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## Constrained Choices: The Shifting Institutional Contexts of Aging and the Life Course

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### INSTITUTIONS AS CONTEXTS AND PROCESSES

Institutions are taken-for-granted schemas about “appropriate” behavior—formal and informal rules and conventions representing collectively developed patterns of living that often reflect organizational and community answers to past problems and uncertainties (Biggart and Beamish, 2003; Sewell, 1992). According to Scott (1995, p. 13), institutions are “cognitive, normative, and regulative structures and activities that provide stability and meaning to social behavior. Institutions are transported by various carriers—culture, structures, and routines—and they operate at multiple levels of jurisdiction.”

This chapter proposes that institutional theory constitutes an important prism through which to advance understanding of the range and impacts of patterned social arrangements channeling age and aging processes, although its use is underdeveloped in the study of aging. While there are a multiplicity of social institutions (policies, programs, practices, and conventions) structuring the expectations and choices, transitions and trajectories, risks and resources of aging adults, they tend to serve as background “givens” in the existing research literature on aging, that is, as contexts and/or “neighborhood” effects (Angel and Settersten, 2013; Bengtson et al., 2009; Binstock and George, 2011; Cagney et al., 2013; Settersten and Angel, 2011; Shanahan, 2013), or else as social roles shaped by unique historical events experienced by different cohorts (see, Baltes and Baltes, 1990; Elder, 1974; Elder and Johnson, 2002; George, 1993). The closest ties to an institutional approach in the current aging field lie along three lines of

inquiry: (1) critical political economy and feminist approaches examining how existing institutional arrangements (norms, policies, and practices) are developed and maintained by those in power to promote their own positions of advantage, thereby preserving the existing distribution (across gender, race, and class) of resources (see Acker, 1992; Arber and Ginn, 1991; Estes, 2004; Harrington, Meyer, and Herd, 2007; Pampel, 1994; Quadagno, 1988); (2) age stratification/life course frameworks underscoring how social welfare and labor market policies have “institutionalized” the age-graded life course (Kohli, 2007; Kohli et al., 1991; Mayer, 2004, 2009; Meyer, 1986; Moen and Spencer, 2006; Mortimer and Shanahan, 2003; O’Rand and Henretta, 1999); and (3) sociological (c.f. House, 2002) and social epidemiological (c.f. Berkman et al., 2000) theorizing of *socially structured conditions*—more than individual attributes—as key to health and well-being, generating an emphasis in the interdisciplinary public health literature on the social causes of illness and health (Aneshensel, Rutter, and Lachenbruch, 1991; Berkman et al., 2000; Link and Phelan, 1995; Marmot and Wilkinson, 2006; Mechanic, 2000; Moen and Kelly, 2009; Moen et al., 2011; Siegrist and Marmot, 2006; Syme, 2007; Turner, Wheaton, and Lloyd, 1995; Wheaton, 2001; Wheaton and Clarke, 2003; Wickrama et al., 1997).

Institutional theory “asks questions about how social choices are shaped, mediated, and channeled by the institutional environment” (Wooten and Hoffman, 2008, p. 130). This is in sharp contrast to classic economic models emphasizing choice as a (rational) function of perceived advantage or preferences (c.f. Becker, 1981; Gruber and Wise, 2004). Although institutional theory is rarely explicitly invoked, sociological, demographic, and social epidemiological understandings of age, health, and the life course are implicitly if not explicitly about institutional forces, since scholars increasingly emphasize the embeddedness of individuals in particular social-structural contexts (see Figure 9-1). These contexts are replete with rules, claims, risks, and resources serving to open up or constrain choices, thereby shaping family-level and individual-level beliefs, behaviors, health, and life quality (see Berkman and Kawachi, 2000; Fry and Keyes, 2010; House, 2002; Kawachi and Levin, 2004; Link and Phelan, 1995; Lutfey and Freese, 2005; Phelan and Link, 2005; Phelan et al., 1998; Turner, Wheaton, and Lloyd, 1995). Nevertheless, the state of the field is such that the preponderance of research on aging examines *individual-level predictors of individual outcomes*, not the *institutional-level contexts and processes* shaping both.

Three things make something an institution: language, customs, and a body of rules and laws—and all serve to “regularize” behavior (Biggart and Beamish, 2003). What is key is that all three are in flux around aging processes, pointing to the importance of institutional change and even deinstitutionalization across cohorts and history. Thus, Boomers (born

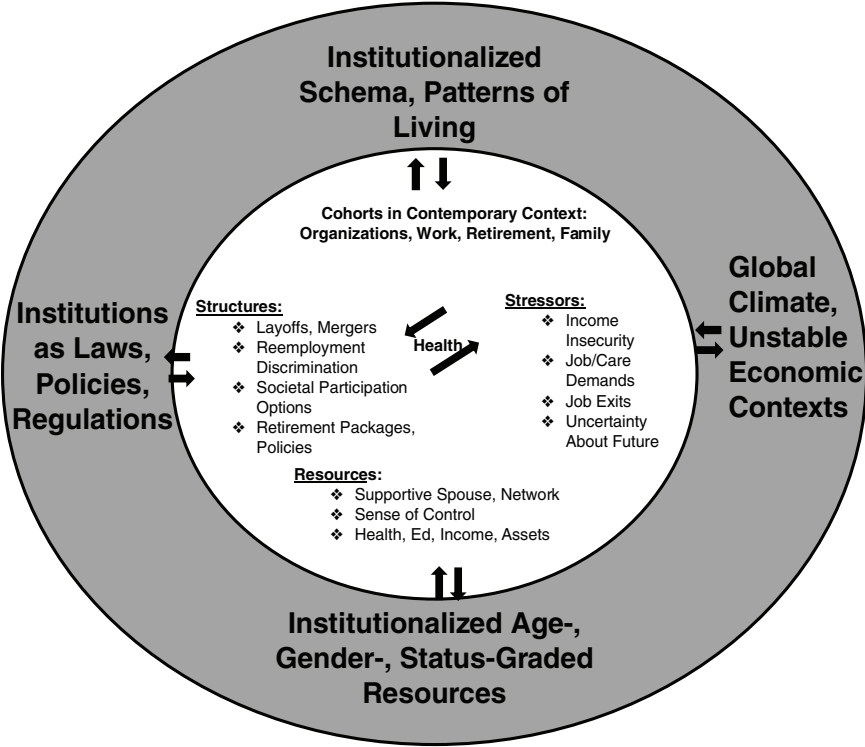


FIGURE 9-1 Multilayered institutionalized contexts shaping aging.

1946-1964) now moving to and through the retirement years are confronting unraveling labor market exit and pension expectations, policies, and practices that their parents and grandparents took for granted. In this way, cohorts responding to outdated policies and new circumstances become the engines of social change (Alwin and McCammon, 2007; Ryder, 1965). It is now members of the Boomer cohort who are reshaping what it means to retire and grow old in contemporary society.

Consider how taken-for-granted *language* (about elders, the aged, seniors, retirement, being/becoming old) is being redefined or challenged. For example, Gilleard and Higgs (2005, p. 157) conclude: “to be done and outside the labour market is no longer to be old. Old age is a status conferred by others. . . . For the majority, what continues is the symbolic connectedness of individualized lives.”

In terms of *customs* as well as a body of *rules and laws*, systems of educational, labor-market, corporate, retirement, social-welfare, family, and health-care policies and practices constitute a web of age-graded

institutionalized regimes (social structures of resources and schema) based on a very different workforce and “retired” force in the middle of the past century (de Vroom and Bannink, 2008; Ebbinghaus, 2006; Kohli, 2007). These regimes continue to define and shape age, aging, the life course, and health with different logics (and not always internally consistent ones). Moreover, note that such institutional arrangements cannot usefully be studied separately, because they are closely connected and interdependent. They both constrain and facilitate individuals’ options as they confront emerging 21st-century risks and realities in family life, the economy, and life expectancy. Consider, for example, the mismatch between presumed institutionalized protections and the disappearing employment contract. Today older workers confront the off-shoring of jobs, heightened job insecurity, unemployment, and nonstandard employment—all of which have been shown to affect health (c.f. Price and Burgard, 2008).

But institutions need not be seen as immovable. Some also provide impetus for change (see, Friedland and Alford, 1991; Sewell, 1992), such as the ways higher education as an institution has equipped many Boomers with the tools to redefine age in their own biographies and rewrite their own scripts around the aging process. And social forces—a tumultuous global economy, an aging population, technological shifts, and other social dislocations—are challenging taken-for-granted institutionalized conventions and practices around work exits, retirement timing, life post-retirement, Social Security, pension policies, and health care. This means that social actors (individuals, groups, organizations, governments), facing often contradictory rules, laws, and realities about labor market and retirement exit and entry portals, pensions, and health-care eligibility, must make *strategic adaptations*, which can then become the seeds of innovation and institutional change. For example, a competitive uncertain global economy has increased concerns of older workers about their job security, retirement timing, and future pensions, including whether they can “afford” to retire. This is the impetus for the development of bridge and part-time jobs, self-employment, and delayed retirement options for a growing older segment of the workforce. Another example is the rising costs of a currently institutionalized arrangement for long-term care—nursing homes. Such facilities are being challenged as unsustainable in their present form, in light of the coming age wave of Boomers. Arrangements like continuing care retirement communities, home care, and new technologies to facilitate aging in place are among proposed alternatives.

Institutions may seem static and intractable, but they are transformed through nonconformity, negotiation, improvisation, institutional entrepreneurs, and social movements (DiMaggio, 1988). It is often the *mismatch* or *structural lag* among existing institutional logics, or between institutions and the social forces rendering them obsolete, which generates

opportunities for social change. Such mismatches (lag) help to deinstitutionalize conventional arrangements and legitimate new institutions, often through a recombination or reconfiguration of existing elements.

This chapter illustrates the value of a program of future research using a combined institutional and life course approach to advance understanding of aging as a social process *embedded in multilayered institutional contexts*, with both individuals *and* institutions *changing over time*. It provides an overview of (1) current concepts and research in the sociology of aging, demography, and social epidemiology that articulate (although not always explicitly) with institutional theory and the ways institutions target and/or impact different subgroups of the population; (2) how institutions intersect and change over time in intended and unintended ways as a result of both social actors' behavior and other large-scale social forces; and (3) potential scientific and societal pay-offs of an innovative program of future research crossing levels of analysis to address ways (taken-for-granted, age-graded) institutions systemically open up *and* constrain life chances and life quality for those at different ages and life stages, often in distinctively gendered ways. The chapter is organized around several major social science constructs that, when married with an institutional/life course approach to age and aging, offer a promising agenda for a program of research over the coming decades: (1) *stratification and inequality* (including cumulative disadvantage and the life course); (2) *risk and uncertainty*; (3) *social support, integration, isolation*; (4) *agency, control, and adaptive strategies*; and (5) *time and place*. It concludes with a section on future directions.

## STRATIFICATION AND INEQUALITY OVER THE LIFE COURSE

One hallmark of sociology is its emphasis on the effects of social environments on behavior, resources, and health, the seemingly fundamental social structure of inequality (House, 2002; Link, 2008; Link and Phelan, 1995; Lutfey and Freese, 2005; Phelan and Link, 2005; Phelan et al., 2004; Phelan, Link, and Tehranifar, 2010). Some social structures—such as gender, race, education, and income—are markers of location in (institutionalized) status hierarchies. Social environments tied to these attributes produce and reproduce enduring inequalities (Tilly, 1998). Scholarly analysis of disparities associated with these social locations has been essential in spotlighting the role of existing and emerging social arrangements in the production and reproduction of inequalities. But while race, gender, and even education are enduring factors, other aspects of social structure, such as neighborhoods, work, and social networks, *do* change with age, as individuals select or are allocated to different social ecological niches (see also Brooks-Gunn et al., 1993) over the life course. Moreover, the deleterious effects of social-locational markers can be lessened or exacerbated by

events (such as the Great Recession of 2007-2009) or with age, in light of institutionalized age-graded policies and practices (such as Social Security and Medicare) offering an income and health-care safety net for older Americans that in the past century served to legitimize retirement as normal life transition (see Atchley, 1982; Costa, 1998; Han and Moen, 1999; Hayward and Grady, 1990; Henretta, 1992; Wise, 2004). Social forces, as well as deliberate policy *changes*, can also shift social structures, challenging taken-for-granted institutionalized expectations and practices that disadvantage some segments of the population while advantaging others (Blossfeld and Hofmeister, 2006; Blossfeld, Buchholz, and Hofäcker, 2006; Hudson, 2009; Warner, Hayward, and Hardy, 2010; Williamson, 2011). Consider, for example, public and corporate policy directives aimed at reducing age and/or gender discrimination (Shuey and O'Rand, 2004) or the development of "bridge" jobs as a way of gradually easing older workers into retirement (Kim and Feldman, 2000; Quinn and Kozy, 1996).

### Age and Gender Stratification

Age and gender are not simply characteristics of individuals shaping their preferences; rather, they are themselves social institutions, key axes organizing social life and "channeling" social choices, such that women and men of different ages and life stages are both *allocated* to and *socialized* to expect distinctive roles, resources, and relationships (Dannefer, 2011). While concerns about gender stratification are deeply embedded (institutionalized) in social research on inequality (c.f. Grusky, 2001), Riley (Riley, Riley, and Foner, 1994) also emphasized the importance of *age stratification*: age as a key marker of unequal access built into existing institutions (e.g., the labor market, education, social-welfare policies) that perpetuate age differentiation and inequalities within and across organizations, communities, and societies. (See also Settersten and Lovegreen, 1998, for the ways that education is constrained to certain ages and stages.) Others point to the *intersection* of age and gender stratification as institutionalized in families as well as public and organizational policies (Allen and Walker, 2000; Harrington Meyer and Herd, 2007; Harrington Meyer and Parker, 2011; Moen, 1994, 2001; Moen and Chermack, 2005; Moen and Spencer, 2006). The ways work and retirement are organized through legislation, regulation, and convention are based on a (male) breadwinner model presuming full-time, full-year investment in one's job, with family responsibilities off-loaded to someone else (a wife). These built-in assumptions make it difficult for women (or men) with family care obligations to work continuously throughout adulthood in "good" jobs that provide high wages, pensions, and security (Han and Moen, 1999; Moen and Roehling, 2005). Moreover, Social Security in the United States is predicated on this lock-step

model, presuming one's highest wages just prior to retirement. But women's movement in and out of jobs, in and out of the labor force in light of their family responsibilities, has meant lower wages, lower pensions, lower Social Security benefits, fewer assets, and great risk of economic insecurity in old age, especially for widows and divorcees (Budig and England, 2001; Budig and Hodges, 2010; Harrington Meyer and Herd, 2007; Harrington Meyer and Parker, 2011).

Gendered scripts also guide relationships with organizations and institutions. For example, among dual-earner couples, it is wives who tend to time their retirements around their husbands' retirement plans (Moen et al., 2005, 2006).

The processes by which people are allocated to different roles, resources, and relationships and socialized to expect and choose different life paths depending on their age and gender (as well as their race and class) are the direct result of social policies as well as cultural conventions—norms and practices—related to them. European scholars have pointed to the ways social-welfare policies have constructed and institutionalized the life course as a series of patterned role entries, trajectories, and exits based on men's occupational careers in the mid-20th century (Guillemard and Rein, 1993; Kohli, 2007; Kohli et al., 1991; Krücken and Drori, 2009; Marshall, 2009; Mayer, 2009; Meyer, 1986).

Thus the institutionalized life course is in reality a *gendered* life course (Arber and Ginn, 1991, 1995; Harrington Meyer and Herd, 2007; Harrington Meyer and Parker, 2011; Moen, 1994, 2001; Moen and Roehling, 2005; Moen and Spencer, 2006; Pavalko, 2011; Venn, Davidson, and Arber, 2011), grounded in gendered norms and social policies about work, family, and social relations that intersect with age. As an example, in the United States, unemployment insurance is typically based on men's experience of being laid off. People (women) who have spent time out of the workforce raising children are not "eligible" for unemployment insurance when they re-enter the labor market but cannot find jobs. And women who "work" at home taking care of children or infirm adults do not earn Social Security credits.

The distinctive life courses of women and men tend to disadvantage older women, in particular, in light of the gendered nature of their care-work obligations, along with discriminatory practices in the labor market and in welfare distributions throughout the life course (such as the ways part-time jobs do not provide pensions, unemployment insurance, or even health insurance). Family obligations and gender discrimination made it unlikely that current cohorts of older women followed the conventional lock-step of continuous full-time work, often for the same organization, that became the "hook" for the development of labor market and social welfare policies (Barley, 1989; Moen and Roehling, 2005). The result?



Older women find themselves with no or low pensions, Social Security payments based on lower wages, and caregiving obligations for ailing spouses or infirm parents that often precipitate unexpected and early labor market exits (Dentinger and Clarkberg, 2002; Harrington Meyer and Herd, 2007). But institutional innovations in the form of greater flexibility offering employees greater control over the time and timing of work and opportunities for more customized careers (Benko and Weisberg, 2007), together with the greater proportions of women attending college and having fewer children (along with men's declining wages), mean that some women's career paths are becoming more continuous than discontinuous, suggesting that future cohorts of older women may have different sets of resources. However, women's greater engagement in the labor market is occurring even as both men and women are increasingly at risk of (1) discontinuities due to layoffs and forced early retirement buyouts and (2) declining pension/income security (Shuey and O'Rand, 2004; Sweet, Moen, and Meiskins, 2007). Whether this has implications for narrowing gender differences in aging processes (compared to gender disparities among prior cohorts) in future cohorts is an empirical question. Similarly, Bonilla-Silva (2006) proposes a racialized social system framework emphasizing racism as a structure and a set of social practices developed to maintain the advantages of the dominant group, not merely a set of ideas or beliefs, with this system of racialization developing "a life of its own" (p. 32) (see also Jackson, Govia, and Sellers, 2011; Mutchler and Burr, 2011). Future research is necessary to identify the ways women and men of different minorities, immigrants, and other disadvantaged subgroups are aging, and whether institutionalized safety nets narrow or accentuate inequalities within and across gender in intersection with these identifiable subgroups.

An institutional/life course theoretical approach points to the ways the social, economic, and political institutions of particular societies—public and business policies and practices embedded in work, career paths, family, unemployment, pensions, retirement norms, and disability regimes—were developed based on the everyday experiences of mostly white-collar and unionized blue-collar men in the middle of the 20th century, but then came to organize the lives of everyone, including women who entered the workforce, along with other displaced and disadvantaged groups. These outdated templates continue to shape the lives of those in new cohorts now working, retiring, and aging in the 21st century in gendered ways. The range of institutionalized options in the wake of certain biographical events (such as illness, retirement, divorce, death of a spouse, or long-term unemployment) depends on a person's age, gender, and education (see also Dannefer, 2011). For example, there are both *pull* factors (such as Social Security, Social Security's Supplemental Security Income [SSI], and pensions) and *push* factors (corporate hiring, training, firing, pension, health insurance, and retirement

policies) that shape the timing of and pathways through the retirement transition (Ebbinghaus, 2006; Guillemard and Rein, 1993; Henretta, 1992; Kohli et al., 1991; Rix, 2011; Williamson, 2011; Wise, 2004), but these may well operate in different ways for men and women. Future research is needed on the different resources and experiences of different cohorts as they age—and on the heterogeneity of resources and experiences depending on one's gender, but also on one's race/ethnicity, nativity, education, occupation, and disability status—in the context of both outdated and innovative institutional arrangements.

### Cumulative Advantage/Disadvantage

A key theoretical and empirical question that could benefit from an institutional/life course approach to advance the study of aging is: Does growing older *amplify* or *reduce* existing disparities (by gender, socioeconomic position, race/ethnicity, and their intersections) in stressors, health risks, and material or emotional resources? *Cumulative advantage/disadvantage* theory proposes that the amplifying process has been the case historically (Dannefer, 2011; O'Rand, 1996; Wilson, Shuey, and Elder, 2007). A variant of cumulative advantage/disadvantage proposes heightened disadvantage as a result of a cumulation of adverse risk factors (Ferraro, Shippee, and Schafer, 2009), and the fundamental cause approach holds that existing social-locational inequalities persist throughout adulthood despite medical advances that are disproportionately allocated to or adopted by those with higher levels of education (Link and Phalen, 1995). But an alternative, *age as leveler* hypothesis suggests that institutional arrangements advantaging older Americans may help to attenuate economic and health disparities with age (Berkman, Ertel, and Glymour, 2011; Herd, Robert, and House, 2011). However, studies of age as a leveler need to take into consideration the differential mortality of different subgroups.

Life course scholars have shown that rewards in later adulthood accrue to those following the standardized lock-step life course of first education and then continuous full-time work, an option available to increasingly fewer individuals and never a reality for most women, the poorly educated, or minorities (Han and Moen, 1999; Moen and Roehling, 2005). As an example, Elman and O'Rand (2004) find that those Boomers who went back to school to obtain college degrees in midlife (typically women and minorities) did not receive earnings commensurate with those who obtained their degrees prior to beginning their full-time labor market participation. An important question for future research: Is it still the case that being "off-time" in transitions continues to matter, in light of the fact that labor market and family transitions no longer adhere to strict templates as to timing, sequence, or duration?

In contrast to the medical model focusing on helping individuals who are already sick, a growing body of scholarship emphasizes illness prevention, and with it the value of theorizing inequalities in illness and dependency as the consequence of existing, but *modifiable* social conditions (Berkman and Kawachi, 2000; Syme, 2007). Health is improved or hindered by age- and gender-graded paths and possibilities embedded in existing systemic arrangements shaping family, education, work, retirement, religion, health care, and communities. An example, Medicare insurance becomes available only at age 65, constraining the health care of those older Americans (often women) out of work or without work-related health insurance. Future research advances can come from understanding the ways institutionalized social factors affect health, as well as from investigations of the health impacts of emerging innovative arrangements. This promising research agenda could capture the significance of existing—and emerging—institutional conventions and conditions for both life chances and life quality over the life course.

### RISK AND UNCERTAINTY IN THE CHANGING LIFE COURSE

An example of ways institutions reflect past solutions to past social problems: earlier 20th-century concerns about economic insecurity and mortality hazards produced historically organized ways of insuring against risk in old age, in the form of the taken-for-granted institutionalization of life insurance, Social Security, SSI, disability policies and long-term care insurance (see also Costa, 1998; Gruber and Wise, 2004). In the middle of the past century, Social Security provisions (such as linking levels to earnings histories), mandatory retirement ages, and the development of defined benefit pensions served to institutionalize retirement as a taken-for-granted one-way, one-time status transition protected from extreme income insecurity (Costa, 1998; Henretta, 1992; Kohli, 2007). But, as an example of unequal distribution of risk in later adulthood, Quadagno (1994) describes how domestics and farm workers were initially excluded from Social Security policy, thereby fostering racial disparities. Scholarship reinforces that insurance against risks continues to be unevenly distributed, with a distinction between public policies framed as “insurance” and policies framed as providing (often means-tested) “assistance” (Estes et al., 2009).

### Aging as a Risk for Society

Research underscores that risk is also a way policy makers and practitioners are framing the “problems” of an aging society, producing a focus on older individuals as inherently “at risk” (Carr and Muschert, 2009). This risk approach to later adulthood defines old age (and population

changes producing rising numbers and proportions of older people) as a *social problem*, creating challenges for the larger society. This framing, in turn, sets the stage for a politics of aging grounded in a scarcity model of intergenerational conflict and a medical/biological model of the inevitability of disability and dependency with increasing age (Estes and Associates, 2001; Estes et al., 2009; Hudson, 2005, 2009; Pampel, 1994). It also produces social arrangements (such as health-care practices, residential facilities, and the potential privatizing of Medicare and Social Security) that both diminish the autonomy of older adults and emphasize the dependence of frail older adults, often ignoring others in the same age group who are not at risk.

Another potentially rich area for inquiry involves the ways age is being socially constructed (Berger and Luckmann, 1966) to take on biomedical, commodified, privatized, and rationalized aspects (Estes, 2004; Estes and Associates, 2001; Estes et al., 2001, 2009). The biomedicalization of aging emphasizes aging as a *medical problem* associated with disability and dependence, along with the behavioral and policy implications of this medicalization approach. “Commodification” of old age relates to services and goods that are bought or sold. What Estes and Associates (2001) call the *aging enterprise*—pension programs and businesses focused on older people—further serves to differentiate older from younger adults through the use of age thresholds and programs that effectively “commodify” old age. Commercial efforts amplified in the mass media create age groups and cultures as “cultural fields,” such as the youth culture, a set of products and practices of young people (especially related to their leisure and buying of goods and services; see Capuzzo, 2001) that continue to define the beliefs and behavior of the large Boomer cohort. “Privatization” has to do with the financing of health insurance, social services, and health care through the private sector, a trend that may promote rather than reduce inequality. “Rationalization” of old age refers to the provision of care in the most efficient ways, with cost concerns and cutbacks often trumping the quality of the care provided, even in nonprofit organizations providing medical and social services.

### Exposure and Vulnerability

In another body of literature sociologists, demographers, and social epidemiologists theorize *exposure and vulnerability* to the risks of poor health and mortality as systematically stratified by age, gender, and other social locational markers (such as education, income, labor force status, nativity, occupation, race/ethnicity, and marital status). Pearlin’s (1989, 2010) stress process model theorizes the importance of the structural contexts of lives contributing to disparities in the risks of chronic stress exposure and

in the personal and social resources and capabilities with which to deal with both chronic and acute stressors. Life course epidemiologists model the health impacts of risk exposures at different ages and life stages (Davey Smith and Lynch, 2004; Kuh and Ben-Shlomo, 2004), as well as the accumulation of risks through the life course. However, Syme (2007) warns against an exclusive focus on classifications of health risks, encouraging scholars to focus instead on the social, environmental, and community forces contributing to them.

Most existing social institutions are (deliberately or not) designed to produce age-graded distinctions that affect the allocation of goods, services, income, risks, and opportunities for those of different ages. (Thus, educational scholarships are available for “college-age” young people; entry-level jobs are expected to be filled by “young” adults; academic tenure is based on both productivity and years in the system; pensions are “earned” through years of service.) These arrangements can exacerbate, perpetuate, or reduce age, gender, or socioeconomic inequalities in health and other outcomes. For example, there is some evidence that age-graded policies (such as Social Security and Medicare) actually mitigate prior disparities in income, health care, or health outcomes. An empirical example: Herd, Schoeni, and House (2008) drew on census data to investigate whether within-state changes in maximum SSI benefits lead to changes in disability among those aged 65 and older, theorizing that changes “upstream” in socioeconomic status through income supports would reduce subsequent health problems. They found that more generous state benefits—specifically a \$100 increase in SSI benefits—produced lower disability rates (in terms of reporting having a mobility limitation). This provides tantalizing support of the idea of *age as a leveler*, in that modifications with age to individuals’ socioeconomic position (in the form of increasing income supports in later adulthood) can improve health, among even the poorest Americans.

An important theoretical focus with potential for future research advances is on “upstream” risk factors very early in the life course (such as parents’ education and childhood deprivation) affecting older adults’ life chances and life quality. However, this framing could result in scholars paying insufficient attention to (1) the ways people’s *current* social location moderates or exacerbates risk factors at every stage of the life course; (2) the disparities in exposure, duration, and vulnerability to risk factors and disparities in actual health outcomes, not only across, but also *within* social groups; (3) the ways biographical pacing and pathways (trajectories and transitions in employment, family, education, military service, neighborhood residence) change income, knowledge, perceived mastery, and other psychosocial resources, and, in doing so, perpetuate, exacerbate, or moderate risk exposures and vulnerabilities; and (4) how risk exposures and vulnerabilities are shifting within as well as across larger populations,

including the increasing risks of downward mobility among previously “advantaged” groups. An empirical example of how risks change is a Health and Retirement Study (HRS) showing that, unlike with younger workers, job strain is not related to older workers’ (average age 60) alcohol misuse, though it is related to their depressive symptoms.

In line with these considerations, Kuh and Ben-Shlomo (2004, p. 458) argue for the need for life course epidemiologists and policy makers to move beyond childhood interventions to “identify opportunities to break adverse chains of risk at other life stages” (see also Berkman et al., 2011). Their emphasis on the need for policies around adolescent and early adulthood transitions “to provide not just safety nets but springboards to alter life course trajectories with benefits for subsequent health” could also be applied to transitions throughout older adulthood. Consider, for example, the effects of taken-for-granted policies that limit access by age (such as Medicare at 65) or age discrimination related to limiting the rehiring of laid-off older workers.

Risk is also rooted in the theory of socioeconomic position as a *fundamental cause* (House, 2002; Link and Phelan, 1995, 2002) of health disparities. A promising future sociological research agenda on age, health, and well-being would build on a growing body of work emphasizing the embeddedness of individuals in particular social structures with corresponding risks, rules, claims, and resources that shape their beliefs, behaviors, health, and life quality *over the life course* (see House, 2002; Link and Phelan, 1995; Lutfey and Freese, 2005; Phelan and Link, 2005; Phelan et al., 2004; Tilly, 1998; Turner, Wheaton, and Lloyd, 1995; Wheaton and Clarke, 2003).

The fundamental cause theoretical approach suggests that changing the allocation and distribution of key socioeconomic resources (such as education and income) early in life may well be the best way to prevent health and mortality risks and to reduce disparities in them (Hasse and Krücken, 2008; Hayward and Gorman, 2004). But adult development and aging are not simply *path dependent*, unfolding as a result of childhood experiences and early adult choices. (Related to this focus on the early life experience, Kuh and Ben-Shlomo [2004] suggest that “magic bullet” policies of a particular pill or early biological programming of fetal or infant growth are deeply suspect.) Rather, development throughout adulthood takes place within interdependent structures and schemas of interpretation (institutions) guiding its progression and possibilities through processes of allocation, socialization, and strategic adaptation throughout the life course. A promising area of future inquiry concerns *institutionalized mechanisms*: how the social organization of education, occupations, neighborhoods, consumption, and health care perpetuates differential access to and quality of information, medical treatments, income, stress, self-esteem, and other

resources, along with different lifestyle behaviors (such as smoking, exercise, and diet/eating habits).

Stress process and life course scholars (e.g., Avison et al., 2010; Elder, 1974, 1998; Moen and Chesley, 2008; Pearlin, 1999; Pearlin et al., 1981, 2005) underscore the fact that both resources and claims shift with time, altering the social environments in which lives play out. For example, it has been well established in observational research that social conditions of work matter for health and life quality, including positive self-conceptions, depressive symptoms, and behavior, as well as heart disease (e.g., Kahn, 1981; Karasek, 1979; Karasek and Theorell, 1990; Keyes, 1998; Kohn and Schooler, 1982; Mirowsky and Ross, 1998; Muhonen and Torkelson, 2004; Ross and Mirowsky, 1992; Ryff and Keyes, 1995; Thoits, 1999; Wheaton, 1990). But how are favorable social conditions of work *and of retirement* distributed by age and social location? Much is known about healthy work and the psychosocial job conditions promoting physical and mental health, but the impacts on health and well-being of psychosocial *retirement conditions* have *not* been as fully investigated.

Rather than focusing on health care or the treating of medical conditions once they have arisen, scholars are increasingly pointing to the value of social and economic policies as “health” policies, in terms of the potential for policy initiatives lessening the risks of socioeconomic, gender, racial/ethnic, age, and other inequalities at all ages and life stages. This opens up a fertile future research agenda when prevention is framed as social and economic policies, such as those shaping labor markets, social welfare, housing, and pensions, not only health-care policies (Hedge and Borman, 2012; Mechanic, 2006; Schoeni et al., 2008; Syme, 2007). Even ostensibly “age-neutral” policies and practices are often age-graded. For example, a cable company has launched an initiative to “Bridge the Digital Divide” by providing poor households with a computer and Internet connection for a low monthly fee. But “eligibility” is defined by whether the household has a child who qualifies for free breakfasts at school, effectively removing the households of older adults from the pool.

### A New Risk Environment

Scholars are increasingly theorizing “risk” as characterizing the contemporary life experience, concomitant with an uncertain global economy, new information technologies, and the unraveling of conventional employee protections around job security and conventional retiree protections around health insurance and income security (Beck, 1992; Blossfeld, Buchholz, and Hofäcker, 2006; Neumark, 2000; Quadagno, Kail, and Shekha, 2011; Schmid, 2008; Taylor-Gooby, 2004; Williamson, 2011). Taylor-Gooby (2004) defines new social risks as “the risks that people now face in the



course of their lives as a result of the economic and social changes associated with the transition to a post-industrial society” (pp. 2-3). One set of risks emerges from the need for two incomes to support a family and the attendant difficulties of integrating work and family obligations. Another comes from the rising numbers of older people, along with gendered and family-based patterns of care (Daly, 2001; Pavalko, 2011; Saraceno, 2008). Third are changes in a labor market that has become globally competitive, interdependent, and unpredictable. The risk concept has moved beyond simply safety nets, given that existing safety nets are both increasingly costly and eroding, producing a need for future scholarship capturing the escalation of uncertainty and risk now being institutionalized in the form of temporary jobs, the erosion of the contract linking seniority with job security, and the dismantling of economic security in the move from defined benefit to defined contribution pension programs.

A combined institutional and life course research agenda theorizing and investigating age-graded risk would emphasize the ways both the structures and cultures of society (and the social policies and processes they generate) operate so as to unevenly distribute risk across social groups and how these disparities shift with age, life stage, and across cohorts. Research is needed on how established protections for older adults are at risk of diminishing or even unraveling (being deinstitutionalized) and how *institutional entrepreneurs* might be responding with the development of new arrangements. Sociologists, demographers, and social epidemiologists can make real contributions to science and society by investigating whether and under which conditions deliberate *shifts* in social structures—including policy regimes shaping retirement, civic engagement, education, housing, income supports, and paid work—produce corresponding shifts in exposure to and durations of risk factors contributing to poor health and mortality. Income and insurance supports (such as Social Security and Medicare aimed at later adulthood), SSI programs (aimed at those with a disability), and private-sector pensions and disability insurance can be key mechanisms for reducing socioeconomic disparities in health and risks among adults as they age. Required are systemic programs of research similar to that by Herd, Schoeni, and House (2008) showing that later-life income supplements can reduce self-reported disability. A first step is investigating existing institutionalized social environments to locate antecedents, exacerbators, and moderators of later adulthood disparities in risks and protective factors. Second is documenting how policies, risks, and protective factors *change* over the life course, across cohorts, and *over* historical time (c.f. Van Dalen and Henkens, 2002). These are especially promising directions for future research and theory development. Most fruitful would be *multilevel, longitudinal* analyses and randomized field experiments in organizations and communities incorporating policies and practices into the dynamic analysis



of risk processes and mechanisms by locating individual (micro-level) risk behaviors and other outcomes within the shifting macro-level contexts of nations, states, regions, or cohorts (and/or more meso-level forces across workplaces, work groups, local government agencies, social networks, voluntary associations [such as Senior Centers], neighborhoods, or medical clinics) (see also Silverstein and Giarrusso, 2011).

A promising future research agenda on risk based on a combined life course and institutional theoretical framing would draw attention to the multilevel factors shaping the processes culminating in risk behaviors, such as obesity, smoking, or insufficient sleep. It can also help to identify other age-graded institutionalized pathways and mechanisms promoting health and well-being. Scholarship to date often seeks *individual-level* explanations, ignoring the larger socioeconomic, policy, and organizational systems shaping them. Considerable future study is needed as to why and how risks and risk-related behaviors are socially distributed by education, race, gender, *and* age (and their intersections), and how institutionalized age-graded policies and practices can *reduce* as well as exacerbate risk.

### SOCIAL INTEGRATION/SUPPORT/ISOLATION

Closely aligned with themes of age stratification and health risks are the concepts of *social integration* (and related concepts of engagement and participation), *social support*, and *social isolation*. These, too, are institutionalized in terms of role allocations and expectations; as individuals age, they exit the traditional adult roles of gainful employment and childrearing—both key sources of social integration—typically without moving into other public or family roles (other than that of care-provider for infirm relatives and grandparenthood). Some (Berger and Luckmann, 1966; Durkheim, 1897 [1951]) see institutions like the family, religion, and community organizations as key *intermediary mechanisms*, mediating institutions buffering individuals from the larger bureaucratic forces of markets and governments (see Figure 9-2).

But fundamental changes in the institutions of marriage and the family (c.f. Cherlin, 2009) and changes in family demography (in the form of fewer children, parenthood initiated at later ages, increasing divorce and remarriage, growing legitimacy for same-sex marriages, the high proportion of unwed pregnancies, and marriage or parenthood forgone) are challenging established norms about filial responsibility and reducing (or sometimes expanding) the networks of kin available for and willing to care for ailing older relatives. Extended durations of family relationships as a result of increasing longevity also change the nature of kinship ties, meaning that generational roles are lasting longer than ever (Saraceno, 2008), increasing the odds of older adults becoming care-providers for even older aging

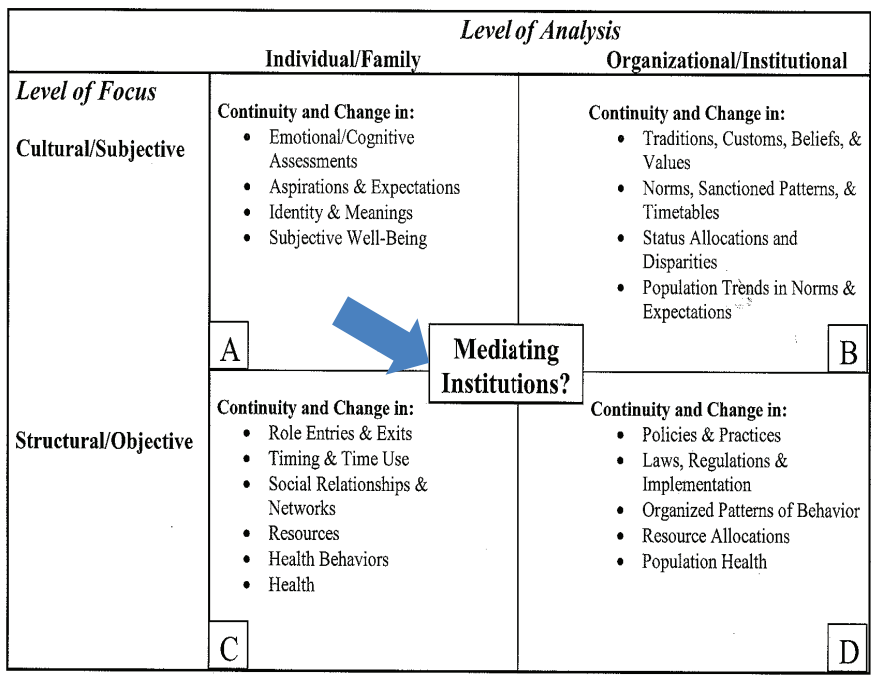


FIGURE 9-2 Different levels of analysis and focus.

parents/infirm spouses as well as sources of economic support for their adult children. Marriage is an important form of social support and has been linked to reduced illness and increased longevity. But divorce and step-families, along with lower fertility rates, have increased the odds that older adults will move through their later years alone, with little family support. Women are more apt than men to be or become single (due to different widowhood, remarriage, and mortality rates). An extended kinship system, long believed to be key source of support for African Americans, may no longer be operating as such (see Brewster and Padavic, 2006; Franklin and Ragoné, 1998; Moller, 2006; Wilson, 1987). What is not known is under what conditions kinship and/or personal ties promote greater stress or support, or some mix of both, how this changes over the life course, and the consequences for individual health and well-being.

Essential for future theory, research, and policy development on aging in the 21st century is recognition that institutionalized policies and norms undergirding the standardized life course (based on education in youth, childrearing, and employment through earlier adulthood, and withdrawal from these roles in later adulthood) mean progressively fewer

*institutionalized options with age for meaningful public engagement*, even as the proportion of (healthy) older Americans is expanding exponentially (Freedman, 2011). The primacy of paid work and the (male) career mystique are reified in policies that support and reward (with pensions and Social Security as well as income) the lock-step patterns of continuous full-time work followed by the continuous full-time leisure of retirement, based on middle-class, white, married men's experiences in the middle of the 20th century. What opportunities do exist for continued public engagement in later adulthood are not evenly distributed; for example, an HRS study found that educated older adults are more apt to be engaged as formal volunteers for organizations than those less advantaged (McNamara and Gonzales, 2011; see also Cutler, Hendricks, and O'Neill, 2011; O'Neill, Morrow-Howell, and Wilson, 2011).

A life course/institutional approach also points to the potential payoffs of innovative scholarship on changes in social integration as a result of life transitions resulting in the movement of individuals into, out of, or through institutions, occurring in the contexts of both expectations and large-scale transformations. Transitions out of paid work, the onset of disability, or chronic health conditions can trigger changes in network ties, possibly precipitating greater isolation (Cornwell, Laumann, and Schumm, 2008; Smith and Christakis, 2008). A turbulent economy, unexpected layoffs, and spells of long-term unemployment limit opportunities for paid work in later adulthood, even as paths to other public roles (such as unpaid community service) are not always clear. Because research evidence underscores the importance of social relationships and meaningful activity for health and well-being (see Berkman and Breslow, 1983; Berkman and Syme, 1979; House, Landis, and Umberson, 1988; Rowe and Kahn, 1998; Umberson, Crosnoe, and Reczek, 2010), there has been a focus on productive engagement in later adulthood (Morrow-Howell, Hinterlong, and Sherraden, 2001). But this approach is often based on a choice model and can lead to blaming individuals who are not engaged for their own social isolation. As Estes, Mahakian, and Weitz (2001, p. 194) observe: "The use of the productive aging concept obfuscates what is a macro problem—a society that stigmatizes and 'throws away' a particular age segment (and more) of its people—and redefines it as a micro problem of individuals who are aging."

### CONSTRAINED AGENCY: CONTROL CYCLES, ADAPTIVE STRATEGIES

Loose coupling between institutionalized rules, policies, and conventions, on the one hand, and organizations, families, or individuals on the other, opens up opportunities for agency in the form (individual, family, or organizational) of nonconformity, noncompliance, lip service, innovation,

and change. The concept of agency is defined by Emirbayer and Mische (1998, p. 970) as “temporally constructed engagement by actors” operating through “the interplay of habit, imagination and judgment.” Similarly, Mortimer and Shanahan (2003) define agency as the ability to exert influence on one’s life. Sociologists’ attention to agency parallels the importance psychologists and social psychologists place on the concept of *control* or *mastery* (c.f. Bandura, 1976, 2001; Gecas, 2003; Pearlin et al., 2007) and the emphasis by epidemiologists and occupational health scholars on the importance of (job) control for health and well-being. Sociologists point to the unequal distribution of control (agency/mastery), with life course scholars in particular emphasizing “cycles of control” that ebb and flow over the life course (Elder, 1974, 1985, 1998; Moen and Spencer, 2006; also Shanahan et al., 1996).

Importantly, agency (mastery/control) is not simply the absence of constraining social structures; rather, *degrees of choice and control are institutionalized within the social organization of and power distribution in roles and relationships*. Some policies, practices, and conventions permit greater opportunities for agency than others (see, for example, a workplace innovation giving employees greater control of their work time in Kelly, Moen, and Tranby, 2011; Moen et al., 2011). For example, children cannot “choose” whether or not to attend grade school, but older adults with sufficient economic resources can choose to go back to school, whether formally in colleges or informally in institutions like Elderhostels. Thus, agency is itself a variable, with individuals having more or less control over their lives depending on their location—within history (Hitlin and Elder, 2007), within institutionalized social structures (Marshall, 2005), and within existing age-related exigencies (such as level of income or poor health).

Control (mastery/agency) operates within the cultural dimensions of institutional *logics* (Thornton and Ocasio, 2008; see also Friedland and Alford, 1991; Meyer, 2008; Meyer and Jepperson, 2000; Scott et al., 2000), the principles and vocabularies of motive defining the meaning, beliefs, and practices of institutions. Individuals and organizations are embedded within different (and sometimes contradictory) institutional logics dictating both legitimate goals/values and the legitimate means with which to achieve them. What is important is that these very contradictions can open up opportunities for greater agency and institutional change. Moreover, actors reproduce or change structures in “interactive response to the problems posed by changing historical situations” (Emirbayer and Mische, 1998, p. 970). When there is *loose coupling* or *decoupling* (deliberate disconnects) between institutionalized means and goals (Boxenbaum and Jonsson, 2008), or across what Settersten and Gannon (2005) call “adjacent” institutions (such as government and business, or work and family), there is sometimes greater room for discretionary action (see also Merton, 1968).

An innovative research agenda investigating the links between institutions, age, and the life course should attend to two promising concepts—*control* and *strategies of adaptation* as worthy of further theoretical development and analysis.

### Control

While agency is often discussed broadly as a philosophical issue (Meyer and Jepperson, 2000), analogous concepts of mastery and control have been theorized and empirically tested as key components of risk (the absence of control) and resilience (control or mastery as a protective factor (see Avison et al., 2010; Fry and Keyes, 2010; Pearlin, 2010; Pearlin et al., 2005, 2007). In his job strain model linking stress and negative health outcomes with high psychosocial demands and low job control, Karasek (1979, p. 290) describes job control as an employee's "potential control over his tasks and his conduct during the working day," operationalizing job control as having two related components: "decision authority" and "intellectual [or skill] discretion." Building on Karasek (1979) and Karasek and Theorell (1990), scholars have theorized the importance of job control for health, demonstrating empirically in observational studies (cross-sectional and longitudinal) that job control (over how work is done) has both direct and buffering effects in reducing the risks of strain and the impacts of stress on health and well-being. Job control has been empirically linked to exhaustion and depressive symptoms (e.g., Mausner-Dorsch and Eaton, 2000), happiness (e.g., Argyle, 1999), psychophysiological stress responses (e.g., Lundberg, 1996), blood pressure and mood (e.g., Rau and Triemer, 2004), alcohol use (e.g., Tinney, 2003), heart disease (e.g., Bosma, Stansfeld, and Marmot, 1998), mental and physical health (e.g., D'Souza et al., 2003), work-family conflict and strain (e.g., Thomas and Ganster, 1995), and a more integrated concept of organizational wellness (e.g., Bennett, Pelletier, and Cook, 2003). Thus, there is ample evidence in the occupational health literature linking job control (decision latitude and skill discretion) with health and well-being (see also Van Der Douf and Maes, 1999). Note that this research is on working-age populations, with age considered only as a control. But this body of work suggests the importance of future research on control among older adults, both in the form of a sense of mastery and in terms of control over the amount and type of their engagement in employment, (grand)child care, caregiving for aging spouses and parents, and the timing of retirement.

Congruent with this approach, there is a great deal of research in the occupational health literature looking at person-job "fit," as well as the role of job control in moderating the effects of job demands (Muhonen and Torkelson, 2004), suggesting a potentially fruitful research agenda on "fit"

in older adulthood. In his Effort-Reward Imbalance Model, Siegrist (1996) broadened the job strain model to theorize the impacts of the mismatch between workloads and control over long-term rewards (such as job security, self-esteem, and income, as well as opportunities for advancement), a mismatch that may push older workers out of the workforce or require them to put off a retirement they cannot afford.

While *job control* is theorized as a key risk factor impacting mortality and health, *retirement control* may encompass control over the timing of retirement and control over the nature of the exit (voluntary/involuntarily, a gradual or a sharp exit, multiple exits/re-entries), as well as control over the *conditions* of life in retirement. But this has not been theoretically developed. Do older adults have real control over the tasks, scheduling, and conduct of their days and the use of their skills? How is control institutionalized and distributed across subgroups in the later adult years? These are fertile areas of future inquiry.

Control over work time and over the timing of the retirement exit from paid work has received little attention in this literature. And yet temporal work conditions that offer older employees greater *schedule control* in the form of greater flexibility and work-time options, and greater *retirement control* may be especially important for older employees, given the increasing time pressures, time speed-ups, and time conflicts characterizing a global risk economy (see Ganster, Fox, and Dwyer, 2001; Hochschild, 1989, 1997; Kelly and Moen, 2007; Moen and Kelly, 2009, as well as Lesnard, 2008; Thomas and Ganster, 1995). An Amsterdam study (Cooper et al., 2011), for example, shows complex links between mastery and disability, which suggests a rich topic for future research.

A sense of mastery or control is both a function of the institutionalized social environment *and* a contributor to individuals' decisions to *change their environments*. It is also part of the "vocabularies of motive," in terms of how individual actors define their situations and their past actions. To understand individual and organizational behavior requires understanding of the institutional contexts that not only define appropriate behavior but also provide explanations or accounts of that behavior, often couched in the language of choice and control (Friedland and Alford, 1991; Sewell, 1992). This attention to meaning and control is crucial in the study of aging, health, and life course trajectories and transitions, in that individuals define and assess their age-graded behavior (such as retirement, employment, and residential mobility) as voluntary or involuntary, expected or unexpected, with corollary health outcomes. For example, a retirement exit can be seen as a passage to (well-deserved) leisure, the unwanted result of downsizing and accompanying (early) retirement packages, the result of a health condition, a necessity in order to care for spouses or parents, or a transition to

a new career (as in exits from a military career into a “civilian” one), with adults perceiving different degrees of choice.

### Adaptive Strategies

Life course scholars (e.g., Elder, 1974; Elder and Johnson, 2002; Elder, Johnson, and Crosnoe, 2003; Marshall, 2005; Moen and Wethington, 1992; Settersten and Gannon, 2005) describe how individuals and households confronting situational exigencies typically respond according to institutionalized blueprints. But in times of social change and in the absence of relevant blueprints, or else when different sets of rules associated with different institutions (such as work and family) seem to contradict one another, or when there is loose coupling between goals and means (see also Elder and O’Rand, 1995), actors try out various *strategies of adaptation* (Moen and Wethington, 1992) in seeking to meet the challenges of their lives. One of Elder’s key life course principles is that people fashion their own life courses, making choices within the confines of the times and circumstances of their lives (Elder and Johnson, 2002). An institutional/life course perspective suggests that the *toolkits of possible adaptive strategies* are themselves constrained at different ages and life stages by existing structures (schematic and material resources; see Sewell, 1992), with the degree of personal control socially stratified and unevenly distributed across the life course.

An example of the way institutional arrangements limit or expand adaptive strategies in later adulthood (and in doing so affect geographical population distributions and compositions as well as health and well-being) is in decisions around residential shifts versus “aging in place” (Haas and Serow, 2002; Krout and Wethington, 2003; Longino, Perznski, and Stoller, 2002; Streib, 2002). Consider the development and proliferation of residential communities for “active adults,” typically aged 50 and older, an emerging institutional arrangement specifically commodifying old age that is selectively available to those who are both healthy and well-off. Older adults with sufficient wealth and income may choose to move to such communities or simply to apartments or condos in warmer climates. These are what Gilleard and Higgs (2005, p. 132) call “silver-agers,” poised to “transform the chilly landscape of later life” by making what Longino terms “amenity” moves (Longino, Perznski, and Stoller, 2002). By contrast, older adults with low incomes have few choices as to whether or not to relocate except to nursing homes or subsidized group residences or else to move in with their adult children. Other recently institutionalized housing arrangements are Continuing Care Retirement Communities (see Krout and Wethington, 2003; Krout et al., 2002), but these, too, are only available for those who can afford them. Programs established in the 1960s, such as



“meals on wheels,” aim to facilitate older adults remaining in their own homes. But, older singles who “choose” to live alone in their own homes can be especially at risk of social isolation even as they may feel a greater sense of agency. Future study of how institutions articulate with the choice and nature of living environments may be increasingly significant for understanding aging processes.

### TIME, PLACE, AND SOCIAL CHANGE

Sociologists can promote understanding of both behavior and life quality in the aging process by investigating the ways time, age, and the life course are socially organized; institutionalized time and age regimes are both simultaneously invisible *and* fundamental to the human experience. The concepts of “time” and “place” point toward institutionalized regimes defining where and when different behaviors should occur; they also serve as markers of the (institutionalized) contexts of history, political regimes, cohorts, and cultures, both as they exist and as they change over time. Temporal structures of some sort are, of course, essential for coordination and regulation. Durkheim (1912) observed the regulatory aspects of the calendar as an expression of “the rhythm of collective activities, while at the same time its function is to assure their regularity.” And Merton (1968) highlighted the importance of socially structured durations. But little is known about the temporal regularities and socially expected durations of those older people whose lives are no longer organized by paid work.

When scholars locate individuals within existing institutions, there is the danger of treating the organized structural environment as fixed, the background or stage upon which the experiences of social actors (individuals or families) play out. It is hard but essential for innovative research over the coming decades to study changing lives *and* changing structures, as well as the links (including mismatches) between the two. For example, what does it mean to grow old in a society that is itself growing older? Gilleard and Higgs (2005, p. 147) suggest that changing norms and practices potentially free individuals from outdated arrangements: “The weight of neighbourhood, work and family traditions has become less heavy.” Another example, the increasing proportion of the older population who are healthy challenges traditional images and identities associated with growing older. It also suggests the future importance of a powerful interest group of older voters that is already shaping social policies (Campbell, 2009).

As Riley (1998, p. 151) points out, “changes in lives and changes in social structures are fundamentally interdependent.” Promising future research directions lie in capturing the power of social life in influencing individual development and aging even as “social contexts, no less than individuals, are continuously reconstituted in social activity” (Dannefer,



2011, p. 12). Scientific and social advances can occur through theory development and policy analysis of the ways policy makers' efforts to respond to 21st-century realities of an aging population are having both deliberate and unintentional (as well as sometimes contradictory) effects on the multilayered, overlapping social structures shaping age, aging, and the life course paths. For example, the shift to delay full Social Security benefits to age 67 and the movement away from defined benefit private pensions are transforming the taken-for-granted clockworks of retirement. In what ways is the Age Discrimination in Employment Act of 1967 together with changes in the tax code facilitating post-retirement employment?

Lives are lived upon a multilayered moving platform of change that is either (1) reproducing or reconstructing existing institutionalized assumptions or arrangements, (2) challenging existing institutionalized assumptions and arrangements, or else (3) constructing and legitimizing new ones. Hargrave and Van de Ven (2006) describe four modes of institutional change: (1) *institutional design*, deliberate efforts at changing policies and practices; (2) *institutional adaptation*, changes made in order to conform to external environmental forces; (3) *institutional diffusion*, as when some arrangements are widely adopted and spread; and (4) *collective action*, when political behavior leads to the development of new institutions. It is the fourth form that is the least understood. Studies promoting understanding of *changing social institutions and contexts* shaping the aging process, therefore, need to be incorporated into a research agenda investigating the links between social structures, aging, and individual outcomes in order to identify promising interventions to promote life quality and life chances.

## FUTURE DIRECTIONS

There is a multiplicity of social institutions (policies, programs, practices, conventions) structuring the expectations and choices, transitions and trajectories, risks and resources (including health and well-being) of adults as they move through later adulthood. This chapter has provided an overview of fundamental concepts in sociology, demography, and social epidemiology that, when combined with an institutional and life course framing, suggest potential for major theoretical and empirical advances.

Studies of the aging process could be considerably advanced through conceptual, theoretical, and methodological reformulation that incorporates and infuses both institutional and life course framings with central social science theories and constructs. The result? A fruitful research program encapsulating both *institutional embeddedness* and multiple layers of individual, family, organizational, policy, and societal *change* (as depicted in Figure 9-1). I propose four ways of organizing scholarly inquiry with

possible payoffs for the development of new knowledge about the aging process and the promotion of policy agendas.

### Moving Beyond Individuals as the Unit of Analysis

Theory and research on aging to date tend to focus on proximal *individual* predictors of outcomes, not larger (institutionalized) contexts, processes, and mechanisms (Syme, 2007). To address larger questions about the impacts of the conventions, policies, and practices institutionalizing social life requires comparative, ecological, panel, and/or intervention research designs looking at multilevel collective properties and empirical social processes. Sampson (2010, p. 72) notes that survey research with an emphasis on precise population estimates for individual parameters continues to rule the roost. He proposes: "The basic idea is take the measurement of ecological properties and social processes as seriously as we have always taken individual-level differences." Sampson (2010, p. 72) also points to the need to "take seriously the study of community-level processes in their own right." To that I would add to take seriously organizational, occupational, associational, regulatory, family, and governmental policies and conventions as well, as they intersect with individual lives in later adulthood to shape health and multiple aspects of the aging process.

A research program of comparative cross-cultural and cross-cohort analysis is essential for revealing the *socially constructed nature* of (within country and within cohort) age- and gender-based divisions and supports, as well as understanding the impact of existing *and emerging* institutional regimes on individual experiences, such as gendered employment paths and the timing of retirement (Blossfeld and Hofmeister, 2006; Ebbinghaus, 2006; Kohli et al., 1991; Schmid, 2008).

### Studying Social Change Within and Across Cohorts

A rich research agenda lies in understanding agency in the form in which individuals negotiate conflicting institutionalized norms and arrangements as they age, as well as the ways social actors are changing both norms and policies in light of increasing life expectancy and a turbulent global economy. Tied to this agenda is understanding the impacts of these changes on the experiences, risks, and resources of different cohorts and different subgroups of the population.

Institutionalized beliefs, expectations, practices, and structures shaping later adulthood risks and possibilities are both deliberately *and* inadvertently changed in transaction with other social forces, including the aging of the population, the Boomers swelling the ranks of older workers, new technologies, and an uncertain global economy. Important future research

questions are as follows: What are the impacts on aging processes of a global information economy combined with the new flexibilization of work that is destroying the conventional social contract linking seniority with security? How is the deinstitutionalization of “normal” retirement affecting the self-concepts, expectations, preferences, and decision making of older workers and retirees (men and women) in different cohorts at different ages and stages? Studies are needed investigating how changes in the structure of the employment relationship are articulating with other structural changes in the economy to reshape the job insecurity and retirement exits of older workers (see also Neumark, 2000).

Another fundamental matter for future research on aging is whether and to what extent *deliberate changes* in social structures (such as loosening the time/age cages around retirement and employment) can produce corresponding changes in the health and well-being outcomes of older Americans. Deliberate policy shifts can also change social structures, challenging taken-for-granted expectations and practices (structural *leads* rather than *lags*). I see four possible avenues for change that might delay exits from the workforce, all requiring considerable lines of investigation:

1. Reframe the standard duration of work days, work weeks, and work lives to include more options.
2. Develop new standards or norms regarding work *sabbaticals* for workers in a range of occupations, as well as possibilities for *scaling back* on time demands.
3. Facilitate possibilities for *second, third, or fourth acts* in schooling, civic engagement, and employment for people of all ages.
4. Modify *social insurance policies* and promote *training and skill upgrades* for older workers to respond to the risks and transitions of a turbulent labor market, reduced job stability, and chronic job insecurity.

Fundamental questions for a course of future research have to do with such structural changes in schematic and material aspects of aging and social entrepreneurs fashioning *structural leads*: What organizations and agencies are introducing transformative innovations in career paths, retirement options, education/training opportunities, civic engagement, and illness prevention? What innovative policies regarding work time, retirement timing, health care, education, and income would promote alternative and flexible employment paths that might promote the mastery, health, and well-being of older Americans?

Urie Bronfenbrenner (2005) often said (quoting his own mentor, Charles Dearborn) that if you truly want to understand something, try to change it. Kuh and Ben-Shlomo (2004, pp. 454-456) and Berkman, Ertel,

and Glymour (2011) point to the importance of intervention studies and natural experiments that can provide the best evidence in terms of causality, direction of effects, and the importance of factors not commonly considered in public health research, noting the potential value of systematic literature reviews and meta analyses. Important topics for aging research within and across cohorts include how peoples' sense of efficacy, mastery, or *control* over their lives shifts behavior (such as the incidence and timing of employment and family transitions); how (expected and unexpected, voluntary and involuntary) *transitions* alter older adults' sense of control; and whether unraveling institutional arrangements promote or detract from feelings of control.

### Capturing Social Heterogeneity, Risk, and Inequality

There is increasingly a range of diverse paths by which people age, but insufficient scholarship theorizing and empirically assessing whether and under what conditions taken-for-granted, institutionalized age-graded regularities continue to operate, as well as the costs of deviating from the standardized life course. For example, Social Security provisions reward the typical adult life course of uninterrupted employment, thereby privileging those (often educated men) who have historically been able to follow such a path (Wise, 2004). But contemporary cohorts of older workers now include large numbers of women as well as men, and both women and men are making their final labor market exits in a variety of ways. More research is needed on the order of the scholarship on earlier cohorts by Henretta (1992); Warner, Hayward, and Hardy (2010), who examine different retirement exit patterns of women and men; and Wise (2004), who links the labor force participation of older workers to particular social policies.

Another concept, risk, may also benefit from a combined life course/institutional approach—from studies of age as a risk factor in social policy development to risk exposure, vulnerabilities, and experiences (including employment, economic, and retirement insecurity) addressed by social psychological theories of the stress process and social epidemiological emphasis on (institutionalized) social conditions directly and indirectly impacting health throughout the life course. The new “risk” economy, for example, may be lessening the advantages of middle-class adults, given that both public and private benefits and job security protections are eroding (de Vroom and Bannink, 2008; Schmid, 2008; Taylor-Gooby, 2004).

Importantly, age and gender persist as key organizing principles shaping society through existing and emerging institutional arrangements. Studies of mortality, health, and other outcomes that statistically “control” for age and gender, along with studies that do not consider the historical context or the cohorts being investigated, cannot capture the ways institutionalized

opportunities and constraints—stratified by both of these locational markers and by history—affect the outcomes being studied. Treating gender, socioeconomic status (such as educational level), race/ethnicity, nativity, and disability status as individual attributes potentially ignores the ways they *systematically structure* the experiences of individuals and families (such as by defining care as a family [and specifically women’s] obligation and through the differential wage rates and advancement opportunities advantaging white, college-educated men) throughout the life course, culminating in disparities in life chances and life quality in later adulthood. A research agenda on inequality by race, class, gender, and age (as well as other markers) as *embedded in institutions* suggests intervention possibilities and policy solutions, rather than simply documenting inequality across these attributes.

Most existing social institutions are (deliberately or not) designed to produce age-graded distinctions that affect the allocation of goods, services, risks, resources, and opportunities for those of different ages. Promising future research could document how these arrangements can exacerbate, perpetuate, or reduce age, gender, or socioeconomic inequalities in health and other outcomes in later adulthood.

The Mathew Effect, the idea that the rich get richer and the poor get poorer that is the basis for the cumulative advantage/disadvantage theory, is about long-term disparities. But there are also age-based disparities and protections that emerge in tandem with growing older, a consequence of the setting up of later adulthood as a distinctive stage of the life course separated from “prime” adulthood through images, meanings, and values (culture), as well as social organization and policies (structure) that serve to create and sustain social group distinctions (seen as “seniors,” “the aged,” “pensioners,” “retirees,” the “young-old,” the “old-old,” and increasingly, “the third age”). Whether the age-boundaries around these groupings are becoming more blurred, and whether they are more or less blurred for individuals differentially located in the social structure (such as by gender, class, race/ethnicity, nativity, or disability status) are important theoretical and empirical questions for future scholarship. The answers may well turn on labor market, income support, and residential policies, as well as the health and disability statuses and family circumstances of individuals within particular subgroups of the population (see also Hudson, 2011). Considerable future study is needed as to why and how risks and risk-related behaviors are socially distributed by education, race, nativity, disability, gender, and age, and how institutionalized age-graded policies and practices can *reduce* as well as *exacerbate* risk.

Social policies, cultural norms, and everyday practices effectively categorize and reify age groups (such as “60 and over”) and statuses (such as retired, not retired), *as does social science theory and research*, even though

there may be more heterogeneity within than across categories. Future directions should emphasize the considerable heterogeneity within age groups that make analyses of binaries (such as “55 and older” versus “under 55,” or even “70 and older” versus “under 70”) less useful than more fine-grained age categories (operationalized with ceilings as well as floors) or categories based on ability or life stage. Future research is needed on the conditions under which family, health, career, or retirement course stage matter more in predicting behavior, resources, life chances, and life quality than simply age. For example, a 58-year-old father of a preschooler may behave far differently than a 58-year-old grandfather of a preschooler in terms of labor market/retirement expectations and behavior.

Other binaries are not inclusive, especially of the rising proportions of unstandardized circumstances falling outside of conventional institutionalized structures. Consider, for example, the employment/retirement dichotomy. It omits those with no “career job” to retire from, the increasingly common “working retirees,” or what Gibson (1996) refers to as the “unretired retired”—those 55 and older who define themselves as not working and not retired. What is needed is a fuller conceptualization of the range of conditions older Americans experience, and their consequences.

Thinking about sample selection is another major theoretical as well as methodological issue. Who is “selected” into or out of research samples is critical in estimating the implications of the findings. For example, there is selective mortality in the fact that those with the most health problems die at earlier ages, meaning that older populations always consist of more healthy survivors. And studies of the retirement expectations or behaviors of “older workers” of a certain age omit those who are not in the labor force as well as those who have *already* retired, suggesting the value of future studies capturing the dynamics of trajectories and transitions over a period of time.

Future directions should include comparative and multilevel studies across cohorts, historical periods, regions, organizations, and policy regimes to highlight the ways differences and/or shifts in social policies and conventions affect patterns and processes of population and individual aging, as well as the mechanisms involved. Natural and randomized field experiments of changing policies and practices are promising research methodologies permitting scholars to assess the micro-level impacts of changing meso-level contexts or changing macro-level forces.

Another vital topic for future research in the coming decades is: Which and under what conditions do families, social networks, and community organizations *buffer* older adults from institutionalized state and market bureaucracies (see also Figure 9-2). For example, marriage has been shown to have a protective effect on survival (Rendall et al., 2011) even as loneliness has negative consequences (Cornwell, Laumann, and Schumm, 2008;

Luo et al., 2012). As Lutfey and Freese (2005, p. 1,332) argue, there are very likely “massively multiple mechanisms” linking structures with health. And there are also other moderators beyond age, gender, race, and class. Investigating potential moderators of the links between institutions and individuals and how these change over the later life course are fruitful avenues for future research.

### Investigating Cycles of Control, Adaptive Strategies, and Meaning

One important future contribution of the social sciences is in clarifying the relationships between structured experience, agency, and self-concepts (e.g., Gecas, 2003) over the aging process. The earlier half of the adult course has been high on research agendas (c.f. Arnett, 2004). There is ample evidence that going to college, getting a job, marrying, having a child, and serving in the military change identities in terms of how people see themselves, and how others see them. But there is insufficient scholarship on how later adult role exits and entrances (as well as their duration and timing) shape self-concepts, feelings of mastery or control, or the perceptions of others.

The lock-step structuring of first education, then full-time employment, then retirement can also affect subjective experiences of cycles of control and stress. Research is needed on the patterns and rhythms of the days and weeks of individuals of different ages and life course stages, as well as how these patterns and rhythms relate to the identities, health, and life quality of older Americans. Current scholarly emphasis on older workers' labor market participation and retirement exits ignores the multidimensions and processual aspects of the life course—that older adults, whether or not employed, are simultaneously community members, friends, family members, and possibly students, with identities, narratives, and expectations associated with their pasts, presents, and futures.

To understand individual and organizational behavior requires seeing institutional contexts as not only defining appropriate behavior but also as providing older individuals with *explanations or accounts* of that behavior that helps them to make sense of their lives (Friedland and Alford, 1991; Sewell, 1992). This attention to meaning is crucial in the study of aging and life course transitions, in that it captures whether age-graded behavior (such as retirement, employment, caregiving, and residential mobility) is voluntary or involuntary, expected or unexpected, all of which are aspects that may well shape health risks. Studies need to be designed to capture subjective assessments. A single case in point: the Current Population Survey asks respondents whether their part-time employment, but not full-time employment or retirement, is voluntary, reinforcing the “normalcy” for



full-time paid work and retirement. But people may be working full-time or retired involuntarily.

Sometimes there is loose coupling or decoupling (deliberate disconnects) between the ways older adults *and organizations serving them* define goals and the means to achieve them (Boxenbaum and Jonsson, 2008). In “Social Structure and Anomie,” Merton (1938) theorized the relationship between widely accepted, socially legitimate goals and the institutionalized means available to attain them, with some segments of the population lacking the means and thus unable to achieve certain goals (or else doing so in less legitimate ways) and others seeking different goals but without the institutionalized means of achieving them. But in later adulthood, are goals typically clearly articulated, much less the means with which to achieve them? A fertile field of sociological, epidemiological, and demographic inquiry consists of studies of the ways (1) older individuals differently located in institutionalized organizations and social structures tend to have different (or any) goals, as well as differential access to institutionalized means of achieving them, and (2) investigations of the ways older adults’ goals and means are related to exposure to and duration of health risks, vulnerabilities, and protective factors.

In sum, this chapter points to the need to theorize and operationalize structures as contexts, that is, institutionalized schematic and material patterns of living (Sewell, 1992) shaping the aging process in myriad ways. Some contexts are physical, such as the absence of sidewalks in certain neighborhoods inhibiting the exercise of older adults. Others constitute built-in inequalities, such as the paucity of medical information for some populations, or the absence of income needed to afford healthy foods. Still others consist of the taken-for-granted conventions about age-related and gender-related participation in paid work, retirement, voluntary associations, caregiving, community activities, etc., that affect the identities, behavior, and well-being of those of certain ages and life stages *as well as* the data and topics scholars pursue. For example, surveys typically sample individuals, but it appears particularly fruitful to sample individuals (or couples) in particular contexts, such as those embedded in certain networks (Smith and Christakis, 2008) or work teams (Kelly et al., 2012).

Finally, the life course itself is more than a developmental trajectory. It is also a gendered social institution, shaped by social norms and structures embedded in systems of education and training; marriage, family, and caregiving; work, retirement, and community; and health behaviors, health care, and social-welfare policies *that are themselves in flux*. This further underscores the value of a dynamic, institutionalized, life course focus on age and aging.



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