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The Elderly Outside the Metropolis: Myths and Realities

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"In youth we run into difficulties. In old age difficulties run into us".
Josh Billings

Introduction

It is a great honor and privilege to be asked to deliver this Master Class at what is known to be one of the premier universities in the United States. I want to thank those who have made this possible – the Haskell family and Distinguished Professor Emilia Martinez-Brawley in particular.

You will know very well that the States of Arizona and Florida were leaders in 'retiree attraction' policies for several decades. This policy has more recently been adopted by other States and localities, many of them rural or non-metropolitan. Yet elders moving from the cities to rural areas may in some cases be dazzled by romantic myths and images of rural communities, and turn a blind eye to the sometimes harsh realities of rural living.

If we conjure up images of rural life, many - and especially the town dwellers amongst us, fed on a diet of '***The Waltons***', '***Little House on the Prairie***' and other such television imagery - may have images of life in the 'sticks' which are mostly or entirely mythical today. The agrarian myth – the belief in the superiority of those who toil on the farm – has been powerful in both the US and Europe (Bryden, 1990; Longino, 2001). At the beginning of the 21st century, the image of extended farm families living off the land together, and indeed the image of rural society as agrarian society is far removed from reality. It deflects our attention from what poses to be a critical world-wide problem as demographic changes

[1] I am grateful for helpful conversations and papers from colleagues at the University of Missouri-Columbia, in particular, Judith Stallman, Matt Fannin, Morgan Mundell, and at the University of Aberdeen, especially Mark Shucksmith, Euan Phimister, Natasha Mauthner, Lorna Mckee and Lorna Philip. The last four named recently completed a useful scoping study of older people in rural Scotland (April 2002). I am also grateful to Kirsty Hay for research assistance in finding some of the data and literature on which this paper is based.

coupled with economic restructuring and new lifestyles create significant challenges for rural people. Longer life expectancies and lower rates of natural population growth have culminated in a general increase in the number of persons over the age of 60. It is not, then, ironic that demographic imbalance which is already a significant problem to many rural areas, and especially those on the periphery or in declining farming areas, is a 'problem' that other rural areas are actively encouraging such as the Sunbelt states in the USA and certain regions in Europe through retiree-attraction policies.

The idea behind attracting retirees is that this is good economic development policy. Yet it is clear that there are both costs as well as benefits in such policies, and that the nature and distribution of these depends not only on the type of retirees attracted and the nature and structure of the local economy in question, but also on institutional and taxation questions which are quite complex. Moreover, what rural communities might gain from attracting retirees, may simply be an equivalent loss for the cities, turning into a kind of 'beggar my neighbor' situation, or 'zero-sum game'. There are also important consequences in terms of political change in rural areas that follow from significant inward migration. Finally, while short-term gains may be had, these may turn to losses in the long run.

There is a further issue that I would like to touch on, and it is this. The focus on retiree attraction policies may divert attention away from the very serious problems facing the 'indigenous' elderly population, in particular concerning health care and related services, housing, transportation. These problems are particularly severe for the poor, and for women, who constitute the majority of retirees.

By comparing the situation in the USA with that in Europe, we can say something about the influence of particular fiscal and institutional arrangements on the distribution of gains and losses to cities and rural areas.

This more or less describes the scope of this Master Class. Let me start by looking at a few facts - not too many, because I know that facts can get boring! A well-known statistician once said '***there are damn lies and statistics'*** – he was talking about the fallacies of aggregation and averages of course! Another famous person, this time a politician during an exceptionally long-winded briefing intended to cause him to change his mind on some matter, said ***'don't confuse me with facts'***. The even more

famous Harry Truman said: "***give me a one-handed economist***", referring to their tendency to offer not one, but two sets of facts and conclusions!

A few facts

- In USA – people over 65 comprised 13% of population in 2000. Up from 11.9% in 1995. This is projected to grow to 18% in 2020. In the EU, the proportion of the elderly within the total population is projected to increase from about 21% at present to around 34% by 2050 (Eurostat, July 1999). Those aged 80 and over are predicted to increase from 4% to 10% of the European population.

- The rural population is 'older' than the urban population in both the USA and Europe. In the US 11.9% of the total population was aged 65 or over, while 13.9% of the non-metropolitan population was 65 or over in 1995.

- The US census projects that by the year 2050, the number of persons in the population 65 and older will more than double, the number of persons 75 and older will triple, and the number of people 85 and older will quintuple. Similar trends are noted in Europe.

- The fastest growing segment is the 'oldest old' – those over 85. This grew by 37% between 1980 and 1990 in the US. It is also expected to grow rapidly in rural parts of the EU.

- The non-metro population is older than the metro population with a median age of 36 in 1998, compared to 34 for the metro population in the US. This is also true in the EU.

- The baby-boom generation on both sides of the Atlantic is ageing, and now reaching the 'third-age'.

- The rural elderly are poorer than their urban counterparts, and the incidence of poverty increases with age, ethnic group, and geographical remoteness[2]

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[2] See Stallman, Deller & Shields (JCOS, forthcoming 2003?) for the USA and Philip, Gilbert, Mauthner & Phimister (2002) for Scotland and parts of Europe.

- Since rural elderly have fewer private pensions, and since social security benefits are based on income during working life that is also lower in rural areas, the overall levels of pensions are lower in rural areas.

- Nevertheless, in the USA, dependence of the rural elderly on transfer payments is higher, particularly supplemental social security and disability insurance payments, Medicare and Medicaid (Stallman et al, 2001). This situation in Europe is disguised by the prevalence of publicly provided health care in both rural and urban areas, although there is a similar dependence on social transfers, especially in remoter rural areas.

- In-migrant 'retiree' households to rural areas in the US tend to be 'young-old', married couple households who are better educated than the population as a whole and who have higher household incomes than longer term residents (Glasgow, 1995)[3].

- There has been a 'demographic turnaround' in many rural areas in the last 20 years – from being areas which usually had a positive natural rate of population change (i.e. births generally exceeded deaths) up to the 1980's, they now have negative rates of change in the natural population (i.e. deaths exceed births). This makes the maintenance or increase of population in rural areas very dependant on net inward-migration [Bryden & Hart 2001].

- Since there is an almost universal tendency for many young people to leave their rural homelands to gain education, training and experience, achieving net-inward migration must focus on encouraging people to return home at a later stage (including for retirement), or encouraging new 'settlers' from elsewhere.

What then are the problems that the rural elderly face on the one hand, and which retiree attraction policies face on the other.

[3] There appears to be no comparable data for western Europe, but I believe we would find the same pattern in many rural areas there as well. There is also no data either in the USA or Europe on whether in-migrants of retiring (or any other) age are returning home, or coming for the first time.

Key problems for retirees, the elderly, and the 'old-old'

"The older you get the stronger the wind gets – and it's always in your face". Jack Nicklaus

A look through the US and European literature on this topic suggests that older people in rural areas face growing problems with ***health and other forms of care, isolation, housing, and transportation***, all of which are in some degree inter-related. These problems are made worse by poverty, the incidence of which generally increases with remoteness from cities. They are also worse for elderly widowed women, blacks, Hispanics and native Indians in the US and ethnic minorities in general in the EU. Let us briefly review the nature of a few of these problems in the US and Europe.

HEALTH

"In the name of Hypocrites, doctors have invented the most exquisite form of torture ever known to man: survival". Luis Bunuel

Rural areas in the USA differ from urban areas in the way that health care is delivered. Small, rural hospitals in addition to being the only source of emergency care are often a community's only resource for health care services such as long-term care, home health services, and outpatient services. Rural areas tend to have access to a narrower and more costly range of health care services and to be served by fewer health care providers. The Medicare reimbursement system actually ***assumes*** that it is ***cheaper*** to deliver health care in rural areas, and its reimbursement rates for rural health providers is correspondingly lower than it is in cities. The rural health care delivery system is so precarious that it has the result of creating insecurity and instability for the elderly.

There is too little time to go into all of the health issues facing the elderly in rural America and identified in the literature, but they can be summarized as:-

1. Problems of ***access to health care***. This is about the growing distance to fewer and fewer delivery points, and the costs, and, especially for the frail elderly, physical challenges involved (JAMA, 2000). Bailey et al (2000) carried out a study of 'elderly heath care utilization in New Orleans County'. 69% of respondent's

physicians were located in the two main centers of population. Those traveling to the nearest Veterans Hospital (3% of the sample) faced a ***round-trip of 160 miles***, necessitating an overnight stay for some. This study also concluded that people who had to travel more than 10 miles to their physician tended to go to their physicians less frequently than those who had to travel shorter distances.

2. The relative ***importance of Medicare and Medicaid*** as a source of financing for health care[4] due to the older populations in rural areas, while Medicare is also ***under-funded*** in rural areas. A recent RUPRI report shows average indexed Medicare spending of $5,081 in urban counties and $4,962 in rural counties in 1999[5]. This is because the ***capitation rates are lower in rural than they are in urban counties***. Rural hospitals are also more dependent on Medicare and Medicaid as a source of revenue. Rural hospitals are therefore constantly at risk and forced to make hard choices about what services they can afford to provide.

3. ***Reductions in Medicare payment rates for home health care*** has adversely affected rural Medicare beneficiaries who make most use of home health and skilled nursing services, substituting such services for care that may otherwise be provided in a hospital in-patient setting. The 1997 cuts passed with the Balanced Budget Act (BBA) were especially hard on the skilled-nursing and home-health care facilities that serve an elderly, Medicare-eligible population. "It's made a huge difference to us. In home health we can't service the same clientele as far as geographic area. We used to go out in a 50-mile radius". Julie Jones, Director of Nursing at Hedrick Medical Center, Missouri (Missourian MO Hospitals Battle with Medicare Cuts). In a recent article Stensland ***et al*** state that the median total profit margin for rural hospitals is predicted to ***"fall from 4 percent in 1997 to between 2.5 and 3.7 per-cent after the BBA, Balanced Budget Refinement Act (BBRA) of 1999, and Benefits Improvement and Protection Act (BIPA) of 2000 are fully***

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[4] Christianson reported in 1990 that, on average, rural hospitals receive 41 percent of their revenues from Medicare. Christianson, Jon B. et al. "Institutional Alternatives To The Rural Hospital." Health Care Financing Review. Vol. 11, No. 3. Spring 1990. P. 87-97.

[5] www.rupri.org/programs/health/misc/medpactable2.html Note that this includes Medicare+Choice and FFS Medicare spending.

implemented in 2004."[6] Although the authors expected some rural hospitals to survive by downsizing to Critical Access Hospital(CAH) status, the problems of profitability and potential closure were expected to be especially severe in the poorest rural areas unable to fund the costs of treating indigents and others who could not, or would not, pay for medical services provided.

4. The ***lower 'quality' of provision*** in rural areas. This is partly because specialist surgeons are just not available, and partly because of the lower access to technology. The latter also seems to be one of the reasons (arguments?) for higher capitation rates to City hospitals[7].

5. ***Declining pharmacists but increasing prescriptions***. A decline ***in graduating pharmacists*** has left rural areas without coverage while the number of prescriptions filled by pharmacists grew 44% from 1992 to 1999.

In the USA, the Internet and ***telemedicine*** are being seen as ways to bring high-quality medicine into isolated rural communities. Telemedicine, or care provided remotely via telecommunications equipment from a specialist urban center is one of the most recent innovations in providing care to rural areas. According to the Association of Telemedicine Service Providers (ATSP), the number of telemedicine consultations has risen more than twenty fold in five years. In1998 there were 141 active telemedicine programs in USA. Services include teleradiology, the use of telephones to perform diagnostic tests, interactive video consultation[8]. However, although Telemedicine might be seen as part of the solution to access problems, it does not negate the need for a viable rural health care infrastructure as its use is only acceptable or feasible for a rather narrow range of health problems. Moreover, the 1996 Telecommunications Act created a new set of rules where market

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6 Stensland et al (2002) The Future Viability of Rural Hospitals. Health Care Financing Review **Provider- and Plan-Specific Measures of Quality Summer 2002, Volume 23, Number 4** http://www.cms.hhs.gov/review/02summer/stensland.pdf

7 This seems to be the implication of Vogel and Mueller's 1995 paper. Vogel, Bruce and Miller, Michael K. "Variations in Rural Hospital Costs: Effects of Market Concentration and Location." Health Care Financing Review. Vol. 17, No. 1. Fall, 1995. P. 69-83

8 It is notable that the US ***Telecommunications Act of 1996*** includes rural health care as one if its targets. Federal Law also encourages development and use of interactive video by providing subsidies to rural hospitals in the form of reduced long-distance rates.

competition was to be the primary regulator. Universal service would no longer occur because cross-subsidisiation was ruled out by the new regulations. Rural areas, are now at greater risk of being left behind even further than they were before in the information technology stakes. Finally, although Teleradiology consultations have been reimbursed by Medicare almost since their inception, interactive video consultations are generally not reimbursed by Medicare, thus discouraging practitioners from consulting by video.

Another set of solutions has been through diversification of rural hospital services. The ***'swing bed' program*** was introduced in 1982 specifically to allow rural hospitals to receive payments under Medicare B to increase the availability of rehabilitation services. Swing beds allow patients to stay in the hospital beyond the end of their acute stay and receive nursing services they need. 60% of rural hospitals participate in the swing bed program, and 47% of patients are discharged directly home after their swing bed stay.

For sparsely populated and remote areas where full-service hospitals are not financially viable, another solution has been limited-service hospitals, known as ***Critical Access Hospitals*** (CAH). These hospitals tend to be in remote sites, with services limited to short-stay inpatient care and emergency care. CAH allows for cost-based reimbursement by Medicare and is designed to provide inpatient care for no more than 96 hours. Only facilities located in a county with fewer than 6 residents per square mile or more than 35 miles from the nearest hospital can be certified. A CAH is limited to 15 or fewer inpatient beds.

The problems in western Europe are to some extent different because of their almost universal publicly funded system of health care. However, there have been reforms in the ways in which health and other forms of care are provided and funded, as well as in related social welfare policies, in most western European countries since the 1980's, and many but not all of these have impacted adversely on rural areas. In particular, with a few exceptions like Sweden and Norway, there has been a centralization of hospitals offering specialized care, and a devolution of care services that has proved almost impossible to organize and resource adequately in rural areas. The lack of long-term care facilities in many rural areas has meant that elderly people have often had to move to places where such care is provided, and away from home, friends and family. The distances which people have to travel to health care have also increased at a time of general decline in public transportation services, impacting

especially on old people without their own car, and able to drive it, and on relatives and friends wishing to visit elderly in hospitals, for example. Equally, it has sometimes proved to be difficult to recruit and retain doctors and nurses in remoter rural areas. Therefore, the rural elderly in Europe share problems of access, quality of service, and related issues with their brothers and sisters in the USA, although details differ from country to country.

Nevertheless, the European systems provide some more or less automatic link between increasing health needs and the provision of services, to greater or lesser degrees. Especially in Norway, and to a lesser extent in Sweden, the decentralized responsibility for health and care services to municipalities and counties, and the transparent and automatic system of fiscal compensation to provide such services, assures a strong link between local needs, local provision, and related employment [Persson & Ceccato, 1991; Bryden & Hart, 1991).

I do not have much information on other forms of care, such as that for those with psychiatric disorders in rural areas. My general impression is that it is very difficult to deliver comparable levels of social care in rural areas beyond the reach of larger towns and cities, and that this, too, is a growing problem on both sides of the Atlantic.

ISOLATION

Several factors including work history, family roles such as care giving, marital status, changes in pension coverage – affect retirement income and the economic well-being of older women. Women also have a longer life-expectancy than men, and so there are more single women who are elderly or old-old than there are men. ***Compared to rural older men***, the majority of older women are therefore more likely to live alone, to be poorer, and to experience greater vulnerability to the problems specific to aging in rural environments. These problems include isolation due to lack of public transportation, limited access to health care, substandard housing and difficulties with property maintenance.

For example, West Virginia has become the oldest State in the nation. The fastest growing segment of the population is women over the age of 85. These elderly women usually cannot maintain their homes, so housing and a safe housing environment become critical.

Of course what the man said about statistics and averages is correct, and we should recall that now. Rural people are no more a homogeneous

group than urban people are. In particular older women ***vary according to the length of time they have resided in a rural area***. In general, rural women can be classified as lifelong community residents, or incoming retirees, some of whom will be returning to their family and/or friends. Lifelong residents can be distinguished as to whether or not they have a large family, social support networks etc. Return migrants frequently are making a move into a rural area to receive more support from a local helping network and so may be frailer. Women who migrate to rural areas are more likely to be married and to have higher levels of education and income than those indigenous to these areas. (McCulloch et al 1998)

There are similar problems in Europe reported by Mullins et al (1996), Wenger (2001), and by the recent analysis of the Scottish Household Survey (Philip et al, op cit). They are exacerbated by poverty, lack of public transport, and housing problems discussed below.

HOUSING

Housing for seniors in the countryside has certain characteristics that differ from city and suburban conditions in both needs and resources. Rural areas of the USA had 6M occupied housing units with elderly householders in 1995, compared to 5.8M in non-metro areas [Beldon, 1998].

The main problems in both Europe and the USA seem to revolve around poor housing conditions for the indigenous elderly and the less well-off, lack of choice – especially assisted living (termed sheltered housing in the UK), apartments and rented accommodation – and a failure of the rural elderly to access assistance programs, for example those that subsidise housing in the USA[9]. Shucksmith et al (1994, 1996) identified an underprovision of sheltered housing in most rural areas, and an almost total absence of very sheltered accommodation in all rural areas in Scotland.

There are of course several programs that seek to tackle these problems. In the USA the most important are the Rural Housing Service (RHS)[10] Section 504 home repair assistance available to very low-income elderly,

[9] See especially Beldon (1998:93-97) for the USA and Black et al (1994), as well as Philip et al (2002) for Europe.

[10] RHS is an Agency under the Under-Secretary for Rural Development in USDA. It emerged from the reorganisation of USDA in 1994 that eliminated the Farmers Home administration.

the Federal HUD[11] Section 202 program which assists non-profit sponsors to build apartments for low income elderly over 62, and RHS Section 515 rental housing program which builds apartments for low-income rural elderly. However, although two of these programs have withstood budget cuts, RHS 515 has suffered steep budget cuts since 1994 (Beldon & Wiener, 1998:96). Innovative programs, such as self-build and mutual-build, are also not as feasible for the elderly.

TRANSPORT

The problems of health, isolation and housing are all made the worse by the relative lack of access to private and public transportation by the rural elderly and poor. In the 1990 census Rucker (1994) found that one in 14 households in rural America had no car. 45% of the rural elderly and 57% of the rural poor had no car. Despite such obvious transportation needs, 38% of the nation's residents live in counties with ***no public transport*** service. Many small areas have no taxi service, intercity and interstate bus, train and air service to rural areas has greatly diminished. (Hearing before the Senate, 2001) Similar problems are reported in Europe.

Once again, there are programs and projects on both sides of the Atlantic to try to cope with these problems. For example there are ***three key sources of Federal Support*** for rural transportation services for older persons in the USA. 'The Administration on Aging Title III program' – which serves to initiate transport services in rural areas and spent $68M in transportation services in 1999. 'The Health Care Financing Administration's Medicaid Program' – sponsored by the Social Security Act assists access to health care and absorbed about $840M of Medicaid funds in 2000. Then there is 'The Federal Transit Administration's Section 5311 Non-Urbanized Area Formula Assistance Program. In all, there are about 1,250 public transportation operations supported by Federal, State and local funding in rural communities across the USA, many of which have been in operation since the 1970s and 1980s. Burkhardt cites examples of good local systems run by the Mountain Empire Older Citizens group in Big Stone Gap, Virginia, and Pensylvania's Transit Programs for Seniors [2001].

I do not know what the situation is in most of western Europe, but do know that deregulation and privatisation of transport services, as well as

[11] HUD is the US Department of Housing and urban Development.

increased fuel taxes, have disadvantaged rural areas and the elderly and poor in particular. In the UK there is a national scheme for rural transport, and there are many local schemes often involving a 'dial-a-bus' system providing transport for shopping and other trips. There is also a 'Retired and Senior Volunteer Program' (RSVP) designed to keep older people active has around 8000 volunteers aged over 50 taking part in social and environmental projects from helping in schools to transporting people to the doctor. I do not know how well these work in the remoter rural areas.

In general, it seems that insufficient public resources are available to provide adequate public transport in most rural areas, and that problems grow with remoteness. There is increasing reliance on local and voluntary schemes, and donations.

RETIREMENT COMMUNITIES

Given these problems we might close by spending a little time thinking about why some rural areas are relying on retiree-attraction as a major plank in their economic development policies. At this stage, I think it is helpful to classify retirees into five different types as follows[12]:-

- the indigenous poor elderly who lack resources in the form of employment related pensions, and who are more reliant on various transfer payments. They are usually the majority;
- the relatively well-off indigenous elderly, who have sufficient resources to hire home help or pay for privately provided assisted living or nursing homes;
- the less well-off return-migrants at or near retirement age, returning to a family home, to be near to relatives and friends who will be similar in many respects to the first group;
- the better off return-migrants, who are in many ways similar to the second group;
- the incoming retiree migrants without local connections who are generally more educated and materially better off.

[12] The classification is mine, and is based on the proposition that these three groups will differ in their economic and social impacts, as well as the challenges they face in rural areas. Deller, Stallman & Shields (2000) use an alternative classification based on age and income in their analysis of economic and fiscal impacts.

It is a real handicap to analysis that we lack sufficient data on these categories, or sub-categories of them. But it helps to keep them in mind as we work through the issues.

We may also note that, in the USA, there is a growing concentration of elderly person in the Sunbelt States in general, and in several specific retirement areas, including a band of counties stretching from northwestern Arizona, the Ozarks in Arkansas, and central and south Texas to western North Carolina and eastern West Virginia. Non-metro retirement counties[13] have grown rapidly since 1980. While retirement counties' populations grew by 16% and received 12% net in-migration during the 1980s, non-metro areas in general had population growth of only 4%.

Retiree attraction policies began to gain favor in the USA during the late 1980s and early 1990s in hopes of rekindling rural economic growth, as a result of declines in employment and real earnings in traditional rural industries, and stagnation of income in rural manufacturing areas. The target was the relatively well off, younger and fitter retirees. I understand that the marketing usually featured golf-courses, scenic attractions and tax breaks, and said little if anything about health and other forms of care.

The economic benefits which such retirees bring to local economies are said to be:-

1. increase in ***population and tax bases***;

2. inflow of capital, which may be invested locally by local banks.

3. economic diversification, including increased tourism

4. given that in-migrating retirees are covered by Medicare and this pays the bulk of their health costs, they may contribute to hospital profits and occupancy and help to keep them open for everyone;

5. Increased employment, especially in trade and service sectors, including some well-paid occupations like doctors and lawyers;

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[13] A 'Retirement Community' is defined in the USA as a county with 15% or more net in-migration of person age 60 and over.

6. They may boost local churches, charities, volunteerism, and other civic activities.

Against these potential benefits, we must set potential costs:-

1. Employment created in trade and service sectors is often, if not always, low-wage;

2. Low wage and income households may find themselves unable to afford housing as housing demand increases and pulls up house prices

3. As retirees age, they may become an increasing drain on the local tax base as their incomes erode with inflation and they demand more health-related services.

4. Retirees' long-term impacts on heath-related costs of State and local governments could be negative for retirement destinations, especially if the hospital is run by the local government, as is more often the case in rural areas.

5. Retirees have been found to be less supportive of economic development spending when they believe this might detract from quality of life. They also demand more of certain kinds of services such as public protection services [Longino, 2001]. Research on retiree voting behavior indicates that retirees in some places have been less supportive than other residents of tax increases for schools. They may also exhibit 'NIMBY-ism'. Thus retirees voting behavior can affect local tax and spending policies in ways that are against the interests of younger residents.

6. Rural communities have particular difficulty in capturing a large share of retirees' economic benefits because rural communities often lack the full range of goods and services demanded by retirees, leaving retirees (and others) with no option but to spend much of their money elsewhere – 'leakages'. As a rule these leakages will be larger in small communities with limited economies and in communities located near metro areas or near non-metro towns that serve as regional shopping and service centers.

Nevertheless, most studies of the economic impact of retirees, such as those by Deller, Stallman & Shields and Fannin, show net positive

benefits for rural communities, even if these may sometimes be small. Unsurprisingly, these studies also suggest the net economic benefits are likely to rise with the income, and fall with the age, of retirees attracted. Reeder and Glasgow's study, however, suggests that although the promotion of retirement migration can be a viable economic development option, it is not an unmitigated blessing [Reeder & Glasgow, 1990; Longino, 2001].

The findings are nevertheless sensitive to the fiscal context in the USA because local communities can 'capture' benefits from sales and property taxes paid by retirees, whereas most of the public expenditures, especially the very high costs of health care as retirees age, are met by the State and Federal budgets. This of course means that net benefits to individual communities may not translate into net benefits for States.

These doubts about net benefits to States are increased to the extent that the retirees are moving within the State itself, from the Metropolitan areas and suburbs to the rural areas, since this will simply involve displacement – in other words, the gains to rural communities are more or less the same as the losses to the cities. Charles Longino's study does not deal with this issue, as it is based only on net migration between States (1995). However his map indicates that several rural states, notably in the Mid-West and North-East, Oregon, and the two southern States of Louisiana and Virginia, were net losers between 1985 and 1990 [see Fig 3 in Fannin].

It might be different up there, but recent data for Canada show that the rates of internal retirement migration within Provinces are highly variable. In British Columbia, for example, roughly two-thirds of in-migration to rural areas and small towns was from BC between 1991 and 1996. However, in Nova Scotia, only about half of in-migration to rural areas and small towns was from within the same Province. Both received net in-migration in the 60+ age group during that period.

Before closing, I want to return briefly to the impact of retiree migration on the politics of communities to which they move, and from which they come. Empirical studies such as those by Deller and Watson and Kelsey (for Pennsylvania) find negative impacts on local expenditure on schools. My own hypothesis is that the problems of conflict between retirees and the local population are likely to be greatest in the case of those relatively wealthy retirees coming in to a rural area for the first time, rather than those less well-off who are returning to their home communities. This is because the wealthy in-comers do not have the local social and

community connections that moderate or even subsume individual interests. They are more likely to demand services that they are used to in the towns and cities they came from (Siegal, Lethold and Stallman). They are less likely to vote for, or otherwise contribute to, other forms of economic development, and for badly needed expenditure and effort for the rural schools, and for welfare activities concerning poorer people in the community. They will be less concerned about local health care when they can have ready access to hospitals and clinics in urban areas. Ironically, this group is thought to contribute most to the local economy. As they generally have higher education, they could also make significant contributions to the community in other ways. It seems to me that we need to know more about the characteristics and social behavior of this group, as well as other inward and outward migrants in order to complement and refine the economic and fiscal analysis.

Few people have considered the impacts on city and State politics of the flow of elderly migrants from the cities to rural areas. As 'gray politics' takes over in retirement communities, so the politics of youth and the working age groups with children could in some scenarios take a stronger hold elsewhere[14]. Since cities are often more 'connected' to State politics, this in turn could have adverse impacts on State policies for the elderly in general. Yet it is ultimately the younger generations who are producing the output and taxes that sustain policies to cope with the many inevitable demands old age. Were this to happen, it would be the indigenous elderly, and the elderly poor, in rural areas who would suffer most.

I admit to a prejudice, based on my own family experience, that older people are generally better off in all respects remaining in communities where they have family, friends, knowledge and networks – social capital if you will. I am not alone in this. In a recent report produced by CECODHAS, the European Liaison Committee for Social Housing, to mark the United Nations' Year of Older Persons, one of the main recommendations was that Governments and providers of social care and support should help people stay in their own communities. If this is correct, then perhaps rural areas should focus on attracting back retirees who once lived there rather than those who have not[15].

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[14] Although in the USA it seems that at least in 'retirement counties' there is also a high in-migration of youth (Stallman, pc).

[15] Incoming retirees may of course be able to form new social networks, but this may be more difficult with advancing years, and especially in

I am of course only too aware of the challenges facing rural areas in the light of losses of traditional employment, negative changes in the natural population, out-migration of the young, and policy neglect. Rural areas do need to think hard about how to attract people of all ages, and how to orientate their resources and energies to this end, if they wish to survive. But I do believe that many retirement attraction policies are based on at least partial data, misunderstandings and even myths, as well as rather short-term thinking.

We must think of the elderly themselves. What is it like for the less well-off to grow old in a community without adequate health and social care, transport and housing? What is it like to grow old away from support networks of family and friends?

We must also think of the relationships between the young and the old. About the transmission of knowledge and culture between generations. About the nature, creation and sustaining of community. In circumstances where the grandparents live far away from their grandchildren, either because their children migrated, or because they themselves moved, we need to think about how support networks can be created which bring the indigenous elderly in contact with those of younger generations, children and youth, with whom they have no family relationships.

On this last point, one of the things which has impressed me during my stay in the USA is the huge extent of voluntary effort in all age groups. I am aware that it is often the retiree population who are often providing care for the elderly through voluntary schemes. However, I have been most impressed by schemes which involve youth in caring for the elderly, helping with house repairs, taking them shopping, mowing their lawns, and giving them company and conversation. This is often a two way process – the young also gain. This is one reason why we have to challenge the notion that specialised 'retirement communities' without children are either a good thing, or sustainable.

What then are my messages from this paper?

My first message is to the elderly – think carefully before moving to a 'place' where you have no friends or family, no local knowledge, and which is not familiar to you. Social capital is worth a great deal, and it is getting more, not less, valuable.

My second message is to the rural communities – think carefully before seeking to attract wealthy retirees in the hope of a quick buck. They may change your local politics, and displace your culture. Focus on policies that will bring back your emigrants, preferably when they are in their child rearing years, but also up to and including their retirement years.

My third message is to States – think carefully about the economic, social and political costs of retiree attraction policies, and whether these are the best use of increasingly scarce public resources. Pay more attention to the forthcoming boom in elderly populations, and think of the elderly as a potential resource in helping to address the many issues and problems that face them, and you, in future.

My final message is to the Nation – devise a proper and adequately funded rural development policy that includes serious attention to the deficiencies of national policies for health and social care, transport and housing for the indigenous elderly in rural areas, and supports local initiative.

Some Questions/ Issues to reflect on

- **What about other forms of care which do not involve doctors, hospitals and the health administration in general? I am thinking here about the often serious problems of delivering other forms of social care to the elderly in rural areas.**
- **Why do we assume that it is cheaper to deliver health and other forms of care in rural areas (especially in the USA)?**
- **What are the limitations on the role of Information and Communications Technologies in providing rural health care, as well as other forms of care (especially to the poor, and the remote)?**
- **What is the role of communities ('places') in tackling the deficiencies of health and social care policies in rural areas?**
- **Do solutions to the transport problems of the poor and the elderly have to be *local* solutions, and if so, how can central Governments assist?**
- **Is it better that the elderly should stay close to family and/ or their social networks? If so, how can this message be better conveyed?**
- **How do relatively well-off incoming retirees change local and State politics through their voting behaviors? How does this affect younger generations?**
- **What are the cultural impacts of relatively well-off incoming retirees in rural areas, and what are the longer-term implications of these impacts for local economies and societies?**

- **What are the State-local differences in economic impacts of incoming retirees, and what influences these?**
- **How can we best tap the many and various resources that the elderly have to offer?**

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