

WHAT RESEARCH TELLS US ABOUT AGING AND INEQUALITY - AND HOW THIS MATTERS TO WELFARE STATES

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We live in an aging world. The dramatic increase in life expectancy means that societies around the world are gaining an additional one million older persons each month.<sup>i</sup> If the growing number of elderly people were all financially independent and enjoying good health this would not be a resource challenge.<sup>ii</sup> However, the elderly generally have more health challenges compared to younger citizens. In addition, while there are improvements in health and other old-age outcomes, these have been unevenly distributed between the rich and the poor, and between those of high and low education.<sup>iiiivv</sup>

This “unequal aging” is a phenomenon which can be observed even in advanced welfare states. Even in my own country of Denmark with a Scandinavian welfare state that provides universal and free access to health care – a 40 year old who has completed primary education can expect to live 5.1 years less than his/her higher educated peers.<sup>vi</sup> Life expectancy is not the only outcome where old-age inequality is reflected. Already at age 50 a large social class difference can be observed in physical functioning between individuals from low and high occupational social class.<sup>vii</sup> These disparities are reflected in public health expenditures, where elderly Danes from the lowest income quartiles have higher health and elder care expenditures than their richer peers from the highest income quartiles.<sup>viii</sup>

The puzzle remains: why can we observe unequal aging even in advanced welfare states?

*In this policy brief I will examine some basic facts on how social inequalities shape life in old age, based on the existing literature, and I will discuss the major policy implications that these findings have for welfare states facing aging populations.*

## **How Social Inequalities Shape Life in Old Age**

**Socioeconomic status** represents education, income, neighborhood, and occupational features that affect individuals’ life chances throughout their life-course. Several studies have found enormous health disparities across socioeconomic groups in terms of the incidence, prevalence and burden of disease, the mortality rate, and other negative health outcomes in old age. These differences have been explained through the following mechanisms:

First, at the broader level, scholars theorize that *‘the enduring association [between socioeconomic status and health] results because [socioeconomic status] embodies an array of resources, such as money, knowledge, prestige, power, and beneficial social connections that protect health no matter what mechanisms are relevant at any given time’*<sup>ix</sup>. Thus **socioeconomic status is a fundamental cause** of health inequalities. And inequality tends to **accumulate over the life course**.<sup>x</sup> Taking education as an example, throughout their life course individuals of lower socioeconomic status are exposed to a different set of risks and opportunities than individuals of higher socioeconomic position<sup>xi</sup>. Less educated workers, for instance, tend to take up more precarious jobs, and also experience less job security than their higher educated peers. In old age the result is, among other things, less accumulated wealth and pension.

Second, much research focuses on the powerful effects of **lifestyle and life choices** on extending both the quality and quantity of years spent in old age. The key identified beneficial mechanisms include: avoiding health risk behaviors such as smoking and excessive drinking; adhering to healthy food consumption and controlling weight; engaging in regular physical activity. In all of these areas, poorer health behaviors tend to be correlated with lower socio-economic status. However, inequality in old age is not primarily the result of individual *choices* and actions but is structurally generated, and thus it is rather a result of *life chances*.

Third, a number of studies have documented the detrimental effects of healthcare being less available to elderly of low socio-economic status. While this inequity ought to be a lessor concern in universalistic welfare regimes, where citizens enjoy full coverage, the **quality of care** remains an issue. Research shows that elderly of high socioeconomic status benefit more from treatment, and enjoy better chances of recovering from disease than do their low socioeconomic status peers

Fourth, social class tends to **intersect with other sociodemographic factors**, such as gender, race, and minority status, in shaping old age. Taking gender as an example, women's traditional responsibilities for unpaid domestic labor in the home shapes their retirement by lowering their potential accumulated income in old age. Since women also often outlive their partners,<sup>xii</sup> they may face particular economic strains when reaching old age.<sup>xiii</sup> Thus low socioeconomic status women face an additional risk of being economically disadvantaged in old age<sup>xiv</sup>. Furthermore, women often take upon themselves the care responsibilities of family members who are ill, resulting in continued informal labor even when having reached retirement age.<sup>xv</sup>

Based on these findings on how social inequalities shape old age outcomes, I will now turn to suggesting three areas which welfare states should prioritize in order to address the problem of unequal aging.

### **What Can Welfare States Do to Tackle Unequal Aging?**

#### *Early and targeted interventions*

Risk factors, resulting from poor socioeconomic position, tend to accumulate over the life course resulting in adverse health and social outcomes in old age. Recognizing the life-course nature of unequal aging calls for policy-makers to promote early-life interventions. Such interventions should aim at improving equal access to educational attainment in early life, as well as job-security and healthy working lives in mid-life. This again means that welfare states need to introduce labor market policies that favor a better work environment at much earlier ages rather than shortly before retirement. Furthermore, despite the longevity revolution and the past decades' improvements in the health of adults above the age of 65, progresses in late-life outcomes are unevenly distributed between social groups. Thus, welfare state policies should make sure to facilitate a good senior life not only for the majority of elderly citizens who may live to enjoy a healthy senior life, but should prioritize interventions targeted to those elderly who are frail or isolated, those who have accumulated few material and social resources throughout their life-course, and those whose functionality is affected by chronic conditions or cognitive decline.

*Improved formal care*

It is well established that a strong social network, and especially marriage, serves as an asset when coping with disease and disability in old age. However, this resource is not always available to elderly who lack close social ties. At the same time, spouses who may function as primary care-givers are often themselves of old age, and the majority of adult children who care for their aged parents are still active on the labor market. As a result, care-givers often have to juggle work obligations with the requirements of caring for their older dependents. Some studies find that taking care of an ill spouse or parent has adverse impacts on the care-giver in terms of increased morbidity and mortality rates among care-givers.<sup>xvixvixviiiixix</sup> Collectively, this calls for the establishment of a strong and publicly financed *formal* care-regime which offers not only assisted living facilities, (in fact most older adults wish to stay in their own home as long as possible) but also high quality home care services, as well as support to potential informal care-givers.

*Flexible reforms*

As a result of the increasing old age dependency ratio (the number of dependents aged over 65 compared to the working-age population aged 15 to 64) public expenditures on health and elder care services are expected to rise dramatically in the next 30 years, and welfare states are bound to respond to this transition by introducing labor market and pension reforms. A focus on unequal aging calls for attention to at least two factors which are important in the process of reforming the welfare state. First, an increased *fixed* retirement age does not seem reasonable: whereas most workers could work longer, workers with health problems need to retire earlier. Rather, a *flexible* retirement system which gives early exit-routes to those in need seems to be an appropriate way of dealing with the heterogeneity of the old age working population.<sup>xx</sup> Second, there is a need to nurture intergenerational solidarity in order to maintain the support for the welfare states and taxes to finance comprehensive health and elder care programs.

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