***Draft – Please do not quote or circulate without authors' permission.*

Differences that Amplify: Canadians and Americans in Mid-Life Looking to the Later Years

Susan McDaniel, PhD, FRSC, Prentice Research Chair in Global Population and Economy, and Professor of Sociology, University of Lethbridge
susan.mcdaniel@uleth.ca

and

Amber Gazso, PhD, Department of Sociology, York University, Toronto, Canada
agazso@yorku.ca

Abstract

The renowned U.S./Canada comparative political sociologist, Seymour Martin Lipset remarked that "Looking intensely at Canada and the United States sheds light on them both" (Lipset, 1990: xii). We argue here that comparative examination of these two similar but different countries provides a kind of natural experiment, the underpinning ideas of which can usefully travel. In this paper, we offer a comparative study of Canadians and Americans in mid-life in the contexts of sharp shifts in income distributions known to be tied to health, relatively comparable aging populations, and similar but contrasting social policy regimes. The current tumultuous economic climate offers a sense of immediate demand for our research, which attempts to understand and respond to pressing and complexly interwoven social policy challenges. Our perspective here is a synthetic life course perspective, looking both forward to the later years of those now in mid-life and even further forward to the life course prospects for their offspring or younger relatives. We first retrospectively explore how particular policy conceptualizations of globalization, fiscal and social crises (e.g. population aging), new risks, and market citizenship have discursively shaped the restructuring of health and income support policies in ways that exacerbate income inequalities and later life health risks. We then tease out contemporary differences between the two countries and highlight contradictions between policy prescriptions and everyday realities, drawing upon quantitative and qualitative research. We conclude by prospectively considering the toll of income inequalities in later life for younger generations in Canada and the United States.

Paper prepared for International Sociological Association Research Committee 19 Conference, ***Social Policies: Local Experiments, Travelling Ideas***, Montreal, 20-22 August 2009

Comparing the United States with Canada has become something of a sub-industry in the social sciences. Zuberi (2006:23) notes that "…comparing Canada to the United States is a national sport in Canada, second only to hockey." Yet, "[l]ooking intensely at Canada and the United States sheds light on them both" (Lipset, 1990: xii). We argue that comparative examination of these two similar but different countries provides a kind of natural experiment, the underpinning ideas of which can usefully travel. In this paper, we offer a comparative study of Canadians and Americans in mid-life in the contexts of sharp shifts in income distributions known to be tied to health, relatively comparable aging populations, and similar but contrasting social policy regimes. The current tumultuous economic climate offers a sense of immediate demand for our research, which attempts to understand and respond to pressing and complexly interwoven social policy challenges.

Our perspective here is a synthetic life course perspective, looking both forward to the later years of those now in mid-life and even further forward to the life course prospects for their offspring or younger relatives. We first retrospectively explore how particular policy conceptualizations of globalization, fiscal and social crises (e.g. population aging), new risks, and market citizenship have discursively shaped the restructuring of health and income support policies in ways that exacerbate income inequalities and later life health risks. We then tease out contemporary differences between the two countries and highlight contradictions between policy prescriptions and everyday realities, drawing upon quantitative and qualitative research. We conclude by prospectively considering the toll of income inequalities in later life for middle and younger generations in Canada and the United States. Comparing those in mid-life over

time as they anticipate their later years in two neighbouring, similar countries with contrasting policy approaches, particularly to health care but also on other social policies, sheds light on the social forces, including policies, that make a difference in people's lives and mitigate (or not) the challenges of aging populations.

Income inequality has increased significantly in recent decades on both sides of the 49th parallel. Why does this matter to health risks in later life? Because a high-inequality equilibrium means that aging tomorrow may be riskier for health and well-being overall than aging today. Today's elderly are, on average, the beneficiaries through their life courses of good socio-economic times – rising real incomes, job security and benefits, more reliable public risk insurance, and more stable families. Expectations are generally high about "good aging" among those looking toward their later years. This may lead to a false sense of security and mask the implications, both policy and personal, of growing income inequalities for healthy aging for those now in mid-life. We ask two research questions in this paper: 1) What are the implications of growing income inequalities for health risks in later life in Canada and the U.S.? 2) How do health risks in later life in Canada and the U.S. compare given differing health and aging policies in the two countries? In the context of the theme of this conference, we further ask whether and to what extent knowledge gained about these two countries can travel to either country and/or to other situations?

That aging populations may pose policy challenges has been a topic of great interest and angst in the United States and also but less so, in Canada. That population aging *per se* is less of a challenge than is sometimes presumed has been definitively shown, although not fully accepted in policy circles in Canada (McDaniel, 2003; Prince,

2000). Less research has been done on the policy challenges to health of aging population in the context of growing income inequalities. And virtually no research as yet has been done on the interaction of aging population and growing income inequalities in the current context of economic crisis and recession.

This is a propitious moment for our research for several reasons. The largest generation (born 1946-66), the leading edge of which is encompassed in our focal group, is entering later life over the next 20+ years. Alarmism about demographic aging creating dire policy implications is in need of empirical testing (McDaniel, 1998a). The period of post-World War II (encompassing most or all of the life courses of our mid-life group) has been characterized by growing material prosperity for most in both countries, large-scale and diverse immigration, and increasing instability and variation in families and lifestyles (Mandell, Wilson and Duffy, 2008; Wolfson, 1998). Recent decades have seen a shift away from deep-seated ageism and widespread lack of means among those in later life, to a more thorough-going acceptance of the later years as a time of recreation and enjoyment of the fruits of a lifetime of hard work (McDaniel, 2001; Wolfson, 1998), a tendency being called into serious question with growing income inequalities (Gazso, 2007b; Heisz, 2007) and the current economic debacle. The most important reason why this is a propitious moment to study those moving into their later years is on the inequality side, with sharp recent income distribution shifts in both the U.S. and Canada, having effects on health risks for all, but particularly for those who are older. That this is occurring prior to and during the worst economic crisis since the Great Depression makes our research even more compelling and relevant to policy. Of course, the growth in income inequalities is directly connected to the current economic situation.

Context

This research situates itself in three literatures: the policy implications of demographic aging, income inequalities and their implications, and the literature on the relationship of inequalities to health risks. Providing an overarching framework for this paper is the life course perspective (Bernard and McDaniel, 2009; Hicks, 2003; Marshall and Mueller, 2002).

Policy implications of demographic aging generally suggest that with the Baby Boom cohort beginning to enter later life, pressures can be anticipated on health care and pensions, essentially driven by the force of demographic numbers. This has been contested in various national contexts (OECD, 1996), but the image remains prevalent. Our research, in looking at those not yet in the later years, asks the futuristic question of whether or not the cohorts now in midlife will indeed face greater health risks as they head into later life, and pose policy challenges in Canada and the U.S. To explore this question, we place demographic change and cohort size in shifting socio-economic contexts, with particular attention to growing income inequalities and the current not unrelated economic crisis.

The proximate cause of the 2008-09 economic recession is, without much doubt, the housing bubble and sub-prime loan debacle in the United States which has now spread worldwide as a result of intricate global financial instruments such as derivatives and collateralized debt obligations. That said, it has been compellingly argued by Bob Rubin a Goldman Sachs economist and White House advisor (Rubin, 2009), among others, that the underlying structural cause of the current crisis is stagnation in wages (mean and median income has stagnated in the U.S., particularly since the mid-1990s, as shown in

Table 1, yet the U.S. economy grew by 86%), declining household income in the U.S. in the bottom quintile, also shown in Table 1, along with vastly growing incomes at the top of the distribution (in the top 1%, incomes grew by 160%; and in the top 10th of 1% by 350% since 1980).

Table 1 about here

In essence, extensive and deep borrowing by most in the middle and lower income groups in the U.S. made up for wage stagnation, and masked the implications of vastly growing income inequalities. Prosperity was the abiding image, illusory as it was built on borrowed money and the presumption of ever rising house prices. Growing income inequalities, fuelled by the American dream of material aspiration and home ownership, turns out to be a significant contributing cause of the economic crisis of 2008-09, with strong implications for those entering their later years over the next few to twenty years. This may be particularly so in the U.S. but poses problems for those entering later life in other countries as well, including Canada.

Inequality of income in the U.S., growing large in recent decades, is exacerbated by sharp inequalities of public amenities. This is certainly most vivid in the lack of universal public insurance in the U.S., the only country in the developed world to have that situation. It is also apparent with respect to public transit, or rather its absence or inadequacy in most U.S. cities. This means, as pointed out by Rothschild (2009:9), that the poorest spend more than three times more on transportation than the richest, as well as spending much longer times traveling to and from work, shopping and services. And we might add, often paying more for goods and services as a result than those with private vehicles to take them to the suburban big box grocery stores and malls.

In Canada, the pattern of inequalities over time shadows that in the U.S., but is less dramatic. While there was, as seen in Table 1, slippage in the median and mean incomes of Canadians in the 1980s to mid-1990s, gains were made, albeit small, from the mid-1990s. These gains, as for the U.S. in both the 1980s and the 1990s, were less than the OECD average. What has occurred in the top quintile of income from the mid-1980s to the mid-2000s is astounding, however, as shown in Table 1, from a -0.2 average annual increase to +2.1. It is almost as if Canada were rushing to catch up with the U.S. in gains at the top in this period (Murphy, Roberts and Wolfson, 2007). For the top 1% in Canada, incomes grew by 100%; and for the top 10th of 1%, by 260% since the mid-1980s, with most of the growth at the top occurring in the mid-90s to mid-00s (Yalnizan, 2007). In terms of ratios of the richest 10% to the poorest 10%, Canada's ratio in 2006 was 9.4, in the company of countries like Ireland and The Netherlands, while the U.S. ratio was 15.9, comparable to Turkey's (United Nations, 2008).

The link between levels of income inequality and population health is a large question. Wilkinson and Pickett (2006), in a meta-analysis of 168 studies on income inequality and health, find that in 70% of the analyses (some studies included more than one analysis), health is found to be less good in societies where income disparities are larger. Income inequality, they conclude building on Wilkinson's path-breaking previous research (1992; 1996), is an indicator of a society's success in building and implementing equitable social policies and practices. Although the pathways from social inequality to population health need further specification (Starfield, 2007), definitive experiments are difficult to mount given the scale of the interventions necessary (Braveman, 2007), not to mention the challenges of obtaining ethics approvals. We, therefore, benefit in this study

from the long-standing natural experiment in two neighbouring countries with similar standards of living but contrasting policy regimes and levels of inequality.

A key pathway from income inequalities to population health is the *social gradient of health* where each socio-economic level is found to be less healthy than the one above it (Wilkinson and Marmot, 2003; WHO Commission on the Social Determinants of Health, 2008). As inequality increases, the number of socio-economic strata increases largely at the bottom of the continuum, and population health overall declines. That the geographic or neighbourhood effects of the social gradient might be different than those at the national level is important to recognize (Bernard *et al*., 2007; Wen *et al*., 2003), but this goes beyond our focus in this paper. This is particularly so in the later years since longevity, although greater at present than it has been in the past, tends to reach a ceiling for the top socio-economic groups, while for the bottom groups, disability and death come earlier than what we typically think of as the later years (Ferraro and Shippee, 2007; Marmot, 2006). In essence, as the inequality spread widens, people at the bottom of the income distribution age at a faster rate with increased health risks, and there are more bottom strata. As Goran Therborn, the respected Swedish sociologist, argues, *resource inequalities* (income and material capabilities) are deeply linked with *vital inequalities* (of health and life) (Therborn, 2006). This is echoed in the World Health Organization's Commission on the Social Determinants of Health (WHO, 2008:2) when they recommend that improving health requires that we "tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions, globally, nationally and locally." Growing social inequalities enter bodies as they move through life and time with implications for health and aging policies, and ultimately for individual

practices in creating a "life of one's own" (Beck and Beck-Gernsheim, 2002) in the later years.

We rely here on a life course perspective to explicate if, how, and with what policy implications, growing inequalities create population health risks in later life. Our perspective is that advantage and disadvantage accumulate over the life course (Ferraro and Shippee, 2007; O'Rand and Isaacs, 2006; O'Rand and Shuey, 2007), tending to peak in mid to later life. The life course perspective has four basic principles: 1) life is longitudinal**;** 2) lives are multifaceted with individuals contributing to, and deriving resources from, many interlinked social institutions; 3) lives are linked with those of others with profound implications for individual life courses (and for policy) when others close to us experience life changes or challenges; and 4) lives unfold in multiple layers of social contexts – local, national, historical – that shape opportunities and constraints.. For this study, we focus mainly on lives as longitudinal, unfolding trajectories in multiple layers of shifting social contexts, especially the broad contexts provided by close and yet different societies such as Canada and the U.S.

Data and Methods

A multi-method approach is used to answer our research questions (Morse, Wolfe and Niehaus, 2006; Morse, Niehaus, Wolfe and Wilkins, 2006). Quantitative, uni- and multivariate analyses of two waves each (those aged 45-64) of the U.S. National Survey of Family and Households (1998-99 and 2001-02), and of the Canadian Population Health Survey (1994-95 and 1998-99)[1], are examined to assess the relative degree of incidence of income inequality among the cohorts and the resources projected to be

[1] Our hope to use the 2002-03 wave of the National Population Health Survey in Canada was thwarted when we discovered that no public user file had been created for this wave.

available for later years. Health variables in the two surveys are used to assess health status. These analyses are framed by U.S. and Canadian national trends analysis.

After considering a wide range of surveys, the research team decided in favour of two waves each of the National Population Health Survey (Canada) and the National Survey of Families and Households (U.S.). Our reasons were that these two surveys offered the greatest numbers of comparable health and income variables and that two panels of each could be argued to be roughly comparable temporally.

The National Population Health Survey (NPHS) Canada uses the Labour Force Survey sampling frame to draw a sample of approximately 22,000 households. In each household, some limited information is collected from all household members and one person, aged 12 years and over, in each household is randomly selected for a more in-depth interview. NPHS is conducted by Statistics Canada in seven waves every two years beginning in 1994-95 as a longitudinal survey, excluding residents of the three territories and fulltime residents of institutions (Statistics Canada, 2009). In this study, we focus on those aged 50-64 in the 1994-95 and the 1998-99 waves, for a total of 3059 in 1994/95 and 6398 in 1998/99.[2] The NPHS includes questions related to health status, use of health services, determinants of health and a range of demographic and economic information. For example, the health status information includes self-perception of health, a health status index, chronic conditions, and activity restrictions. The use of health services is probed through questions on visits to health care providers, both traditional and non-traditional, and the use of drugs and other medications. Health determinants include smoking, alcohol use, and physical activity and in the first survey in

[2] See footnote 1.

1994-95, emphasis is placed on selected psycho-social factors that may influence health, such as stress, self-esteem and social support. The demographic and economic information includes age, sex, education, ethnicity, household income and labour force status.

The National Survey of Family and Households (NSFH) U.S. is also a longitudinal survey with three waves, 1987-88, 1992-94, and 2001-03. A considerable amount of life-history information was collected, including: the respondent's family living arrangements in childhood, departures and returns to the parental home, and histories of marriage, cohabitation, education, fertility, and employment. The design permits the detailed description of past and current living arrangements and other characteristics and experiences, as well as the analysis of the consequences of earlier patterns on current states, marital and parenting relationships, kin contact, and economic and psychological well-being (National Survey of Families and Households, 2009). Wave 2 (1992-94) includes personal interviews with the original respondents (N=10,007) as well as interviews with spouses/partners and with ‘focal’ children. We rely only on the interviews with original respondents, and again only those aged 50-64 (T=1842). Wave 3 (2001-03) continued interviews with the original respondents and focused particularly on those aged 45+. Our focal group included those 50-64 (T=2880).

For the purposes of the analyses here, we treat each of the four survey points as independent panels with no attempt to do micro-level longitudinal analysis. That will come in subsequent research.

To assess the implications of growing income inequalities for health risks for mid-life individuals as they look to their later years and how prospects look for younger relatives as they age in 2008-09, qualitative interviews were conducted simultaneously in Winnipeg, Manitoba and in Salt Lake City, Utah, cities that are relatively comparable.[3] Two different socio-economic groups, middle and working class, in each city were selected for the qualitative interviews[4]. Target respondents are in the age group, 45-64. Ten interviews were aimed for in each of the four selected groups for a total of 40.[5] The research approach asks respondents what those older than them generationally need and receive in terms of supports, and what those who are younger need and receive from them. We also ask about their impressions of what they previously were eligible for from governments and what their entitlements are now, about costs involved, and about what they see as a just and equitable situation for their multi-generational families as they age. We inquire how their exchanges of supports have been facilitated or inhibited by policies over their lives and how interdependencies in their extended families and with policy have changed/adjusted as they move closer to their later years.

Income inequalities can be measured in a number of ways. And of course, there are other dimensions on which socio-economic inequalities can be captured in addition to income, including deprivation and relative deprivation (for which several indices have been developed), access to opportunities, and access to resources of various kinds. Here,

---

[3] Our initial intention to conduct interviews in Toronto was changed when the research team agreed that a Canadian city more comparable to Salt Lake City would be Winnipeg, Manitoba.

[4] These groups were obtained through work connections in the case of the working class group, and through clubs to which middle class people belong for the middle class groups. Our research protocols for pre-arranged telephone interviews with volunteer respondents who contacted us through an e-mail address set up specifically for this study were approved by university ethics panels at both University of Utah (McDaniel) and York University (Gazso).

[5] The interviews are still in progress and will be completed over the coming months. Some preliminary findings from interviews completed thus far in both countries are presented here.

we focus on income inequalities only, and rely on Gini coefficients as our measure, a widely used indicator of income inequalities across and within countries (see OECD, 2008). The Gini coefficient is a measure of statistical dispersion most prominently used to capture inequality of income distribution. It is defined as a ratio of high to low income (different percentiles can be used with the most common being the ratio of those above median income to those below, which is the ratio we use here) with values between 0 and 1: A low Gini coefficient indicates more equal income or wealth distribution, while a high Gini coefficient indicates more unequal distribution.

Findings

The U.S. is found to have "the highest overall level of inequality of any rich OECD nation at the beginning of the 21st century" (Smeeding, 2005:981). Moreover, government policies and social spending have lesser effects in the U.S. than in any other rich nation (Smeeding, 2005). Canada's income inequality is somewhat better, and there is evidence that government policies have had an effect in reducing inequality, at least to a degree, in Canada (Mahler and Jesuit, 2005; OECD, 2008; Osberg, Smeeding and Schwabish, 2003; Picot and Myles, 2005; Smeeding, 2005; Weeks, 2007). Whether this continues into the present day, with all the challenges of the current economic crisis, is an open question. **Table 2** shows point changes in Gini coefficients from the mid-1980s for Canada, the U.S. and the OECD average. An increase in a Gini coefficient of 1 point is equivalent to a hypothetical lump sum transfer of 2% of average income from all those below the median to all those above the median. The increase of 0.05 from the 1980s to the mid-2000s for the U.S. means a transfer of 0.1% of income from those below the median to those above. Similarly, the 0.035 point increase in Gini for Canada over the

same period means a transfer of 0.07% of income from those below the median to those above. But, it is notable that Canada's point change in Gini in the 1980s to mid-1990s was negative. The OECD average point change is less than both Canada's and the U.S.'s.

Table 2 about here

Given our focus on health risks, it is useful to look at overall trends in basic health-related indicators such as the United Nations' Human Development Index, defined in **Table 3**, and life expectancy in the time period paralleling the increases in inequalities in the two countries. Life expectancy in the U.S. has been consistently lower than in Canada from the 1970s through until 2008, the last year for which data are available. And, the gains in years of life lived has been greater for Canadians than for Americans in this period. Even more notable are the relative rankings of Canada and the U.S. on the Human Development Index, a composite measure of health and quality of life. While Canada has been consistently ranked in the top 5 countries of the world, the U.S. ranks 18th in the world in 1990 and only 15th in 2008. These are significantly large differences for similar neighbouring countries.

Table 3 about here

Turning now to the analyses of the comparative survey data, **Table 4** shows the four survey samples, two in each country, with the ages, birth dates, years at which they reach age 65 of those sampled, and Ginis for each survey date and by age and survey date. Income inequality is larger overall in Canada and the U.S. than it is for our target midlife groups in either country. The U.S. has consistently higher Ginis overall and for each age group than does Canada, consistent with our earlier population trend findings. And, it is expected that inequalities would be lower for our mid-life age group than for the entire

population. Our four survey design captures the edge of the Baby Boom, enabling differentiation between that cohort and those of smaller cohorts born earlier.

Table 4 about here

To see whether the relationship between income inequalities and health risks holds when controlling for other variables, we performed multivariate regression analyses progressively including other variables into the initial model in which overall self-reported health was the sole dependent variable[6]. Other variables introduced include sex, age, marital status, socio-economic (education, occupation, source of income), debt, homeownership, assets, savings and investments. For the U.S. multivariate analyses, race was also included.

Logistic regression models were used. Fractional sampling weights were used in all the statistical procedures to take into account the complex sampling procedure used for the survey. For better understanding of the impact of income inequalities, our discussion of the results will focus mainly on the differences in overall self-reported health status, with the results for other explanatory control variables mentioned only when deemed necessary. Complete models are not presented here in the interest of space. We show only the model coefficients (and their associated levels of significance) in the tables below, which are to be interpreted in relation to the reference category, those age 50-54; that is, positive coefficients indicate higher levels of health, and negative coefficients indicate lower compared to the reference group.[7]

[6] In analyses not reported here, we use multiple indicators of health and well-being.
[7] The usual way of presenting the results from logistic regression models is to use odds ratios. We avoid this here because we are interested only in higher or lower level of health status. The sign of coefficients in the models is sufficient for this purpose. Further, for the sake of parsimony and not cluttering the tables

Tables 5 & 6 about here

Comparing Canadians in 1994-95 with Americans in 1992-94, roughly equivalent time periods, as shown in **Table 5**, we find that both age groups 55+ in Canada have relatively poor self-reported health than those 50-54. The same is true for Americans, but only for those 55-59. For the older group, born 1928-32 (see Table 4), a very small cohort because of the Great Depression, statistically significant better health is found. It must be wondered if this cohort tends toward seeing the "bright side" of health, even if they are really experiencing health issues. Education is positively related to health status in both countries, and is significant. Receipt of income from government sources is negatively related to health in both countries. Health insurance is positively related to health status in the U.S. and of course, is not variable in Canada with universal coverage. Race, ie. being white, in the U.S. is also positively related to health. In Canada, a different pattern emerges with household income emerging as a positive effect, and being single (never married) a slight negative effect.

Moving to the second set of comparisons between the two countries, in 1998-99 in Canada, and 2001-03 in the U.S. in **Table 6**, a similar pattern emerges by age group as in the earlier time point comparison. It is only those Americans age 60-64 who have a positive effect for health. This cohort was born (again, see Table 4) in 1937-41 and are likely mostly retired by 2001-03. This cohort is the World War II cohort, a very small cohort similar to that born in the Great Depression. That they may have benefited from not having to compete with a large number of those of similar ages, and benefited from post WWII society such as fuller employment, growing prosperity, more stable families,

---

with too many numbers, we present the levels of significance with conventional asterisks (without showing the standard errors of the coefficients).

more reliable risk insurance, may help explain this finding. In the U.S., having health insurance matters as does household income and owning one's own home, with the latter two variables mattering positively in Canada as well. The surprise is that education in the U.S. is negatively related to health status while in Canada, it is a positive association as it was for the previous time period. Government and other income are both negatively associated with health status in Canada in 1998-99 as they were in both Canada and the U.S. in the earlier time period. In the millennial period in the U.S., however, these sources of income do not emerge as statistically significant.

Lower income inequality equilibrium in Canada at both survey points than in the U.S. seems to suggest a more stable constellation of factors contributing to health status: younger midlife age, home ownership, higher educational attainment and higher household income. In the U.S., by contrast, it is the older midlifers, age 60-64 who have the better self-reported health, suggesting perhaps a cohort effect, but as likely an income inequality effect, ie, as income inequality accelerates, health status drops. The set of factors that contribute to health status also varies much more for the U.S. sample at the two time points than in Canada. Having health insurance looms as a much more important factor in 2001-03 for health than it does in the earlier sample.

Next steps in the multivariate analysis of these four survey points will be to develop a comprehensive index of well-being including but not limited to self-reported health. Using this index as our dependent variable, we will regress various measures of Gini indexes, and then control for all the variables included in these analyses.

For the qualitative phase, as mentioned earlier, the interviews are still in progress. We have interviews, however, at present, from sufficient numbers in Canada and the U.S.

to provide some hints of our findings. This is particularly important since this is the only part of our research that captures the current economic situation. Interviews began in late Fall 2008 and are continuing into 2009, times of decided economic uncertainty, acute for those in mid-life facing later life on the near horizon. The numbers of interviews completed do not permit a class or gender analysis, so the focus here will be primarily on the Canada – U.S. comparison.

Two themes recurred as we analyzed the qualitative interviews thus far completed, that were both recorded electronically and inputted into a computer file as the interview progressed. The first theme is the contrasting ways Canadians and Americans in midlife saw risks. We asked them what future health risks they might experience, and how they are preparing for these risks. Americans tended more to define risks in terms of specific familial health risks such as heart disease, scoliosis, colon and other cancers, arthritis, or a fear of losing independence. Canadians, on the other hand, were more inclined to see risks in terms of stress or attitudes that they themselves had and thought they could control. In terms of how they are preparing to manage health risks, even greater divergence emerged. Americans all mentioned concerns about health insurance, particularly significant since in this middle-class sample, all had private health insurance, for example:

> NO, can't get good health insurance these days! Dental, vision, flex, it doesn't cover it all. I have lots of health insurance, but it's not good enough, not adequate. Health insurance is a worry. [American midlife respondent]

The Canadians, in contrast, mentioned that they didn't really know how to be prepared, but that they felt positive in having public health insurance. Here is an example:

> How would I be prepared? I guess if something happened I wouldn't be

> prepared mentally because my attitude is I'm going to be fine, so I guess I would struggle with that. We have quite a different health care system here in Canada. Financially, the financial burden of being sick, a lot of it would be covered. [Canadian midlife respondent]

The second theme is the difference in ways that Canadians and Americans saw the relation of the economy and the state to their own lives. Canadian respondents almost take government involvement as a given, and a beneficent given:

> The service that the government provides that I don't even think of is the medical care. It's just so much part of our culture. Also in [my province] if your income becomes low after a deductible, they'll pay all of your pharmacy costs, so as I age I imagine I will be taking advantage of that.. [Canadian midlife respondent]

By contrast, Americans like the sense of government staying out of their lives. Here is an example:

> I don't expect or want government support, would like government to be less intrusive. [American midlife respondent]

Yet, midlife Americans express deeper concerns about the economy and the implications for their later years. One has this to say when asked about the current economic situation:

> I am definitely concerned. My 401k is tanking. My husband is on a fixed pension from his union, is it fully funded? Will social security be there when we need it? [American midlife respondent]

So, what is the solution? One American respondent was clear:

> There needs to be healthcare for everyone, people need a safety net, availability of healthcare if catastrophic disease or illness, could be financially devastating. [American midlife respondent]

By contrast, Canadians seem to see the economic crisis as more American than Canadian but worry that it will be coming to Canada:

> Well, I feel that it's not a pretty picture. When you look at what's going on, Canada is more sheltered than US, but Canada gets 70 percent trade from US.

> Eventually the flu will reach Canada and we will have pneumonia.
> [Canadian midlife respondent]

But he/she feels somewhat insulated by Canadian health care insurance and public policies:

> I've got insurance coverage because I'm in Canada. I feel very fortunate. We have excellent coverage. Our costs are lower.
> [Canadian midlife respondent]

Discussion and Conclusion

In response to the first research question posed in this study, what are the implications of growing income inequalities for health risks in later life in Canada and the U.S., we find that the U.S. with its very high levels of income inequalities, growing over the period of our study (from mid-1980s to mid-1990s for the overall national trends analyses; from the mid-1990s to early 2000s for our quantitative survey analyses; and for the current period for our qualitative analysis), there are indeed implications for health and well-being in midlife. This is found to be so for all but the oldest of the midlifers, those 60-64. Further, we find a less stable constellation of forces that contribute to health and well-being in the U.S. with its higher degree of income inequalities than in Canada. The implications of growing income inequalities for later life health risks seem to be clear and positive, in that growing inequalities will make for more health risks for those now aged 55-59 as they age in the U.S.

In response to the second question, how do health risks in later life in Canada and the U.S. compare given differing health and aging policies in the two countries, we find significant differences that will amplify going forward, all else being equal. This is most apparent in the divergence of effects at age 60 in the U.S. where younger midlifers report

less positively about their health. That they are younger does not bode well for them as they age, when health problems tend to get worse. The same pattern is not found in Canada by age. The qualitative interviews hint at other concerns. That Americans see health risks more in terms of factors such as family history, over which they have less control, while Canadians talk more of health risks in terms of positive attitudes, may means that Americans in midlife are taking less personal responsibility for their health as they age. Added to this is the great worry expressed by Americans about the current economic crisis and how it may imperil whatever health insurance they have now. This contrasts to the positive feelings expressed by midlife Canadians about having a secure health care system, there when it is needed whatever happens with the economy or one's job or pension. Compounded with different and growing gaps in income inequalities in the two countries, it can readily be concluded that differences in health risks in midlife looking to later life are amplified, with Canadians, even if not doing particularly well, doing much better than Americans over time. "The development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health" (WHO, 2008: 1)

This paper is the first in a series of several from this project. We plan, in subsequent papers, to focus on a range of variables that broadly define well-being in the surveys we analyze here, specifically control over one's life, stress including financial stress, life satisfaction, depression and activity limitations, and to develop an index of well-being to use as our dependent variable. We will address gender and class dimensions of the relationship of income inequalities to later life health risks, and do deeper comparative

analyses of the qualitative data presented here only sketchily. Future research plans include comparative analysis of more recent national survey data in the U.S. and Canada that focuses specifically on the baby boom cohorts as they begin to retire. And we anticipate pursuing multi-level analyses that will enable us to examine the relative influence of individual factors, community forces and national influences on the relationship of income inequalities to health risks in later life. This will entail the application of GIS techniques which we are actively pursuing through collaboration. Our project building on this one broadens from survey data to Canadian and U.S. population data, with comparative analyses of the only two population databases in North America, the Utah Population Database and the Manitoba Population Health Registry. We also are developing plans to include other developed countries in our comparative analyses of health risks in mid and later life as income inequalities grow.

Acknowledgements: We appreciate research funding from the Canadian Embassy, Washington D.C. and the Institute of Public and International Affairs, University of Utah. We thank our colleagues in the project for their valuable contributions: Paul Bernard (Université de Montréal), Janice Morse (University of Utah), Angela O'Rand (Duke University) and Ming Wen (University of Utah), and research assistants at University of Utah, Jamie Day, Ethan Doetsch, Jennifer Givens and Nekehia Quashie, and at York University, Hugh McCague. We also express our deep appreciation to our interview respondents in both countries who generously shared their time so that our research could benefit.

References [Research team members' names are in **bold]**.

Beck, Ulrich, and Elizabeth Beck-Gernsheim. 2002. *Individualization: Institutionalized Individualism and its Social and Political Consequences.* Thousand Oaks: Sage Publications, in association with Theory, Culture and Society.

Bernard, Paul and **Susan McDaniel**. 2009. "Lifecourse as a Policy Lens: Challenges and Opportunities," Human Resources Development Canada, prepared for HRSD and presented at a Policy Dialogue, Ottawa, January.

Bernard, Paul, Rana Charafeddinea, Katherine L. Frohlicha, Mark Daniela, Yan Kestensa, Louise Potvin 2007. "Health inequalities and place: A theoretical conception of neighbourhood," *Social Science & Medicine* doi:10.1016/j.socscimed.2007.05.037

Braveman, Paula. 2007. "We Also Need Bold New Experiments: A Response to Starfield's 'Commentary: Pathways of Influence on Equity in Health,'" *Social Science and Medicine* 64(7): 1366-1366.

Ferraro, Kenneth F., & Tetyana P. Shippee. 2007. "Aging and Cumulative Inequality: How Does Inequality Get Under the Skin?" Paper presented at the Gerontological Association of America meetings (Won GSA award for the best paper in theory).

Gazso, Amber. 2005. "The Poverty of Unattached Senior Women and the Canadian Retirement Income System: A Matter of Blame or Contradiction?" *Journal of Sociology and Social Welfare* 32(2): 41-61.

Gazso, Amber. 2006. "Creating Social Cohesion? The Paradoxes Posed by B.C. Welfare Reform," *Canadian Review of Social Policy* 57:46-70.

Gazso, Amber. 2007a. "Balancing Expectations for Employability and Family Responsibilities While on Social Assistance: Low Income Mothers' Experiences in Three Canadian Provinces." *Family Relations* 56(5): 454-466.

Gazso, Amber. 2007b. "Staying Afloat on Social Assistance: Parents' Strategies of Balancing Work and Family." *Socialist Studies*: *The Journal of the Society of Socialist Studies* 3(2): 31-64.

Heisz, Andrew. 2007. "Income Inequality and Redistribution in Canada: 1976 to 2004," Statistics Canada Analytical Studies Branch Research Paper Series No. 298, Catalogue no. 11F0019MIE.
http://www.statcan.ca/english/research/11F0019MIE/11F0019MIE2007298.htm

Hicks, Peter. 2003. "New Policy Research on Population Aging and Life-Course Flexibility," *Horizons: Policy Research Initiative* 6(2):3-6.

Lipset, Seymour Martin. 1990. *Continental Divide: The Values and Institutions of the United States and Canada*. New York: Routledge.

Mahler, Vincent A., and David K. Jesuit. 2005. "Fiscal redistribution in the developed countries: New insights from the Luxembourg Income Study." *Socio-Economic Review*. 4, 3: 483–511.

Mandell, Nancy, Susannah Wilson, and Ann Duffy. 2008. *Connection, Compromise and Control: Canadian Women Discuss Midlife*. Don Mills, Ontario: Oxford University Press.

Marmot, Michael. 2006. "Being Poor is a Matter of Life and Death, so Governments Must Close the Wealth Gap," *New Scientist* 2553:22-23.

Marshall, Victor M. and M.M. Mueller. 2002. “Rethinking Social Policy for an Aging Workforce and Society: Insights from the Life Course Perspective,” Canadian Policy Research Networks. www.cprn.org
McDaniel, Susan A. 1997. "Serial Employment and Skinny Government: Reforming Caring and Sharing among Generations," *Canadian Journal on Aging*, 16(3):465-484.
McDaniel, Susan A. 1997. "Intergenerational Transfers, Social Solidarity, and Social Policy: Unanswered Questions and Policy Challenges," *Canadian Public Policy/ Canadian Journal on Aging* (Joint issue). 23(Supplement 1): 1-21
McDaniel, Susan A. 1998a. "Public Policy, Demographic Aging and Families," *Policy Options/Options Politiques* September 19(3):33-35
McDaniel, Susan A. 1999b. "Untangling Love and Domination: Challenges of Home Care For the Elderly in a Reconstructing Canada," *Journal of Canadian Studies*, 34(3):191-213.
McDaniel, Susan A. 2001. “‘Born at the Right Time’: Gendered Generations and Webs of Entitlement and Responsibility,” *Canadian Journal of Sociology* 26(2):193-214.
McDaniel, Susan A. 2002. “Women’s Changing Relations to the State and Citizenship: Caring and Intergenerational Relations in Globalizing Western Democracies,” *Canadian Review of Sociology and Anthropology* 39(2):1-2
McDaniel, Susan A. 2003. “Toward Disentangling Policy Implications of Economic and Demographic Changes in Canada’s Aging Population,” *Canadian Public Policy/ Analyse de Politiques* 29(4):491-510.
McDaniel, Susan A. 2004. “Generationing Gender: Justice and the Division of Welfare,” *Journal of Aging Studies* 18(1): 27-44..
McDaniel, Susan A. 2006. “Linked Generations in Families, Labour Markets and Welfare States: Aging Policy in Canada, France and Britain,” Society for the Advancement of Socio-Economics Conference, Trier, Germany, June 30 –July 2, 2006.
Morse, J. M., Wolfe, R.& Niehaus, L. (2006). Principles and procedures for maintaining validity for mixed-method design. In Leslie Curry, Renée Shield & Terrie Wetle (Eds.) Qualitative Methods in Research and Public Health: Aging and Other Special Populations. (pp. 65-78). Washington, DC: GSA and APHA.
Morse, J. M., Niehaus, L., Wolfe, R., Wilkins, S. (2006). The role of theoretical drive in maintaining validity in mixed-method research. Qualitative Research in Psychology, 3 (4), 279-291.
Murphy, Brian, Paul Roberts, & Michael Wolfson. 2007. “High Income Canadians,” *Perspectives on Labour and Income* 8(9):5-17.
National Survey of Families and Households. 2009.
http://www.ssc.wisc.edu/nsfh/design.htmn
OECD. Organization of Economic Cooperation and Development. 2008. *Growing Unequal? Income Distribution and Poverty in OECD Countries.* Paris: OECD.
OECD. Organization of Economic Cooperation and Development. 1996. *Ageing in OECD Countries: A Critical Policy Challenge*. Paris: OECD.
O’Rand, Angela M. and Katelin Isaacs. 2006. “Changing Social Contracts and the Changing Life Course,” Paper prepared for the meetings of the Society for the Advancement of Socioeconomics, Trier, Germany June 30-July 2, 2006
O’Rand, Angela M. and Kim M. Shuey. 2007. “The Devolution of Pension Risks in the United States,” *Current Sociology* 55(2): 287-304.

Osberg, Lars, Timothy Smeeding and Jonathan Schwabish. 2003. “Income Distribution and Public Social Expenditure: Theories, Effects and Evidence,” Russell Sage Foundation Papers.
Picot, Garnett and John Myles. 2005. “Income Inequality and Low Income in Canada: An International Perspective,” Analytical Paper Series, Statistics Canada, February 10, 2005, Catalogue no. 11F0019M20055240.
Prince, M.J. 2000. “Apocalyptic, Opportunistic, and Realistic Demographic Discourse: Retirement Income and Social Policy or Chicken Littles, Nest-Eggies, and Humpty Dumpties,” In E.M. Gee and G. Gutman (Eds.), *The Overselling of Population Aging: Apocalyptic Demography, Intergenerational Challenges, and Social Policy*. Don Mills, Ontario: Oxford.
Rothschild, Emma. 2009. “Can We Transform the Auto-Industrial Society?” *New York Review of Books* February 26: 8-9.
Rubin, Robert. 2009. “Inequality More of a Problem than Economic Growth,” Interview on National Public Radio, February.
Sauvé, Roger. 2006. "The Current State of Canadian Family Finances." 2007. Ottawa: The Vanier Institute of the Family.
Smeeding, Timothy. 2005. “Public Policy, Economic Inequality, and Poverty: The United States in Comparative Perspective,” *Social Science Quarterly* 86(s1):955-983.
Starfield, Barbara. 2007. “Pathways of Influence on Equity in Health,” *Social Science and Medicine* 64(7): 1355-1362.
Statistics Canada. 2009. National Population Health Survey information page. Statistics Canada. http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?lang=eng&catno=82F0001X
Therborn, Goran. 2006. “Introduction to Inequalities,” in Goran Therborn (Ed.), *Inequalities of the World: New Theoretical Frameworks, Multiple Empirical Approaches*. London, UK: Verso.
United Nations. 2008. *Human Development Report 2007/08*. New York: United Nations. http://hdrstats.undp.org/indicators/10.html, accessed February 2009.
Weeks, J. 2007. “Inequality Trends in Some Developed OECD Countries,” In J. K. S. & J. Baudot (Ed.), *Flat World, Big Gaps*, pp.159-174. New York: ZED Books (published in association with the United Nations
Wen, Ming, Christopher R. Browning, Kathleen A. Cagney. 2003. “Poverty, Affluence and Income Inequality: Neighbourhood Economic Structure and its Implications for Health,” *Social Science and Medicine* 57(2003):843-860.
Wilkinson, R. G. 1992. “Income Distribution and Life Expectancy,” *British Medical Journal* 304:165-168.
Wilkinson, R.G. 1996. *Unhealthy Societies: The Afflictions of Inequality*. London: Routledge.
Wilkinson, R.G. and M. Marmot. 2003. *The Social Determinants of Health: The Solid Facts.* Geneva: World Health Organization.
Wilkinson, R.G. and K.E. Pickett. 2006. “Income Inequality and Population Health: A Review and Explanation of the Evidence,” *Social Science and Medicine* 62(7):1768-1784.
Wolfson, Michael. 1998. “’Good Life Time’ (GLT): Health, Income and Time to Enjoy Them,” Paper presented at CSLS Conference on State of Living Standards and Quality of Life in Canada, 30-31 October, Ottawa.

https://webmail.csbs.utah.edu/horde/index.php?url=https%3A%2F%2Fwebmail.csbs.utah.edu%2Fhorde%2F
Wolfson, Michael, George Kaplan, John Lynch, Nancy Ross and Eric Backlund. 1999. "Relation between Income Inequality and Mortality: Empirical Demonstration," *British Medical Journal* 319(7215):953-957.
World Health Organization. Commission on the Social Determinants of Health. 2007. *Achieving Health Equity: From Root Causes to Fair Outcomes, Interim Commission Report.* Geneva: World Health Organization.
World Health Organization. Commission on the Social Determinants of Health. 2008. *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health.* Geneva: World Health Organization.
http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf
Yalnizan, Armine. 2007. *The Rich and the Rest of Us: The Changing Face of Canada's Growing Gap.* Toronto: Canadian Centre for Policy Alternatives.

Table 1
Trends in real household income by quintiles
Canada, U.S. and OECD Average

	Average annual change mid-1980s to mid-1990s					Average annual change mid-1990s to mid-2000s				
	Bottom	Middle Three	Top	Median	Mean	Bottom	Middle Three	Top	Median	Mean
Canada	0.3	–0.2	–0.1	–0.2	–0.1	0.2	1.2	2.1	1.1	1.4
U.S.	1.2	1.0	1.9	1.0	1.4	–0.2	0.5	1.1	0.4	0.7
OECD	1.2	1.4	2.1	1.4	1.7	1.5	1.8	1.9	1.9	1.8

Source: Derived from OECD. 2008. *Growing Unequal? Income Distribution and Poverty in OECD Countries.* Paris: OECD, p.28. Note: OECD average here excludes Turkey and Mexico, which have very high levels of income inequality.

Table 2
Trends in Income Inequality, Canada & U.S.
Point Changes in Gini Coefficients
Mid-1980s to Mid-2000s

	Canada	**U.S.**	**OECD Average (22 countries)**
Mid-1980s to mid-1990s	-0.01	0.03	0.015
Mid-1990s to Mid 2000s	0.05	0.02	0.01
Cumulative change Mid 80s to mid 00s	0.035	0.05	0.02

Gini coefficient is measure of inequality, ranging from 0 (perfect equality) to 1 (perfect inequality. Here, the measure is the point change in Gini coefficients showing the degree to which inequality is changing over time.

Source: OECD. Organization of Economic Cooperation and Development. 2008. *Growing Unequal? Income Distribution and Poverty in OECD Countries.* Paris: OECD, p. 28.

Table 3
Human Development Index and Life Expectancy
Canada and U.S. Trends

HDI Rank/ Value	**Canada**	**U.S.**
1990	5th / 0.931	18th / 0.919
2005	4th / 0.961	12th / 0.951
2008	3rd / 0.967	15th / 0.967
Life Expectancy		
1970-75	73.2	71.5
2000-05	79.8	77.4
2005	80.3	78.0

2008	80.4	78.0
	> +7.2 years	> +6.5 years

Human Development Index: Average achievement in three basic dimensions: long and healthy life, knowledge, and decent standard of living. Measured comparatively by the United Nations Human Development Index.

Source: United Nations. 2007/08. *Human Development Report 2007/08*. New York: United Nations. http://hdrstats.undp.org/indicators/10.html, accessed February 2009.

Table 4
Comparative Survey Data, Canada and U.S.
Age Groups 50-54, 55-59, 60-64
Birth Years, N's & Ginis

	CANADA NPHS		**U.S.** NSFH	
Survey date **Gini at survey**	**1994-95** **.41**	**1998-99** **.43**	**1992-94** **.45**	**2001-02** **.46**
50-54	N=1109	N=2805	N=719	N=1154
Age 65 in… Gini by age	b. 1940-44 2005-09 .38	b.1944-48 2009-13 .39	b. 1938-42 2003-07 .39	b. 1947-51 2012-16 .40
55-59	N=1007	N=1928	N=584	N=889
Age 65 in… Gini by age	b. 1935-39 2000-04 .37	b. 1939-43 2004-08 .37	b. 1933-37 1998-02 .40	b. 1942-46 2007-2011 .39
60-64	N=943	N=1665	N=549	N=837
Age 65 in… Gini by age	b. 1930-34 1995-99 .37	b.1934-38 1999-03 .37	b.1928-32 1993-97 .40	b.1937-41 2002-2006 .39
Total N	N= 3059	N=6398	N=1842	N=2880

Source: National Population Health Survey (NPHS), Canada, 1994-95 and 1998-99; National Survey of Family Health (NSFH), U.S., 1992-94 and 2001-02.

Table 5

Model of Self-Reported Overall Health
Canada and U.S
NPHS, 1994-95 and NSFH 1992-94

	Canada NPHS		U.S. NSFH	
Survey date	**1994-95**		**1992-94**	
Gini at survey	**.41**		**.45**	
	Coef [8]	Sig	Coef	Sig
Constant				
50-54 yrs				
55-59	-.043	**	-.045	
60-64	-.018		.160	***
Male	-.026		-.043	
Single	-.003	**	.015	
Wid/Sep/Div	.039		.014	
Own home	.045	**	.042	
Highest educ	.113	***	.091	***
HouseIncome	.154	***	1.78	
Int/Dividends				
Main source	-.021		.022	
Govt income	-.178	***	-.324	***
Other income	-.068		-.129	**
Health ins(US)			.127	**
Race (US)			.052	
R Square of Full model	11.9%		20.7%	

Significance levels ***1%, **5%, *10%

Source: 1994-95 National Population Health Survey, Canada; National Survey of Families and Households, 1992-94, United States, extracted from Appendix Table 1A.

[8] Standardized

Table 6

Model of Self-Reported Overall Health

Canada and U.S
NPHS, 1998-99 and NSFH 2001-03

	Canada NPHS		U.S. NSFH	
Survey date		**1998-99**		**2001-03**
Gini at survey		**.43**		**.46**
	Coef [9]	Sig	Coef	Sig
Constant				
50-54 yrs				
55-59	-.033	*	-.081	*
60-64	-.065	**	.049	***
Male	.033		-.034	
Single	-.011		-.050	
Wid/Sep/Div	-.023		.[10]	
Own home	-.091	***	.143	**
Highest educ	.135	***	- .004	**
HouseIncome	-.003	***	3.33	**
Int/Dividends				
Main source				
Govt income	-.177	***	-.050	
Other income	-.063	***	.171	
Health ins(US)			.410	***
Race (US)			-.036	
R Square of Full model	9.0 %		13.2%	

Significance levels ***1%, **5%, *10%

Source: 1994-95 National Population Health Survey, Canada; National Survey of Families and Households, 1992-94, United States, extracted from Appendix Table 1A.

[9] Standardized
[10] Data not available for this variable. All other than married were combined into one category.