Policy Roundtable
Aging in the Americas: Critical Social Policy Issues

Strategic family Decisions and Migration: Implications for Health and Aging Dynamics in Mexico and the United States
(Beth Soldo, Rebeca Wong and Alberto Palloni)

The Mexican Health and Aging Survey (MHAS), coordinated by Beth Soldo and collaborators, started operations in late January of 2001. The survey was motivated by the lack of comparative information between Mexican-born and US native-born population, that undermines a complete understanding of unexpected health differentials in favor of the first group (the so called Hispanic Paradox). The purposes of the MHAS as well as its motivations are more fully explained in this report, as they were presented by Beth Soldo on February 16, 2001 at the University of Texas at Austin.

Hispanic Paradox

Mexico contributes the greatest number of migrants to the United States each year. Despite their lower levels of education, higher rates of unhealthy behavior (smoking, alcoholism, obesity and diabetes) and larger earning differential, Mexican-born migrants experience lower morbidity and mortality indexes than non-Hispanic Whites and native-born Hispanics. This "paradox" has been understood to be the result of an unobserved selectivity process: individuals who choose to become international migrants, specifically, long term migrants have higher levels of health and human capital than short term migrants and those who choose not to migrate. Nevertheless, the magnitude or direction of the migration selectivity cannot be inferred only from US data on migration. Information from the sending communities is also necessary.

Soldo's presentation implied that the study of elderly population in sending communities will help to understand the health profile of the people who do not migrate or who migrate and do not stay in the US**.** Comparative studies with native-born residents of the US will be then possible. In addition, the rapid aging of population in Mexico increases the need for data to foresee future health and socioeconomic demands.

As a result of the demand for such information, the authors initiated the 2001 Mexican Health and Aging Survey (MHAS). The MHAS is designed to collect data on Mexicans 60 years old and over, on substantive fields of health status, health service, migration history, household economic measures, community variables.

Hypotheses:

Health profile in Mexico: People born before 1940 in Mexico have experienced a period of epidemiological transition where infectious diseases were still prevalent while chronic diseases emerged in the national scenario. Current elderly individuals were exposed to infectious diseases as children, but many of them never contracted the diseases while others in this group survived these diseases.

Under this scenario of unusual interaction between infectious and chronic conditions, the elderly population in Mexico would be expected to present higher physical limitations and functional disability than the elderly population in the developed world. Thus, it is hypothesized that increasing demands on health care would put pressure on constrained federal budgets and family's resources to care for these elderly.

Migration: ***Migration, and especially international migration, is a mechanism by which migrant and his/her family acquire wealth. Migration involves intergenerational transfers. It can be seen as a strategy to increase sources of family wealth. Migrant and family develop a mutual net of responsibilities to increase their sources of support and reduce their collective risk to financial problems.***

The authors hypothesize that children who receive greater investments in education, health or migration opportunities, will be more likely to make financial transfer to their parents, while children who receive less opportunities will be more likely to make time-transfers to their parents. Parents with low levels of wealth or health will receive more cash or in-kind assistance than parents with greater resources. It is also expected that migration will affect the probabilities of making a transfer to parents as well as the relative size of the transfer.

Because established networks on both sides of US-Mexico border have made the migration process easier, it is hypothesized that families will no be as selective in choosing family members to migrate and, consequently, current levels of health and education of Mexican-born in the US will decrease compared to earlier migrants.

MHAS Project

Supported by National Institute on Aging (NIA) the Mexican Health and Aging Study (MHAS) will collect information on Mexicans born prior to 1951 who live in six important sending states. Key points to be addressed include:

- An evaluation of the distribution of disease status within the Mexican population cohorts prior to 1950
- An evaluation of the effects on health status of migration and work histories, community characteristics, socioeconomic conditions and intergenerational transfers
- An estimate model of two-year health transitions
- An examination of how systems of intergenerational transfers affect health and wealth in a context of high migration and remittances
- A comparison of the health of the elderly population in Mexico with a comparable population of Mexican immigrants in the United States and second generation of Mexican Americans

The MHAS uses as a sampling frame the 2000 National Employment Survey (Encuesta Nacional de Empleo, ENE) carried out by the Mexican National Institute of Statistics Geography and Informatics (INEGI). This institution is responsible for the direct implementation of MHAS in Mexico. The survey collects specific information on major chronic conditions, occurrence of symptoms, performance on activities of daily life

(ADL), problems of vision hearing or speaking, no-hygienic behaviors (smoking, alcohol consumption), cognitive status, anthropometrical measures, health services, respondents childhood health and living conditions, detailed migration history, remittances during international and domestic migration, marital and fertility history. Community level variables will be obtained by merging data from different waves of MHAS (2000 and 2002) with the 2000 Mexican Census of Population and the 1999 Economic Census (both of them carried out by INEGI). Data collection began in January of 2001, and the data should be available to the public next spring.

Responses:
Peter Ward.
Gender analysis should be present in the study. The selectivity migration process is expected to produce a differential health profile between men and women. Because men usually migrate first, followed by wives and children once they are established in the receiving community, men **might** be the actor on which the selection process operates strongly.

Bryan Roberts
Differences in human capital should be taken into account when the selectivity migration hypothesis is tested. Mexican migrants in the US generally work in jobs that require more physical effort than migrants who move to another village or city within Mexico, where their literacy and other skills are more valuable. Such differences in human capital might be also accompanied with different profiles in health, education and socioeconomic characteristics.

Understanding of migration as family strategy to face poverty problems should be reviewed under the light of important structural changes in the Mexican landscape, especially small villages, were opportunities for local investment through remittances are eroding after the implementation of NAFTA. Migration is not only a strategy that produces benefits to the family as a whole. Whatever its shape (rural/urban or urban/urban), migration is also a process that weakens the family ties by diminishing the number of family members.

Migration should be understood as an event that also occurs outside the family strategy idea. Some movements, international or national, are based on personal or individual reasons (studying) rather than collective strategies of survival.

Summarized by Leah Kegler and Benjamin Nieto-Andrade

Everything is Relatives: Individual, Family, and Collective Roles in Elder Care

Douglas A. Wolf

Introduction

This paper addresses a set of issues that are located at an intersection of demography, gerontology and public policy. It uses the arena of elder care to address the question of "Where, how, and why do we draw the line between what we expect people to do for themselves, what we do in families, and what we do collectively as a society?" A paper by Linda Waite, "Does Marriage Matter," (1995) serves as a launching point. Although it is not certain that the apparent benefits of marriage are a causal result of marriage, if there are large public benefits resulting from this cultural institution, society could have a rationale for influencing individual, private decisions. Dr. Wolf uses a similar line of thought to pose issues related to eldercare and to prompt discussion. Specifically, this paper looks at intergenerational relationships, analyzes policy implications, and identifies upcoming challenges.

Intergenerational relationships

Resource transfers can serve as an empirical means of looking at relationship patterns. Transfers occur in two directions, with several types of transfer each way, as follows:

- From parents to adult children
  - Costs of higher education: e.g. cash support, loans, and in-kind gifts
  - Housing assistance: e.g. downpayment assistance, which can allow purchase of a more expensive house at an earlier age
  - General financial support
  - Child care: roughly one third of pre-school age children receive some form of care from their grandparents
- <u>From adult children to elder parents</u>
  - Money: less common that parent-to-child transfers
  - Space, e.g. co-residence
  - Time, i.e. time spent "helping" or "caring for" others

Time transfers from children to parents have been researched a great deal, examining the relationship between assistance from society and assistance from family members. He has studied data on the care given to non-institutionalized, disabled elderly (National Long-term Care Survey, 1989). Categories of types of care include: those who receive care only from family (informal care), those who receive it only from society (formal care), and those who receive some from both. Regression analysis was used to identify relationships between amounts of each type of care.

- Family care comprises the majority of elder care.
- Those who receive family care receive more total care than those who get formal care alone.
- Those who have more family members receive more care, and the number of family caregivers per elder is negatively related to the amount of care given per family member (reduced caregiver burden).

Policy implications:

Benefits to society of care provided by the family:

- Delay or prevention of institutionalization

    - Over half of annual nursing home payments are made by Medicaid
- Reduced need for formal care among non-institutionalized disabled elderly
    - Half of home health care costs are publicly funded. Although Medicare benefits are supposed to be allocated without regard to availability of family support, the rate at which this care is sought may depend on family situations.
    - Medicaid is designed to supplement informal home care-giving.
    - Costs to individual family members of informal care-giving
    - Economic losses, e.g. reduced employment
    - Psychological and health costs associated with stress and burden.

It is very difficult to try to come up with a system of accounting of social benefits and costs. In particular, the details of public funding for home health care and long-term care are complex. One conclusion he has been able to draw is that time given to elder parents generally comes out of the unpaid leisure time of family caregivers. However, others have concluded differently, and it is an unsettled question.

Future challenges

There have been many critiques and calls for change for the current system of elder care in the United States. Advocates have cited inadequacy, inequity, inefficiency, and anticipated demographic changes as some reasons for system reform. He sees roles for analysts in pointing out to advocates the downsides as well as the benefits of the proposals that they are advocating, and in questioning and analyzing the rationales offered for proposed changes. Key questions that should be asked must include "What are you really trying to accomplish?" We need to direct our efforts towards identifying and quantifying the societal costs and benefits of elders' lost capacity for caring for themselves. This knowledge will help us design policy innovations that would reward those who provide informal care to elders in proportion to the benefits that informal care provides to society.

DISCUSSION

Ron Angel

Professor Angel opened with a discussion of the concept of markets and a rationale for their use in health care delivery: With the aging of the "baby boom" generation, we are approaching the largest intergenerational transfer of wealth in history. The existence of very large estates in this context presents a great inequity, and has implications for collectivism. He presented data on average income and average wealth for white populations, non-white Hispanics, and black populations. The ratio of average income levels between whites and the other groups is about 1.7:1, however the ratio of the average levels of accumulated wealth were closer to 10:1. The unintended consequences on different population subgroups are not really neutral, and framing the inquiry to include "market" as well as "family" and "state" would be an interesting addition to Wolf's paper.

Kelly Raley

This paper indicates that policies which discourage elderly from receiving formal care will lead to a decrease in total care. When we look at the composition of the population providing informal care and control for spouses in the regression, there is a more complete substitution effect between formal and informal care, implying that the spouses' role is dominant. She suggests that a longitudinal observation, including level of income, as an approach that might help clarify the potential effect of increased formal care. It is also important to address the effects on care-giving of changes in status of the care-giver, and to consider the gender issue.

COMMENTS:

Bryan Roberts
Expressed curiosity about how the analysis would be affected by variations in region, other factors of location, decreasing family size, family mobility, and immigration trends. He points to the American tendency for mobility and suggests that there are different implications for our society here than in others. For example he raises the case of Latin America, where the assumption is that the family does the eldercare. Formal care has often been ignored, and current social changes such as family disruption, childless families, and extreme poverty have led to tragic cases of elderly with no care at all. He suggests looking at the interplay of all possible sources of care, e.g. family, market, state, community, and what the U.S. perspective is regarding the proper roles.

Professor Wolf responded that in the U.S. many still view the family as the default source of care. He states that there is no current trend of increase in the mobility of American citizens, but he does agree that dispersion affects the amount of care that can be received on average by the informal sector. Family size is certainly a major current constraint.

Peter Ward
Professor Ward asked if anyone has done work on those who have finished caring for their elderly parents, after the parents' death. Also, he is curious about the influence that the age of parents at birth might have on the issues.

Professor Wolf responded that these are great questions and he has never heard them posed before. He was unaware of any existing data regarding "done carers". Also, life-cycle analysis would be another approach, but that this was not part of the research he has done.

Marion Aguilar
Professor Aguilar pointed out that most of the Medicaid users in nursing homes are elderly white women who have no other care givers.

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