# Birth Cohort Differences in Family Care Availability among U.S. Older Adults

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## Abstract

In the United States, family members provide most long-term care for older adults, yet demographic shifts like declining marriage rates, lower fertility, and greater geographic mobility have altered family structures across birth cohorts, potentially reducing caregiver availability as later birth cohorts enter old age. We examine how family care availability (FCA) differs across birth cohorts among older adults, with particular attention to those at high risk for Alzheimer's disease and related dementias (ADRD). Using the Health and Retirement Study (2006-2020), we developed a novel FCA measure integrating network size, spatial proximity, health status of potential caregivers, and competing demands. Comparing four birth cohorts (pre-1920-1930, 1930-1940, 1940-1950, 1950-1960) stratified by age group (60-69, 70-79, 80+), we found that FCA declined substantially among adults aged 60-69. This decline occurred despite slight increasing functional limitation prevalence in recent birth cohorts, indicating that changing family structures—particularly declining spouse availability—rather than delayed disability drove the reduction. Similar patterns emerged among those at high risk for ADRD. Thus, more recent cohorts of older adults face substantially reduced family care resources at younger-old ages, with important implications for long-term care policy and planning.

## Introduction

In the United States, family members, primarily spouses and adult children, provide the majority of long-term care for older adults (Wolff et al., 2018). Yet this care system is being reshaped by profound demographic shifts across birth cohorts. Declining marriage rates, rising divorce, and falling fertility mean that successive cohorts are entering late life with fewer spouses and children (Furstenberg, 2010; Hareven, 1994; Ryan et al., 2011). Increasing geographic mobility has also dispersed families spatially (Stanger-Ross et al., 2005). But do these demographic and mobility shifts actually translate to diminished family care resources? And if so, by how much?

Birth cohorts experienced different historical contexts that influenced their marriage and childbearing decisions, leading to variation in family structures and potentially care dynamics as they enter older ages. Cohorts born in the 1920s-1930s formed families during an era of near-universal marriage, high fertility, and lower geographic mobility. In contrast, Baby Boomers (born 1946-1964) experienced rising divorce, declining marriage, and greater residential mobility (Agree & Hughes, 2012; Ryan et al., 2011). Yet the relationship between family structure and care availability is complex—family presence does not always translate into care provision. Geographic proximity, health status, relationship quality, and competing demands all shape caregiving capacity. These cohort differences in family formation patterns may have produced not only different family structures but also different patterns of proximity, relationship quality, and competing demands. Without measures that capture this full constellation of factors, we cannot determine whether, or to what extent, recent cohorts face diminished care resources.

Understanding cohort trends in care availability is particularly urgent for people with ADRD, whose numbers are expected to double in coming decades (Hebert et al., 2013; Rajan et al., 2021) and who require sustained, intensive family care (Friedman et al., 2015; Kasper et al., 2015). Limited family care among those with ADRD is strongly associated with earlier nursing home placement (Lo Sasso & Johnson, 2002; Wolff et al., 2018), higher healthcare costs (Alzheimer's Association, 2022; Kelley et al., 2015), and reduced quality of life. For this vulnerable population with intensive care needs, cohort differences in care availability—if they exist—have direct implications for projecting future nursing home demand and healthcare costs.

Prior research on cohort differences in family caregiving has treated family availability as a structural characteristic rather than as a behavioral capacity, relying on simple binary and count measures of family presence and proximity. Ryan et al. (2011) compared cohorts using binary measures of marital status and whether an adult child lived within 10 miles; Choi et al. (2015) similarly used presence of a spouse and proximity of children in examining socioeconomic differences; and recent studies continue to rely on indicators like presence of partners and children (Freedman et al., 2024) or distance thresholds such as coresidence and living within specific mile (Choi et al., 2020; Schoeni et al., 2022). These measures capture whether family members are present and nearby, but not whether they have the capacity to provide care given their own health, employment demands and competing responsibilities. Even analyses that examine actual care outcomes, such as Choi et al. (2021) on nursing home transitions and studies of informal caregiving (Wolff et al., 2016; Kasper et al., 2015), model each family relationship type independently rather than considering how multiple family members jointly constitute a network of care.

More importantly, no existing measures are calibrated to actual caregiving behavior. Prior indices implicitly assume that all spouses, all children, or all nearby family members contribute equally to care, when in reality their contributions vary substantially based on a serious of contextual factors. Thus, previous measures cannot distinguish between family configurations that appear similar structurally but function very differently in practice: for

example, a person with a spouse and two nearby children may have very different actual care availability if the spouse is also disabled or if the children are employed full-time with young children at home. Moreover, prior cohort comparisons have not examined how cohort differences vary across age groups (e.g., Ryan et al., 2011), making it difficult to determine whether observed differences reflect cohort differences or individual life course trajectories, and obscuring whether cohort patterns differ among high-need subgroups such as those at risk for ADRD.

This study addresses these gaps through three innovations. First, we develop a comprehensive Family Care Availability (FCA) measure that integrates network size and composition across five relationship types (spouse, children, siblings, grandchildren), spatial proximity, health and functional status of potential caregivers and their competing demands. The FCA is calibrated using observed caregiving behavior among those who need care through relationship-specific two-part models (Mullahy, 1998), capturing both the size of family caregiving and behavioral capacity, i.e. how family characteristics translate into actual care provision. Second, we examine cohort differences with age-stratified analyses comparing four birth cohorts (pre-1920-1930, 1930-1940, 1940-1950, 1950-1960), with separate analyses by age group (60-69, 70-79, 80+) to disentangle cohort from age effects and reveal how cohort disadvantages vary across the life course. Third, we conduct additional analyses for those at high ADRD risk to determine whether cohort differences are more pronounced among this vulnerable population (Friedman et al., 2015; Kasper et al., 2015).

**Data and Method**

We use data from the Health and Retirement Study (HRS), a nationally representative longitudinal study that surveys US adults aged 51 and older. The HRS collects extensive information on physical and cognitive health, family relationships, and sociodemographic characteristics. Our analytic sample includes community-dwelling respondents age 55 and older during survey years 2006-2020. For the ADRD analysis, we focus on those who developed ADRD during this period and reported at least one limitation in activities of daily living (ADL) or instrumental activities of daily living (IADL). We identify ADRD status using the 27-point cognitive functioning score developed by Langa and Weir. The final sample includes approximately 98,643 person-wave observations in overall older adult sample and 2,173 person-wave observations in the high ADRD risk sample.

*Family Care Availability Measure*

We construct a novel FCA measure that integrates five key dimensions of family context: (1) network size and relationship composition (number and types of living family members including spouses, adult children, grandchildren, and siblings); (2) spatial proximity (coresidence, proximity within 10 miles, and calculated distances for spouses, and children); (3) disability status of spouse (ADL and IADL limitation status); and (4) competing demands (employment status and other caregiving responsibilities).

Because family contextual factors are not uniformly applicable across all relationship types, we employ a stratified statistical model. To avoid bias in estimating the relationship between family availability and care provision, we restrict the calibration sample to community-dwelling adults aged 55+ who have at least one ADL or IADL limitation. This restriction is critical because care hours are specific to ADL/IADL help; including those without functional limitations would generate zero care hours that do not reflect a lack of care receipt but rather a lack of care need.

We model care hours as a function of family contextual factors separately for each relationship type (spouse, adult child, sibling, grandchild). Given that a substantial proportion of care hours consists of zero values even among those with functional limitations, we use a

two-part model: logit regression for the probability of providing any care, and generalized linear models (GLM) with a log link for the intensity of care provision among those providing any care.

Using these models, we construct relationship-specific FCA indices for each relationship type by predicting total care hours. We then apply these relationship-specific FCA indices to the full population of adults aged 55+, regardless of their function limitation status. This approach allows us to measure potential family care availability for all older adults, including those who do not currently need care but may require it in the future. We then create a composite FCA index for each respondent by aggregating the relationship-specific sub-indices across all relationship types.

*Analytical Strategy*

We compare FCA across four birth cohorts (pre-1920-1930, 1930-1940, 1940-1950, 1950-1960) stratified by age groups (60-69, 70-79, 80+) to disentangle cohort effects from age effects. We examine both the general older population and those at high risk for ADRD. To address potential endogeneity concerns, we measure family contextual factors from two years prior to the period of interest, ensuring that our measures reflect pre-caregiving conditions rather than responses to care needs.

**Result**

Figure 1. Mean FCA by Birth Cohort and Age Group

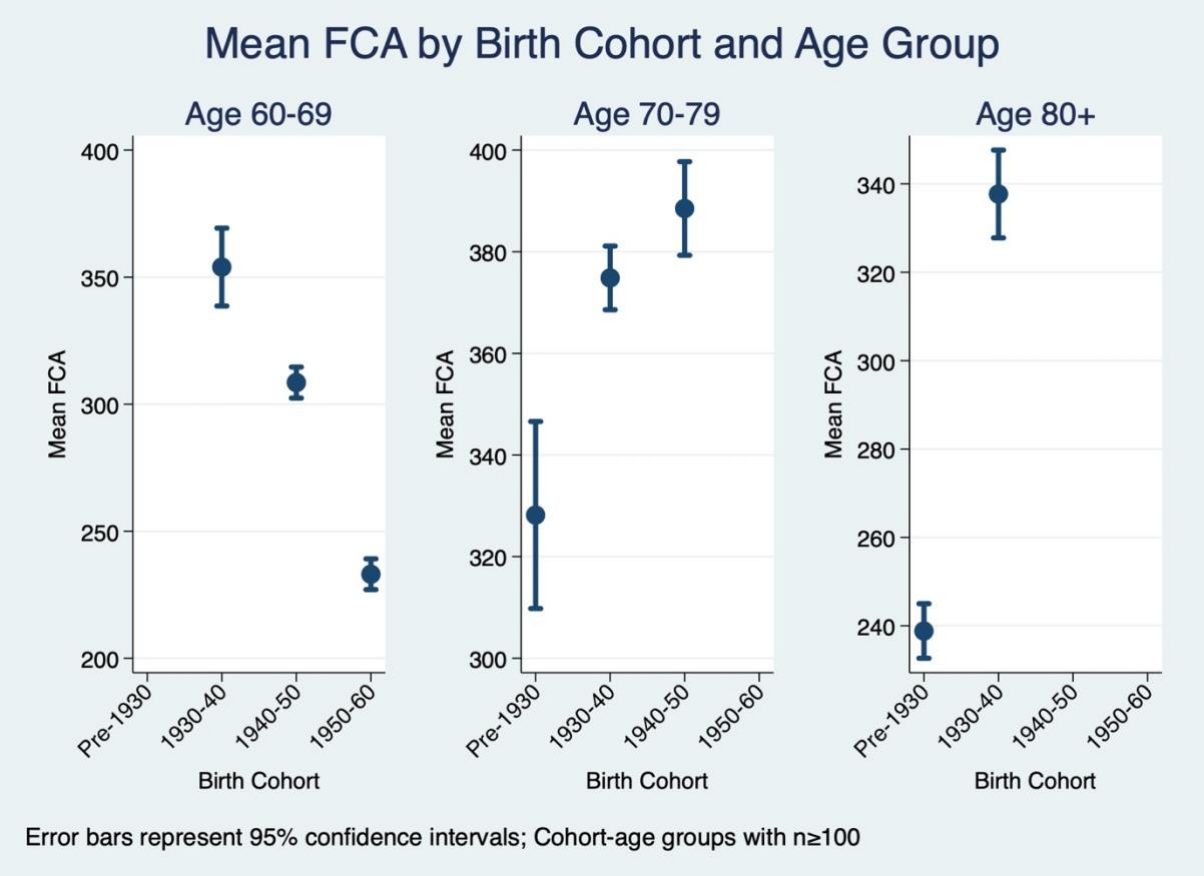



Figure 1 shows that, among adults aged 60-69, we observe a clear and substantial declining trend in FCA across successive cohorts. FCA decreased from 354 (95% CI: 339-369) in the 1930-1940 cohort to 309 (95% CI: 302-315) in the 1940-1950 cohort, and further to 233 (95%

CI: 227-239) in the 1950-1960 cohort. This represents a 34% decline in family care availability from the earliest to the latest cohort observed at these ages.

Among adults aged 70-79 and 80+, the patterns differ substantially. At ages 70-79, both the 1930-1940 (375, 95% CI: 369-381) and 1940-1950 (389, 95% CI: 379-398) cohorts show similar and elevated levels of FCA compared to the pre-1920-1930 cohort (328, 95% CI: 310-347). At ages 80+, the 1930-1940 cohort (338, 95% CI: 328-348) has substantially higher FCA than the pre-1920-1930 cohort (239, 95% CI: 233-245).

To understand this finding, we examined whether the declining FCA among younger cohorts might simply reflect delayed disability. If healthier populations do not yet require care, which will result in reduced care provision and lower predicted FCA, we would expect lower proportions of people with functional limitations in later cohorts. However, Table 1 shows the opposite pattern: proportions of respondents aged 60-69 with functional limitations remain stable or increase slightly across successive cohorts (15.5%, 15.1%, 16.7% for ADL; 10.9%, 11.9%, 12.9% for IADL in the 1930-1940, 1940-1950, and 1950-1960 cohorts, respectively). That FCA declined by 28% while prevalence of functional limitations remained stable or increased suggests that the declining care availability is more likely to be driven by compositional changes in family structure rather than delayed disability onset.

Table 1. Percentage of respondents with any ADL or IADL limitations in each birth cohort

| | Age 60-69 | | Age 70-79 | | Age 80+ | |
|---|---|---|---|---|---|---|
| Birth Cohort | Any ADL | Any IADL | Any ADL | Any IADL | Any ADL | Any IADL |
| Pre-1920-1930 | / | / | 22.8% | 18.8% | 40.3% | 40.7% |
| 1930-1940 | 15.5% | 10.9% | 19.9% | 16.3% | 29.4% | 27% |
| 1940-1950 | 15.1% | 11.9% | 17.2% | 14% | / | / |
| 1950-1960 | 16.7% | 12.9% | / | / | / | / |

Note: / indicates insufficient sample size (n<100). ADL = Activities of Daily Living (bathing, dressing, eating, getting in/out of bed, walking across a room, using the toilet); IADL = Instrumental Activities of Daily Living (using the phone, managing money, taking medication, shopping for groceries, preparing meals).

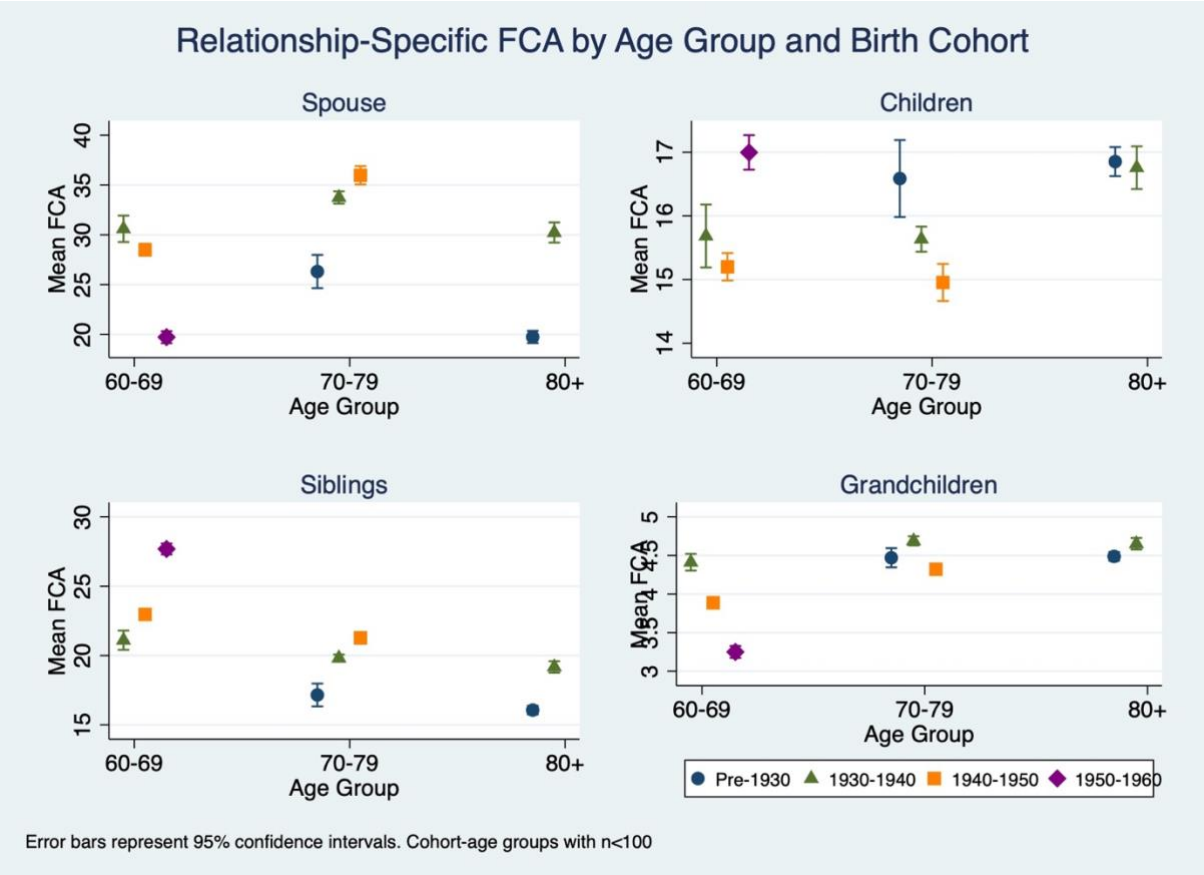
The declining FCA among younger cohorts is driven primarily by decline in spouse and adult child availability. As shown in Figure 2, spouse FCA shows divergent cohort patterns across age groups. At ages 60-69, the 1950-1960 cohort exhibits substantially lower spouse FCA compared to the 1930-1940 cohort. This decline at younger-old ages likely reflects lower marriage rates and higher divorce rates in more recent cohorts. In contrast, at ages 70-79 and 80+, spouse FCA increases for later cohorts, likely reflecting increased life expectancy and longer joint survival of couples.

Children FCA demonstrates mixed cohort patterns across age groups. At ages 60-69, the most recent cohort (1950-1960) shows higher children FCA than the two preceding cohorts. This suggests that factors such as greater coresidence, or reduced geographic dispersion may be offsetting declining fertility in recent cohorts.

Interestingly, sibling FCA shows an increasing trend across successive cohorts, particularly among individuals aged 60–69, with those born between 1950 and 1960 experiencing the highest levels of sibling availability compared to earlier cohorts. In contrast,

grandchildren FCA remains relatively stable across cohorts and age groups, except at ages 60–69, where grandchildren availability declines across birth cohorts, with the 1950–1960 cohort exhibiting the lowest levels of grandchildren availability. This may be related to lower fertility rates among children of the 1950-1960 cohorts compared to the previous cohorts.

Figure 2. Relationship-Specific FCA by Birth Cohort and Age Group

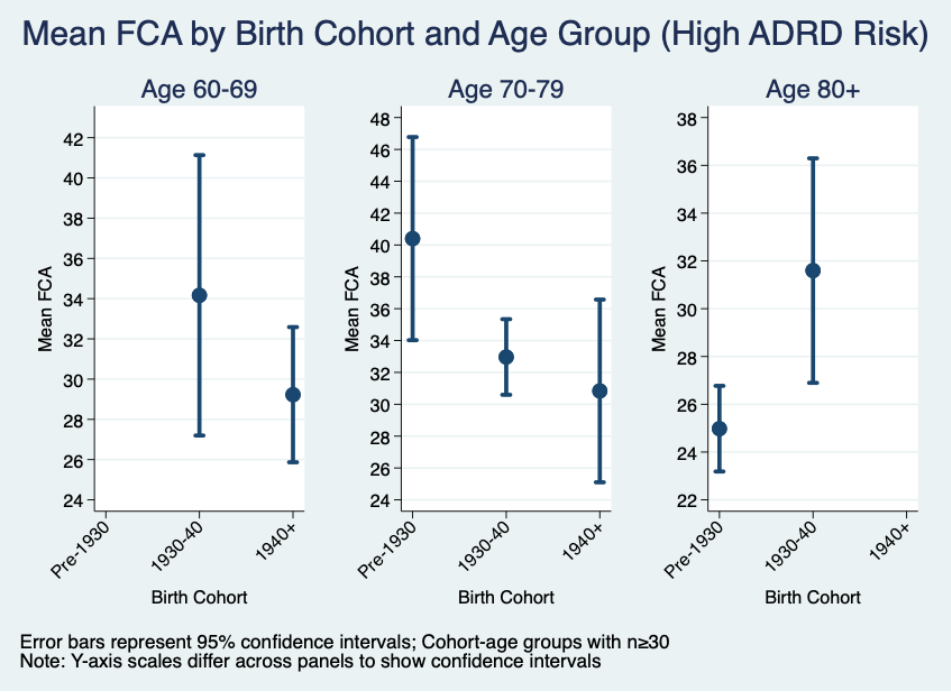



*High ADRD Risk Population*

Among those at high risk for ADRD, cohort patterns in FCA are generally consistent with the general older population. At ages 60-69, FCA shows a declining trend from the 1930-1940 cohort (approximately 34, 95% CI: 27-41) to the 1940+ cohort (approximately 29, 95% CI: 28-32), though wider confidence intervals reflect smaller sample sizes in this high-risk subgroup.

The pattern at ages 70-79 is different: the pre-1920-1930 cohort exhibits elevated FCA (approximately 40, 95% CI: 31-49) compared to both later cohorts (approximately 33 and 31), possibly reflecting selective survival among those with stronger family support. At ages 80+, the 1930-1940 cohort shows substantially higher FCA (approximately 32, 95% CI: 26-38) than the pre-1920-1930 cohort (approximately 25, 95% CI: 24-26), which is consistent with the general population pattern.

Figure 3. Mean FCA by Birth Cohort and Age Group, high ADRD risk population




**Tentative Conclusion**

This study provides the first evidence of birth cohort differences in family care availability using a novel measure. We found that more recent cohorts of older adults face significantly reduced family care resources, with a 28% decline in FCA among adults aged 60-69. This decline is driven primarily by reduced spouse and child availability. As later cohorts with diminished family resources age into periods of high ADRD prevalence, demand for formal care services will likely increase substantially, with important implications for long-term care policy and planning.

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