Social policy and population ageing: challenges for north and south

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The challenge of social policy for older people

Social policy for older people has had to respond to a series of challenges. The first, and perhaps most significant, of these is a generalized perception of a social policy ‘crisis’ and the need to reappraise the role of the state. This has been closely associated with an apparent paradigm shift away from state-centred welfarism that emphasised solidarity and aspired to universality. In its place has come a neo-liberal model, which emphasizes individual agency and pluralism, while playing down the role of the public sector. This shift is reflected in international debates about social policies for older people, including pension reform and health care. However, some of the basic precepts underlying this apparent paradigm change are open to question. Revisionists have cast some doubt on claims that western welfare states are inherently inefficient and unsustainable. While social policies in developing countries suffer many shortcomings, they have often contributed to rapid improvements in basic indicators of wellbeing.

In fact, few developed countries have profoundly reoriented their welfare policies in response to neo-liberal dictates. In some cases, such as the US, there was little scope for further reducing state involvement in social provision (barring occasional calls for the break-up of Medicare). In others, a strong ideological attachment to state welfarism, and political barriers have precluded a radical overall of social policy. Moreover, the fiscal imperatives of the 1980s have relaxed somewhat since that time. A further reason is that hard evidence that privatized social policies work better than traditional models remains weak and highly contested.

By contrast, the paradigm shift has been strongly felt by many developing countries. In these countries fiscal constraints remain acute, and the influence of multilateral organizations such as the World Bank and International Monetary Fund is much larger. The impact has been especially significant in middle-income countries where social policies were already reasonably well-developed, and where there was therefore more to be lost. Whether these changes should be seen as nefarious or ‘necessary medicine’ remains a matter of heated debate.

A second set of challenges relates to the changing social, economic and cultural contexts in which social policies for older people are located. According to Esping-Andersen:

‘The contemporary welfare state addresses a past social order … The much greater occupational and life-cycle differentiation that characterises ‘postindustrial’ society implies also more heterogeneous needs and expectations…Also the welfare state’s erstwhile ‘model family’ is no longer pre-eminent.’ (ref. 2, p. 9)

A host of changes including the status of women, in patterns of living arrangements and in the labour market may have profound influences on the needs of older people and how these can be met. The standard modernization thesis posits that older people become increasingly isolated and vulnerable as the result of such changes. Research from developing countries shows that ‘traditional’ social structures, such as extended families and communities are becoming less reliable sources of care provision in such countries.

A third challenge stems from demographic change. Many developed countries now have highly aged population structures, which has led to fears about an ‘old age crisis’, and the sustainability of existing welfare programmes for older people. According to the more sensationalistic commentators:

‘Official projections suggest that within 30 years, developed countries will have to spend at least an extra 9 to 16 per cent of GDP simply to meet their old age benefit promises. The unfunded liabilities for pensions … are already almost US$35 trillion. Add in health care, and the total jumps to at least twice as much … Global ageing could trigger a crisis that engulfs the world economy. This crisis may even threaten democracy itself.’ (ref. 7, pp. 46 and 55)

But are such apocalyptic views of a future ‘ageing crisis’ justified? Population ageing may not inevitably lead to a social policy cost explosion, as the needs and capabilities of future generations of older people are likely to be different to those of elders today.

For example, epidemiological research has shown that the relationship between chronological age and health status is fairly elastic. Also, the way in which social policies are organised can have a large impact on their cost effectiveness. Moreover, if developed economies enjoy rapid growth, meeting the needs of older people should not be beyond their financial means. These issues are discussed further below, with reference to health costs.

For most low-income countries, the impact of ageing on social policy will be rather different. While their population structures are still relatively youthful, the speed of ageing is projected to be very rapid. To date, social policies have tended to focus on the needs of other age groups, such as children, mothers and ‘workers’. This is particularly apparent in the area of health care. Instead of sustaining existing programmes, the
main challenge for low-income countries will be to factor older people into social policies for the first time. For many countries, this will occur against a backdrop of severe resource constraints and generalized social hardship. In these cases, a shift in the priorities of external donors and non-governmental organizations will also be required. For some countries, meeting the needs of elders will be almost entirely over-shadowed by the HIV/AIDS pandemic. In these cases, it should not be forgotten that older people are affected by the pandemic and can play an important role as carers for people with AIDS and orphans.

Social policy and older people: the global agenda

In April 2002, the Second World Assembly on Ageing is due to take place in Madrid. This follows on from the designation of 1999 as the United Nations International Year of the Older Person. It is expected that the Assembly will give rise to an ambitious International Plan of Action, which will include wide-ranging social policy guarantees for older people.

The World Assembly should be welcomed as an opportunity to raise awareness about population ageing issues, but there are reasons for doubting that it will have a substantial impact in terms of actual policy. One reason is that international debate on ageing is still in its infancy, and has yet to produce an influential global policy community whose principal concern lies with the health and wellbeing of older people. A second cause for caution is the degree to which social policy challenges facing developed countries can be reconciled with the very different sets of problems confronted by poorer nations. There was considerable criticism that the First World Assembly (held in Vienna in 1982) was dominated by northern gerontologists, leading to proposals that were inappropriate to and beyond the means of the south. Fears that the same will occur again have led to disagreements in the preparatory meetings for the Second Assembly.

A further problem is that global debates about ageing are permeated by a negative paradigm of old age. This draws on Western experiences, which equate old age with withdrawal (from both economic and social spheres), dependency, physical frailty, and pensioner status. The applicability of these stereotypes in the context of developed countries is highly contestable, but in most developing countries they are largely meaningless. Older people are seen as marginal to economic activity and development, and are usually excluded from labour force statistics, yet empirical research from around the world challenges this view.

The negative paradigm of old age is clearly apparent in international debates about pension policy reform: an issue that has dominated the global ageing agenda. Current orthodoxy rests on the questionable notion of inevitable economic withdrawal in later life, and overlooks the fact that for many older people in poorer countries the prospects of receiving a pension are remote. The content of pension reform debates has been strongly conditioned by the welfare paradigm shift mentioned above. This has mainly entailed an ideological disagreement between traditional ‘welfarists’ (as typified by the International Labour Organization), who have championed the continued role of the state, and neo-liberals (principally the World Bank), who have advocated privately managed individual savings funds. By the mid-1990s the debate had largely been won by the neo-liberals. However, some recent studies have queried aspects of this consensus, and have suggested that state financed old age support may even be a feasible policy option in poorer countries.

In a similar way, this negative ageing paradigm means that older peoples’ health needs are often characterized as requiring high cost, long-term treatments. Elders are therefore seen as part of the ‘problem’ of overly curative health care, low technical efficiency (narrowly defined) and mounting costs. In an extreme form this has given rise to statements that adding years to later life simply brings closer the bankruptcy of schemes such as Medicare. These views lose sight of the fact that, whilst the very old are more likely to suffer from chronic illnesses, there is still considerable scope to improve their health and quality of life through relatively low cost interventions. Also, access to basic services remains a key issue for many older people in poorer parts of the world. Far more could be done to mainstream older people into primary health care programmes, particularly in low-income countries. Indeed, launching a global campaign for primary health care in later life might be a suitable rallying point for the Second World Assembly.

Health policy: is a cost explosion inevitable?

Studies from developed countries consistently show that levels of health spending are significantly higher for elders than for other age groups. It would therefore seem logical that population ageing will inevitably lead to an increased financial burden on the health services. Nevertheless, claims that population ageing will lead to a health care cost explosion, both in the north and the south, would appear to be exaggerated for a number of reasons.

First, even if population ageing is associated with a global increase in the incidence of certain forms of chronic disease, its impact on health services may not be as direct as is widely predicted. Rather than driving up health spending, the main impact of ageing may be a shifting of priorities. Any society is faced by a higher demand for health services than it can meet, and therefore some form of rationing is always present. The gap between demand and provision is especially wide in lower income countries, highlighted by failures such as the lack of access of most AIDS sufferers to effective drug therapies. The likelihood that changing demographics will lead to a health care cost explosion in these contexts is remote.

Even in developed countries there is clear evidence that health care spending is not directly affected by population ageing per se. A range of other factors, such as technological change, and national wealth have been found to be more significant. Current spending is heavily concentrated in the last years of an individual’s life, and so is more influenced by mortality than by the average age of the population. Indeed, the costs of dying may be lower for elders, if they receive less treatment as a result of ageist bias. In developing countries rapid population ageing will lead to a rise in mortality, but this will be far smaller than the mortality decline achieved in recent decades. Figure 1 shows that in Brazil, despite rapid ageing, mortality levels in 2050 will be roughly on a par with those of 1980.

Comparisons across developed countries show that differences in expenditure are largely the result of how their health
care systems are organised and financed rather than of demographic change. This is an area where policy can have a large impact in heading off cost escalation. Two issues of particular pertinence are the desirability of dedicated health funds for older people, and the influence of private health insurance.

Only two countries have health funds specifically concerned with older people: the US and Argentina. The US experience with Medicare is fairly well known; the Argentine experience less so. Between 1967 and 1984 Medicare expenditures grew at 9% annually in real terms. Only a small proportion of this can be accounted for by growing affiliation or an increase in average member’s age. Since then, levels of coverage provided by Medicare have been eroded, and the scheme now incorporates incentives for members to take out additional insurance with health maintenance organizations (HMO) or other private organizations. Argentina’s programme was established in 1971, and was initially successful in extending health and other social services to insured older people (about two-thirds of the total). However, by the mid-1990s it had begun to accumulate substantial deficits, which had reached US$1.5 billion in 1995.

The experiences of the US and Argentina are not encouraging. Whether similar programmes are appropriate to the needs of other countries depends on the broader context of health care financing and organization. In countries with unitary, universal social insurance schemes there would seem to be little point in creating separate programmes. Indeed, such a move might ghettoize health care for the aged, prevent inter-generational solidarity and create an institutional logic of cost escalation. However, in countries where health care programmes are fragmented and non-universal, and where private insurance is a major component, there may be little alternative. This is because market mechanisms and private health insurance often discriminate against the aged when selecting affiliates. For example, private HMO have become a major component of Chilean health care financing since 1980, but only 3% of their patients are aged 60 or more, compared to 12% in public hospitals and clinics. Similarly, surveys of newly-formed private insurance companies in Russia indicate a strong tendency to discriminate against the aged. Access to insurance is particularly limited for those older people with pre-existing conditions.

In most countries with private insurance, attempts to prevent cream-skimming through regulation have proved to be largely ineffective. Also, firms may be discouraged from employing older people because they are unable to find moderately-priced health cover for them. In these cases, separate programmes for the aged may at least ensure that they receive a satisfactory level of resources and attention.

As such, the growing international role of private health insurance (encouraged by the welfare paradigm shift) is likely to further marginalize health care for elders, unless demarcated old age funds à la Medicare are in place. The apparent problems of such funds, and the lack of alternatives to them should be considered as an intrinsic cost of shifting away from unitary publicly funded health systems, and, where possible, these costs should be passed on to private insurers.

Conclusions

Population ageing creates the need for particular forms of social policy. In later life, people face greater income uncertainty, as well as increasing health and care needs. However, the policy challenges for north and south are distinct. This reflects the different contexts in which ageing is occurring, including pre-existing social policy infrastructure, resource levels, and the impact of HIV/AIDS. While lessons may be exchanged between countries, global social policy blueprints should be avoided.

International debates about effective interventions have been hamstrung by simplistic views of the ageing experience, wider ideological disputes and paradigmatic narrow-mindedness. The risks of an ageing-related social policy ‘meltdown’ should not be exaggerated. However, current trends (especially the extension of private pensions and health insurance) are likely to spur cost escalation, as well as promote inequality across older populations. As such, demographic ageing provides further cause to rethink welfare policy, and to reinstate universal public provision as the lynchpin of social policy in both north and south.

References


