one hand, demographic changes reflected in population aging have led to an increase in the average length of time that older Americans may spend in grandparent and great-grandparent roles, as well as the great responsibility for some in caretaking for their grandchildren and great-grandchildren. One the other hand, many contemporary assessments of the "American Family"—from sociologist
Popenoe (1993) to politician Newt Gingrich—appear to focus on a restricted and outdated conceptualization of the family as a household of two parents and their children. This ignores two things: (1) the increase in years of “shared lives” between adult children and parents, and between adult grandchildren and grandparents or great-grandparents; (2) the emerging pattern of high intergenerational support mechanisms found in family today.

Aging in Ethnic/Racial Minority Groups and Families

A second example of “structural lag” concerns discussion of minority groups within American society. Here we will focus again on the family, a principal dimension of social structure. Generalizations about ethnic or racial minority American elders frequently contradict each other: on the one had there is the belief that racial minority families—such as African-Americans—are disorganized and chaotic. On the other hand there is the opinion that ethnic/racial minority elders are embedded in stronger and more durable kin networks than whites, that they have greater numbers of people who can provide support for them because of higher fertility rates, extended family living arrangements, and the incorporation of fictive kin (non-blood relatives) in definitions of family (Angel & Tienda, 1982; Chatters, Taylor, & Jayakody, in press; MacRae, 1992; Rogler & Clooney, 1989; Ruggles, 1994; Sanchez-Ayendez, 1988).

The “disorganization of minority families” generalization comes from views in the 1950s and 1960s, to the effect that minority families were “pathological”—that they displayed more problems, more deviance, and less adequate socialization than white majority families (Dilworth-Anderson, Burton, & Boulin Johnson, 1993). During this period, social deficits in every major aspect of minority family life were widely publicized: problems in family structure, family decision making, fertility, and child rearing. This perspective is primarily associated with Senator Daniel Patrick Moynihan’s (1969) report which suggested that black American families were involved in a “tangle of pathology” at the heart of the deterioration of black communities.

In response to this perspective, however, a significant body of research emerged that stressed the strength of minority families (Billingsley, 1968; Hill, 1971; Staples, 1981). For example, in studies of the black family, some researchers (Gutmann, 1976; Martin & Martin, 1978; Stack, 1974; Taylor, 1990) found blacks are involved in extensive kin and pseudo-kin networks. Among Native-Americans, the family is defined as everyone in the tribal
group or community, and relationships are close regardless of whether one is related by blood (Red Horse, 1980). The needs of the family collectively supersede the needs of each individual member. Mutual financial assistance, exchange of work and other skills, and advice and support in solving personal problems are ideally available in the traditional Mexican family from the extended kin group. Grebler, Moore, and Guzman (1970) note that the major theme dominating the classic portrayal of the traditional Mexican family is the deep importance of the family to all its members.

While this emphasis on the strengths of extended kin dynamics in minority families provided a useful correction to the stereotypically negative portrayals in earlier accounts, it may have led unwittingly to a new myth, suggesting to policy makers and program developers that since minority families are so strong they do not need as much assistance from governmental agencies or programs providing support to families.

However, recent studies that have systematically compared kin assistance among representative samples of black, Hispanic and whites have not found superior support networks among minority families (Eggebeen & Hogan, 1990; Hofferth, 1984; Hogan, Hao, & Parish, 1990). Moreover, the strength of familial ties among ethnic minorities must not be considered to be invariantly high. There is extensive variability both within and across minority groups in the prevalence of strong familial ties. Sensitivity to ethnic group diversity clearly has implications for the appropriate planning and implementation of programs for minority elders.

And another factor must be mentioned: while minority elders may have a large extended kin network, this also means that the elders potentially have more people for whom they must provide support.

Declining economic conditions facing minority families, especially those who live in poor inner-city neighborhoods, strain the capacity of kin networks to provide support (Eggebeen & Hogan, 1990; Farley & Allen, 1987; Hogan et al., 1990). The cost of being in extensive kin networks has been noted in recent studies of grandparenthood (Burton, 1992; Burton & Dilworth-Anderson, 1992; Minkler & Roe, 1993; Burton, Dilworth-Anderson, & Merriwether-deVries, 1994; Tinsley & Parke, 1984). The numbers of grandparents who are surrogate or co-parents for the children of adolescent mothers are rapidly growing (Chalfie, 1994; Field, Widmayer, Stringer, & Ignatoff, 1980; Furstenberg & Crawford, 1978). For example, Colleta and Lee (1983) found that, for 66% found that, for 66% of the black teen mothers they interviewed indicated, their mothers (the grandmothers) were the primary caretakers of their children. Chase-Lansdale, Brooks-Gunn, and Reiss (1989) note that three-quarters of the children of teen
mothers live in households with their grandmothers or great-grandmothers during their first three years of life.

A number of studies have documented that grandparents do a great deal as care providers for their grandchildren (Stevens, 1984; Wilson, 1986). However, little has been written about the costs to the grandparent of assuming such parental responsibilities. Burton’s (1990) case study of a black grandmothers’ support group illustrates the impact of surrogate parenting on the grandparental role. Many of the grandmothers, who assumed the parenting role with their grandchildren because of the parent’s drug dependency, were in poor health. Many had assumed primary care not for just one, but several of their grandchildren and great-grandchildren because the parents were chronic drug abusers. These grandmothers raising grandchildren identified five areas of needed social service support: (1) respite child care to relieve strain from constant caregiving for their grandchildren and great-grandchildren; (2) physical or mental health care for themselves; (3) legal counseling concerning foster care and guardianship; (4) financial assistance; and (5) training programs for coping with family members who were drug dependents (Burton, 1990).

The research reviewed above suggests another example of structural lag. In America’s ethnic/racial minority communities, cross-generational support patterns are increasingly strong; but are often perceived as deficient or weak.

THE CONTEXT OF PUBLIC POLICY RESPONSES TO AGING IN THE U.S.

In the Nineteenth Century and early part of the Twentieth Century, aging was considered a personal problem to be dealt with by individuals and their families. Only gradually, when faced with increased economic difficulties for elders and changes in the labor force which pushed older persons out of their positions and left them financially vulnerable, American society began to respond to aging as a social problem, requiring a public response. The introduction of a social insurance program in 1935 to help support the economic well-being of the elderly established a legal relationship between America’s elderly and the federal government. This “contract” grew from the 1950s through the early 1970s, has experienced strains since the 1980s, and is currently under political and economic criticisms which will soon lead to a revision of the “contract across generations” in American (Bengtson 1993).

What was once considered a sacred link between seniors and policy makers in the United States has been questioned at its very foundations,
and newly elected political officials are proposing dramatic changes to the relationship between the federal government and the elderly, as well as challenging the fundamental philosophical assumptions of government (public) versus individual (private) responsibility for the problems associated with old age.

While no single policy toward the elderly exists in the United States, a loosely connected system of programs and services in different policy domains have evolved. The four main policy areas are employment and retirement, health care, social services, and housing, as will be discussed below.

*The history of Old age Policies at the Federal Level*

In 1933, in response to the social and economic consequences of the Depression as well as the increase in the number of Americans over 65, the Roosevelt administration began to react to human needs by creating programs for specially targeted groups such as the elderly. The first major policy to institutionalize a formal relationship between the federal government and the elderly was the Social Security Act of 1935 (Hendricks & Hatch, 1993). This law established a public social insurance program to which older persons contributed a portion of their earned income to a trust fund while working. Upon retirement at age 65 or older, persons who contributed to the system received monthly payments from the program. Subsequent amendments to the act expanded the proportion of the working population covered and later added cost of living adjustments to the benefits paid out (for more details see Kingson & Berkowitz, 1993).

Thirty years later, the U.S. government legislated two other landmark programs that responded to the needs of an aging population: Medicare and Medicaid (for program details see Kingson & Berkowitz, 1993). The first is a health care social insurance program which individuals contribute to during working years and then draw from in retirement, while the second is a means-tested health care program that is reserved for the poor, blind, or disabled. Many elderly fit at least one of these categories in 1965.

The 1960s was a period of growth in which the federal government's role in the lives of American individuals and families increased; aging programs flourished during this time (Achenbaum, 1988). Congressional leaders responded to the problems associated with aging in a generous fashion. For example, the Older Americans Act of 1965 identified the federal government's goals for the elderly and mandated a system be established to coordinate programs for the elderly and provide them assistance. This act
created what has been called "the aging network," a system of state and local programs and services for senior citizens in need (for details see Gelfand, 1993). In addition, many public housing programs benefiting the poor elderly expanded during this time (see Koff & Park, 1993).

The 1960s was also a period in which new interest groups representing the needs of the elderly were created (for discussion see Pratt, 1976), many of which hired professional lobbyists to advocate their causes in Washington, D.C. Research devoted to the aging process and problems associated with aging gained more funding with the creation of the National Institute on Aging in 1974 (Koff & Par, 1993). This institute was established by Congress and charged with supporting research and training related to aging and the needs of the aged.

However, in the early 1970s the emphasis in federal government began to shift from expansion to cost-containment and incrementalism (Achenbaum, 1988; Estes & Newcomer, 1983). What this meant for the elderly was more means-tested benefits, a fixed amount of resources, and no new "big government" programs. In the 1980s policies such as the prospective payment system were put in place to control the cost of spending on health care for the elderly. This policy set limits on reimbursement rates for Medicare payments in an effort to control hospital costs. Concerns also shifted from extending life to the costs of extending life (Callahan, 1987). And, in anticipation of the aging of the Baby Boomers, policymakers debated the implications of a decreasing working age population for the two major social insurance programs of Social Security and Medicare (see U.S. Select Committee on Aging, 1993). A persistent question is how these programs will be financed by decreasing revenues from payroll taxes as the size of the workforce shrinks.

In the past year, the "purse-tightening" concerns in Washington have dramatically increased. With the November 1994 change in leadership controlling the two major houses of Congress (control went from the Democrats to the Republicans), previous "welfare" programs began losing support—including provisions for the well-being of the elderly. Much concern has been raised about the viability of the Social Security program, and legislation to reduce future growth in spending for Medicare health benefits have been proposed. Moreover, appropriations for several smaller programs, including food stamps, heating and energy assistance, and housing have been reduced. It is likely that appropriations for the Older Americans Act will be reduced, as will search money allotted to the National Institute on Aging.

In short, as of 1995 many federal programs designed to benefit the
growing population of older Americans are either being contained at
current levels, shrunk, or eliminated. The response of interest groups
representing the elderly has been predictable: criticism of plans to cut
programs and fear about the future well-being of senior citizens, especially
the vulnerable elderly who tend to be women and minorities who are below
the federally established poverty level (for a discussion of inequities in
aging policy provisions see Hendricks, 1994).

The trend that began in the 1980s, and is likely to continue into the 21st
Century, is this: more state and local—rather than federal—responsibility
for aging programs, and less federal money to support states and local
efforts. Moreover, more calls are being made for the private sector to step in
and take over some of the federal and state governments' responsibilities
for vulnerable populations (Hudson, 1994). In light of the demographic
trends summarized earlier, many gerontologists do not feel this is feasible.
This raises the specter of age-group conflicts because of growing
perceptions that American society's "contract across generations" is being
broken (Bengtson, 1993; Bengtson & Parrott, 1995).

Major Public Policies for the Aging in an Aging Society

The programs that the U.S. federal government established for the elderly
in the 1960s and 1970s can be analyzed in four major categories: income and
employment, health care, social services, and housing. Table 3 summarizes
these categories and gives a few examples of each (for an overview of each
policy area see Kim, 1994).

Income and employment policies: These have had the goal of either securing
an income for retired persons or protecting them in their work status. Some
programs focus on the segment of the older population that are poor or
near-poor, while others are "entitlements" by age, regardless of need.

For example, The Social Security Act has the goal of making sure that
when elderly persons retire from the paid work force they have a stable
source of income to help support them. In 1983 steps were taken to ensure
that the Social Security Trust Fund surpluses would be built up, in
preparation for the retirement of the Baby Boomers, so that the system
would remain viable through 2029. Supplemental Security Income is a
welfare program for older persons who are economically disadvantaged,
living below the poverty level. In contrast to Social Security, eligibility for
benefits from the Supplemental Security Income program are not based on
whether or not an older person worked in the paid labor force; this program
is based on economic need. Funding for Supplemental Security Income has
been less stable than Social Security and there is great variation in benefit
<table>
<thead>
<tr>
<th>POLICY AREA</th>
<th>EXAMPLE PROGRAMS</th>
<th>BRIEF PROGRAM DESCRIPTION</th>
</tr>
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<tbody>
<tr>
<td>Income and Employment</td>
<td>Social Security</td>
<td>— Financed by payroll taxes, this is a mandatory social insurance program that protects retired workers. Some benefits are taxed and age eligibility and earned income restrictions exist.</td>
</tr>
<tr>
<td></td>
<td>Supplemental Security Income</td>
<td>— A means-tested income maintenance program. Unlike Social Security, this welfare program is not linked to workforce participation.</td>
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<td></td>
<td>ERISA</td>
<td>— A program to regulate and insure private pension plans.</td>
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<td></td>
<td>Age Discrimination in Employment Act</td>
<td>— A law making age-based mandatory retirement illegal.</td>
</tr>
<tr>
<td>Health Care</td>
<td>Medicare</td>
<td>— Hospital insurance program, eligibility for which is determined by eligibility for Social Security. An optional medical insurance program is also available and requires a co-payment from the elderly.</td>
</tr>
<tr>
<td></td>
<td>Medicaid</td>
<td>— This is a program of &quot;grants of aid&quot; to states to help finance medical care for the poor. Medicaid funds a large portion of nursing home costs for the elderly.</td>
</tr>
<tr>
<td>Social Services</td>
<td>Older Americans Act</td>
<td>— A system of agencies to coordinate and develop programs for the elderly. This act includes provisions for transportation, legal assistance, education and job training, nutrition programs, senior centers, and other community-based social services.</td>
</tr>
<tr>
<td>Housing</td>
<td>Section 202/Section 8</td>
<td>— A loan program to support construction of low-income housing. / A rent subsidy program for private housing.</td>
</tr>
<tr>
<td></td>
<td>Congregate Housing</td>
<td>— Housing offering a &quot;sheltered environment&quot; for elderly residents. Various housing acts exist to support these group living arrangements.</td>
</tr>
<tr>
<td></td>
<td>Home Equity Conversions</td>
<td>— Policies allowing seniors to use the equity in their homes to pay for health care and other old-age expenses.</td>
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*Adapted from Gelfand (1993) and Koff and Park (1993).
levels between states.

The Employees Retirement Income Security Act (ERISA), established in 1974, set up federal standards for pension plans and created the Pension Benefit Guaranty Corporation, a corporation charged with insuring pension programs (see Employee Benefit Research Institute, 1990). While participation in pensions at one time rose to more than half of the working age population, now less than fifty percent of the paid work force have a pension plan. One reason for the drop in pension coverage is because of the change in the labor force: there are more people with flexible jobs and jobs that lack benefits or who are laid off by employers and then re-hired as consultants with no job benefits. ERISA, while it cannot make a company offer a pension plan, does require companies to retain enough financial resources to fund pension plans. The corporation charged with insuring plans is supposed to help protect workers from fiscally irresponsible company policies which lead to under funded pension plans and plans that fold and leave retired employees with no benefits.

The Age Discrimination in Employment Act of 1978 made age-based mandatory retirement illegal. This policy targets discrimination in hiring and firing practices and protects older workers that are on the job.

Health care policies: These provide older persons access to health care in retirement (many people have health insurance benefits through their employers, but lose this coverage when they retire) or when they lack the financial resources to purchase health care on their own due to poor economic status.

Medicare is the major health insurance program established specifically for senior citizens. This program has two sections: Part A covers hospital insurance and is set up like a social insurance program and financed through payroll taxes; Part B is an optional medical insurance program that requires a co-payment from older persons. In order to be eligible for Medicare, a senior citizen must be eligible for Social Security. Similar to Supplemental Security Income, Medicaid program is partially funded by grants-in-aid from the federal government to states and by state funds, thus the extent of medical care that is covered varies by state. Increasingly, Medicaid has been paying for the high cost of nursing home care for the frail elderly in the United States.

The long-term outlook for both health care programs are major concerns for current policy makers and advocates for the elderly. The Medicare program is projected to be in deficit in seven years if current levels of spending and growth persist (Bipartisan Commission on Entitlement and Tax reform, 1994). Recently, proposals to cut future spending on boty
programs have gained momentum.

Social Services: The older American Act of 1965 established a system of agencies throughout the country to coordinate and develop programs that serve and assist the elderly (see Gelfand, 1993). This program helps support services that range from nutrition and health screening to transportation to educational and job training for seniors. This program also helped to set up senior activity centers in communities nation-wide; these are places where older persons can gather for activities, social support, information, and assistance. Some funds from this act also go towards training professionals to work for or with the elderly. Funding for the Older Americans Act has been diminished and many scholars have questioned the successfulness of these services and the broad scope of the Act’s mission (see the journal, Generations, Volume XV, Number 3, 1991 for an in-depth review of the Older Americans Act and its twenty-five year history). Lately, there has been a push toward focusing social services funded by the Older Americans Act on minority populations of senior citizens and those with the greatest needs.

Housing: The Housing Act of 1956 was the first housing policy to include elderly persons in the category of persons eligible for low-income family housing (McGuire, Walker & Cooper, 1987), but it was not until 1962 that the first housing project for elderly low-income residents was built. Public housing in the U.S. is part of the larger welfare system, which provides access to public housing programs that serve the elderly as well as low-income housing.

Congregate housing is another type of housing that has been developed to deal with the needs of the elderly. This type of living environment offers a “sheltered” residential group-living space for the elderly, and this type of arrangement may provide meals and some social services to residents.

Home equity conversions have recently become popular in the United States. Since the largest asset that many older persons have is their home (sometimes the elderly are called “house rich but money poor”), these programs allow older persons to use the equity in their homes to pay for health care and other expenses incurred in old age.

The Future of Aging Policy:

Some of the major dilemmas facing policies for an aging population in the U.S. include the following: the U.S. federal budget deficit, possible changes to old-age eligibility for benefits, claims for “intergenerational equity,” and current trends toward scaling back programs.

The federal budget deficit in the U.S. has been an on-going concern for the
past two decades. Of particular import for aging policy is that while the Social Security programs is running a surplus, the future outlays from the program’s trust funds will be greater than the money coming into the fund (U.S. Select Committee on Aging, 1993). Projections by the Social Security Administration predict the trust fund will be in deficit by 2029. Another aggravating factor is that the U.S. Treasury uses surplus funds to purchase treasury bond that help finance day-to-day government operations. These bonds are essentially I.O.U’s that are placed in the trust fund. Many policy analysts and aging interest group leaders are worried that government leaders will be tempted to either cut benefit pay-outs to decrease the deficit, or use up the trust funds to finance deficit spending and be unable to pay back the I.O.U.’s when they come due.

Coupled with the growing discussion of cutting Social Security benefits is the possibility that changes will be made to the eligibility requirements for receiving retirement benefits. Currently, Social Security benefits are an entitlement—any retired worker who paid into the system for a given number of years and who meets the age requirements is eligible for receiving benefits, regardless of his or her retirement income. Policymakers are considering alternative eligibility schemes which would be based more on need than entitlement (for further discussion see Binstock, 1994; Kingson, 1994; Silverstone, 1994). Changing the nature of the eligibility standards would change the overall goal of the program and could possibly undermine public support for the system.

Claims for “intergenerational equity” also threaten many old age programs, including Social Security and Medicare (Bengtson & Parrott, 1994). Many children’s advocacy groups have claimed that the elderly are receiving more than their fair share of public monies and it is time that other groups were given priority (for a demographer’s viewpoint see Preston, 1984). Intergenerational equity proponents (for an example see Kotlikoff, 1992) argue that the tax burden on younger generations is greater than that of past generations and that the elderly have had a better standard of living than future generations will have. Or, as one magazine put it: “The greedy geezers are stealing our children’s inheritance!” (Chakravarty, 1988). A backlash against entitlement programs has been the result of equity demands and a move to provide benefits based on need is the underlying theme.

Last, current trends toward scaling back programs and ending entitlement increases is underway in Washington, D.C. How much real change will actually occur is still unclear, and the 1996 presidential election politics may very well get in the way of reform. However, it is evident that
for the first time in history the two major programs for the elderly which were once considered "untouchable"—Social Security and Medicare—are now on the cutting block and are less likely to escape budget cuts unscathed than ever before. Indeed, as this chapter is being written, the new Republican majority in Washington is drafting legislation to reduce future Medicare spending. Ironically, the $270 billion in cuts proposed for Medicare is nearly the same as the tax cuts they propose to benefit higher-income Americans.

SUMMARY AND CONCLUSIONS: AGING IN THE U.S. IN THE 21ST CENTURY

Many Americans hold to the belief that we are a "young" nation, and cherish our historical values of individualism, self-reliance, and individual productivity which are a legacy of our nation's development from the 18th through the mid-20th Century. In fact, however, we are today an "aging" population, in terms of the demographic facts reviewed in this chapter. And, like most other industrialized nations, we are now only beginning to face the consequences of "population aging"—in terms of changing social structures and challenges to existing public policy provisions.

In this chapter we have summarized the demographic transition of the United States by presenting a number of facts such as these: One in eight Americans are above the age of 60. One-quarter of the adult population is outside the paid workforce. And teenage girls can look forward to spending well over half of their remaining years of life as grandmothers.

Demographic facts such as these reflect only some of the contradictions about aging in the United States at the turn of the 20th Century. We have also discussed social structures and aging, emphasizing the phenomenon of "cultural (or structural) lag" in two social contexts: the aging family, and ethnic/racial minority groups.

We have described some public policy responses to aging in the United States, looking a government programs in four major categories: income, health care, social services, and housing. We noted that policies are presently in a state of flux, reflecting the proposal by House and Senate conservatives to balance the budget by reducing welfare benefits.

At the beginning of the 21st Century, aging in the United States will be very different from what it was at the beginning of the 20th Century. Our population characteristics have changed, particularly as regards age and race. Our social structures have changed—not, perhaps, as fast as have peoples' lives. Our public policy programs have changed: 100 years ago
there were no public provisions for the elderly; 30 years ago there began a burst of governmental programs benefitting the aged; and in 1995 those programs are being reduced. It remains to be seen what the long-term reductions will be. But one thing is sure: growing old will be quite different in the decades to come.

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