The Bright Side of Aging: Shifting Images, Reframing Policy Issues

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Abstract

Average life expectancy expanded by about 30 years across the industrialized world since the late 19th century due to improved living conditions and medical care. Changing demographics obviously requires adjustments in public pension schemes, healthcare services, labor markets and fiscal and social policy. The good news is that demographic change occurs over a very long period of time, allowing for gradual policy adjustments. Other industrialized nations, with much older populations, have already adjusted their public pensions or healthcare without dramatic cuts, and there is no reason to believe that such adjustments will become unaffordable. Moreover, most people in the Western world will live their additional decades in relative wealth, prosperity and good health—of course that do not apply to all; many elderly persons do need financial and other support for daily living. Following shifts in images of the elderly, the policy debate in the U.S. about policies for elderly citizens has changed color and focus. Reignited during the 2016 presidential election, it prompted policy proposals and measures that, we argue, are misguided, inconsistent and disproportionate. The policy debate about aging provides interesting examples of reframing of policy issues, expressive of divergent ideological perspectives. It resulted in both overt and somewhat covert and gradual changes in policy directions, the latter sometimes framed as policy drift, layering or conversion. In older political science literature, such policy change was simply labeled as marginal adjustment or ‘muddling through.’ While the 2016 U.S. Presidential elections resulted in a-for most political commentators-unexpected victory for Republican candidate Donald Trump. His repeated claim that he would “repeal and replace” the Patient Protection and Affordable Care Act the first day in office, flies in the face of Pierson’s finding that the “institutions, once in place, tend to create their own constituencies of beneficiaries, administrators and political supporters who will fiercely oppose the erosion or demise of such programs. Early February 2017, however, less than one month later, Trump said that replacement of the ACA was not likely until the end of this year or in 2018. Indeed, “change is difficult”, former President Obama concluded, especially in times of hyper-partisanship.

It is important to add that this ‘healthy, wealthy and active’ label does not apply to everyone. Chronic illnesses like diabetes or chronic heart failure have largely replaced contagious diseases in the industrialized world. Many older people need external support for their daily living. A substantial minority of elderly with low or modest pension incomes faces financial strains of high medical bills, and many older people in urban areas live in social isolation [4]. But on balance, being ‘old’ nowadays is strikingly different from being old two or three generations ago. Never in history had an older generation access to so many resources to enjoy life.

Nonetheless, population aging has become a topic of fretting and concern. The policy debate about the future of public pensions and healthcare programs—particularly in the U.S.—increasingly framed the growing burden of elderly in alarmist terms in the last decades of the 20th century. Claims about the unaffordability and unsustainability (and thus undesirability) of social policies supporting the elderly became common currency.

ABBREVIATIONS

ACA: Patient Protection and Affordable Care Act; AMA: American Medical Association

INTRODUCTION

All industrialized countries experienced major demographic change in the 20th century. The continuous drop in child and maternal mortality rates since the beginning of the century, with advances in medical science, contributed to the rise in average life expectancy. People born after 1950 can expect to live, on average, 20 to 30 years longer than their parents or grandparents. They are much healthier, too. Contagious diseases common around 1900 have largely disappeared in North America and Western Europe [1-3]. The current generation of elderly—defined in this paper as people 65 and over—is much wealthier, better educated and more mobile than previous ones. Their financial independence means that they do not have to move in with their children but can live wherever they want.

often disguised as concerns about ‘intergenerational justice’. Aging resurfaced as a policy concern for both Republican and Democratic candidates during the 2016 presidential elections. Many Republicans followed earlier proposals of the Speaker of the House Paul Ryan to replace Medicare and Social Security with vouchers or tax subsidies for low-income families to purchase private insurance. At first, Donald Trump took a different position and wanted to keep the social insurance programs Social Security and Medicare. But later in the campaign he seemed to have changed position. In Fall 2016 he advocated replacing traditional Medicare by vouchers for low-income elderly to purchase private insurance (as well as liberalization of private insurance markets to encourage competition across state borders). The two major Democrat candidates took sharply different positions. Both Former Secretary Hillary Clinton and Senator Bernie Sanders (D-Vermont) advocated maintaining and strengthening Social Security for retired workers. Regarding healthcare, however, their positions diverged. Clinton proposed to keep and improve the Patient Protection and Affordable Care Act (ACA) as the base for future health policy, while Sanders advocated replacing the current system with universal coverage (“Medicare for All”), modeled after Canada’s universal health insurance.

This contribution aims to assess current policies and programs for elderly and discuss the experience with demographic change across industrialized nations. We argue that claims about the unaffordability of those programs find their origins more in ideological and partisan opposition to social insurance rather than empirical evidence. We will address the following questions: What are the causes and consequences of demographic transitions in Western Europe and North America? How do those changes affect public (and private) expenditure for pensions and healthcare? To what extent does the aging of society require adjustments in markets and government policies? What are the options? What are the experiences of other nations in North America and Western Europe? How did the 2016 U.S. presidential election affect the policy debate on aging?

We conclude that population aging requires adjustments in work and living arrangements, pension schemes and long-term care. Growing numbers of very old and frail elderly, we should add, also require adjustments in the organization of healthcare such as improved home care and care for frail elderly or chronic ill patients. That does not, we believe, require the elimination of social insurance, nor does it lead inevitably to economic decline or intergenerational conflict. The effect of demographic change obviously varies across (public) pensions, health expenditure and categories of other public spending. While living longer requires additional (public or private) retirement pension spending, international data show there is no correlation between the degree of population aging and the level of health expenditure.

The policy debate about aging provides interesting and sometimes stark examples of reframing policy issues [5]. The shifting images of elderly prompted shifts in policy proposals and policy directions. Such change does not always take place directly; it sometimes occurs in indirect and somewhat covert ways. Hacker [6] categorizes policy changes as explicit and transformative programmatic change (e.g. ending social insurance or fully replacing the program by vouchers or fiscal subsidy) versus policy drift or gradual transforming programs into a different direction than originally intended (e.g. by adding new criteria for eligibility), layering (adding new policy directions on the original program) or conversion (gradually changing a program into an entirely different one). This categorization suggests a certain preference for the former form of change: open, transformative, supposedly well thought through versus covert forms of change, not open to scrutiny or the public eye. But we should not forget earlier warnings of political scientists. In his seminal article “The Science of Muddling Through” of 1959, for example, Charles Lindblom [7] describes how much of what governments do consists of more of the same, talking care of things, keeping the system on the rails and making it work rather than dramatic change and innovation. Marginal adjustments and gradual change is the rule, not major transformation. Similarly, Kingdon [8] concluded that major overhaul in government policy is rare; a “window of opportunity” for fundamental change does not occur often, and requires the confluence several factors (or “streams”) as well as the presence of policy entrepreneurs who will skillfully grab that opportunity to enhance a particular policy agenda. Klein and Marmor [9] describe most policy-making “dull as darning old socks” (it is not clear whether the authors themselves have had much experience with that activity). They also point to the pressure of politicians to come up quickly with new proposals, and leen to embrace fashionable if untested policy ideas: “who wants to be seen wearing yesterday’s policy ideas?” Klein rhetorically asks in another paper [10]. Paul Pierson [11] adds another point to those warnings about the real world of policy change, namely the fact that large programs, once in place, tend to create their own constituencies of beneficiaries, administrators and political supporters who will fiercely oppose the erosion or demise of such programs. Finally, there is a wide body of literature about the decentralization of administration of public programs, both from the federal level to the state and local level and to the level of the individual bureaucrat. At that level of programmatic administration, there is both need for clear rules and fair and unbiased application, but also for some discretionary powers.

MATERIALS AND METHODS

This article presents an historical analysis social insurance policies in the U.S. based on the academic and policy literature and a review of public statements from policy leaders in the U.S. In addition, we present descriptive statistics on population aging, labor force participation and health based on data from the OECD health database, the United Nations and the U.S. Bureau of the Census.

RESULTS AND DISCUSSION

The public image of elderly shifted dramatically during the 20th century [11]. The positive traditional (or biblical) image depicted older people as heads of extended families, source of wisdom and knowledge, and keepers of moral values in communities—as illustrated by Moses’ Council of Elderly, or the Commandment ‘Honor Thy Father and Mother’. During the 1930s, that traditional image changed. Elderly became objects of pity, care and government concern. This ‘compassionate ageism’ portrays older persons as poor, frail, in need of and, importantly,
deserving of public support after a long working life. In the United States, (most) Democrats and (many) Republicans favored government intervention[12].

With a further improvement of economic wellbeing of the older generation, the late 1970s witnessed another shift towards a modern and positive image of elderly as healthy, vibrant, independent, and self-assured. Specialized magazines and brochures depicted cheerful seniors engaged in travel, life-long learning activities, wearing the latest fashion (widows no longer dressed in black), and ready to exercise their market power and political clout. By the early 21st century, the American Association of Retired Persons (AARP) was, after the Roman Catholic Church, the largest organization in the world with over 38 million members[13].

By the late 1980s, however, the growing visibility of the elderly as a high-consumption generation also fueled a backlash. Under the label ‘intergenerational justice’, conservative commentators and media presented a new negative image of ‘greedy geezers’ who, after spending down their assets (that their children had perhaps counted on as future income), were becoming a growing burden to society [14,15]. The very term intergenerational justice suggests that the transfers from the (working) adults to (non-working) elderly transfers are not fair. With the above shifts in images, elderly somehow lost their preferential position as ‘deserving poor’.

Two events catapulted the issue of generational equity into visibility in the early 1980s. Senator Dave Durenberger (R-Minn.) founded Americans for Generational Equity (AGE) to promote the concept of generational equity among America’s political, intellectual and financial leaders [16]. AGE called into question the prudence, sustainability, and fairness of federal old age benefit programs to future generations. Vehicles for AGE’s message included conferences, books, articles, newspaper op-ed pieces, speeches and comments by members of Congress. AGE is now defunct, but it was important in reshaping of political discourse: “…so that all future policy choices will have to take generational equity into account” [17]. The Concord Coalition, funded by investment banker and former U.S. secretary of commerce Pete Peterson, took up where AGE left off. Its aim was to curtail entitlements, especially Social Security and Medicare, framing its proposals in terms of generational equity [16]. Both AGE and the Concord Coalition sought to influence the public debate in meetings, conferences, publications and speeches in Congress. They were effective in spreading the idea that increased spending on elderly is unfair to younger generations.

The demonization of older people became part of the broader ideological claim that the welfare state is not a solution to social and economic problems, but a cause of economic stagnation [18]. In the 1990s and early 2000s, several publications invoked impending disaster caused by demographic change by their very title: “Averting the Old Age Crisis”[19], “The Gray Dawn” [20], “The Coming Generational Storm” [21] and “Shock of Dawn” [22]. The Economist published a special report “A Slow-Burning Fuse”[23], and the New York Times discussed “The Financial Time Bomb of Longer Lives”[24].

**U.S. Policy Debate: Reframing Issues and Changing Policy Directions**

Social Security’s Old Age and Survivor’s Insurance (OASI) of 1935 was expressive of wide-spread popular support for elderly as ‘deserving poor’. So were the establishment of Medicare and Medicaid in 1965 along with a host of other policies targeting elderly citizens, for example the energy assistance programs, housing subsidies, home delivered meals and special tax provisions [25]. The programs initially faced political and ideological opposition. Many Republicans and some conservative Democrats never accepted the social insurance premise of Medicare. The American Medical Association (AMA) remained one of the fiercest opponents for many decades. Speaking on behalf of the AMA, Ronald Reagan urged voters to:

“…. write those letters now; call your friends and tell them to write them. If you don’t, this program [Medicare] will pass just as surely as the sun will come up tomorrow, and behind it will come other federal programs that will invade every area of freedom as we have known it in this country…And if you don’t do this and if I don’t do it, one of these days we are going to spend our sunset years telling our children and our children’s children, what it once was like in America when men were free” [26].

Social Security and Medicare rapidly became popular by recipients and other population groups, however. The programs’ popularity, coupled with Democratic control of the U.S. House of Representatives, meant that most Republicans came to accept them. Surveys show that a large majority of the American population is still willing to pay more taxes because they value Social Security, not only for themselves but also for others [27]. Social Security and Medicare have been successful in lifting elderly persons out of poverty (ibid.). Older people no longer needed to move in with their children after exhausting their life savings. Reversely, children no longer were fiscally responsible for their parents.2

Since the mid-1990s, however, the political consensus unraveled and the opposition against the social insurance programs resurfaced. In 1996, Republican presidential candidate Senator Robert Dole (R-Kansas) boasted about his opposition to the original Medicare bill. During a speech to the American Conservative Union, Dole said, “I was there, fighting the fight, voting against Medicare…because we knew it wouldn’t work in 1965” [30]. Early 2009, Republicans proposed to replace Medicare with vouchers or fiscal subsidies for older people to purchase private health insurance (ibid.). Ironically, despite this long-standing opposition to Medicare, chairman of the Republican National Committee (RNC) Michael Steele opposed the 2010 healthcare reform proposal of the Obama administration, claiming it would harm Medicare [31]. In August

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1 The labeling of elderly as ‘deserving’ implies that other groups are less deserving, for example, beneficiaries of unemployment or welfare support.

2 In Germany, in contrast, children are fiscally responsible for the cost of long-term care for their parents and in France, families are seen as the first to take care of ailing family members. Across Europe, views and policies differ on the allocation of responsibilities of individuals, families and the state in providing and financing long-term care [28,29].
2009, the RNC proposed a ‘Healthcare Bill of Rights for Seniors’ to protect of Medicare from cuts and outlaw medical care rationing on the basis of age [32]. Conservative radio talk show host Rush Limbaugh joined the defense of Medicare, arguing that any cuts in Medicare would violate an existing social contract:

“There are certain agreements that we have as a society made with people, and one of those agreements, via legislation, is Medicare. So the elderly, knowing that the program is devised to provide health insurance coverage and healthcare for the elderly at a point in time when their earnings disperse. It’s the same thing with Social Security. So, people have been living their lives and planning their lives based on that promise made to them by their government” [33].

In the fight against expanded government involvement in healthcare, the political rhetoric thus shifted dramatically. Rather than presenting Medicare as an unaffordable and unfair transfer of resources from the young to the old, conservative critics characterized the program as a key feature of the existing social contract—one that should be defended against cuts proposed by the Obama administration. The Republican opposition now depicted older people as vulnerable victims of a callous abandonment of a long-standing promise, rather than greedy geezers disproportionally and unfairly consuming society’s resources.

During the 2010 U.S. congressional elections, however, the debate flared up again and old claims resurfaced. The arguments were not new, but the political climate had changed. Disputes over Medicare, Medicaid and Social Security intertwined with a highly partisan and acrimonious political debate about the federal deficit and national debt. The programs became clear targets for spending cuts. In 2011, the Republican House majority passed a proposal by Congressman Paul Ryan to replace Medicare with vouchers (now labeled ‘premium support’) for low-income beneficiaries to purchase private insurance. The proposal—as expected—died in the Senate, but it contributed to the reframing of the issues on the policy table. By mid-2011, even Democrats seemed to accept the need to alter social insurance programs—such update with the original goals, what policy levers to use to change service delivery, costs and revenues.

The 2016 presidential elections showed a similar pattern. At the Republican side, the stunning and unexpected success of outside candidate Donald Trump forced all other Republican candidates into defensive positions. It led to acrimonious debates that focused more on personal attacks than substantive policy issues. March 2016, the field of original 16 candidates had narrowed to four: Trump, Ted Cruz, Marco Rubio and John Kasich. Next, Rubio dropped out as well. Trump was vague on most policy issues apart from sweeping statements about improving the American economy (“Make America Great Again”). Cruz and Rubio tried to outdo each other in showing themselves genuine conservatives by attacking Obama care, social policies and Big Government. They also favored shifting from the social insurance model to vouchers for low-income elderly to purchase health insurance. But, like Trump, their programmatic ideas about policies regarding elderly lacked specificity. Kasich’s health proposals consisted mostly of ‘repealing and replacing’ Obama care by ‘market-based principles’, ‘patient-centered primary care’ and ‘episode-based payments’, but were somewhat short on details [34]. Both Cruz and Kasich next dropped out in May 2016, leaving Trump as the only candidate. Trump’s healthcare policies gained more details during the year [35]. Obviously inspired by Paul Ryan and other conservative Republicans, he advocated “repealing and replacing” the ACA, liberalizing insurance markets by allowing the sale of health insurance across state boundaries, turning Medicaid into block grants to the states, and allowing people to deduct the cost of their health insurance from their taxes. Finally, Trump also favored expansion of health savings accounts and allowing tax-free passage of the balance of those accounts to heirs [36]. His program does not mention measures to reduce the numbers of uninsured, or steps needed if the repeal of the ACA would lead to a dramatic rise in the rate of uninsured. Trump’s proposals, in line with conservative Republicans mostly seek to reduce regulation and government spending, lower taxes and providing people more low-cost insurance options (the latter in fact meaning high deductible plans with limited coverage). Those proposals are of little help to low-income families who pay little or no taxes, but face high medical bills. There is no mention of pre-existing conditions or mechanism to ensure that sick people can get coverage. High-deductible plans with savings accounts are generally not good for chronic ill or for low-income groups (ibid.). In contrast to Paul Ryan, Trump did not favor replacing Social Security with private savings, however. He argued that his economic plans would generate enough economic growth to safeguard future financing for Social Security, together with rigorous action to combat “waste, fraud and abuse” [35]

At the Democrat side, by Summer 2016 the two remaining candidates were former Secretary Hillary Clinton and Senator Bernie Sanders of Vermont [37,38]. Both were in support of keeping and fortifying Social Security. While Clinton favored keeping and improving Medicare and the ACA, Sanders advocated a shift towards a universal health insurance that would automatically include all elderly (“Medicare for All”). In May 2016, obviously pressured to act by her opponent Sanders, Clinton embraced the proposal to lower the age for eligibility for Medicare for certain groups of uninsured on a voluntary basis.

Defeating almost all projections by political commentators, Donald J. Trump won the elections by a substantial majority of the electoral colleges (even while Hillary Clinton won the popular vote by almost three million). Trump was sworn in on January 20, 2017. He repeated his promise the “repeal and replace the ACA”, and the first week in office he signed an executive order to “unwind” the Affordable Care Act. Within one month, however, he had softened that position, announcing that is was not likely that the health law will be ready within year or in 2018 [39]. This announcement followed news about rising confusing and a lack of agreement within the Republican Party about the future course of America’s health care. Republicans increasingly acknowledge the technical complexity and political difficulty of finding a replacement Obama care that fulfills earlier promises of better and cheaper care for more people [40]. In fact, there seemed to be sharp divisions within the Party about the different options and some Republicans seem to be edging away from ACA repeal altogether [41]. Indeed, as President Obama wrote in his
2016 article in the JAMA journal in 2016, reforming health care is difficult—even when one Party has a majority in the Congress [2]. Dismantling of an elaborate system that has given entitlement to over 20 million people will be a daunting task to the new administration.

What does that mean for the future of Medicare and Social Security, the two largest social insurance programs protecting the incomes of over 60 million retired American citizens? Efforts of former Republican presidents to either substantially reduce public spending for those two schemes, or to privatize them (e.g. by giving vouchers to beneficiaries to purchase their own insurance) met with too much opposition. President Trump already announced that he would keep the programs in place, even after he had signed an executive order aimed to dismantle the ACA. So there are (at least) three competing directions, but none very appealing to large fractions within the Republican Party (or to the Democrat opposition). It is not likely that the new administration will find a solution to this problem any time soon ("...either at the end of this year or in 2018", in the words of President Trump—if at all). A more likely outcome is that the programs will remain in place, with some further shift towards the Medicare Advantage plans, in fact, publicly funded plans administered by private insurance.

**Facts about Aging**

At this point, we want to present evidence about five interrelated issues that are central to the policy debates: ageing and poverty; social insurance; ageing, labor market participation and dependency ratios, intergenerational solidarity and intergenerational transfers; and ageing and healthcare spending.

The populations across the industrialized countries are aging, but the patterns of aging are strikingly different. North America and Canada are still relative ‘young’ countries, whereas Japan, Germany and France, our main industrial competitors, have aged (much) more than we see (Table 1,2).

As their incomes and wealth have risen, older people as a group are no longer the poorest segment of society in North America. Poverty rates among older Americans dropped from 30 to about 15% since 1965, and persons older than 55 nowadays have lower poverty rates than those under 18 [44]. This newly gained income security is due to the post-war economic boom, real estate appreciation, pension savings, and improved income protection by Social Security and Medicare. It also contributed to a growing economic and physical separation between generations. Older people no longer need to move in with their children after exhausting their life savings. Children no longer are primarily responsible for their parent’s financial wellbeing.

The majority of older people are healthy, independent, and not in need of external support. They often provide a substantial amount of informal care to their spouses, children and grandchildren, older relatives or neighbors (see below). Over 90% of all long-term care is provided by informal caregivers, mostly close relatives [45]. At present, the age cohorts between 40 and 70 are the largest populations in North America and Western Europe (the shape of the ‘population pyramid’ has morphed into a ‘fat lady’). The current debate about the rising costs of healthcare largely ignores this substantial supply of financial support and informal care.

**Social Insurance: Life-long Transfers**

Social Security is the largest social insurance program of the U.S. It provides old-age pensions to over 60 million retired Americans. It also offers life insurance, disability and survival protection by Social Security and Medicare. It also contributed to a growing economic and physical separation between generations. Older people no longer need to move in with their children after exhausting their life savings. Children no longer are primarily responsible for their parent’s financial wellbeing.

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**Table 1: Population estimates (1960 to 2015) and projections (2020 to 2050) of selected countries (millions of persons).**

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benefits to over 10 million widows, children and younger adults [15]. The second largest social insurance is Medicare, the health insurance for over 57 million retired (and 9 million disabled) citizens [47]. A life-course perspective is needed to understand social insurance. Social insurance is basically a social contract between the state and citizens that protect family incomes against the major risks of unemployment, disability, illness, death, or outliving one’s savings. Mandatory pension schemes impose savings during working life in order to prevent poverty in old age. Social health insurance pools the financial risk of illness by charging contributions based on income while safeguarding access to healthcare according to need. This implies transfers within and between generations from the young to older people, from the healthy to the sick and from higher income groups to low-income families and individuals. Public pension schemes transform mandatory savings into life-long future income streams for all participants.

Some social policies (e.g. subsidies for home adjustments) and tax expenditures benefit elderly citizens more than others. Tax expenditures (exclusion from the requirement to pay taxes) means forgone government income. Non-profit hospitals, for example, do not pay corporate taxes (they supposedly spend over five percent of their revenues on charitable activity including non-paying patients). Over one third of hospital patients are older than 65 years. Over 40% of hospital admissions in 2009 were Medicaid patients [48].

The framing of the very purpose of social policies reveals sharp differences in ideological perspectives. The above quote of President Reagan illustrates a common conservative perception that social insurance takes away individual freedom and responsibility. The contrasting perspective emphasizes that social insurance is not just government income support, but expressive of the social contract between state and citizens that alleviates the fears of poverty. Social insurance helps to support the market economy, in this perspective, because it encourages entrepreneurship. Collective protection arrangements against major financial catastrophe due to disability, poor health or unemployment allow individuals and families to take risks because they know that failure will not wipe out their resources. Social programs also offer a “safeguard against misfortunes which cannot be wholly eliminated in this man-made world of ours,” including “illness, disability, old age, or the loss of the support of a father or husband” [49]. Most American voters support social insurance because they agree with the moral imperative to support older people. Younger voters also realize that one day they will be beneficiaries themselves.

The ideological battle about the future direction of Social Security is not unique to the United States. In many other industrialized nations, too, there is extensive policy debate about the affordability and sustainability of the current and future public pension arrangements. The outcome of those debates, depend as much on ideological preferences as on economic and fiscal conditions. Let’s have a look at the relation between changing demography and labor markets across industrialized nations.

### Aging, Labor Market Participation and Dependency Ratios

When Chancellor Otto von Bismarck introduced social insurance in Germany in 1883, he set the retirement age for industrial workers at 65, knowing that those workers would, on average, live another three years. Almost 140 years later, the formal retirement age is still the same in most industrial countries, while average life expectancy had increased by 20 to 30 years. In many countries, the actual retirement ages had even dropped below 65 [50].

Some experts associate population aging with a decline in economic growth: “…. from a macroeconomic point of view, the
main effect of aging is to reduce the relative size of the labor force as a share of total population. Unless this is compensated by an increase in total factor productivity and/or an increase in the capital stock, their national output will decline” [51]. Others argue that there is no direct link between demographic change and economic growth [52]. Human beings often remain creative as they age [53]. The small birth cohort of the Great Depression generation enjoyed more prosperity than the large birth cohorts of the baby boomers after the Second World War. France and Italy are the fifth and seventh largest economies in the world, yet both have low birthrates. Despite major demographic change, the 20th century witnessed extraordinary innovation, continuous improvement in labor productivity and high economic growth rates, disrupted by wars and economic stagnation. This growth also greatly broadened the tax base for public spending.

There is reason to believe that low rates of labor market participation of the elderly in industrial economies have less to do with their ability or desire to work than with financial incentives. Older workers face hurdles in the labor market when employers assume that their skills are outdated, or just prefer younger workers. Older workers in the U.S. increasingly reported incidents of age discrimination as governments and industry preferred to hire so-called ‘prime-age’ workers [54]. Consequently, those over 45 (quite another definition of elderly!) were more likely to experience long-term unemployment during economic downturns [55,56].

At first sight, the demographic trends justify dramatic change in the public pension schemes—after all, the schemes now have to support rapidly growing numbers of retirees for a much longer period of time. No wonder there is panic about the future of Social Security, particularly when looking at strait trend extrapolations of revenues and spending. Those worries are fueled by the intergenerational-justice debate. The traditional definition of dependency ratio referred to the ratio between numbers of dependents versus workers who support them. The dependents included all non-workers, young, old or adult. In the intergenerational justice debate, however, the term is now commonly taken as the ratio between only elderly dependents and workers. That redefined dependency ratio obviously shows a steep incline due to changing demography. But it ignores the declining numbers of younger dependents. The total dependency ratio actually declined in the last three decades of the 20th century across industrialized nations due to demographic change (more elderly but fewer children) and increased labor market participation by women and older men, but it then started to go up again in the early 21st century (Table 4).

This illustrates the importance to carefully look at all the factors that determine the future outlook of demographic and economic dependency: on the one hand, the cost factors: the number of elderly that will draw pensions; other dependents who need support (children, students, unemployed, disabled), and the level and duration of support; on the other hand, the factors that determine the inflow of money: the number of workers (men and women), their working hours and years, labor productivity trends and taxes and contributions paid into the pension system.

While most youngsters under 18 do not (formally) work, and substantial numbers of adults do not participate due to disability, unemployment, prolonged education or other reasons, most individuals between 18 and 65 are in the labor force, and the labor market participation has generally risen across industrialized nations (with some variation between countries, (Table 2). Table (3) shows the rapid growth of labor market participation of women in all major industrialized nations, another important determinant in the financial balance of pension systems.

The above tables also illustrate that trend of early retirement reversed itself across the industrialized world in the last two decades. The participation rates of workers between 60 and 64 years of age rose in all industrialized nations. That increase varied from 46.0 to 48.5 in the United States, 34.2 to 46.8 in Canada, 13.7 to 17.0 in France, 20.0 to 38.6 in Germany, and from 36.1 to 44.9 in the UK between 2000 and 2009 [57]. The share of workers over 65 also increased, in particular in white-collar jobs. That trend has not yet ended.

The participation rates of women aged 55 to 65 rose even faster than that of men in that decade: from 50.6 to 56.4 in the U.S., 39.1 to 53.1 in Canada, in France from 30.3 to 36.6 in Germany, 29.0 to 48.6 in Germany and from 41.4 to 56.4 in the

| Table 3: Labor force participation rates, men and women, age 55-65, selected countries, 1990 to 2010. |
|------------------|------------------|------------------|------------------|------------------|------------------|------------------|
|                  | Men   | Women | Men   | Women | Men   | Women | Men | Women |
| Brazil           | 70.6  | 25.2  | 71.3  | 37.5  | 71.8  | 40.0  | 1.7 | 58.7  |
| Canada           | 64.0  | 34.9  | 60.7  | 41.4  | 68.4  | 56.7  | 6.8 | 62.5  |
| China            | 74.6  | 37.2  | 70.9  | 47.2  | 71.4  | 48.4  | -4.3 | 30.1  |
| France           | 39.4  | 26.8  | 35.4  | 28.1  | 45.0  | 39.8  | 14.2 | 48.5  |
| Germany          | 55.6  | 24.3  | 52.7  | 33.7  | 70.9  | 54.5  | 27.5 | 124.7 |
| India            | 85.0  | 29.6  | 84.5  | 30.1  | 83.1  | 28.0  | -2.2 | -5.4  |
| Japan            | 83.2  | 47.2  | 84.1  | 49.7  | 84.0  | 53.9  | -1.0 | 14.2  |
| Mexico           | 84.6  | 24.2  | 79.9  | 28.2  | 79.4  | 36.2  | -6.1 | 49.6  |
| UK               | 66.1  | 38.6  | 63.3  | 42.6  | 69.0  | 50.2  | 1.3  | 30.0  |
| US               | 67.8  | 45.2  | 67.0  | 51.9  | 70.1  | 60.2  | 3.4  | 33.2  |

Source: [57]; last columns computed by authors
UK. Moreover, increasing numbers of people worked part time or part of the year only. They may be ‘partially dependent’ or ‘temporarily dependent’ of external support by family members or public schemes.

One particular issue is whether the labor market can absorb the growing number of older workers, particularly when young workers face high unemployment. Some governments encouraged older workers to retire to make room for younger ones. For example, the Dutch government offered stunningly high early retirement bonuses to ‘elderly’ civil servants in the early 2000s. Basically, all bureaucrats of 57 years and over working for central government received full salary until 64, plus annual contributions to their pension fund if they retired. The offer also extended to workers aged 55 and 56—but those ‘only’ received contributions to their pension fund if they retired. The offer also lasted three months.

Some experts disagree with the idea of a ‘fixed’ labor market demand: “there is every reason to believe that the labor market will equilibrate supply and demand for labor in response to an increase in labor supply by older workers, just as it has accommodated increases in the labor supply of women, particularly married women” [59].

Another important factor in determining the balance (or the fiscal affordability) of pension system is the long-term trend in labor productivity. In the decades after World War II, between 1950 and 1973, the countries in Western Europe and North America had exceptionally high productivity growth rates of 4.77 and 2.77 percent; those rates dropped to 2.35 respectively 1.41 in the 1970s and 1980s and to 2.16 and 1.74 percent in the last decade of the century [60]. Combined with the continued rise in labor market participation this meant a substantial increase in the total national wealth available for current consumption and redistribution across current and future generations.

Brief, population aging can be associated with independence and—to the extent that longevity is associated with good health-productive lives, rather than dependency and economic stagnation [61].

Intergenerational Solidarity versus Intergenerational Justice?

Comparing the levels of (public) spending on younger versus older generations at one given moment in time does not provide evidence that we are spending too much, too little or the ‘right’ amount on either group. Nor does it provide enough information about the total (financial) support between generations. Such comparison may help, however, debunk claims that spending on older people is unfair or that it crowds out spending on children or reduces the standard of living of future retirees.

Demographer Samuel H. Preston argued in the mid-1980s that rising costs of Social Security and Medicare caused poverty among children [16]. Former Speaker of the House Newt Gingrich used a similar argument in 2009 to explain why Americans should oppose Obama’s healthcare reform (and vote to remove President Obama and the Democrats from office):

“Obama represents the greatest transfer of wealth from the young to the old in American history. It’s grotesque. We used to pay off the mortgage and give the kids the farm; now we’re selling the farm and giving the kids the mortgage. It’s exactly the opposite of sound and healthy policy. So you want to have this larger question: ‘Which kind of America do you want?’ I think when you recognize that virtually no American, except the hard left, believes that a centralized, bureaucratic, high tax, politician-defined system can work. You have a chance to win a cataclysmic election on the scale of 1932, not 1980, but 1932” [62].

So the question is here: is there empirical evidence of a disproportionate consumption of (public or private) resources by elderly or retired citizens? How do we measure that?

As all parents know, raising children is not cheap. According to the U.S. Department of Agriculture, middle class families spent over $220,000 on raising one child the first 18 years in the early 21st century [63]. For families with incomes over $100,000, those costs were on average $475,000. Four-year college education added between $1,500 per year for public schools and $35,000 for private schools per child. Public spending on education and other programs for children increased those amounts by 40%. Those estimates are based on figures of the early 2000s; by 2016, the cost of private college education had almost doubled.

In fact, there is evidence that total public spending on children is comparable to spending on older people. This includes education, Social Security and healthcare through Medicare, Medicaid and the State Child Health Insurance Program [15].
Apart from being taxpayers, older people contribute, often substantially, to younger generations in different ways [64-67]. Retired parents and grandparents often move to live closer to their offspring (they also move to states with better weather or warmer tax climates, like Florida, Texas or Arizona). They contribute to college and graduate education, help their children or grandchildren to buy a house or pay off student debt, or contribute in kind, for example as baby-sitters and chauffeurs. Growing numbers of young adults are moving back in with their parents or grandparents after college graduation when they cannot find a job. Much of that support is based on altruism and solidarity, not on selfish behavior as ‘greedy geezers’. Moreover, elderly citizens are a major source of voluntary work, both as caregivers within families and within their communities. In fact, as mentioned above, over 90 percent of all long-term care is provided within families, and most of those informal caregivers are over 50 years old themselves, taking care of spouses, handicapped children or aging parents. The morphing of our population pyramid into a ‘fat lady’ shows that the current cohorts of 40-70 year olds are now the largest population groups—and they are the groups that are the major caregivers themselves.

Aging and Healthcare Spending and End of Life

At first sight, there are good reasons to believe that population aging will push up healthcare spending. On average, the demand for healthcare services increases with age. Some studies predict that age-related spending in industrialized countries will rise by around 6 to 7 percentage points of GDP between 2000 and 2050 [68]. Yet, international data show that there is no correlation between the percentage of the population 65 years and older and the level of total health spending [69]. The most important factor explaining the high level of U.S. health expenditure are the incomes of physicians and other health professionals and prices of pharmaceutical products and medical devices.

As noted above, most people in North America, Western Europe and other countries who are 65 can expect to live another 20 to 30 years in relative good health. Older persons are generally healthier than those in earlier generations [58]. It is also important to emphasize that improvements in health are unevenly distributed. While the health of elderly continues to improve in many countries, there has been some decline in activities of daily life of older Americans—perhaps reflecting unhealthy lifestyles associated with growing economic inequities [70].

Medical spending generally increases with age, but not all age groups over 65 spend the same. Most people between 60 and 80 years of age live independently, and their medical expenses do not push up the average substantially. The United States has one of the youngest populations of the OECD, yet it spends more on healthcare than any country in the world. Japan, the Scandinavian countries, Italy, Sweden, Germany and France, all with much older populations than the U.S., spend much less on healthcare, both as share of their national income and in dollar amounts. Likewise, within the European Union, there is no correlation between population aging and health spending. France and Germany are both younger than Italy and Sweden, but have higher levels of healthcare spending. The tables below also illustrate that there is the higher spending on health care has not resulted in better results in terms of increased life expectancy or decreased child and maternal mortality (see tables 5b and 5c below). The four middle income nations on the list—Brazil, China, India and Mexico—made the most progress in extending the average life expectancy of their population. While the rates of child and maternal mortality deaths in those countries were still higher than those of the wealthier nations in the table, in relative terms the former had made more progress in a short period of time. Brazil’s child mortality went down from 62 to 14 per 1,000 live births; China’s from 54 to 13, India’s from 126 to 53 and Mexico’s from 46 to 15 between 1990 and 2013. The decline in maternal mortality for the four nations followed the same pattern: Brazil from 104 to 44 per 100,000 live births, China from 97 to 27, India from 556 to 174 and Mexico from 90 to 38 in the same period. Obviously, there is room for further improvement but the point is here that improving health outcomes does not require high health spending; neither does the demographic transition towards aging populations by itself necessarily mean higher spending levels for healthcare (Table 5a-c).

Brief, most if not all studies found that price (incomes of health professionals, prices of pharmaceuticals and medical equipment), volume and the spread of technology, not population ageing, are the major drivers of healthcare costs [69,74,75]. Despite spending more than any other nation, the use of healthcare services in the U.S. is actually below the median for the OECD on most measures.

When people get (much) older, they obviously need more healthcare and related support services, and that requires adjustments of existing healthcare arrangements. The international experience suggests that there are very different—and not necessarily more expensive—ways of doing so and as aging is a very gradual process, is allows for gradual policy adjustment over time [76].

In fact, there is reason to redefine the very term ‘aging’ as it regards health and healthcare. The more important age category nowadays is the demographic group over 80 or perhaps 85 years, with growing frailty and dependence—rather than 65. The growing numbers of over 80 in our societies require adjustments in the organization of healthcare, like expansion of home care (including support for informal caregivers), assisted living and nursing facilities.

One particular complicated and sensitive policy theme concerns the high costs at the end of life. A number of studies in Europe and the U.S. concluded that proximity to death—regardless of the age of dying—is associated with high spending [77,78]. Aging thus leads to postponement of some spending to a later point in time, rather than higher costs [68]. Interestingly, the cost of dying for the very old (over 90 years of age) is lower again, on average, than for persons who die between 60 and 90. Perhaps the ones survive into that high age cohort are the strongest indeed, or perhaps they are the ones who do not insist so much on prolonging life or futile medical treatment.

There is wide variation in the medical costs during the last year of life within and between countries [79]. End-of-life costs are (much) higher in hospitals than in other places, and (much) high in some countries than in other. Paradoxically, while a vast majority of Americans prefer to die at home when their time has
come, over 80% will actually die in a hospital, nursing home or long term care facility, and only about 15% at home [80].

Concerns about the high end-of-life costs implicitly and sometimes explicitly blame older people for absorbing too many resources during the last months of their lives. But the international variations discussed here suggest we can find better solutions by looking across borders and listening to patients and their families rather than blaming them.

### Table 5a: Health spending, selected countries, 1970 to 2015 (total public and private health spending as % of gross domestic product).

<table>
<thead>
<tr>
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<td>6.1</td>
<td>6.2</td>
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<td>US</td>
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Source: [71]

### Table 5b: Life expectancy at birth, selected countries, 1960 to 2014 (years).

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</tr>
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<td>79.0</td>
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</table>

Source: [71]

### Table 5c: Child mortality and maternal mortality rates, selected countries, 1990 to 2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Country</th>
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<th>Maternal Mortality rates (per 100,000 live births) (b)</th>
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<td>4</td>
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<td>Germany</td>
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<td>3</td>
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</table>

Summary and policy options

The populations of North America and Europe are aging. In this contribution we emphasized “The Bright Side of Aging” arguing that the positive sides of aging are undervalued. Most of those born after 1950 in the industrialized world are healthier and wealthier than their parents or grandparents, with access to more resources to live productive lives. They can choose to live with or close to their offspring, or move to another place for fiscal reasons or a better climate. They can continue to work, choose a new job or restart their education, enabled by life savings and investments as well as public programs that protect their incomes against high costs of medical care.

The current generation of elderly, as we have shown, is on balance contributing more to the next generation than it receives in support. They regularly help their offspring with the cost of education, buying houses and reducing student debt. They often provide support in kind as babysitters, house sitters or chauffeurs. The current cohort between 40 and 75 is by far the largest population group—they are also the informal care providers to their sick or handicapped children, spouses or aging parents. Increasingly, students move back in with their parent and sometimes grandparents after graduation and before finding a job. This pattern of mutual support between the generations flies in the face of the acrimonious picture of ‘greedy geezers’ by ‘intergenerational-justice’ debaters who argue that public programs in support of elderly unfairly take away resources from younger generations.

Our “Bright Side of Aging” statement does not mean we do not recognize the need for policy adjustment. Obviously, growing numbers of retired and longer living people will require safeguards for fiscally sound pension finance. We also acknowledge that a substantial minority of elderly is in need of support because of poverty (for example, widows or divorced women with low savings), poor health or mental problems. But, as we showed, population aging occurs very gradual. There is ample time for policy adjustments. The experience of other nations that aged well before the U.S. provides a menu of policy options for prudent policy-makers.

At the revenue side of pension schemes, given the improved spending categories. Most countries also control pharmaceutical education and hospital capacity. In several European countries, include budgets, price controls, and restrictions on medical ‘new’ cost control measures [84]. The traditional instruments others in reining in costs. Most if not all used a mix of ‘old’ and witnessed rapid rises in their health expenditure in the past decades, but some nations have been more successful than others in reining in costs. Most if not all used a mix of ‘old’ and ‘new’ cost control measures [84]. The traditional instruments include budgets, price controls, and restrictions on medical education and hospital capacity. In several European countries, as in Canada, central or regional governments set overall spending limits as well as budgets for hospitals and other health spending categories. Most countries also control pharmaceutical leave, and tax credits for taking care of (sick) children [81]. Pension credits could also apply to volunteer work, or providing care for children or dependent elderly and help women who have not participated in the formal labor market long enough to build up their own pension. All these measures are in place in many European countries as part and parcel of the labor market policies, in particular in Scandinavian countries. It is also important to mandate young people to join pension schemes, and to open access to those schemes for part time workers to encourage life-long saving. Still other measures aim to expand the tax base for social insurance by increasing the income ceiling or broadening the definition of taxable income. Finally, the option is to increase contribution rates.

At the expenditure side, the three most obvious options include (temporary) lowering of freezing current levels of pension benefits, (temporary) changing the indexation of pensions, or postponing the eligibility age of pension benefits.

Those measures are not mutually exclusive. All of those steps imply marginal adjustments, not major transformations or abandoning the social insurance principle, and none entail drastic cuts in public programs with substantial shifts in financial burdens to older people and their families (as noted by Reno and Lavery [28]). Many if not all of those options have been widely tested and implemented across the industrialized world without causing great disruption.

Brief, there is need for a detailed analysis of the changing labor market, based on realistic scenarios of work patterns of all age groups before drawing policy recommendations merely based on (current or future) elderly dependency ratios.

Some politicians have proposed to increase immigration to counterbalance the projected population decline. That might work on the short term, but does not provide a viable long-term solution [82]. It would require record-setting numbers of working-age immigrants to offset population decline. Further, immigrants are aging, too, and will themselves become beneficiaries of pensions and other provisions for elderly citizens [83]. The current heated and emotional immigration debate in the US and other countries does not seem receptive to this notion (there is hardly support for option to open the way for the 10 million or so illegal residents of the U.S. to become tax-paying citizens and thus contributors to the social insurance, and much resistance against inviting more refugees from Syria, let alone a substantial increase of other immigrants).

Pensions versus Health

While there is an obvious direct relation between aging and the cost of pensions, that is not the case for health expenditure, we showed. All countries in Western Europe and North America have witnessed rapid rises in their health expenditure in the past decades, but some nations have been more successful than others in reining in costs. Most if not all used a mix of ‘old’ and ‘new’ cost control measures [84]. The traditional instruments include budgets, price controls, and restrictions on medical education and hospital capacity. In several European countries, as in Canada, central or regional governments set overall spending limits as well as budgets for hospitals and other health spending categories. Most countries also control pharmaceutical
expenditure by setting prices, implementing drug formularies, and bargain with representatives of hospitals and physicians over payments and fee schedules. They seek to influence patient behavior by providing information about medical treatment alternatives and healthy behavior. Cost control measures also include critical assessment of new technology. For example, Australia requires pharmaceutical companies to present proof of cost-effectiveness of new drugs before allowing them to enter the market. In the UK, the National Institute for Health and Clinical Excellence (NICE) assesses the cost-effectiveness of new medical treatment. None of those curtail access to healthcare for elderly patients, or shift the financial burden disproportionally to this population group.

Policy makers in some countries discussed financial incentives for patients and competition between healthcare providers and insurers as new directions in health policy, and a few actually implemented market-oriented policies. For example, Switzerland (in 1995) and The Netherlands (in 2006) introduced health insurance mandates for all residents, administered by private insurance in the expectation (or hope) that that would help rein in health spending. The results have not been very promising as both countries saw an acceleration of market concentration, cost escalation and decline of public trust in health insurers [85]. The new ’markets’ did not do away with the need for substantial government regulation.

The effectiveness of policy measures depends on the political willingness and power of policy-makers to act and to use collective bargaining power at the national or regional level. There is no magic bullet for any one course of action, but the international experience shows that certain policies have been more effective than others in reining growth of health expenditure--without dramatic cuts in the services for older people or shifting costs to elderly patients. That is not a matter of ideology or political preference, but common sense in using evidence of what works and what does not. The percentage of our resources that we dedicate to healthcare, compared to other spending categories, is a political, not a technical decision. In the rich democracies, spending more than 10 percent of national income on healthcare may be unnecessary or wasteful, but it certainly is not unaffordable.

CONCLUSION

The policy debates around aging, pensions and healthcare provide many examples of reframing issues. For example, the very definition of elderly shifted within one or two generations from ‘deserving beneficiaries’ to ‘greedy geezers’ perceived as a growing drain on society. As another example, the intergenerational-justice debate reframed the ‘dependency ratio’ from its traditional definition of the ratio between working and non-working individuals to the ratio between workers and elderly dependents.

We used the term “The Bright Side of Aging” to emphasize that the framing of the issues of aging of our populations in very alarmist terms had led to misguided and disproportionate policy proposals. Instead of labeling everybody over 65 ‘elderly’ or ‘old’, we argue it is more appropriate to label the share of population over, say 75 or 80 as ‘elderly’ instead given the current life expectancy rates. The actual retirement age has been rising in many countries, especially for women. Most of us between 60 and 80 are healthy and live independently, and do not feel that the label ‘old’ applies.

Finally, we showed how the reframing of the issues in the debate about aging led to zigzagging policy perspectives and proposals: from general pension and health insurance schemes for deserving elderly to means-tested tax subsidies for greedy geezers to buy insurance; from broad income protection by federal social insurance to narrowly defined welfare support for the very poorest at the state level; from popular government-sponsored social insurance (Social Security, Medicare and other programs for the elderly) to programs under attack, with government that apparently need protection by conservative radio talk show hosts.

Similarly, the debate about the future of the Patient Protection and Affordable care Act (ACA, or Obama care) during and after the 2016 presidential elections showed how the “repeal and replace” slogan of the Republican presidential candidates gradually morphed into “repeal without replacement”, to “repeal and perhaps replace later”, towards a much vaguer statement about a future plan to deliver “something within a year (or so)”. The internal division of the Republican party about the future of Medicare and Social Security, the two largest social insurance programs--combined with the promise of President Trump that he would protect those two programs in place—means that we cannot expect major change towards privatization of a voucher model any time soon.

The debate and current political situation also illustrate how proposals for policy change, or actually implemented policies, can take shape as transformative change or more covert change sometimes labeled policy drift, layering, and conversion, or--in term of the previous generation of political scientists--just marginal policy adjustment or ‘muddling through’, as the most dominant forms of social policy making. Examples of the former are the proposals to replace Social Security or Medicare with vouchers (tax subsidies) for low-income elderly to purchase private insurance. Examples of the latter include, in fact, almost all of the examples of policy adjustment presented in this last section. Muddling through does not sound very stately, but it may be the most effective way to deal with the issues and problems of our time.

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