Perspectives on Aging-Related Preparation

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Abstract

When older adults face age-related life challenges, anticipating what to expect and how to access potential coping strategies can both prevent and provide the possibility of easier recovery from crises. Aging-Related Preparation (ARP) is defined as the continuum of thoughts and activities about how to age well, often beginning with the awareness of age-related changes, or the anticipation of retirement, and concluding with specifying end-of-life wishes. In the current paper, we introduce the concept of ARP and related formulations regarding plans for aging well, describe both predictors and outcomes of ARP for several the domains of ARP, and consider the elements of ARP within the context of existing social policy. We conclude that ARP is determined by a variety of influences both intrinsic to the older person (e.g., personality, cognitive ability, beliefs about planning, problem-solving skills), linked to social class and education, as well as dependent on family structures, access to and knowledge of options, services, and local community resources, and social policy. We further provide evidence that ARP has positive effects in the domain of pre-retirement planning (for retirement adjustment), of preparation for future care (for emotional well-being), and of ACP (for a good death). However, other domains of ARP, including planning for leisure, housing, and social planning are under-researched. Finally, we discuss policy implications of the existing research.

Keywords: Age-related preparation, Retirement planning, Preparation for future care, Proactive Coping, Long-term care

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Perspectivas sobre la preparación relacionada con el envejecimiento

Resumen

Cuando los adultos mayores enfrentan desafíos de la vida relacionados con la edad, anticipar qué esperar y cómo acceder a posibles estrategias de afrontamiento puede prevenir y brindar la posibilidad de una recuperación más fácil de las crisis. La preparación relacionada con el envejecimiento (ARP) se define como el continuo de pensamientos y actividades sobre cómo envejecer bien, a menudo comenzando con la conciencia de los cambios relacionados con la edad o la anticipación de la jubilación, y concluyendo con la especificación de los deseos del final de la vida. En el artículo actual, presentamos el concepto de ARP y formulaciones relacionadas con respecto a los planes para envejecer bien, describimos tanto los predictores como los resultados de ARP para varios dominios de ARP y consideramos los elementos de ARP dentro del contexto de la política social existente. Concluimos que el ARP está determinado por una variedad de influencias tanto intrínsecas a la persona mayor (p. Ej., Personalidad, capacidad cognitiva, creencias sobre la planificación, habilidades para la resolución de problemas), vinculadas a la clase social y la educación, así como dependientes de las estructuras familiares. acceso y conocimiento de opciones, servicios y recursos de la comunidad local, y política social. Además, proporcionamos evidencia de que ARP tiene efectos positivos en el dominio de la planificación previa a la jubilación (para el ajuste de la jubilación), de la preparación para la atención futura (para el bienestar emocional) y de la ACP (para una buena muerte). Sin embargo, se están investigando otros dominios de ARP, incluida la planificación del ocio, la vivienda y la planificación social. Finalmente, discutimos las implicaciones políticas de la investigación existente.

Palabras clave: Preparación relacionada con la edad, planificación de la jubilación, preparación para la atención futura, afrontamiento proactivo, atención a largo plazo

关于老龄化相关准备的视角

摘要

当老年人面临老龄化相关的生活挑战时，预期未来规划以及如何获取可能的应对策略能防止危机并提供从危机中快速恢复的机会。老龄化相关准备（ARP）被定义为关于如何健康老去的想法和活动的连续体，经常以意识到老龄化相关变化、或预期退休开始，以确定遗愿结束。本文中，我们引入了ARP概念和有关健康老去规划的相关定义，描述了几个ARP领域中ARP的预测物和结果，衡量了现有社会政策背景下ARP的各要素。我们的结论认为，ARP由一系列影响因素决定，这些影响因素不仅是老年人所固有的（例如性格、认知能力、关于规划的信念、问题解决技能），与社会阶层和教育相联系，并且取决于家庭结构、对选择、服务和地方社区资源的获取及理解、以及社会政策。我们进一步提供证据证明，ARP在退休前规划（用于退休调整）、未来护理准备（用于情感福祉）、ACP（用于善终）这三个领域中具有积极效果。不过，其他ARP领域，包括娱乐规划、住房和社会规划，还有待研究。最后，我们探讨了现有研究的政策意义。

关键词：老龄化相关准备，退休规划，未来护理准备，主动应对（Proactive Coping），长期护理

Perspectives on Aging-Related Preparation

Planning for the future is considered a common activity among young adults seeking to exert agency over their own development (Lerner & Busch-Rossnagel, 1981). Among older adults, however, future preparation is much less the norm (Freund et al., 2009). When older adults face age-related life challenges, being able to imagine what to expect and how to access potential coping strategies is a "mental dress rehearsal" (Evans et al., 1985, p. 369). Whether older adults can achieve positive developmental outcomes and maintain well-being as they age may depend in part on the extent to which they have engaged in preparation activities or developmental regulation. Aging-Related Preparation (ARP) is defined as the continuum of thoughts and activities about how to age well, often beginning with the awareness of age-related changes, or the anticipation of retirement and concluding with specifying end-of-life wishes. Early goals and plans revolve around leisure, social relationships, and housing tran-

sitions; later plans focus on preparation for health challenges, the loss of loved ones, and managing situations in which autonomous decisions may be compromised by dementia or other severe illness (Baltes & Smith, 2003; Lang, Baltes & Wagner, 2007; Sörensen et al., 2012). Vital to effective aging-related preparation is recognizing the risks for aging-related losses and identifying potential resources to managing those challenges. As Lang and Rupprecht (2019) note "aging may also involve the need to accept some kind of vulnerability" (p. 2).

Demographics, labor markets, and policy shifts have contributed to an increase in the importance of individual and family-based ARP. In response to the increasing proportion of older adults in the population, declining birthrates, the baby boom cohorts retiring, and the resulting decrease in number of working adults per older person in most industrialized countries (e.g., Social Security Administration, 2020; Vincent & Velkoff, 2010; Bogetic et al., 2015), more governments expect their citizens to be individually responsible for preparing for old age, rather than relying primarily on government services with regard to financial retirement planning, housing, and receiving care (Preston et al., 2019; Soichit, & Khophai, 2017; Niu et al., 2020).

The purpose of the current paper is to explain the process and domains of Aging-Related Preparation and to discuss how the findings in this area of study are relevant to aging policy. While we aim to address the primary issues in this field, this review is not comprehensive. To orient the reader, we briefly review the concept of ARP and the theoretical basis for ARP; then we summarize the current findings regarding the nature of, reported frequency, predictors, and outcomes of ARP; finally, we the explore the policy implications of these findings, in view of social policy and intervention. Given our concern with policy relevance, we focus, with some exceptions, on findings from the U.S. and from the last 10-15 years, during which the baby boomers have begun to retire.

The Concept of Aging-Related Preparation

Our concept of Aging-Related Preparation (ARP) encompasses several related preparation activities: *pre-retirement planning* (e.g., Baltes & Rudolph, 2012; Donaldson et al., 2010; Freund et al., 2009; Löckenhoff, 2012), *preparation for future care* (e.g., Pinquart et al., 2017; Sörensen & Pinquart, 2000a), *housing decisions* (Adams & Rau, 2011; Oswald et al., 2006), and *advance care planning* (e.g., Detering et al., 2010; Hines, 2001; Dixon et al., 2018). Across these contexts, we consider planning and preparation as life-span processes (Freund et al., 2009; Löckenhoff, 2012) in a multi-domain environment (Kornadt & Rothermund, 2014). A related concept is *preparation for age-related changes*, which defines multiple domains of preparation for old age (Kornadt et al., 2020). ARP is distinguished from this literature by its focus on *processes,* as informed by the psychology of everyday cognitive planning (e.g., Berg

et al., 1997; Craik & Byalistok, 2006; Das et al., 1996; Friedman & Scholnick, 2014; Scholnick & Friedman, 1993; Hayes-Roth & Hayes-Roth, 1979; Rebok, 1989). Combining the literature on cognitive planning and preparation for future care (Sörensen et al., 2011), ARP processes include, for example, awareness of the need for aging-related preparation (due, perhaps, to a loss of mobility), gathering information about future threats and options (e.g., difficulty with stairs necessitating single-level house or assisted living), making decisions about goals and preferences (e.g., wanting to maximize privacy), and enacting preliminary steps (e.g., seeking a new house). In addition, the study of ARP is informed by the literature on goal setting.

Goal Setting. Establishing goal states toward which to strive can organize an individual's active engagement in their own development. Goal setting is considered a critical element of successful aging and better health (Fisher & Specht, 1999; Fooken, 1982) or a "good old age" (Street & Desai, 2011). Mental representations of successful aging (Rowe & Kahn, 1997) can be described as *possible selves* (Cross & Markus, 1991; Markus & Nurius, 1986), *developmental tasks* (Hutteman et al., 2014), *personal life tasks* (Cantor et al., 1991), *life goals* (Nurmi, 1992), *personal goals* (Brunstein, Schultheiss & Maier, 1999; Riediger, Freund & Baltes, 2005), *personal projects* (Little, Salmela-Aro & Phillips, 2017), *personal strivings* (Emmons, 1989; 1999), and *personal life investment* (Schindler & Staudinger, 2008).

Older adults report different goals than younger adults (Strough et al., 1996), with older adults' goals centering around health and health maintenance, retirement adjustment, sleep, chores, community, recreation, and spirituality (Chen et al., 2012), maintenance/loss prevention, present-day experiences and emotions, generativity, and social selection (Penningroth & Scott, 2012), and independent living (G. Carstensen et al., 2019). Kornadt et al. (2020) outline eleven domains of preparation for age-related changes covering both the "Third age" (ca. ages 60-80) when retirement, continued activity, generativity, and health maintenance are salient (Laslett, 1989), and the "Fourth age" of increasing frailty and loss of functioning associated with advanced old age (Baltes & Smith, 2003; Gilleard & Higgs, 2011). Below, goal setting is discussed as a component of the four most researched domains of ARP (pre-retirement planning, preparation for future care, housing decisions, and advance care planning).

Theoretical Considerations. Aging-related Preparation is informed by several theoretical approaches, including theories of proactive coping (Aspinwall & Taylor, 1997), the model of *Selection, Optimization, and Compensation* (Baltes & Baltes, 1990), and theories of life-span control (Heckhausen & Schulz, 1995). Regarding proactive coping, ARP is recognized as a way to manage future stressors either by *preventing* some of them or *coping* with them more effectively (Berg et al., 1997) by developing *potential responses* to physical and cognitive health stressors (Aspin-

wall, 2005). Selection, Optimization, and Compensation suggests specific actions that assist with adjustment to aging-related changes, such as the *selection* of valued activities (e.g., ones that are safer), *optimization* of goals (e.g., social, activity, and independence goals by moving to a less demanding but more social environment, like assisted living; see, e.g., Perry & Thiels, 2016), and *compensation* for age-related losses (e.g., through the use of assistive devices; see Freedman et al., 2017). Life-span control theories (Heckhausen & Schulz, 1995) suggest that the use of primary control strategies, such as seeking out new activities and friends and engaging in preventive action, and secondary control strategies, such as regulating the emotions resulting from the prospect of future loss and the actual experienced losses (Löckenhoff, 2012) through flexible goal adjustment (Brandtstädter, 2009; Brandtstädter & Rothermund, 2003). Finally, the notion that making plans helps bridge the intention–behavior gap for older adults (Reuter et al., 2010) presents a potential *mechanism* for the benefit of ARP.

Notably, the conceptualization of ARP is also consistent with the theory of preventive and corrective proactivity (Kahana et al., 2012). Similar to SOC and life-span theories of control, this conceptualization suggests that older adults can perceive threats to future goal states, such as to their future emotional well-being, and select environments, behaviors, and responses, thus attempting to control their quality of life (to a certain extent) in advance of predictable age-related losses. However, the motivation for ARP is likely influenced by the perceived control over these events and beliefs about the time frame within which these threats are likely to occur (Ouwehand et al., 2007) as well as the *type* of event. For example, preparation for unexpected events, such as falls and fractures or financial setbacks due to stock market crashes, is considerably less likely than planning for age-related changes that are either normative or easily anticipated, such as loss of physical strength or the need for stronger visual aids.

In sum, whereas the ARP literature incorporates a sociological understanding of societal and contextual influences, especially with regard to demographics, policy change, and pre-retirement planning, it is at its core an application of life-span developmental approaches to self-management in late life for retirement, preparation for managing gains and losses of aging, living with chronic illness (Barlow et al., 2016; Greenglass et al., 2006; Heckhausen et al., 2013), future health care anticipation and determining preferences, housing decisions, as well as dying with dignity (for which there appears to be no current theorizing). Thus, while we acknowledge the role that the sociological understanding, especially the understanding of cross-cultural and policy research has played in the development of the ARP literature, our theoretical emphasis relies more explicitly on life-span developmental approaches to aging and ARP.

Findings Regarding ARP

Four topics dominate the empirical literature in ARP. These include the frequency of ARP in different populations and at what level of concreteness or extent it typically occurs; the predisposing and facilitating factors, as well as the barriers to ARP among older adults; the evidence for the usefulness of ARP for health and well-being outcomes; and attempts to increase aging-related preparation among older populations.

How Much Do People Prepare?

The extent to which older adults report preparation in different domains varies by samples and measurement tools, and how questions are asked. Also, the extent and concreteness of preparation does not speak to the quality or realism of plans.

Retirement Planning

Research on pre-retirement planning has emphasized that age-normed transitions constitute turning points (Stenholm & Vahtera, 2017) affecting the individual's *financial stability* (e.g., Hershey & Mowen, 2000), necessitating *psychological adjustment* to changes in work demands and social opportunities (e.g., Wang & Shi, 2014), and requiring *preparation* for the financial and psychological effects of retirement-related transitions (e.g., Adams & Rau, 2011; Earl & Archibald, 2014; Gonzales & Nowell, 2017; Löckenhoff, 2012; Street & Desai, 2011; Wang & Shi, 2014). Critiques of this literature suggest that the predominantly male-centered framing of retirement as an abrupt change is less relevant to women (Loretto & Vickerstaff, 2013) and Baby Boomers (e.g., Kojola & Moen, 2016) who are redefining retirement as a more gradual process with periods of non-work, part-time work, and return to work. A historical focus on financial aspects of retirement in the research (e.g., Appleton, 1900; Buck, 1926; Meriam, 1918; Hershey & Mowen, 2000) is now counterbalanced by studies investigating multiple domains of retirement planning including psychological (career and employment decisions, leisure/recreation), financial (income, employment, estate planning), psychosocial (social and interpersonal), and health-related preparation (Hershey et al., 2001; Yeung, 2013).

Active retirement planning that incorporates non-financial plans into retirement preparation, however, is rarely performed by American workers; fewer than 1/4 engage in planning for *where* they would retire or whether they would continue employment during retirement (Turner et al., 1994). Ferraro (1990) reports that about 40-60% of a nationally representative sample of 3,464 U.S. pre-retirees aged 18-67 who were surveyed in 1974 engaged in each of seven preparation activities.[1] More recently, only 12% of workers aged 51 to 61 report that they do not know or have not thought about their retirement timeframe, and about 43% report having "no plans" about the *form* of their retirement (Ekerdt et al., 2001). Thus, retirement preparation beyond finances is quite limited.

Although pre-retirees report seeking information about retirement

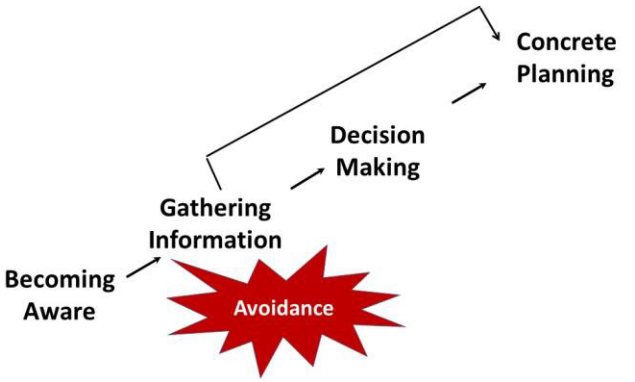
from other retirees, coworkers, company officials, Social Security personnel, general reading, and the media (Evans et al., 1985), most retirement planning still focuses on financial planning. However, rates vary widely across studies (Ameriks et al., 2003; Bucher-Koenen & Lusardi, 2011) and many people report rather cursory plans. For example, only 29% of TIAA-CREF participants "agreed" or "strongly agreed" to have spent "a great deal of time" developing a financial plan (Ameriks et al., 2002). Results from the Retirement Confidence Survey suggest 37% of American workers have given *little or no thought* to their retirement and that only about one-third report having calculated their financial needs for a comfortable retirement (Dickemper & Yakoboski, 1997). Only about a quarter of baby boomers (currently ranging from age 56 to 74) are financially prepared for later life—60 percent will not be able to maintain their current lifestyle without continued employment, and 60 percent suffer from chronic health problems; one quarter have a current average income of only $15,000 (Court et al., 2007).

Preparation for Future Care (PFC)

Almost 70% of adults over 65 will require some type of long-term care services during their lifetime (U.S. Department of Health and Human Services, 2017), but only 37% believe that they will need these services (AARP Public Policy Institute, 2007). Most elders underestimate their potential future needs for assistance and report rarely or never thinking about these needs (Walz & Mitchell, 2007). This evinces a need on the part of aging individuals to engage in more substantive Preparation for Future Care (PFC), defined as thoughts and activities focused on how to obtain assistance with daily tasks or personal care, as well as enact housing adjustments that allow the individual to age well. Informed by models of cognitive processes in everyday planning situations (e.g., Berg et al., 1997; Craik & Byalistok, 2006; Scholnick & Friedman, 1993; Hayes-Roth & Hayes-Roth, 1979; Rebok, 1989), PFC is described as a series of steps, from a general awareness of the need to plan, to enacting and evaluating concrete plans for specific care options. Drawing on qualitative, life-history data from a study of 51 mid-life and older Canadians, Denton and colleagues (2004) propose that *anticipating risk* of gains and losses, as well as recognizing the need to manage that risk, and understanding the life conditions that contribute to risk, should result in "reflexive planning." Sörensen et al. (2011), discussing preparation for late-life transitions, suggest that awareness of risk must be followed by *information-seeking* about the present situation, potential future threats, as well as available options (see also Ouwehand et al., 2007), as well as determining future goal states or *preferences*, *comparing* various options for reaching these goals, *deciding* on specific steps to take, and following up with steps that ensure access to those options (e.g., putting one's name on a waiting list). This process is depicted in Figure 1**.** Once needs emerge, the authors suggest that *implementing* these

plans will be easier—and better—than turning to ad hoc solutions, and *evaluating plan effectiveness* will allow their calibration (Sörensen et al., 2011).

Figure 1.Preparation for Future Care as Process



Both early and more recent studies of PFC note a distinct lack of concern about future illness and care among older adults. In 1965, Heyman and Jeffers (1965) reported that that 50% of older adults in North Carolina said they were **not** concerned about a future long-term illness, and only 16% expressed that they were "very concerned" (cf. Kulys & Tobin, 1980, who report 43% anticipate future care need). Thirty years later, 70% of older women in three-generation families said they had *thought about* what to do if they needed help with personal care and 63% had talked to others about it, but only 9% reported having made *concrete* plans (Sörensen & Zarit, 1996). Although older Americans worry more about paying for long-term care than paying for retirement, 48% of have done little or no long-term care preparation (National Council on Aging and John Hancock Mutual Life Insurance Company, 1999). In an AARP survey, about half of informal caregivers to adults of all ages say their care recipient has made *no plans* for future care or they are unsure if plans exist, 40% if the care recipient is a spouse. If the care recipient is over 50 or has dementia, the likelihood of preparation increases. Only 40% of the caregivers have plans for their *own* care (AARP Public Policy Institute & National Alliance for Caregiving, 2015). It is also worrisome that just 9% of seniors have talked with a financial professional about long term care (Age Wave & Harris Interactive, 2010). Baby boomers, although they have a higher rate of chronic illnesses than the previous generations (Soldo et al., 2006), are also not likely to have long-term care plans; 2/3 are concerned about their health in retirement and 71 percent about health care costs (Court et al., 2007).

The lack of preparation for care becomes even more apparent when broken down by its concreteness: Among women 64 and older, about one third rely primarily on others (individuals or organizations) to plan their care (Girling & Morgan, 2014), whereas 34%

engage in "autonomous planning," and the rest report awareness of preferences, but have taken no action, avoid planning altogether, or engage in unrealistic wishful thinking, staying mostly disengaged from care preparation. Similarly, 30%-52% of community dwelling older adults report general plans for their future needs with no specific notion of how to implement these preferences, but only 1% to 15% report having *concrete* plans for their care (Black et al., 2008; Sörensen & Pinquart, 2001b); 55% state that they have no plans at all for future care (Sörensen & Pinquart, 2001b).

BOX 1. Policy Recommendations for Improved Preparation for Care:

- The provision of a basic income for all caregivers of the young, disabled or old at home, most of whom are women unable to take up paid employment, would increase preparation for future care.
- Information on services for elder care must be more easily accessible both by website and in brochures available at medical centers, dementia care clinics, senior centers, local community and recreation centers, and grocery stores. Older adults and their families need easy access to information.
- Policies requiring the training and perhaps registration of formal caregivers are needed to ensure the steady availability of well-trained care providers, whose schedules are organized in communication with consumers, thus enabling long-term care planning around family and work schedules.

Housing decisions often emerge once older adults are already retired. They may include care considerations, but this is not always the case. The majority (78%) of middle-aged and older adults surveyed by the AARP in 2014 preferred to "age in place" (Barrett, 2014), particularly rural elders (e.g., Carver et al., 2018). Due to advances in telemedicine, health monitoring systems, home dialysis, and other in-home aging and medical services, it is possible to age in place, but aging in place requires careful planning to include home modifications, access to medical care and social contact, home upkeep, and contingency plans (Erickson et al., 2006).

In the housing domain goals and plans are often not aligned. Despite the fact that 49% of workers and retirees in upstate New York expect to stay in their own homes without modifications (Robison & Moen, 2000), only a small percentage of these persons have an entrance without steps, a walk-in shower, or the ability to live on one floor; repair and maintenance tasks are often deferred (Begley & Lambie-Hanson, 2015;

Kelly, 2014), both because of financial reasons and the inability to coordinate the work. Aging in place is threatened by increases in property taxes and utility costs, changes in family composition, and diminished health, whereas greater home equity, financial resources, and stronger community ties contribute to a higher likelihood of aging in place (Sabia, 2008). Also, many home modifications are not possible for renters to implement. Thus, renters are four times more likely to move in a two-year period than homeowners who hold mortgages (Robison & Moen, 2000) and thus often find it difficult to plan for aging in place.

Plans for moving are equally inadequate. In a qualitative study of older adults in the UK who had recently moved to "age-appropriate" housing, most had moved on an ad hoc basis in response to illness rather than planning housing transitions (Tulle-Winton, 1999). Whereas 20% of older Australians in their late 70s expect to move in the next ten years, most do not have firm plans (Byles et al., 2018). However, comparing Baby Boomers to older generations suggests that, unlike their plans for finances and care, Boomers' plans for housing are somewhat more realistic, including moves to apartments, retirement communities or assisted living, or living with an adult child (Robison et al., 2014). What stands out, in this literature, is that despite the desire to "age in place," many older adults are unable or unwilling to do critical decision making until they have limited choice or are unable to make a good decision. Without housing preparation, mismatches between the home and the capabilities of its older residents, especially for adults over age 85 (Levitt, 2013), can quickly lead to an unexpected or undesired relocation to a nursing home.

BOX 2. Policy Recommendations for Improved Housing Preparation:

- A holistic approach to housing policy is needed that takes into account that for older adults housing is not only a care location, or a dwelling place, but also a place to get one's social, leisure, mental and physical needs met, and to feel "at home" (Roy et al., 2018).
- Provide or expand programs that support home modification to give older persons the ability to age in place (Pynoos, 2018).
- Increase public transportation for older adults to have access to shopping, social and medical amenities, families and friends, when driving is not an option.
- Increase the supply of subsidized supportive housing by building new complexes and adding services to those that already exist. Apply the prin-

ciples of universal design to meet the needs of residents of all ages, to avoid unwanted age segregation (Pynoos, 2018).

- The needs of older women should be researched more thoroughly, as those widowed or newly single may require different housing options.
- Adjust building and zoning codes for a greater range of housing options, including shared housing, co-housing, and construction-added dwelling units (Pynoos, 2018).
- Provide or expand in-home health and assistance services and their coverage through Medicare so that older adults are not forced to leave their homes.
- In congregate housing for frail older adults, not only resident safety, but also the sense of meaning older adults draw from their homes need to be taking into consideration, allowing older adults to plan for and adapt to their new dwellings and rebuild their feeling of being-at-home (Roy et al., 2018).
- Achieve better coordination of housing, health, and social service programs (Pynoos, 2018).

Advance Care Planning

The lack of attention to proactively gathering information and making decisions about care preferences (Carrese et al., 2002; Sörensen & Pinquart, 2001) has raised concerns about how older adults' care needs and preferences will be met (Court et al., 2007; Moses, 2011). Similar concerns about ACP, including designation of a health care proxy, completion of a living will, and, in some states, the completion of a Physician's Orders for Life Sustaining Treatment forms, or a "Do Not Resuscitate" order (DNR) has been expressed in the last two decades (Detering et al., 2019).

Empirical research on Advance Care Planning (ACP) emerged after passage of the Patient Self-determination Act of 1990, when clinicians observed that advance directives are mandated and advocated, but poorly understood. About one-quarter of Americans of all ages have completed an advance care planning document (Rao et al., 2014). In a review of 148 studies, ACP rates among elders were just 26.7% (averaged across all the studies, Yadav et al., 2017), but 78% for people with multiple chronic illnesses. Particularly for critically ill patients and older adults with dementia, communicating end-of-life preferences is important, as they can lose their ability to communicate. Because data on ACP discussions or advance directives completion rates are not standardized,

reports of ACP rates are highly variable and difficult to interpret.

Older adults in institutional settings, and frail homebound older adults or those enrolled in special programs related to advanced care needs, are most likely to have completed some type of advanced directives (Gerst & Burr, 2008). In a nationwide survey of over 3,700 nursing home residents in 1996, about 58% had at least one type of advance care document (Degenholtz et al., 2002), but rates among adult day center attendees are 41% (Lendon et al., 2020). Among frail older adults, 66% to 81% of Caucasian and African Americans, but only 39.1% of Hispanics (Black et al., 2008; Eleazar et al., 1996; Golden et al., 2009) report at least one ACP document. Ethnic minorities report informal talks about their end-of life wishes (60%), but fewer (30%) have a durable power of attorney for health care, or living will (26.5%; Hong & Kim, 2020).

In sum, while retirement planning, preparation for future care needs, and housing preparation are not well-established among the older adult population, advance care planning is increasingly common, especially in the form of informal conversations. How much aging-related preparation occurs in other domains, such as, leisure planning, planning for maintenance of social ties, has rarely been reported. However, Baby Boomers appear at higher risk than older generations for not having engaged in much ARP (regarding health, financial resources) and many are at risk for ending up alone in old age. Boomers appear to have high levels of, perhaps unrealistic, optimism, believing that they can control their own destiny and survive anything life throws at them (78%; Court et al., 2007), whereas the very old have more accurate perceptions of their vulnerability (Kotter-Grühn et al., 2010).

Facilitating and Inhibiting Factors for Aging-Related Preparation

As we have seen, the intention to age well does not guarantee the enactment of retirement plans or care preparations. In order to translate intention into action, one needs sufficient internal and external resources. Due to cognitive deficits, lack of education, or limited problem-solving skills, older adults may lack the skills or resources needed to make age-related preparations. Lack of available aging services in their region, lack of caregivers who can assist them, no acceptable residential care, or simply limited financial means are all considerable barriers. Barriers and facilitators to ARP may occur at multiple levels including intra-individual/psychological, family and work, community and neighborhood, wage and health care policy, inequitable structure, national policy, sociocultural, as well as historical change-levels. The interactions between levels also play a role in ARP. Which of these dominates has not been determined in the literature to date.

Psychological Factors in Aging-Related Preparation

At the Intra-individual level, personal resources, such as physical health, cognitive functioning and reserves,

problem-solving skills, emotional regulation, physical health, and personal beliefs about control and planning may play a role in the initiation and shaping of ARP.

Age-related Changes in Cognitive Processing and Functioning. Individual-level age-related changes affect how much older adults engage in behaviors that promote or protect health; these include increased need for assistance with activities of daily living, and diminished health status, as well as changes in information processing and social cognition. To initiate ARP in the health care arena, a level of awareness of the risks for disease-related disability is needed (Apouye, 2018; Slovic et al., 2004), but seriously considering one's chance of frailty or dependence is often unpleasant and thus avoided (Pinquart & Sörensen, 2002; Sörensen & Pinquart, 2000b). Indeed, older adults are more likely than the young to focus on affective information in the context of decisions (Finucane, 2008), especially positive (versus negative) information (Löckenhoff & L.L. Carstensen, 2007; Mather & L.L. Carstensen, 2005), thus blocking out potential negatively valenced options for care. In addition, they tend to overestimate the negative effects on their well-being of options they *don't* like (e.g., moving to age-friendly housing) without considering potential benefits, whereas they recollect primarily positive information about the ones they prefer. These age-related changes serve to optimize immediate emotional experience and well-being (L.L. Carstensen et al., 2003), but may be somewhat deleterious to longer-term outcomes.

In addition to changes in processing positive and negative information, ARP is likely affected by both normal and pathological neuroanatomical changes that occur with aging. Changes in cortical and subcortical regions of the brain (Owen et al.,1997; Unterrainer & Owen, 2006) may affect individuals' ability make good decisions and plan a course of action (Elliott, 2003; Sanders & Schmitter-Edgecombe, 2012) or maintain an optimal level of problem-solving skill. Individuals with better problem-solving skills are more likely able to address current and potential future care problems effectively (Point Du Jour & Sörensen, 2009). Rational problem-solving styles enhance engagement in PFC, whereas dependent and avoidant decision styles inhibit it (Sörensen & Pinquart, 2001b). Decision-making competence affects the quality of retirement planning (Parker et al., 2012).

Cognitive barriers to ARP also include lack of insight into its usefulness (Blackwood et al., 2019) and about the available options for care (Delgadillo et al., 2004). Knowledge of services and health literacy are often enhanced by higher educational achievement, thus disadvantaging individuals with lower education are often lacking in requirements for the ARP process. In addition, older adults are often ill-informed about how formal long-term care is paid for, believing that having paid into Medicare and Social Security qualifies them for long-term care services.

Salience of Health Threat. Whereas age-related changes in information-seeking and decision making may

thwart effective ARP, the salience of potential health threats increases plans for health and care (Ouwehand et al., 2008a), although findings are somewhat inconsistent. For example, age is related to *more* preparation for housing decisions, finances, emergencies, and health among German respondents (Kornadt & Rothermund, 2014), whereas need for ADL assistance and poor self-rated health is related to *less* concrete planning for future health needs among older adults in Florida (Black et al., 2008); but poor health predicts *more* concrete planning among seniors in Utah and Eastern Germany (Sörensen & Pinquart, 2000c). Contradictions in the literature describing the relationship of age and PFC may be attributable to these counteracting forces.

In sum, although "normal" aging does not necessarily prompt more ARP, specific triggers do. Some studies find that among individuals with specific disabilities, such as Multiple Sclerosis, functional losses are mourned and addressed more readily, making room for action to organize supports, and to contemplate future needs (Finalyson & Van Denend, 2003). In the context of policy, these findings suggest that neither scare tactics, nor a focus on future disease and disability are likely to motivate aging-related preparation. Rather, learning to concretize vague goals for a "good" old age, and more accessible information about housing and care options may spark more consideration of that information for oneself.

Mastery and Self-efficacy. Mastery, or the degree to which one feels one has a sense of control over what occurs in one's life, is an important factor in whether older adults engage in ARP. For example, after controlling for the effects of demographics and health, both a higher personal sense of mastery and more favorable retirement conditions significantly influenced adjustment to retirement post-retirement planning among Australian middle-aged and older adults (Donaldson et al., 2010).

Mastery and Self-efficacy may also play a role in the tendency of older adults to neglect spelling out plans or action steps (e.g., commitment to, initiation of, and persistence in goal pursuit) to achieve their goals as compared to younger adults (e.g., Brandtstätter, et al., 2001; G. Carstensen et al., 2019; Schnitzspahn & Kliegel, 2009; Zanjari et al., 2016). The lack of translation of goals into action steps raises the question whether specific processes operating in ARP vary across life domains and are differentially facilitated by factors internal (e.g., attitudes, knowledge, skills, personality) and external (e.g., family, community, culture) to the individual, or whether it matters whether the goals are oriented more toward goal attainment (approach) or avoidance of losses (Marsiske et al., 1995). Self-efficacy also enables older adults to respond to stress with more effective strategies for problem-solving (Li & Yang, 2009). Older adults with low self-efficacy for planning and problem-solving may find that it is not worthwhile to expend their energy making decisions. They may prefer that trusted family members plan for them (Funk, 2004; Girling & Morgan, 2014).

Attitudes and Beliefs. Engagement in ARP is highly dependent on attitudes. Negative and ambivalent attitudes toward retirement are associated with less retirement preparation and failure to seek information about retirement (Eckerdt et al., 2001; Kim & Moen, 2001; Chan et al., 2020). With regard to PFC, attitudes include the belief that care planning is useful, which predicts the likelihood of enacting specific ARP behaviors, such as Gathering Information and Concrete Planning (Sörensen & Pinquart, 2001b). Of course, attitudes can also be a function of underlying external factors, such as community norms. These include beliefs about the outcomes of planning in general. Individuals who reach adulthood in contexts that leave little freedom to plan, such as older adults in former East Germany, are less likely to believe that planning for care is useful (Pinquart & Sörensen, 2002; Sörensen & Pinquart, 2000b). Having a nonaccepting attitude toward planning is also related to reduced likelihood of engaging in both PFC (Sörensen & Pinquart, 2000a) and ACP (Black et al., 2008). Mak and Sörensen (2012), in a longitudinal study of first-degree relatives of Alzheimer's patients in the United States, show that a belief in the usefulness of planning robustly predicts lower baseline Avoidance and more Gathering Information as well as an increase in Decision Making and Concrete Planning over a 6.5-year period.

Religious beliefs may affect older adults' likelihood to engage in Aging-Related Preparation, but findings are inconsistent. Being Catholic is related to a 52% lower likelihood of engaging in PFC or ACP in one study (Black et al., 2008), but higher in another (for both Catholic and Jewish elders; Ejaz, 2000), with no relation in a third (Cohen-Mansfield et al.,1992). The sense that "God will take care of me" appears in several qualitative studies as a barrier to both PFC and ACP (Sörensen & Pinquart, 2000b; Girling & Morgan, 2014). Non-religious adults are more likely than religious ones to complete advance directives (Rurup et al., 2006).

Future time perspective has emerged as another attitudinal variable. A qualitative study by Denton et al. (2004) shows that preparation for late life is associated with a forward-looking future-time perspective. Having a limited time perspective is linked to more preparation in one study (Fowler & Fisher, 2009), but, in others, expected longevity is related to more preparation for finances, housing, and health (Apouye, 2018; Kornadt & Rothermund, 2015) as well as general retirement preparation (Jacobs-Lawson & Hershey, 2005). Participants who report clearer goal expectations for their future prepare more concretely for fitness, social relations, and leisure activities, whereas shorter subjective remaining lifetime is related to more preparation for housing, finances, emergencies, and health care four years later (Kornadt et al., 2018). Also, future orientation is associated with proactive coping for health, social relationships and personal finance in mid and late life (Ouwehand et al., 2008a). Planful attitudes and belief in continuity may enhance older adults' ability to foster their own

planning competency, such as sequencing their activities along a timeline spanning from the current situation to a desired future state (Fretz et al., 1989; Sterns et al., 2005).

From a policy perspective, a shift toward a forward-looking time perspective requires shifts both at the individual and the societal level. ARP is likely to be attempted by more people when they are able to (1) imagine positive aging, (2) access information about resources, (3) receive help with problem-solving skills, and (4) know they can access affordable quality care regardless of income or assets. Current policies advantage those who are already able to access these supports.

Personality, Future Time Perspective, and Mental Health. A wealth of literature attests to the fact that retirement planning is affected by psychological factors, including personality indicators such as conscientiousness (Hershey & Mowen, 2000), emotional stability (Blekesaune & Skirbekk, 2012; Juson & Klat, 2013), risk tolerance or aversion (Dohmen et al., 2011; Grable & Lytoon, 2003), and future time perspective (Bernheim et al., 1997). Other factors noted in the literature regarding financial decision making are future expectations (Lusardi, 1999), clearly formulated financial goals (Neukam & Hershey, 2003; Stawski et al., 2007), current asset allocation (Vora & McGinnis, 2000), attitudes related to the financial planning process (Jacobs-Lawson & Hershey, 2005), and emotion regulation regarding aging-related fears, worries, or losses (Glass & Kilpatrick, 1998; Löckenhoff, 2012; Neukam & Hershey, 2003).

Psychological factors play a role in PFC and ACP as well. Personality traits, such as Openness to new experience, and Agreeableness are positively associated with greater Awareness of care needs, as is Neuroticism; Gathering Information and less Avoidance are also linked to greater Openness (Sörensen et al., 2008). Regarding end-of life planning, higher levels of conscientiousness and openness predict discussions of end-of-life plans, whereas higher levels of conscientiousness and agreeableness are linked to a greater likelihood of formal advance care planning (Ha & Pai, 2012). Trait-level optimism and hope have also been investigated with regard to future care plans. Whereas higher levels of hope are associated with more concrete planning and decision-making about future care (Southerland et al., 2016), greater optimism predicts gathering information and concrete planning (Sörensen et al., 2014). Lower hopefulness is associated with greater *awareness* of future care needs, however.

Depression is independently associated with PFC, particularly gathering information (Sörensen et al., 2008), and with poorer problem-solving (Wetherell et al., 2002). Severe depression also impairs some aspects of memory and short-term planning among older adults (Blazer, 2009). Although depression is common with many chronic illnesses, the effect of depression on the likelihood of advance care planning has, to our knowledge, not been studied; however, patients with more anxiety and depressive symptoms

desire more future discussions (Fakhri et al., 2016).

Understanding the potential effects of depression and personality on ARP is useful because interventions may need to be tailored to different personality types or styles of decision-making to have the desired effect. Policies that take into account the multi-level factors affecting individuals and the ways in which individual differences might affect adherence to recommendations are more likely to be effective.

Demographic, Socioeconomic Factors, and Family Factors in Aging-Related Preparation

Demographic factors are significant predictors of ARP in several domains, but their influence on ARP is often mediated through specific indicators of socioeconomic status (i.e., education, household income, access to social capital). In addition, some demographic factors are related to individuals' tolerance for risk, ability to tolerate ambiguity, retirement goal clarity, general planning practices (Ferraro, 1990; Jacobs-Lawson & Hershey, 2005; Stawski et al., 2005). Here we consider gender, socio-economic status, and family support.

Because women have a higher life expectancy than men (National Center for Health Statistics, 2020) and are often single in retirement (Tamborini et al., 2009), one would expect greater concern with financial planning. However, research into gender differences in retirement planning has had largely inconclusive results. Some studies show no differences (Hershey & Mowen, 2000; Rosenkoetter & Garris, 2001; Reitzes & Mutran, 2004), but others do find small discrepancies, with women planning less (Jacobs-Lawson et al., 2004; Quick & Moen, 1998; Kim & Moen, 2001a; Kim & Moen, 2001b; Noone et al., 2010). Although women do more retirement planning compared to two decades ago, their overrepresentation in lower paid and nonunionized occupations with limited planning resources (O'Rand & Henretta, 1982; Kilty & Behling, 1986; Hayes & Parker, 1993; Muller et al., 2020), differences in financial literacy (Lusardi & Mitchell, 2008), lack of education about retirement (Perkins, 1995), and greater risk aversion (Agnew et al., 2003; Watson & McNaughton, 2007) may still contribute to some discrepancies. Women's financial retirement preparation is also related to home ownership, having longer planning horizons, and working for a large employer (Tamborini & Purcell, 2016).

Regarding PFC, women are more likely to have engaged in decision making (Mak & Sörensen, 2012; Sörensen & Pinquart, 2000c) and concrete preparation for long-term care (Black et al., 2008); their plans are more likely to involve specific long-term care services, like home care, housing arrangements, assisted living, and assistance with maintenance and lawn care (Robison et al., 2014). Although findings are not consistent regarding whether women do more ACP than men (Carr & Khodyakov, 2007; Carr et al., 2012), men are less likely to discuss their care preferences with others (Carr & Khodyakov, 2007).

Socio-economic status has been identified as important in most studies of ARP. Higher SES is related to greater retirement preparation (Noone et al., 2012), consideration of more housing choices (Robison et al., 2014), and PFC (Sörensen & Pinquart, 2000a, 2000c). This is likely due both to greater financial resources with which to plan, as well as more education on the available resources and ways to go about making plans. Consistent with this, advance care plans are most likely completed by older adults with higher education (Black et al., 2008; Triplett et al., 2008; Gerst & Burr, 2008) and income (Carr, 2012).

Family resources, such as more available family members, family financial assets, and social-emotional support allow older adults to plan more concretely (Sörensen & Pinquart, 2000a; Sörensen & Pinquart, 2000c; Song et al., 2016). Not having someone who can provide tangible assistance and living alone are both associated with less future care preparation (Black et al., 2008). But reliance on family may also suppress active preparation: avoidant planners are more likely to rely on adult children for assistance (Song et al., 2017). Experience caring for others enhances anticipation of future care needs, but not making specific plans (Finkelstein et al., 2012).

Even for elders with dementia, family caregivers are not well-prepared for end-of-life decision making (Gessert et al., 2001; Hirschman et al., 2008); yet when cognitive impairment renders elders unable to make decisions, family caregivers are generally called upon to make decisions about their care and treatment. Having supportive family relationships (Boerner et al., 2013) and even having grandchildren increases ACP (Gerst & Burr, 2008) and concern for family members may be a key motivation for older people to engage in ACP (Levi et al., 2010).

Community Factors in Aging-Related Preparation

At the community level, the extent to which aging services, transportation, housing options, and knowledge about those options are readily available influences older adults' ability to engage in ARP. These are often variable between rural, urban, and suburban living spaces. Also, community and cultural norms regarding the importance and acceptability of preparing for aging, and regional health systems' outreach for advance directives vary, and, thus, may influence adults' propensity to think about and engage in aging-related preparation. For example, norms regarding whether one should engage in PFC coming from family, culture, or the government can create social pressure to prepare for or <u>not</u> to mention future care. Family expectations for family caregiving can be unspoken or explicit and affect how elders engage in PFC. Family expectations may be unique to certain family systems (Spitze & Ward, 2000) or based in cultural views of eldercare (Delgadillo et al., 2004). Burton and Stack (1993) describe the concept of "kinscripts" that define how the caregiving role is perceived, who is responsible for family caregiving, and

preferences for informal versus formal support (Stack & Burton, 1993), in African-American families, but potentially also in Asian-American (Pinquart & Sörensen, 2005), and Latino families (Delgadillo et al., 2004). Whether older adults plan for future care depends in part on such community-level factors, explaining, for example, higher rates of PFC among African Americans (Sörensen et al., 2014; Pinquart et al., 2003); this may be related to perceptions of greater caregiver availability in Black extended families (Roth et al., 2007) as well as higher community-level disease burden (Diez-Roux et al., 1997; Gary et al., 2008), which sensitizes African Americans to potential future care needs.

Elder care expectations based in culture and history may translate into filial obligation beliefs which are measurable at the individual level. These contribute to families' expectations of individual members to provide elder care (Ajrouch, 2005; Schans, 2008; Groger & Mayberry, 2001; Miyawaki, 2017; Guo et al., 2019; Wangmo, 2010). High filial obligation does not, however, necessarily translate into appropriate preparation or provision of care for the older adult. This may be a partial explanation for the finding that high filial norms are related to lower life satisfaction among some elders (Lowenstein et al., 2007). Filial obligation has been studied extensively, but how subjective norms contribute to engagement in ARP and planning for family or non-family care has not been assessed.

Local communities and their housing policies are critical in older adults' ability to plan for housing changes or for aging in place. Whereas choices of assisted living, housing modifications, and upscale nursing care are abundant for the wealthy, there is a lack of affordable, aging-suitable housing in many countries (Preston et al., 2019). Other community-level contributions to relocation plans include challenges of in-home management of increasing disability, access to, quality of, and range of aging services, insufficient public transportation, and distance from shopping and other daily needs (Hillcoat-Nallétamby & Ogg, 2014), concerns about neighborhood security, and lack of engagement with neighbors (Kearns & Parkes, 2003). Also, sense of community matters both to those older adults who decide to age in place (Jolanki & Villkoas, 2015) and those who move for the opportunity to reduce the burden of home maintenance and engage in meaningful activities in old age (Oswald & Wahl, 2005).

Community influences on ARP are also reflected in comparisons of ethnic minority communities to non-Hispanic Whites with regard to end-of-life planning. Whereas no differences in informal discussions about ACP are found, formal ACP is less common among racial/ethnic minority groups (Gerst & Burr, 2008; Choi et al., 2020). The relevance of race and ethnicity depends on other socio-economic, personal, and cultural variables, however. These include health status, being in treatment in hospital, or having more chronic illnesses as predictors of greater likelihood of ACP (Choi et al., 2020). Having greater education and health

literacy, being older, and having more income are predictors of higher ACP among Latinx and Asian American groups (Hong et al., 2018). Homeownership increases the ACP engagement among Blacks. Cultural values and differences in priorities, spiritual beliefs, and lack of awareness or lack of knowledge about ACP may contribute to misunderstandings about ACP (Choi et al., 2020; Hong et al., 2018). In addition, Blacks often have had negative experiences the health care system resulting in mistrust and deterring their ACP engagement (Rhodes et al., 2017). In past studies, Latinx individuals were the least likely to participate in ACP (Eleazer et al., 1996), but recent works suggests they are open to end-of life discussions when offered the opportunity to discuss them in their preferred language with individualized, culturally competent materials (Maldonado et al., 2019). One key difference in the way communities of color and non-Hispanic whites approach aging-related preparation is that these communities are more likely to engage in family-centered collective processes in which opinions from family members about moving, care plans, and end of life are valued as much or even more than the elder's own preferences, and interdependence is valued more than autonomy and independence (Bullock, 2011).

Societal and Structural Factors in Aging-Related Preparation

Conceptions of ARP may look quite different across different countries with different social policies and cultures. Comparing older adults from Eastern and Western Germany and from Georgia and Utah, Pinquart et al. (2003) report that American respondents have the highest PFC scores. Although Germans and Americans are equally likely to avoid future care thoughts and worry that care needs might not be met, American elders are more likely to expect care, express awareness about those needs, gather information, decide on preferences, and make concrete plans. They also are more likely to report knowing their options and consider their home environment aging-appropriate. Furthermore, comparing within Eastern and Western Germany, East German elders were more likely to avoid planning for care, even seven years after reunification. Being less informed of possible options, they made fewer decisions, listed less-concrete plans, and were less satisfied with their planning. Many of these differences may be attributed to variations in policy and historical change. East Germans were embedded in a system of guaranteed (but mostly poor quality) nursing home care. With reunification, this system disappeared, and a population of elders already deprived of many life choices struggled to cope with rising nursing home costs and insecurities of social change. Compared the more individualistic policies in the U.S., Germany's social welfare state currently makes it possible to rely on public long-term care insurance which (partially) covers both nursing home and in-home care. These differences in national ethos on caring for the aging population, as well as differences in national dementia strategies that encourage assistance

seeking and early diagnosis may also help families develop aging-related plans (Fortinsky & Downs, 2014).

Comparing adults in the U.S., Germany, and China, Kornadt et al. (2019) report that Germans and Americans claim more preparation than Chinese participants in all nine domains. This is likely due to family kinscripts and filial obligation beliefs within Chinese culture that proscribe care by family, but also differences between individualistic and communitarian societies. Chinese individuals who avoid future care preparation are more likely to rely on adult children for care (Song et al., 2016) and greater familism is related to family-focused care plans (Song et al., 2017). In contrast, awareness of future care needs and gathering information are related to an orientation toward service-focused (formal) care arrangements (Song et al., 2016). Consistent with Pinquart et al. (2003), Kornadt et al. (2019) find that with regard to health preparation, older American participants plan more than Germans elders, but not with regard to "emergency situations," which include health emergencies and end of life care.

Policies in the United States rely heavily on family care, self-financed formal care, or care covered by long-term care insurance, but that insurance has limited accessibility for individuals with limited financial means. Although long-term care is reliably covered by Medicaid for elders with limited income, considerable stress is placed on individuals in the middle-income bracket. As a result, for fear of bankrupting their families, middle-class elders are often advised to transfer any wealth to children or trusts; "spending down" their wealth allows them to be eligible for Medicaid. This practice escalates Medicaid expenditures which were designed only for indigent elders and reduces seniors' choices among facilities that may not accept Medicaid. Elastic Medicaid eligibility rules, according to a report on California's Medi-Cal program, "desensitize the public to long-term care risks and costs, resulting in a false sense of security and entitlement" (Moses, 2011).

Unfortunately, programs and policies that increase pressure for planning for retirement and preparation for future care (Preston et al., 2019) are primarily focused on the cost of living and care, but not the clarification and selection of personal values preferences. Although maintaining one's current quality of life in spite of physical health declines is a primary activating and motivating factor for ARP, there is little incentive for middle-aged and older adults to struggle with issues that they find threatening. Even the acquisition of long-term care insurance may not have much relevance to middle-aged and older adults, if it does not assist them in maintaining quality of life as they define it—including resolving some of the paradoxes of care situations, such as maintaining privacy versus having regular access to one's social contacts or accessing intellectual and social stimulation versus remaining in familiar surroundings. Planning for financial coverage does not provide assurance that one's values will guide care

decisions. Thus, "guaranteed care without a focus on care values may not suffice to maintain quality of life for older adults. Not much social encouragement exists, however, for older adults to clarify the type of care they prefer and why" (Sörensen, et al., 2011, p. 8).

Barriers to Aging-Related Preparation

Based on the findings reviewed above, a primary reason why individuals fail to prepare for age-related transitions is that they lack the financial and educational resources. In addition, knowledge of options plays a substantial role. Only a small minority of older adults can describe the financial coverage of long-term care, and those with lower incomes, who are married, and who have no living children are particularly vulnerable to long-term care financial literacy (Matzek & Stum, 2010). In the United States, the poorly developed private market for long-term care insurance, excludes many types of long-term care expenditures and is inaccessible to those who cannot afford high premiums (Brown & Finkelstein, 2004). Older adults often experience contradictions between wanting to plan and feeling unable to plan because available options are too costly.

A major barrier to ARP is the current structure of Medicare and Medicaid policy and its focus on acute medical care, rather than holistic principles of well-being. With regard to housing, we have suggested that by not planning for home modification or for moving to accommodate frailty (Adams & Rau, 2011; Tulle-Winton, 1999[2]; Gilroy, 2018), older adults may thwart their goals for "aging well." However, structural barriers to making plans for future housing are immense. In particular, the lack of age-friendly housing that does not segregate older adults against their will is lacking in most industrialized nations. Due to existing Medicaid policy, many lower income older individuals who are frail without being destitute may be unable to take advantage of more supportive housing opportunities, such as assisted living facilities (ALFs), because they cannot utilize Medicaid benefits as a form of payment at such facilities. This places such opportunities beyond the financial means of many middle-class elders. In addition, access to additional insurance may be limited due to lack of availability, even for those who can afford it. Aging in place may also not be a viable option, as communities may lack quality services due to insufficient oversight of direct care workers. Thus, even good planners may find they lack the services they need.[3] Other barriers to ARP have been explored in qualitative studies and relate to the stressful nature of preparation for future care. Protecting short-term well-being sometimes outweighs the perceived benefits of preparation (Craciun, & Flick, 2015; Sörensen & Pinquart 2000a; Pinquart & Sörensen, 2002a). Another barrier is the perception that contextual factors, such as national long-term care policies may change with little notice and thus render specific plans irrelevant in the future (Pinquart & Sörensen, 2002a), especially in times of social or economic instability.

Does Aging-Related Preparation Predict Better Outcomes?

The findings regarding benefits of ARP are somewhat inconsistent across the different domains of preparation.

Outcomes of Retirement Preparation

Although multiple studies support the beneficial effects of timely retirement preparation on physical and psychological health (Yeung, 2013; Yeung & Zhou, 2017), positive attitudes and adjustment to retirement (Reitzes & Mutran, 2004; Muratore & Earl, 2015), and higher life satisfaction (Topa et al., 2009; Noone et al., 2013), a systematic review by Barbosa et al. (2016) reports that retirement preparation by individuals is not among the strongest determinants of retirement adjustment. Retirement preparation is beneficial in only about half the studies reviewed; no difference is found in roughly 1/3 of studies, and negative effects of pre-retirement planning are observed in 8.7 % of the studies. Donaldson and colleagues (2010) suggest that physical and psychological health, the conditions under which a person exits the workforce, as well as their financial resources are more powerful predictors of adjustment, but that a higher personal sense of mastery mediates post- retirement planning. Although the inconsistencies between studies may be due in part to measures of planning behavior that focus on financial planning (Petkoska & Earl, 2009), there is some lack of clarity as to which kinds of preparation are beneficial under what circumstances (Donaldson et al., 2010). It is likely, though that retirement planning is not "complete" before the transition and that any early plans require modification over time.

Outcomes of Preparation for Future Care

Greater future care preparation can boost feelings of security and control (Pinquart & Sörensen, 2002a) which in turn contribute to life satisfaction (Kahana, et al., 2012). Care preparation, however, does not follow unitary patterns. Different styles of PFC are related to different short and long-term well-being outcomes. Styles of future care preparation have been identified in both qualitative and quantitative studies. (1) The "Avoiders" (Girling & Morgan, 2014; Sörensen, & Pinquart, 2000a, Steele et al., 2003) make up 5%-20% of the samples; they have particularly low scores in Awareness of Care Needs and Concrete Planning (Steele et al., 2003) and actively endorse not thinking about the future. Denton et al. (2004) also describe a group of "non-planners," who have experienced dramatic disruption in their lives and thus have abandoned making plans. Concurrent assessments of well-being suggest that avoiders have lower levels of concomitant depression outcomes (Steele et al., 2003), but a longitudinal study of older primary care patients shows that avoidance of future care planning is related to higher depression scores at 2-year follow-up (Sörensen et al., 2012). (2) The "Autonomous Care Planners" (34%,

Girling & Morgan, 2014) "Planners" (13.2%, Steele et al., 2003), and "Long-term planners" (45%, Sörensen & Pinquart, 2000a) display more worry, but also higher planning satisfaction than avoiders (Steele et al, 2003). Longitudinal data show that making concrete plans is associated with better outcomes: a lower likelihood of a depression diagnosis and lower anxiety scores after two years (Sörensen et al., 2012). (3) Individuals who engage in "Thinking without planning" (16%, Sörensen & Pinquart, 2000a) are aware of their preferences (20%, Girling & Morgan, 2014), but may agonize over their future (8.8%, Steele et al., 2003). No longitudinal data are available for the effects this planning style, but cross-sectionally it appears to be the most stressful (Steele, et al., 2003). (4) "Externally reliant care planners" (35%, Girling & Morgan, 2014) do not take an active role in planning details, and count on other individuals or agencies (e.g., the V.A., a religious order) to meet their needs. A parallel group with a much lower frequency, perhaps because of more stringent group criteria are "Consenters" (1.9%, Steele et al., 2003), who agree to other individuals' plans (cf. Maloney et al., 1996) and exhibit low levels of awareness but high levels of concrete planning; a comparable group of "Short-term planners" (24%, Sörensen & Pinquart, 2000a) focus on limited and more immediate needs, very general plans, or on saving money for unspecified future needs. In Steele et al.'s study, consenters are the most content with their plans and have low levels of worry. However, in Sörensen and Pinquart's study (2000a) the short-term planners report that disruptions in their lives have led them to think of long-term planning as useless because of life's unpredictability. Taxonomies, such as the one above may be useful when considering policies directed at certain groups with different preparation styles and needs.

Outcomes of Advance Care Planning

The primary purpose for ACP is to ensure an elder's end-of-life wishes are known and respected, and to protect the elders' and their families' quality of life. Detering and colleagues (2010) report that individuals with assistance completing ACP have end of life wishes that are much more likely to be known and followed; their family members have significantly less stress, anxiety, and depression than control patients and their families. Their intervention positively affects both patient and family satisfaction (Detering et al., 2010). In a systematic review of 113 intervention articles, Brinkman-Stoppelenburg et al. (2014) find that ACP is associated with increased compliance with patients' end-of-life wishes, including avoidance of life-sustaining treatment (when not desired), a surge in use of hospice and palliative care among hospital patients, and less emergency hospitalization among nursing home patients.

In sum, longitudinal studies suggest the usefulness of pre-retirement planning for retirement adjustment, of certain types of preparation for future care for emotional well-being, and of ACP for a good death; the longitudinal

effects of other domains of ARP have been studied less extensively. Preparing for changes and planning ahead may ameliorate adverse outcomes in old age, including limited future time perspective; for example, for leisure (Riddick & Stewart, 1994; Yeung, 2013), preventive health behaviors (Gessert et al., 2001; Kahana et al., 2012) and social planning (Yeung, 2013). Nevertheless, except for advance care planning among the very old, actual preparation behaviors are relatively low. It is clear that the positive effect of ARP is often enhanced by higher income and education, and greater problem-solving skill, but also linked to an increase in knowledge of options, services, and public resources. Particularly housing transitions (or aging in place) can be improved dramatically with access to resources; the effect of housing decisions and transitions on psychological well-being is still underresearched.

Interventions to Enhance ARP and Policy Implications

The World Health Organization (WHO, 2015) has recommended five areas that need to be addressed by policy, including (1) devoting effort to healthy aging that requires developing a cohesive set of targeted policies that benefit older adults; (2) developing health system policies that align with the needs of older adults; (3) establishing mechanisms to provide chronic disease care for older adults; (4) creating environments that adapt to older adults' needs; and (5) improving, measuring, understanding, and encouraging the study of factors that contribute to the care and well-being of older adults. As noted above, individual differences in ARP can be attributed to psychological factors, family and community factors, policies, and cultural orientations regarding the necessity and usefulness of planning and the obligations of family, but policies both determine individual actions and affect government expenditures.

State and national long-term care policies differ in the extent to which they support and/or expect families to prepare for retirement, prepare for and provide all care, partial care, or no care, develop advance directives, not to mention engage in leisure or social preparation. In addition, there is a need for informal caregivers to partner with health care providers and acquire adequate skills to adapt to their role as the disease trajectory of care recipients' changes over time. The expectation among healthcare providers and payers is that informal caregivers (family and friends) will provide caregiving services in the home. Unfortunately, there is rarely a meaningful discussion on whether informal caregivers are available, willing, or able to take up the responsibility, for example after hospital discharge (Schulz et al., 2018); about half of all family caregivers report having no choice in taking on the caregiving role. Only about a third of the family caregivers indicate that they have been contacted by the health care providers to inquire what support they need in order to provide care; 84% of family caregivers indicate that they need more caregiving training (Lee et al., 2020).

Since the evidence suggests that older adults tend to engage in inadequate ARP for their own care, and family members often take on care without proper preparation, new policies may be required that better integrate other family members, such as adult children, into the preparation process.

In this context, federal and state governments must recognize the needs of family caregivers who deliver care (Lee et al., 2020). These efforts are obstructed by unresolved problems of how family members, the private sector, and government would pay for caregiving expenses (Gaugler & Kane, 2015). At the federal level, the 2018 Recognize, Assist, Include, Support and Engage (RAISE; Cacchione, 2019) act was passed into law in order to implement a national strategy to support family caregiving. Additionally, new policies of the Centers for Medicare and Medicaid Services and others were also implemented to support family caregivers for people living with serious illnesses (Friedman & Rizzolo, 2016). Despite these initiatives, caregivers' services are currently not adequately supported by policy and practice (Schulz et al., 2020).

We do not, however, think it is reasonable to assume that family members will assume responsibilities for older adults through the sheer force of moral exhortation. Rather, incentivizing assistance with ARP may be required. This could involve providing a guide for adult children through state-level campaigns to initiate discussions about aging-related preparation with their parents, similar to the campaigns for Advance Care Planning and Medical Orders for Life-Sustaining Treatment (Compassion and Support, 2020) that have successfully increased completion of ACP forms (e.g., in New York State; Bomba & Orem 2015; Bomba et al., 2011). However, when considering family-centered approaches to caregiving, researchers and policymakers should be mindful of the manner in which such approaches may differentially impact male and female family members, leading to further challenges related to social justice and equity (DePasquale et al., 2015; Schmid et al., 2011).

Furthermore, family members are not the only social actors who are well positioned to assist with aging-related preparation. Employers, too, can contribute to ARP either by supporting aging employees directly or engaging family members who support them. Aging-related preparation has not been publicly emphasized and, thus, few know how to go about it. This lack of awareness should be rectified through a *consistent* and *extended* public health campaign (because campaign success is increased by the application of multiple repetitions (Wakefield et al., 2010)). The campaign should not only educate the public about the need for ARP, but focus on clarification of interests and values, rather than purely on financial or medical aspects of long-term care. Concurrently, key resources that explain options and services must be available, such as the AARPs resource guide "Planning for Long-term Care" or Minnesota's "Care to Plan" website for dementia caregivers (Gaugler et al. 2016), but in multiple languages and with greater attention to

accessibility for the visually impaired and those with limited literacy, and with a broader scope than caregiving or long-term care.

Governmental shifts to encouraging individual pre-retirement financial planning are frequently tied to attempts to reduce social programs without addressing the structural barriers to preparation for late life (Preston et al., 2019). Thus, a societal focus on "shaping your own future" is a double-edged sword; on the one hand it could encourage greater ARP across all domains of lifestyle planning, potentially increasing older adults' control over their life circumstances and quality of life. On the other hand, it could marginalize groups who lack the necessary resources, skill, or predisposition to plan. The evidence reviewed here, therefore, suggests that individual pre-retirement financial planning is not a suitably effective replacement for social programs and that adequate ARP must be a joint and integrated effort involving all stakeholders, such as the state, the individual, the family, and the community. In the next section we discuss interventions to increase ARP, focusing only on pre-retirement, Preparation for Future Care, and Housing Preparation, as the field of ACP is already replete with effective interventions (Bryant, et al., 2019).

Interventions for Improved Retirement Planning

Pre-retirement planning programs, which originated during the 1950s at several large Midwestern universities, are voluntary (Hayes & Parker, 1993) and usually limited to the financial aspects and immediate post-employment period. Few are more comprehensive in scope, addressing health, leisure, finances, social relations. They are offered as group programs or individual counseling by large employers and—on-line and in written format—by the Social Security Administration and the Department of Labor. Often these programs are oriented to a male career model, and often poorly attended by women (Hayes & Parker, 1993). Based on the inconsistent findings regarding the effectiveness of preretirement programs in improving retirement adjustment (Barbosa et al., 2016), it is likely that preretirement programs require an overhaul (see Box 3). Consistent with our recommendations in the previous section, these programs would benefit not only from a greater focus on enhancing mastery and providing coaching for how to negotiate healthy retirement conditions (Donaldson et al., 2010), but also from addressing the entire range of ARP domains.

BOX 3: Policy Recommendations for Improved Retirement Planning:

- A guaranteed retirement income that will cover basic needs. Retirees should not have to trade purchasing food for getting their medication. At that level of survival, planning becomes a luxury (Denton et al., 2004).

- The implementation of pay equity is crucial for women's ARP.
- Additional opportunities for education and training for women in midlife could contribute to for women's independence in later life.
- The need to plan for a longer period of retirement should be anticipated, given greater longevity.
- Policies need to address the increasingly precarious nature of a workforce subject to short term contracts, part-time and casual employment, that add to more difficulty to the task of saving for retirement, particularly for older women.
- Greater flexibility for older workers approaching retirement to improve the exit conditions, including job sharing, job transfers, sabbaticals, and eliminating forced early retirement, thus increasing employee levels of control in the retirement decision (Quine et al., 2007).
- Because employees may be reluctant to initiate discussions about retirement, culturally sanctioned options for such discussions should be provided by employers. Planning for aging might be integrated into vocational/professional continuing education. Middle-aged workers could receive information about assisting aging parents and begin the preparation process for their own later years.
- HR departments should focus on supporting mastery and employees' self-efficacy beliefs about their ability to plan for positive outcomes using control enhancing experiences and modeling, thus building resilience.

Interventions for Preparation for Future Care

Several programmatic attempts have been made to enhance individual long-term care preparation. A free program offered through State Departments of Aging to encourage long-term care preparation, such as a long-term care consultation service had poor attendance (McGrew, 2006). A six-state campaign to induce individuals to consider long-term care insurance involving a letter from the State's governor inviting adults over 55 to order a long-term care planning kit generated a response rate of less than 8% (Long Term Care Group, Inc. & LifePlans, Inc. for U.S. Department of Health and Human Services, 2006; Tell & Cutler, 2011). The lack of response to these efforts can be attributed to several factors. First, offering such programs to the 55+ population at large may lack the context older adults need

to recognize the need to plan. As mentioned above, functional status losses, need for care, and residential transitions are stressful topics often avoided. In acute health crises there may be an immediate need for action (and therefore ordering a planning kit is unhelpful); if needs are not acute, arousal of negative emotions (Aspinwall & Taylor, 1997) may prevent proactive engagement and foster avoidance, since the discussions are seen as "not yet relevant." Second, one size fits all programs are unlikely to resonate with individuals from different life stages, cultural groups, resource rich or resource poor community environments. Consistent with our recommendations above, programs offered through the community should strive to incorporate the entire family and especially adult children, if available, into the preparation process. A concrete example of how employers can support employees with aging family members is by offering them paid time off in addition to vacation and sick leave. Admittedly, given current norms and economic circumstances this possibility is unlikely to be realized without a significant shift in attitudes, which suggests that in addition to recommending specific policies, advocates should also work towards shifting the Overton window (the range of policies deemed acceptable by the general public) with respect to paid leave (Mackinac Center for Public Policy, 2019).

Third, many older adults, having retired years ago, are not prepared for the new types of problems they are facing, and may lack the information, skills, health literacy, and persistence to accomplish preparation for potential care needs. Thus, programs offered through the community must be tailored to the needs of the individuals within them, taking into account the local resources. One such program, recently introduced by Lee et al. (2019) focuses on encouraging future planning in six areas: housing, medical care, nutrition needs, health incidents, financial needs, and care needs in a 2-session group program administered by cooperative extension program facilitators. An increase in planning activities in pre-post tests suggests that the format is promising. However, a drawback of programs that explicitly invite individuals to learn about future planning is that the attendees are self-selected and that those who need the programs the most often do not attend.

Another intervention to enhance preparation for age-related changes, specifically for older adults with progressive vision loss, has focused on assisting older adults in preparing for future care using a "stealth" approach to future planning. Based on a clinical trial of the program with Macular Degeneration Patients (Sörensen et al., 2015) the project, Resilience-Building Intervention to prevent Late-life Depression with Vision Loss (REBUILD-VL), harnesses the concerns and needs of older adults with vision loss to then interject content and training about future care preparation. After four group classes about different aspects of vision loss, participants engage in "resilience building coaching" (based on problem solving therapy approaches; Areán et al., 2020; Mynors-Wallis et

al., 1995), focusing initially on current issues, such as transportation, personal relationships, lack of social connection. After acquiring this systematic way to approach and (at least partially) solve problems, they proceed to discussing potential *future* issues, such as anticipated housing transitions, replacing valued activities after losing vision, or needing in-home assistance. Pilot work suggests an improvement in problem-solving skill (Point-du Jour & Sörensen, 2009) as well as increases in Decision Making and Concrete Planning (Sörensen et al., 2008; 2014; Sörensen, 2019), compared to a comparison group that conducted a life review. This dual strategy of building problem solving skills and trust, before focusing on topics that are more anxiety-laden could translate to other populations.

Interventions for Housing Preparation

Preparation for housing transitions or aging in place has been very limited in the public forum, compared to income and health (Pynoos, 2018). Because there is a shortage of affordable, accessible, and supportive housing for older adults, many elders are unable to identify the "ideal" living situation that would help them maintain independence, health and everyday competence. Although not an intervention to enhance preparation for housing transitions, a program by Szanton and colleagues (2011), The Community Aging in Place, Advancing Better Living for Elders (CAPABLE) deserves mention. This program allows older individuals with low income and with difficulties performing activities of daily living coordinated access to occupational therapy (up to 6 visits), nurses (up to 4 visits), and handyman repairs (up to $1,300). Compared to attention-control visits, the intervention group shows reduced difficulty with Activities of Daily Living (ADLs) and instrumental ADLs, better self-reported quality of life, and lower risk of falls. Thus, making health care and home maintenance resources more accessible increases the older adults' ability to age in place. Although not explicitly geared toward engaging the older adults in ARP activities, the program assists participants to identify and prioritize goals (such as pain and depression management), construct behavioral plans, modify and repair their built environment to decrease fall risk, increase mobility, and ultimately prevent nursing home placement, while supporting them in their wish to age in place in the residential environment that they know and value.

Conclusion

As increasing numbers of the Baby Boomer cohort retire, interventions and policies need to be built around an understanding of the factors that promote effective Aging-Related Preparation. Current policies make finding age-friendly housing, long-term care, and adequate retirement income a personal responsibility that requires middle-aged and older adults to plan, save, invest, and insure themselves (Moses, 2011; Preston et al., 2019). In our view the effectiveness of the personal responsibility model of preparation has not been vindicated by

the literature. Society's interest in taking care of its aging population would be better served by adopting the language of rights to include older adults' basic needs in order to refocus aging-related preparation as a way to flourish (Gilroy, 2008) rather than merely survive. This would further serve the aims of social justice by partially rectifying systemic inequalities, which otherwise are amplified in late life. As mentioned above, the most disenfranchised societal groups often have the least internal and external resources with which to prepare for aging; thus, they are least likely to attain their goals for old age. Applying more cultural and social pressure for family-based care preparation without providing scaffolding and resources is likely to fail both the individuals affected and the goal of government savings. For this reason, we reiterate the need for an integrated approach that involves the state, the family, and the community.

Framed in such social justice and community-based terms, we see that the majority of interventions may be predicated on a set of unexamined cultural assumptions that are nevertheless accepted as fact in individualistic cultures. Whereas mastery, planning and problem-solving skills, personality, knowledge and beliefs play a role in ARP, the larger socio-cultural context creates the structure within which personal goals can be realized or are perceived as unrealistic. *Knowledge* of resources is not sufficient without *access* to adequate financial, housing, transportation, and medical resources, which provide a basis for effective preparation. Because the majority of interventions to enhance ARP are based on working with individuals on their personal goals, plans, knowledge of resources, and coping skills, we as interventionists are maintaining the status quo regarding the relationship of the aging individual to society. Thus, despite the often intuitive appeal of the individual-based approach to interventionists working in individualistic cultures, the literature suggests that a more communitarian ethos that shifts ARP responsibility from the individual to the societal level could overcome more barriers to preparing for age-related changes. Consequently, interventionists might critically assess and advocate for a new relationship of the aging individual to society. A practical example, based on Szanton et al.'s (2011) work would be to make public funds available for home modifications, allowing older adults to prepare for aging in place with more confidence. Other examples of systemic/policy changes that would enhance effective ARP are shown in Box 2.

While adults in late middle-age and the "third age" are concerned with preparing for financial and role changes associated with retirement, older adults may be tasked with managing increasing chronic conditions that affect mobility and function, while also trying to afford quality housing, and continuing to pursue their personal goals in the areas of family and social relationships, leisure, work and volunteering. National and state policies, as well as future-oriented age-friendly communities can create the environmental, economic, and social contexts that allow older people to identify, plan

for, and pursue their goals. New solutions at the systems level are needed to assist adults with integrating preparation and planning for age-related changes. Planners need to be able to access information about health conditions, care options, financial supports, and available aging services to convert aging-related goals into concrete plans, if ARP is to be realistic.

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Notes

1. 43% built up saving; 45% learned about pension and Social Security benefits and thought about whether to move or age in place; 58% bought their own home; 56% developed hobbies and other leisure time activities; 33% prepared a will; 56% made sure they had medical care available.

2. Tulle-Winton's provocative interpretation of this phenomenon suggests that there is a link between recent "gerontological pronouncements about what it is possible to achieve in old age" and the regulation of populations and the "disciplining of individual bodies" into age-segregated spaces. The author sees the lack of planning for housing transitions as a form of resistance to societal processes that shun old bodies, emphasizing their loss of cultural value. "However, it is recast within a framework of obligations for social actors to avoid social and cultural segregation, thus seeming to act both as goal and as evaluation of later life and of old people's ability to adapt to changing biographical and environmental conditions" (p.296).

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