

LIVING LONGER, LIVING BETTER: Policy Presumptions and New Family Structures

By
Elizabeth A. Kutza, Ph.D.

Introduction

Public policies, as mechanisms for social problem solving and social support, are slow to respond to changing social conditions. Policies are uniquely temporal, and when enacted, presume a state of the world that remains relatively fixed. It takes a long time for new facts and changing realities to be reflected in our public policies. The end result is a growing divergence between what *is* in society and what is needed in social policy. In addition, policies often embody a normative view of social institutions, a view that expresses how we would like things to be rather than how they are.

One area in modern American society that is firmly rooted in normative assumptions is "the family." The prominence of the concept of "family values" in policy debates gives evidence to such normative assumptions. How policymakers view families--their structure, roles, strengths and weaknesses--will shape the programs they develop.

New family structures

Every social institution, be it church, neighborhood, a community, or government, carries with it a symbolic meaning that sometimes is more powerful than its reality. And because being a member of a family is a universal human experience, no institution has more such symbolic meaning for individuals than "family." "The family" evokes a visual impression, a mental picture of two parents, living together with their children, providing both physical and emotional support and nurturance. We all know that this is what the typical American family is *suppose to* look like. This image presumes several things. It presumes that to be a family, there must be co-residence, that is, everyone in the family lives together. It presumes that "family" involves children. It presumes that adults are only bound as a "family" by blood or marriage. And, in many ways, there is an implicit assumption that the functions traditionally performed by families for individuals--emotional support, nurturance, financial support, protection, caring--cannot truly (nor perhaps legitimately) be filled by other social networks.

But social institutions are not static; they are dynamic. And, they come in diverse forms. There is no one, typical family structure or type in the U.S. today. The definition of family varies by historical period and social context. For example, there can be no denying that the number of families that represent the "ideal type" of family consisting of husband, wife and children living together has declined in the past half century. In 1960, 88 percent of children lived in a two-parent household; in 1998, only 68 percent did. Of the remaining 32 percent, four-fifths lived with only one parent (usually a mother), and in 56 percent of these households, no other adult was present.

A greater number of children today than 20 years ago are living in the homes of their grandparents. In 1970, only 3 percent of all children under 18 lived with a grandparent; by 1998, that figure had doubled to 6 percent. In 1998, to a larger extent than in 1970, however, the grandparent was also providing shelter and support to one or both parents.

These data from the Census Bureau, which provide a cross-sectional snapshot of marital status and family composition, mask much of the diversity of these family arrangements with children. For example, children in two parent families may be living with both of their biological or adoptive parents, or with one biological and one step-parent. Children living in single-parent households may, in fact, be

living with another "parent." The family may consist of a heterosexual couple living together but not legally married (one of twenty households headed by a couple are a cohabiting household), or may consist of a lesbian or gay person and his or her life partner.

Even in those single-parent households where no other adult is present, a child may retain a strong relationship with the biological or adoptive parent who lives elsewhere. To assume that a child living in a household with an "absent parent" is really absent that parent is a faulty assumption. A significant number of divorced and separated couples strive to share parenting duties so that both parties continue with their caregiving responsibilities. Thus, for today's child, family can take many forms.

The traditional image of family as husband, wife and children is also being challenged by the rise in the number of childless couples. About 42 percent of today's families are married couples without children. The percentage of U.S. woman not having children has doubled since the late 1970s, to about one in five according to the Census Bureau. In 1998, 19 percent of women aged 40 to 44 had not given birth to a child compared to 10 percent two decades earlier. For some of these women, childlessness is a deliberate choice. Others find themselves unmarried in their forties because they concentrated on their education or careers only now to be unable to find a suitable mate. But roughly one-half of these women are married and would like to have a child, but have been unable to conceive because of age-related fertility problems. Increasingly, then, family may be characterized as two adults who have no children.

Increased longevity has led to more four and five generation families, where 70 year-old "children" have 90 year-old parents. Finally, the growing number of people living on their own, from young adults to older widows, result in fewer families of any kind than there used to be.

As Stephanie Coontz has observed in her book, *The Way We Really Are: Coming to Terms with America's Changing Families*, "Marriage was once the primary way of organizing work along lines of age and sex. It determined the roles that men and women played at home and in public. It was the main vehicle for redistributing resources to old and young, and it served as the most important marker of adulthood and respectable status....All this is no longer the case. Marriage has become an option rather than a necessity for men and women, even during the child-raising years."

Thus, in the last century, we have seen family structures that diverge from the "ideal." Fewer families consist of a husband, wife and their biological children living together. There are now more single-parent families, blended families, childless families, and fewer families all together.

Social roles

Broader changes in the social environment also have affected family life. The widespread availability of contraceptives, for example, has resulted in an ability to control the size of families and spacing of children and hence the number of years that adults are engaged in child-rearing activities. The fertility rate for Baby Boom cohorts is generally less than two children, compared with a rate of between 2.4 and 3.6 children in their parents' cohorts.

More women, both with and without children, are now in the workforce which also affects family patterns and roles. In 1970, 42.6 percent of women over the age of 16 were in the labor force; by 2006, it is anticipated that 61.7 percent will be employed. Only about one in seven families fit the earlier norm of a breadwinning husband, a full-time stay-at-home wife, and their children. The majority of married couples have both spouses in the work force. In 1960, 30.5 percent of married women were in the labor force; by 1998, that figure had doubled to 61.8 percent. A greater increase was seen among married women with children, with labor force participation rates increasing from 27.6 percent to 70.6 percent

between 1960 and 1998. Even in families with preschool children at home, the majority of mothers work. Labor force participation rates for married women with children under the age of six rose from 18.6 percent to 63.7 percent between 1960 and 1998.

Widowed, divorced, separated or single mothers have always had high labor force participation rates. In 1960, over one-half of them were in the labor force. In 1998, 72.5 of single mothers and 79.7 widowed, divorced or separated women with children were in the labor force. One factor contributing in the steep increase in labor force participation of these single parents may be recent workfare policies that require poor, single mothers to secure work in order to maintain welfare benefit status.

Implications for an aging society

What are the implications of changing family structures and roles in an aging society? They are several and important.

Historically, the family has been an important institution in both the care of their children and in the care of adult family members who may be infirm or disabled. This function of family is not limited to the household. Caregivers may live in the next block, the next town, or 1,000 miles away. However, if someone has no family or if the family fails to function this way, then the individual must be able to take care of himself or herself or the state, through its public policies, takes over the responsibility.

American society has a stronger expectation about parents' responsibility to their children than it does about adult children's responsibility toward their parents. With the availability of social security and Medicare benefits, adult children no longer retain primary financial responsibility for their elderly parents, and few older persons actually live with their children. (Contrary to popular beliefs, American households and families always have been nuclear in structure. An earlier generation may have lived near their children, but even in the 17th and 18th centuries, they typically lived in separate households. And given the age structure of American society even at the beginning of the 19th century when life expectancy was 47 years, extended caregiving responsibility for adult children was rare.)

But when infirmity or disability strikes, the family, whether proximate or remote, still is regarded as a primary source of care. Current long-term care policies presume this primacy. Families are expected not only to provide hands-on assistance with personal care activities (i.e., bathing, dressing, toileting, feeding, transferring), but also to provide assistance with instrumental activities such as cleaning the house, transportation to doctor's appointments, and paying bills. In addition, the family is assumed to be the appropriate surrogate for decision making as regards long-term care placement or end-of-life decisions.

Yet relations of mutual support are formed over a lifetime of family interactions that may or may not be positive. Attitudes toward the *obligation* of familial support also changes with each new cohort. In the early part of this century, parents often discouraged the younger daughter from leaving home and marrying so that she could continue to support them. An expectation such as this would be met with disbelief and derision by any young modern American woman. The cohorts that are currently aged, especially the oldest-old, come from an immigrant experience and often retain the historical and traditional attitudes of "the old country." Future cohorts may not have the same strong familial interdependence.

Although some of the intensive historical patterns of family support have survived among first generation immigrant, African-American and working-class families, a gradual weakening of mutual assistance over time has occurred. Gerontological research attests to the persistence of family

involvement in caregiving, but that family involvement may be changing in intensity and consistency. Data from the National Long-Term Care Survey found that in 1984, more than half of the chronically disabled elderly relied solely on family care while another 19 percent used both formal and informal care. By 1994, sole reliance on informal care dropped to about 40 percent while use of both types of care rose to just over one-quarter. Some researchers argue that this trend is likely to continue given the increasing diversity of families in modern society combined with the modern western emphasis on self over family. Professor Colleen Johnson, a Professor of Medical Anthropology at UCSF, has noted the ascension of what she calls "the opportune family," in which individuals exercise options regarding their households, their mutual responsibilities, and their significant relationships.

Several trends noted above may contribute to the declining ability of families to continue to provide intensive caregiving services to their elderly relatives. First, widespread marital dissolution and smaller families result in fewer kin upon whom to rely. Surveys have identified a hierarchy of caregivers. When available, a spouse provides the majority of care. (Nearly one-half of primary caregivers are over the age of 65, most being the spouse of an even older care receiver.) In the absence of a spouse, a daughter is called upon, followed by a son (who usually transfers such tasks to his wife.) If an older person is childless or has outlived his or her children, more distant kinship networks come into play such as grandchildren, nieces or nephews.

Second, some argue that increased labor force participation by women will reduce the amount of uncompensated care they can provide to their older relatives. Research to date, however, has not found that women's employment outside the home has severely limited the supply of informal caregivers. Some analysts have attributed this to women's traditional "ethic of care" which may still strongly influence women's behavior with regard to eldercare. The National Long-Term Care Survey found that even employed women who were caring for severely disabled elders provided, on average, between 32 and 39 hours of care per week. And between 1984 and 1994, the percent of women who were primary caregivers and also full-time workers actually rose from 23 to 27.5 percent.

Third, as women delay childbearing, the proportion that faces the dual responsibility of caring for an elderly parent and a minor child may increase. In 1994, nearly 3.5 million persons were in this so-called "sandwich generation." Of these, nearly 325,000 were actively providing care to a disabled elderly spouse or parent. Such dual responsibilities may put enough stress on a caregiver that they withdraw from their eldercare responsibilities and turn to more formal providers.

These changing social trends, in the context of an expanding older population, suggest a scenario wherein the needs of the old for care can far exceed the capacity of the family to fulfill. Thus, the balance between family care and formal care must shift. The challenge is how to do it.

Implications for policy

Social policies have not yet reflected the changes that have occurred in family structure and roles in modern America. Current policies embody an "either/or" choice, that is, either the family is sufficient or other institutions must step in to make up the deficit. This view is clearly based upon the existence of traditional family forms, rather on emerging "opportune family" forms. Since the 1970s, policymakers have resisted expanding public long-term care services because of the fear that attractive (but costly) formal services would substitute for informal, family (i.e., unpaid) caregiving.

Research over the last several decades has shown that there is little substance to this "substitution theory." That is, expanded formal services do not result in the total withdrawal of families from caregiving. At the margins, formal services supplement care in those cases where the care needs are so

high, that without help, families could no longer continue to support their older relatives in the community.

No existing long-term care policies actually require that families take on caregiving responsibilities for their elderly relatives, but they do factor in such care when developing a service package. In my state of Oregon, for example, eligibility for home and community-based services under the Medicaid waiver, as well as home care services under our state-funded Oregon Project Independence, explicitly includes an assessment of the extent to which relatives, friends, and neighbors can meet a client's needs. Many other states include similar assessment criteria.

Such policies are unlikely to be abandoned. Given scarce resources, Congressional and state policymakers will always want to stretch public funding through shared public/private responsibility for caregiving. These policies are also consistent with the American policy preference of government services as residual, that is, available only to those who have no other options. But given the changing nature of families, the reduction in potential caregivers and the changing age structure of society, policies will have to remain flexible as regards their expectations regarding family involvement in caregiving. Providing informal care should be viewed as a purely voluntary activity that may enhance the person's quality of life, but is not necessary for the person to continue to stay at home.

Professor Rosalie Kane, who with her husband Dr. Robert Kane, have contributed significantly to research in long-term care policy, recently set out three criteria of a "good long-term care policy" related to family caregivers. Such a policy would achieve the following goals:

- It should provide a minimum floor of adequate care for each person needing long-term care.
- It should maintain any self-selected mutually agreeable caregiving relationships between adults and elderly family members needing care.
- It should not force any family members to provide care to elderly relatives in the absence of such agreement.

However, Professor Kane acknowledges that moving to a more explicit family caregiving policy might not be politically feasible. She urges that if we continue our current implicit policy practices of expecting families to be the first recourse for care, then we should do all possible to help families through training, technical support, counseling and respite care.

Another area of policy that is related to family also bears review. Under law, when a dependent person lacks decisional capacity, family caretakers are looked to as surrogate decision makers. It is assumed that families know the preferences and values of their incapacitated family members, and that they will act in the best interest of these family members. It is in this arena that the question of "who is family" becomes important. In our modern, mobile society in which relationships and family ties fluctuate over time, and in which alternative life styles are becoming more common, our policies need to allow for surrogate decision makers who are related neither by blood nor marriage. Only then can we be assured that the "best interests" of the dependent party are served.

Concluding remarks

The policy lag that now exists between the image of family extant in policy and the reality of changing family structures and norms need special attention in our aging society. As more Americans live into late old age and their needs for care increase, we can no longer assume that family members will be available and/or willing to be primary caretakers. Baby Boom cohorts who have grown up on the values of self-sufficiency and independence from family, may even refuse to be cared for by their children,

preferring a stranger rather than burdening their children

It is therefore critically important that you who make our nation's long-term care policy consider carefully and explicitly what caregiving role families can perform, do perform, and should be expected to perform for our frail and dependent older citizens. Most importantly, perhaps, is that you must refrain from romanticizing family relationships especially if this leads to a greater transfer of responsibility for the support of the elderly back to the family.