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## **CARING AN AGEING POPULATION: CHALLENGES, FACTS, ARTIFACTS AND POLICIES**

## **CUIDADOS NO CONTEXTO DO ENVELHECIMENTO DA POPULAÇÃO: DESAFIOS, FATOS, ARTEFATOS E POLÍTICAS.**

## **CUIDADO EN EL CONTEXTO DE ENVEJECIMIENTO: DESAFÍOS, HECHOS, ARTEFACTOS Y POLÍTICA.**

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### **Abstract**

An ageing population is a challenge for every country as the “demographic transition” is about to be an universal phenomenon. In this paper are first analyzed the two main dimensions of this dynamic. The first one is the demographic transition as such. Traditionally stages are defined that are placed in a chronological way. Each country being at different stage. The second dimension is the financing one, as it is necessary to allocate resources in a more efficient way that market forces would do. In a second part, the controversial impact on health care cost will be discussed. It will be demonstrated that the “last wagon” syndrome is nowadays proven. As a result, the rise of the life expectancy will not be such a burden for health insurance, whatever the models (Beveridge or Bismarck) are. To go further in the analysis of policies oriented toward caring elderly, some hints of European policy experience will be given. Beyond the European model ideology, studies show a double divide between South and North and between old and new European Union members. To conclude, the Brazilian situation will be shortly described in the light of the on going dynamic.

**Keywords:** Ageing. Social policy. Europe. Care

### **Resumo**

O envelhecimento da população é um desafio para todos os países a partir do momento em que "transição demográfica" está prestes a ser um fenômeno universal. Neste artigo são analisadas pela primeira vez as duas dimensões principais desta dinâmica. O primeiro deles é a transição demográfica como tal. Tradicionalmente, estágios definidos são colocados de forma cronológica. Cada país está em uma fase diferente. A segunda dimensão é sobre necessidade financeira para alocar recursos de forma mais eficiente que as forças de mercado faria. Numa segunda parte, será discutido o impacto controverso no custo de cuidados de saúde. Será demonstrado que a síndrome do "último vagão" é hoje em dia comprovada. Como resultado, o aumento da expectativa de vida não será um problema para os sistemas de saúde, independente do modelo de saúde (Beveridge ou Bismarck). Para ir mais longe na análise das políticas voltadas para cuidar de idosos, serão mostradas algumas experiências de políticas europeias sobre o assunto. Apesar da Além da ideologia europeia, estudos mostram uma dupla divisão entre Sul e Norte e entre os novos e antigos membros da União Européia. Para concluir, a situação brasileira será brevemente descrita à luz da dinâmica em curso.

**Palavras-chaves:** Envelhecimento. Política social. Europa. Cuidado



## Resumen

El envejecimiento de la población es un reto para todos los países desde el momento en que "transición demográfica" está a punto de ser un fenómeno universal. En este trabajo se analiza la primera vez que las dos dimensiones principales de esta dinámica. La primera es la transición demográfica como tal. Etapas definidas tradicionalmente se colocan en orden cronológico. Cada país está en una etapa diferente. La segunda dimensión es la necesidad financiera para asignar recursos de manera más eficiente que las fuerzas del mercado. En la segunda parte, se discutirá el polémico impacto en el costo de la atención de salud. Se demostró que el síndrome de "último coche" ahora se ha demostrado día. Como resultado, el aumento de la esperanza de vida no será un problema para los sistemas de salud, independientemente del modelo de salud (Beveridge o Bismarck). Para ir más allá en el análisis de las políticas para el cuidado de los ancianos, se mostrará algunas de las experiencias de la política europea en la materia. A pesar de la adición de la ideología europea, los estudios muestran una doble brecha entre el Norte y el Sur y entre los nuevos y antiguos miembros de la UE. En conclusión, la situación brasileña se describirá brevemente a la luz de la dinámica en curso.

**Palabras-clave:** Envejecimiento. La política social. Europa. Cuidado

## Introduction

For every country, an ageing population is seen as a multidimensional challenge. Actually it reveals the weakness and the strength of any society. On the one hand it shows and demonstrate the improvement, not only of the health care system, through the rising of the life expectancy, but also the progress of the whole society in terms of hygiene, education and, generally speaking, of all the public policies involved in well being of all the population. Of course those improvements may go along with high inequalities among social classes, ethnicities or geographical areas. However, at least since the ninetieth century, an ageing population is seen as an indicator of a modern nation. In effect, under the name of "demographic transition", it has been long ago demonstrated, that ageing is the outcome of a double dynamics: an increasing number of elderly people and the decrease of the birth rate; both being mainly due to the GDP /capita growth.

As a whole, and to some extend, a country facing an ageing population is a dynamic country facing the whole range of challenges modernity offers.

As far as health care is concerned, I will first point out two main dimensions of what can be called the "ageing dynamic" : the demographic transition as such (I.1) and the financing dimension of this dynamic (I.2). In a second part, the still hot and controversial issue of the impact of ageing on health care cost will be addressed (II). Thirdly, the capacities of caring will be looked at from a social policy point of view, focusing on the diverse and heterogeneous European experience. In effect, as a set of "old nations", European countries have implemented many ad hoc policies to tackle the effect of ageing and, at the same time, to facilitate this main societal change (III). Doing so, It is assessed that, ceteris paribus, the European stories may be useful for other. Therefore, the conclusive part will be an attempt to draw some lessons for Brazil.



## **I - The two main dimensions of a global demographic issue to be cope by individual countries**

When analyzing the huge literature devoted to the ageing dynamic, it appears that this movement is somehow global even if the maturity degree is very different from one global region to another. It seems that, indeed, every country had, is or will know a kind of another of demographic transition. Two main dimensions appear also to be not only important but seen as policy and political challenges. Each of this dimension is symbolized by three features.

The most visible is quantitative one and is often synthesized by a single and internationally used indicator. It makes not only visible the dimension but makes it easy (sometimes too easy) to identify. The second feature is a “theory” explaining the indicator evolution and its context, whether national or international. This theory is often launched by a social scientist involved in policy making. The third one is a, more or less formalized set of goals and procedures to cope this issue. Combining explicit and implicit moral values and with pragmatic principles this feature may lead to the definition and implementation of specific policies embedded in a given society and history.

### **I.1/ Demographic transition:**

The first dimension is related to the structural connection between demography and economics. In effect, the demographic transition goes along with economic growth: it is characterized by a dynamic at the end of which, the birth rate is low and the population is ageing.

Traditionally stages are defined that are placed in a chronological way. At the first stage, the population is low, thanks to high birth rates and high death rates. At the second stage, the Total population rises thank to the decline of the death rates due to improvements in health care and hygiene while the birth rates is high remain high.

During the third stage, the population continues to grow and the gap between birth and death rates shrinks thanks to the improvement of the purchasing power; contraception is more available and, because of the technical progress, less manpower is needed by the economy and the society. Total population is still rising rapidly. The gap between birth and death rates narrows due to the availability of contraception and fewer children being needed to work - due to the mechanisation of farming. The natural increase is high.

The fourth stage is characterized by a balance between a low birth rate and a low death rate. Finally, stage 5, the total population is high but about to decline due to an ageing population (A. Sauvy; 1982). As stated E. Todd: « when the women know how to write and read, controlling fecundity is starting” (Todd, 2002). This theory, that strongly links demography and education, explain and legitimate the implementation of specific policy aiming at push forward this kind of behavior is reinforced by another theory, assuming that individual preferences can be the outcome of social interaction within altruism (namely, “nonpaternalistic altruism”) plays a decisive role.

According to this theory, a rising life expectancy and an ageing population go along with a growing need for “care”. As, among others Sen stated and demonstrated, The basic postulate of this theory is that the driving force of such social interactions is nonpaternalistic altruism. This concept means that the individual concern toward others respects others’ own preferences. As a



result, each individual preferences are but the outcome of social interactions that take into account others preferences. (Sen, 1995).

Therefore, even from the point of view of standard economics theory, it is not only possible but efficient to settle policy that will improve the utility of the weakest as far as the whole population preference include the quality of life of others. As the reduction of social inequalities is one argument of utility function, it is economically rational to allocate public resources in a way that tend to improve the economic condition of the most vulnerable ; elderly being, of course, among them.

Therefore, as we will see in the next paragraph, the temptation to transfer the charge to the family is at the same time a theoretical mistake and a moral fault.

## **I.2/“He who pays the pipers calls the tune”**

The second dimension is the financing one. As it is necessary to allocate resources in a more efficient way that market forces would do, it is necessary to define “fair” an “unsustainable” inequalities. To go further in this direction it is useful to shortly look back in history. In effect, as far as “care” and “cure” are concerned, Bismarckian model, initiated at the end of the nineteenth century in Prussia, is still dominating in many continental countries (e.g. Germany, France). It has been implemented to face the consequences of rising industrial economy while trying to involve the Unions in the governance of a complex set of corporate insurances to be rationalized. However, since the 1980’s, mainly because of the end of the so-called “*trente glorieuses*”, this model is slightly evolving toward the Beveridgian one <sup>1</sup>. The resources do not come mainly from the wages but more and more from earmarked taxes. In the mean time, because of the economic crisis, the role and power of the Unions (either employees or employers) are decreasing. As a result, even if formally and sometimes legally, the main stakeholders are still belonging to the industry world rather than to the civic one, the States are playing a growing role in the health care sector governance.

The problem is that those States are more and more concerned by the budget deficit issue. Hence, to shrink public service is a temptation shared by most of western countries and, moreover, pushed forward by the European Union as a whole. Given this deficit obsession, there is a tendency to reduce the cost of public services and to transfer a growing share of it to the private sector and/or to the users themselves.

However, at least since K. Arrow (1963), we all know that “market” and “competition” can not be the framework of health care policies. Uncertainty, information asymmetries and professional interests are so strong that the “invisible hand” ideology cannot be applied here. Hence, the health care policy problems can be summarized as such: how to increase the State role in the health and care sector without jeopardize the fragile public budgeting equilibrium inherited from the end of the Keynesian era? In other words, is it possible to call the tune without paying the pipers?

The solution of this problem is to see health care costs as being ambivalent. Yes, on the one hand it is a “burden”; but on the other hand, it is an “investment”. As T. Borg, a European Commissioner, claimed in December 2013, there a need to « shift the (still) widely held perception

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of health expenditure as primarily a "cost" rather than an investment, and to pass across the message that health contributes to inclusive economic growth. This ambition underpins the Commission's policy on 'Investing in Health', which establishes health in EU's 2020 Strategy for growth and employment. Our starting point is that health is a value in itself ... to respond to the challenge of chronic diseases, Health systems would move away from an approach based on “cure” towards a more integrated prevention and care model involving multiple sectors of society and a wider promotion of healthy lifestyles» (Borg, 2013).

In fact, as far as ageing is concerned, there is a growing interest to consider a new economic sector grounded on what is called the “silver economy”. This means that, when some observers point the negative effect of ageing population on the dynamic of an economy, it is possible to argue that an ageing population may also be opportunity. But this optimistic move is not “natural”. Some conditions have to be fulfilled in order to create and maintain this dynamic in a positive direction. From this point of view, the health care cost issue is central either theoretically or politically.

## II - Is ageing an actual threat for health care systems costs?

Indeed, health care costs increase with age. Hence, at first sight, it seems that a rising life expectancy means a rising health care cost. It has first to be noted that this gap is very different from one country to another : e.g : twice as high in Japan than in Germany or France. But, since the work and studies done in the 1990's, this issue appears to be more complex. Grounded on data from different countries, it is now possible to say that the “last wagon” syndrome is but quasi universal. (P. Zweifel, 1999).

For instance, using French data, Grignon has demonstrated that the last year of life costs five times more than the others and that because the proportion of persons being in their last year of life will decrease in the next future, the overall health care cost growth will decrease in the next decades (Grignon, 2003).

Furthermore, another study grounded on French 2008 data shows that last year expenses decreased with age (Ricci et al., 2012).

The main figures are summarized in the Table 1.

Table 1 - Last year health life year, France, 2008  
Source : Ricci et al. 2011

Ages	Expenses (average in euros).
10 – 14	37.000
20-24	12.000



60-64	30.000
80-84	20.000
> 100	8.000
All	22.000

terms of health care costs. As an average, and for all ages, the cost of the last month is as high as 28% of the all last year of life expense. In the present situation, morbidity increases between 56 and 76 year (average age for death). (Fries, 1989).

The three scenarios Fries designs for the future, are linked to different hypothesis being at the same time epidemiological, social and medical. In the first scenario, life expectancy is increasing as well as morbidity; one may conclude that this scenario is the costly. In the second scenario, morbidity starts later than today but still rising with age; this scenario is as costly as the present situation. The third one is characterized by the stability of a morbidity starting later than today. In this scenario, morbidity will benefit from progress in medical care and the number of years in good condition will increase, other things being equal. Furthermore, as the last year cost is decreasing with age, the health care costs are likely to be less important than today.

“Although the prevalence of chronic disease increased, the increase was due to less severe disease with consequently less disability. A good target for public health policy in the light of our ageing populations would therefore seem to be to compensate for the gain in life expectancy by an equivalent increase in healthy life expectancy. In this case all the gain is healthy, changing the proportion of good and bad years and leading to a relative compression of morbidity (Robine and Jagger, 2005)

Under the name of “absolute compression of morbidity”, this third scenario is the more optimistic in terms of health care cost. For this scenario it is “sufficient that the rate of increase in healthy life expectancy is greater than rate of increase in life expectancy” (Howse, 2006). Of course, the likelihood of each of the scenario is different in “old” and in “emerging” nations. However, as the medical progress is more and more globalized, the third scenario is about to be the dominant one.

However, the society as to implement dedicated policies to cope the new burden due to the increasing number of persons in need of care either social, family or medical. European countries are involved in such policies since the 1980’s. We will see in the next part, that, if the concern is everywhere present, the way it is addressed is rather different from one country to another.

### III/ Caring capacity: is there an European model? <sup>2</sup>

Some clever observers point that « entrance in dependence » is but a process (Jonson, Daune Richard et al., 2009). Therefore, the social European policies have to take those personal trajectories into account. The solutions are different from one country to another because of different histories and culture. As the authors stress “national social policies are path-dependent”.

<sup>2</sup> This third part is mainly based on studies recently conducted by C. Martin and his research group in Rennes.



But in the recent years the trend are quite clear. In all the national configurations studied the context of cost containment and the difficulty in developing public support has brought the focus back on to the family ( Le Bihan and Martin, 2012)

But, the European Eurobarometer survey conducted in 1995 and analysed by .F. Valetas, shows that there is a north- south divide. For instance, Swedish people expect a preference for residential care, while Greeks seem to prefer the elderly people to stay in the family home (Valetas, 2001).

As for the policies themselves, the European Union itself has made a diagnosis: “long term care funding in Europe is mostly allocated to care institutions, except in the UK, where formal care delivered at home is allocated three times more funding. Formal care at home receives more funding in Western Europe than in the New Member States. The average cost in EU15 per person receiving care in an institution is about 24.000€, whereas this amounts to 3750€ in the New Member States. In the case of Sweden, the unit costs in institutional care are about 63.000€ and they exceed 200% of the GDP per capita. Cash benefits amount an average of 4640€ per beneficiary in EU15, a figure ten times smaller in the New Member States. Benefits in cash are the main form of expenditure in Italy.

With reference to institutional care there has been a shift in the provision of institutional care, with an increasing creation of places in nursing homes, where the supply of services is less costly. This shift takes place in a context of deinstitutionalisation of health services for the disabled in favour of community-based services. Introducing choice in long term care provision empowers the elderly because it gives them a say in the provision of welfare. It can also lead to an increase in the quality of services as welfare recipients because they can choose the provider and the type of service that in their opinion suits their needs more satisfactorily. As “ageing in place” is the preferred option, introducing flexibility in the provision of welfare usually takes the form of support for home-based formal care or payments to informal care providers.

However, the combination of informal care allowances and generous unemployment benefits can become a disincentive to enter the labour market” (European Social Network, 2008).

Le Bihan and Martin (2008), give an explanation of this tendency, while making a distinction among European countries :

“Yet, in the European context of cost containment, it is not easy to make a case for increasing public support and the caring function of families remains prominent in social policy. As stated by Leitner : ‘in times with tight social budgets it seems to be a reasonable strategy for welfare states to strengthen the family in its basic caring role In this context, adult children of older parents are confronted by a wide range of responsibilities at both professional and familial levels. The issue of how to balance work and caring responsibilities appears central in the field of care of the older people” (ibidem);

This is why, differences exist between on the one hand, “Italy and Portugal, where families were the principal caregivers and, to the other extreme represented by the Netherlands, where public authorities have assumed wide-ranging responsibility for social care. France constitutes an intermediate context, defined as a mixed model. Whatever the care model of the country, long-term care policies are characterised by a process of diversification of policy measures. This general trend cannot be considered only as a reduction of the existing gaps between the different national contexts; it also corresponds to the definition of a common portfolio of measures to meet the





various needs of families. Cash payments and service provision, either institutional or home-based care, are major policy instruments developed to meet the needs of old people.

Since the 80s, the necessity of reducing the costs linked to institutional care has led to the development of home-care services. 18 % of over-65s receive domiciliary care in the Netherlands today (Table 1). Another evolution can be identified with the introduction of a cash-for-care scheme in the 90s, which represents a major turning point in the traditional Dutch conception of care ... giving recipients a choice between a cash allowance and services.

This is also the case in France, where a specific long term care policy has been developed from the mid-90s, based on the introduction of a cash allowance for the over- 60s (the Allocation Personnalisée d'Autonomie). Closely linked to French employment policy, with the objective of supporting new jobs in the services' sector to reduce the unemployment rate, the implementation of this cash payment has entailed the development of professional homebased services, as the use of the allowance has been controlled by local authorities;

Cash allowances, which can be allocated to relatives in the different countries (except the spouse in France) can be an incentive to care for an old parent

Each national data set shows a combination of different resources in addition to the family carer, who cannot bear the full burden of care alone. A housecleaner, a paid care worker, professional or not, a nurse, a sibling, a friend, or a neighbour who delivers informal care, a day care centre: all of these are used in the different countries to organise the old person's home-based care, constituting a veritable mosaic of various care providers according to the availability of the informal carer, the needs of the old person and existing public or private professional support.

Cash transfers to families and the possibility of paying non-professional carers outside or within the family have introduced new hybrid forms of paid work, defined as 'informal care employment' (Le Bihan and Martin, 2012).

As the French government stated in a 2013 Law project, the goal of any reform addressing the ageing issue is to "adapt the society to the ageing" process, meaning :not the old people to the society.

#### **IV/ Conclusion : is there some lessons for Brazil**

On many respects, Brazil may give lessons to other countries as far as social policies are concerned (Gragnolati et al., 2013).

Furthermore, even if "benchmarking" is very much in fashion in most international agencies such as WHO or OECD, it is misleading road when used to transfer reforms from one national context to another. No country can be a model for another because, especially in issues such as policy making, to take into account the national specificities (e.g. history and on going social "rapports de force" among stakeholders, etc.) is one of the condition to be fulfilled if one wants to, softly and efficiently, conduct a change. Therefore, what happens abroad can only be seen as examples, a kind of "tools box" in which it is, or not, possible to pick. From this point of view the current Brazilian situation have three features that can be seen as favorable dynamics.

##### **IV.1/ The demographic "bonus"**



Brazil appears to be an exception in the demographic transition global movement. It is one out of very few nations knowing at the same time ageing and a very young population. According to D. Newman : “In Brazil, a growing proportion of the population enter the most economically active period of their life. Some economists have named this shift as a demographic bonus because it is likely to boost the country's development. Studies show that the demographics bonus was responsible for about a third of the growth rate for Asian 'tiger' economies between 1965 and 1990”. Thus, “the burden of financing dependents is likely to fall. The average size of a Brazilian family has been in progressive decline since the 1960s. As a consequence, more money will be left over for leisure and recreational activities for the parents left in the family home once the children have moved on (Newman, 2011).

That is the reason one the WHO as well as the World Bank give Brazil as the example of a “quick” and positive demographic change : today, a “demographic bonus” ; tomorrow, an ageing population, from 12% over 65 now, to 30% in 2050.

#### **IV.2/ Private or public?**

At the same time, unless other great countries, Brazil has implicitly chosen not to ground its social and health policy on a huge amount of public funding. The share of “public” expenses in health care is low compared to other great countries (around 40 %). Indeed, OECD figures on health care budgeting show that the average share of public expenses has slightly decrease in the early 2000. However the OECD average is still around 73%; this percentage is over the 80% in Scandinavia, UK, France or Japan and is increasing in UK, Japan or France.

The Japanese example shows that it is possible to have at the same time a high percentage of public expenses in health while maintaining a rather low public expenses level in other sectors. In fact, as the market rules cannot efficiently govern the health care sector, a low share of public expense means a poor health care delivery system and poor public health indicators. It also means a huge amount of wasted resources. By the turn of the last century, the USA has show the way not to be followed !

This is not sustainable as, at the same time, the social and economic inequalities are not only high but increasing. In effect, health, as well as education needs a lot of investment (building hospital, developing research, improving professional training, etc.). All those expenses cannot be mainly supported by private funding. Or, to say it in different words, to support a high level of private financing (out of pocket, private insurance, etc.) one has to quit either efficacy or fairness. Market logic can be a dominant one only if the decision is taken not to improve the situation of the poorest and, therefore, to jeopardize the whole nation cohesion. Solidarity is not only a moral and social principle. Looking at other health and caring systems, one can see that solidarity is but the main, if not the only one, road to efficiency.

Therefore, to develop the care needed by a growing number of ageing persons, the choice is clear: either to raise the “earmarked” taxes dedicated to home care and care facilities, or to create financial incentives for the helpers and the professional. As a first step in this direction, studies are needed that should combined economic assessments and political choices about the definition of socially “acceptable” inequalities. From this point of view, again, Brazilian people has a comparative advantage thanks to an appetite for local democracy and political participation.



### IV.3/ The SUS as a lever

Looking to the Sistema Único de Saúde (SUS) efficiency, through Brazilian glasses it may appear as questionable. However, to meet the needs for care and to face the ageing population challenge, it is not only desirable but also possible to use the SUS development and improvement as great opportunities.

« Yet there are good reasons to believe that changes in the SUS have played an important role. The rapid expansion of primary care has changed the patterns of use, with a growing share of contacts taking place in health centers and other primary care facilities. The use of health services has risen, and the share of households reporting problems in accessing health care for financial reasons has declined. Moreover, improvements in health can be attributed at least in part to the health system, with the expansion of primary care bringing about impressive reductions in mortality that is amenable to health care and in child mortality. In short, the SUS reforms have at least partially achieved the goals of universal and equitable access to health care » (Gagnolati, 2013).

Thank to the implementation of SUS, and a strong administration, a large amount of data is needed and actually collected to monitor the system from a central and decentralized perspectives. This information system benefits from the high level of integration (only way to reach the minorities' needs). The SUS is not only an opportunity to sustain a new caring policy it allows a apprenticeship implementing democracy and improving managing and professional competences at different nations levels: the Federal State, the Regional States, the Municipalities, etc.

Observatory to assess the costs repartition and evolution among age and revenue can also be used and mobilized to push forward a necessary dynamic: namely integrating the care sector into a broad policy including social policy as a whole but also, labor market regulation, education and traditional health care services.

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