

Introduction

In the concluding chapter of her book entitled *Aging in Early Industrial Society: Work, Family and Social Policy in Nineteenth Century England* Quadagno (1982) states...“The general trend in research on older people has been to study them in isolation, independent of the economy, the polity and the general structure of society. A central theme in the literature has been adjustment to old age or changing social roles in later life, the expectation being that adjustment should vary according to residence, gender, race, or some other exogenous factor”. In her analysis of the changing status of the elderly and changes in their economic, familial and employment circumstances during the agricultural and industrial revolutions, the need to integrate and interpret changes in the broader infrastructure of the social system was clearly demonstrated if understanding of the changing condition of the elderly was to be generated.

The essays, commissioned for this volume, are an attempt to describe and understand the situation of the elderly today taking into account three major political, economic, and social variations of service provision which can be observed in a number of different national settings. In all developed and most developing societies the welfare state exists or is being introduced but the extent of welfare provision varies substantially. Elderly care varies accordingly, with some countries—Sweden, Denmark and Holland—providing high levels of income support, medical care, sheltered housing in a variety of forms and social services designed to prevent social isolation and the maintenance of community involvement, while others such as the U.S., the former USSR and Poland provide limited social support, income and services. The variation in services and support for the elderly in different countries reflects, at least in part, the extent of development of the welfare state in different national settings. This variation in the degree of development of the welfare state is in turn affected by the political, economic and social values which predominate in different societies. Different degrees of commitment to the principles of collectivism versus individualism for the resolution of social problems differ between—say—the USA and Sweden.

The contributors to this volume were asked to examine the provision for care of the elderly in their respective countries in the light of the broader characteristics of the welfare state of which services to the elderly were a part. Contributors were asked to address the issues of collectivism versus

individualism and distributive justice. Apart from these suggestions, each contributor was free to examine the current state and/or development of elderly care in the way which best explicated the current circumstances and levels of service provision in his/her country. Such 'loose' instructions were expected to and did provide a variety of issues and emphases in describing and analyzing the provision for the elderly in each country.

In the introduction the editors choose to develop a framework of concepts and perspectives which would establish links between elderly care, distributive justice and the welfare state to demonstrate the interaction effects between 'the economy, the polity and the general structure of society' and the condition of the elderly. Then follows the accounts of each contributor's analysis of the provision and extent of services for the elderly in each selected country. Finally in an epilogue we will try to show how and in what ways the concepts developed in the introduction—equity, uniformity, public accountability, individualism, collectivism, institutional or residual welfare state orientation, 'high' or 'low' wage economies—apply to and help to explain the variation in provisions for the care of the elderly in each of the societies represented.

The Welfare State and Distributive Justice: Concepts and Perspectives

Most societies operate some form of a welfare state to protect citizens against expected or unexpected interruptions of social existence such as old age or illness. For the elderly a range of services and provisions are necessary if the complex mix of social, economic and medical problems often associated with old age are to be ameliorated or prevented. A single volume cannot hope to explore all aspects of the welfare state which impinge upon the condition of the elderly. For example, we devote almost no attention to the nature, characteristics and exchange relationships between family units at different stages of the life cycle. Our major focus is therefore restricted to the supports and services which societies provide, qua society, which serve to illustrate varying degrees of commitment to systemic measures designed to meet the needs of the elderly in different countries.

The extent of support for the elderly tends to be related to the overall development of the welfare state. Welfare state development may also be linked to the degree to which collectivist as opposed to individualistic value systems predominate in a given social system. The consequences of this broad distinction are best illustrated by applying these categories to the provision of medical care. While the needs of the elderly are many and varied and medical and social care must often be provided in an integrated and coordinated manner if needs are to be met, the elderly—because of reductions in earning power—often cannot afford medical services without

outside assistance. The distinction between collectivist and individualist oriented societies is particularly useful in examining the allocation of scarce resources and the ways in which national health policies are or were formulated to provide care for the elderly.

A social system which operates with an individualistic orientation may be defined as one which emphasizes the duties and responsibilities of individuals to provide for their medical care; a social system which operates with a collectivist orientation is one which emphasizes the duties and responsibilities of the society at-large to provide medical care for all. Embedded in this distinction is the notion that persons who failed to provide for their medical care are the victims of unfortunate natural events or are, simply, failures. Conversely, those who are able to make adequate provision for their own medical care are successful in the normal economic exchanges of the market place. In a collectivist orientation the financing of medical care is decommodified. Services are made available at zero cost at point of delivery so that those unable or least able to bear the costs of medical care and associated social services necessary for the maintenance of a social existence are not barred from access. The dichotomy between individualist and collectivist orientations is never complete. Most societies use a mix of both orientations in the delivery of medical care services. In Britain a small private sector, providing medical care for those wealthy enough to afford private insurance premiums persists and, in the public sector prescription charges, a regressive tax, clearly antithetical to a collectivist orientation, were introduced to dissuade both patients and primary care practitioners from overutilizing drug therapies for the treatment of minor illness episodes.

In the USA the care of the elderly is largely financed by federal and state governments although co-payments and deductibles are so significant that elderly Americans now pay more out-of-pocket expenses for medical care than they did in 1964, before Medicare was introduced, and that controlling for cost in real terms. But the fiscal situation is made more complex by the confusing mix of public and private funding for other sectors of the medical care industry. Tax rebates to large employers cost more to the country annually than the whole funding of Medicaid, the scheme which provides coverage for the medically indigent. Both Medicare and Medicaid use regulations and policies whose purpose is to drive down hospital and physician costs in the provision of care to the elderly and the medically indigent. Additional financial confusion arises from the fact that somewhere between 30 and 37 million Americans have no medical care insurance and a further 15 million or so (some estimates go as high as 50 million) are deemed to have inadequate insurance coverage. Hospitals, particularly those in the public sector, must absorb the costs of treating the uninsured when they are hospitalized. The need to cover the cost of treatment of uninsured patients is

threatening the very existence of American public hospitals as a recent study from the National Association of Public Hospitals (1991) demonstrates most clearly. The problems of the public hospitals are exacerbated even further, since for many Americans without medical insurance the emergency rooms of public hospitals represent their only source of medical care.

A further factor adding to the increasing cost of medical care in the United States is related to profit. In both the hospital sector and the third party payer market a significant proportion of insurance coverage and medical services are offered on a private-for-profit basis. Costs for medical care are driven upwards by the need to generate and maintain healthy profits for the investors who provide the financing for private-for-profit health insurance companies and proprietary hospitals. Profits and other unnecessary administrative overhead (Woolhandler and Himmelstein, 1991; U.S. G.A.O., 1991), stemming from the large number of third party payers competing in the insurance market, are increasingly recognized as economic factors which in part explain the thirteen percent of the GNP absorbed by medical care in the United States—more than any other country in the western world—while leaving significant segments of the American population without access to medical care.

Of major import and clear relevance to the present project is the extent to which commodification of medical care is a significant component of a country's medical care system and the degree of medical dominance which impinges on both policy issues and the day-to-day administration, management and provision of medical care. There seems to be a clear link between commodification and medical dominance. A fee-for-service payment mechanism for the reimbursement of professional services is a central feature of the commodification of medical care and also seems to enhance the degree of medical dominance within a given medical care system. Nursing homes, for example, might more appropriately be named nursing hospitals since, as Diamond (1986) has so clearly demonstrated, institutionalized care of the elderly is dominated by a medical model of treatment and procedures, rather than by concepts which would enable nursing hospitals to be real homes. A fee-for-service system treats medicine as a commodity like any other in market exchange. Providers charge what the market will bear and consumers are expected to choose between alternative service providers in accordance with the usual principles of economic exchange, quality, cost and effectiveness. It is now, however, generally recognized that the consumer, i.e. the patient in medical care exchanges has little ability to exercise real choices (Gill and Horobin, 1972; Waitzkin and Stoeckle, 1976; Gill, 1978). Physicians control an esoteric body of knowledge inaccessible to the patient which determines both input and outcomes. Physicians decide not only what is wrong with the patient but what treatment modalities are appropriate to

ameliorate or cure the disease condition. Under these circumstances, particularly in a system based on a fee-for-service financing mechanism the costs of the input/outcome equation are determined by only one party to the relationship, the physician.

At the interface between medical and social systems of care medical decisions often determine the extent to which non-medical services may be provided to meet the complex mix of social and medical care necessary to alleviate the problem to be addressed. This is particularly important in geriatric care since declining biological and bodily functions can in part be compensated by the provision of social services whose purpose is to support elderly persons in their current environments through procedures which compensate for declining bio/social abilities. Services for the elderly, therefore, are likely to be affected by the degree of commodification within a medical care system and the element of medical dominance which controls the circumstances in which services are provided. What is to be done?

Decommodification of medical care services would be a first and essential step. This would not, however, deal with the problem of medical dominance in the total array of service provision for the elderly which involves a complex mix of medical and social services if the needs of the elderly are to be adequately dealt with. What follows is a brief outline of a different form of distributive justice which, it is suggested, more adequately and fairly spreads the cost of elderly care and creates the opportunity to generate adequate service provision.

Two principles, uniformity and equity and one process, the direct public accountability of the medical profession through the body politic to the population it serves, would lead to the decommodification of medical care and reduce the element of medical dominance. Uniformity implies the provision of uniform quality of medical services in all geographic locations. Although the USA, for example, possesses a highly favorable physician/population ratio of approximately 400:1 (a higher number of physicians per unit of population than most other Western societies), residents of inner city ghettos and sparsely populated districts often are unable to gain access to medical care, while the suburbs are often over-supplied with physician services. Even what many authorities regard as a current and growing over-supply of physicians in the U.S. has not assured the migration of physicians to all under-served areas.

The second principle, that of equity, requires that medical services should be provided in such a way that no one is barred from access to them. Funding of such a medical care delivery system is probably best dealt with through direct taxation, perhaps with a component of co-payment or deductibles for those in the top quartile of incomes. The U.S. system of taxation is just about the most regressive in the Western world. Indirect taxation is an

important component of both State and Federal government and, of course, is a serious burden for the least well-off. Direct taxation is only mildly progressive and the loopholes are so large that wealthy people may pay little in income tax if they employ competent tax consultants. (Some wealthy people, frequently in the public eye, may not take advantage of all the loopholes so that they may present a favorable public image.) Social Security, a significant charge on low wage occupations, is only mildly progressive.

The third component in the decommodification of medical care would entail the public ownership of hospitals, nursing homes, the medical supply and drug industries and the primary care sector. Physicians would be placed on salary, like most other health care workers; a mechanism which has much potential for reducing medical care costs, as the HMO experiment has shown.

But above all, public ownership of the medical care industry would generate a degree of public accountability in medicine. The body politic would control and be responsible for the allocation of resources to the medical care sector. If nothing else such a procedure could prevent the expensive and unnecessary duplication of medical technologies where, presently, hospitals compete with one another for physician services by offering doctors the full array of high technology procedures to ensure adequate staffing. The city of Denver, for example, has 12 hospitals, 11 of which operate CAT scanners. Current logic forces the question: What is wrong with the 12th hospital? Current data do not enable one to state precisely how many CAT scanners are needed in Denver, but 11 are certainly well above the medical need of the catchment area. Similar arguments apply to the duplication of cardio-vascular surgical units, transplant facilities, intensive care units, with the additional problem that underutilization may also jeopardize clinical outcomes (Enthoven and Kronick, 1991).¹ How irrational it is to attempt to influence distributive decisions through the crude and impersonal process of the market place which takes no account of the medical care needs of the population to be served. Far better to introduce a system where planners, administrators, providers and representatives of the population to be served, exercise their collective wisdom and judgment to determine the allocation and distribution of medical and social services. Morally, the generation of profits from the fear, pain and suffering of people's illnesses and diseases is an obscenity. It is only through adoption of the principles briefly outlined above that the obscenity of private-for-profit medical care can be eradicated.

Any serious attempt to decommodify medical care in the current political climate in the U.S. is unlikely. While interest groups as diverse as organized labor, CEOs of large corporations and representatives of the elderly favor the introduction of a universal form of medical insurance other

forces in U.S. society—the health insurance industry, some physicians, pharmaceutical and medical manufacturing companies, the owners of private-for-profit hospitals and nursing homes (where 70-75% of providers are for-profit entities)—prefer the status quo but with an expansion of public sector funding to enable the less-well-off to purchase medical insurance. Opinion polls suggest that many Americans are dissatisfied with the present medical care system and are willing to support the introduction of reforms aimed at providing a national health insurance program even if it involves higher taxes. Nevertheless the combination of political forces and other pressure groups to form an effective coalition to enforce health insurance reform is yet to be achieved and is unlikely to emerge in the foreseeable future.

This reluctance to address the problems of the provision of medical care in the U.S. seems to be part of a more general lack of commitment to intervene publicly in other areas where the welfare structure is wanting. Public schools are under-financed precisely in those geographic areas where the deprived and the underprivileged are concentrated and where additional resources are needed to combat a wide combination of social insults, unemployment, under-employment, inadequate housing, etc., etc. Western capitalism's most obvious failure is its response or rather lack of response to the dips and swings of the trade cycle. The West seems to have little response to the breakdown of Eastern European economies other than to tacitly accept a massive growth in unemployment in those countries. Domestically Western societies seem equally incapable of eliminating unemployment but provide varying degrees of financial support to the unemployed and some make available re-training schemes for workers made redundant. Moreover, it is only in countries with a highly developed welfare state that unemployment pay and retraining schemes indemnify workers against a sharp reduction in standards of living.

Variations in unemployment insurance illustrate very well the differences in financial support for the unemployed in European welfare states.

Only Belgium pays unemployment benefits permanently but the rate declines with time unemployed. Only Holland, Ireland and Britain provide unlimited income support once unemployment is exhausted by supplementary social security payments, but at very low levels. In the U.S. jobless benefits are unstandardized and vary widely from state to state. Benefits only last for 26 weeks and recently only 42% of Americans out of work were getting benefits compared with 75% in the mid-1970s recession. Tighter eligibility requirements and difficulty in extending benefits beyond the 26-week period in all but a few states account for this reduction of almost a half (*Sun*, June 4, 1991:5). While all developed societies incorporate some degree of welfare provision into their socio-economic structure, the dichotomy between countries with a

TABLE 1
Unemployment Insurance for a Single Person Aged Less than 50 Years

	Maximum duration (months)	% of gross wages Rate (%)	Ceiling on insurable wages (as 1988)**
Belgium	unlimited	60-40*	0.8
Germany	22*	63**	1.7
France	19*	75-57'	5.0
Holland	36*	70	1.8
Italy	6	15"	0.7
Denmark	30*	90	0.8
Ireland	15	85'	1.2
Britain	12	flat	
Spain	24	80-60*	0.9
Portugal	6*	65	2.6
Greece	8*	65	0.7
Sweden	14	80'	1.1

*Depending on employment record

**as proportion of average OECD production worker's earnings

' rate declines with time unemployed

** rate of net wages

' rate is declining function of wage

" 66% in case of redundancy

* flat rate payments fixed at 80% of average wage in industry.

Reprinted in *The Economist*, May 11th, 1991:57 Source: OECD

highly developed welfare state in contrast to those where welfare provision is at a low level is clearly useful to the task we are undertaking. Adequate geriatric care which attempts to meet the social, economic and medical needs of the elderly will be most likely in countries with a well-developed welfare state in which the principles of distributive justice in terms of equity, uniformity and public accountability, influence or control the way in which services to the elderly are delivered.

This distinction between 'high' and 'low' levels of the welfare state is formalized in an article discussing relationships between equality, social solidarity and the Welfare State by Weale (1990). Weale distinguishes between 'high' and 'low' welfare state provision under the terms, respectively, the *institutional* and the *residual* form of the welfare state, in the following ways:

The paradigm of the institutional welfare state is the form of provision that we find in Sweden. High levels of public provision and low levels of private provision are typical in the fields of health care and education. In the field of income maintenance, the emphasis is upon earnings-related benefits built upon a substructure of flat-rate benefits paid from general taxation and not related to occupational provision. The market remains the basic device by which goods and services are allocated and investment decisions made, but it is complemented by an extensive series of policies for countering unemployment, raising the skill levels of the workforce and negotiating "solidaristic" wage bargains that narrow differentials. The paradigm of the residual welfare state remains the United States, with the exception of education provision and some aspects of the social security system. But in the United States there is little public provision for those otherwise able to pay for themselves. There are no family benefits, there is no compulsory health insurance coverage, and the earnings-related social security system still leaves considerable incentives for better-paid workers to take out private coverage.

Further, institutional welfare states tend to share certain characteristics in common:

The Scandinavian and the Continental welfare states share a range of features: access to universal benefits is high and to means-tested benefits is low; the share of "minimum income" benefits in total benefits is low; and the proportion of the Gross Domestic Product devoted to social policy is high. There are differences, of course. The Scandinavian welfare state devotes a higher proportion of its resources to full employment benefits and is more skewed toward meeting current need than matching past contributions, and there are significant differences in management and control. However, both forms seem to contrast with the Anglo-American form of residualism in which access to universal benefits is low and access to means-tested benefits high, and in which the share of "minimum income" benefit in total benefits is high (475-6).

In the case of the elderly the frailties of illness and old age, with the exception of those who die in early old age, are the almost inevitable consequences of the aging process. In the chapters which follow readers can judge for themselves the extent to which each society approaches the institutional or residual forms of welfare state provision.

While the distinction between institutional and residual forms of the welfare state provides a further conceptual tool for comparative analysis, we

must also be aware of the large societal and economic circumstances which distinguish countries and that generate very different economic bases upon which welfare systems are erected. Until recently the major differences in terms of macro-economic organization were to be found between the 'state capitalism' of the former USSR and its Eastern European satellites and the 'mixed' economies of Western Europe and North America.² Today 'state capitalism' in the former Iron Curtain countries is rapidly being dismantled, although it remains to be seen how the populations of for example former Eastern Germany, Poland and even the USSR will react to the introduction of market forces which will steeply increase the costs of food, housing, education and other basic amenities which formerly were controlled to provide a low but essentially guaranteed standard of living. Presumably the forms of welfare provision associated with 'state capitalism' will also disappear. In most cases this may not be a severe loss since medical and social services were often under-funded compared with western countries operating an institutionalized form of the welfare state. In the case of occupational safety and health services, but not anti-pollution programs, formerly East Germany had the most intensive and effective set of provisions in Europe with the single exception of Sweden (Elling, 1986). As unification proceeds it will be interesting to see if the East German example prevails and the well-developed system of OSH provision is adopted throughout all of Germany.

Indeed, the future stability of the former Communist countries is further threatened by the geopolitics consequent upon the annexation of former independent territories (Latvia, Lithuania and Estonia) and the imposition of a 'Soviet' identity upon a landmass containing enormous ethnic and cultural variations which constituted the Union of Soviet Socialist Republics. Will the collectivist ideology, however imperfectly embedded in the 'state capitalism' of Russia and its former satellites, be entirely swept aside or will welfare states re-emerge in the previous territories of Eastern Europe as they begin to re-build and re-arrange their socio-economic structures to accommodate to the new circumstances following the breakdown of Communism? Who knows? Who would be silly enough to attempt predictions upon what will happen in Eastern Europe?

Are the sources of this dilemma to be found only in the distortions of 'state capitalism' in Eastern European societies? Are such circumstances also to be found in Western and North American societies where equally threatening disjunctions to the social order exist and which must be addressed if these societies are to continue to prosper? At this juncture another dichotomy, that between 'high' and 'low' wage economies, may be relevant to the second theme represented in the title of this work—retrenchment or expansion of the welfare state. Westerners object to the lack of political

freedom and expression in Communist countries as do the inhabitants of the USSR, Poland, Hungary, Bulgaria and so on. The inhabitants of these countries similarly object to the limited supply of consumer goods and the low standard of living in Communist regimes. Lack of consumer goods in Eastern Europe is, at least in part, a consequence of the 'low' wage economies of these countries. Under 'state capitalism' 'low' wages represent a form of forced saving which finances state expenditures on large armed forces, support for Communism world-wide and high investments in 'prestige' projects such as space exploration. These forced savings clearly divert current and capital resources from consumer industries. Ultimately guns and satellites are no substitute for butter and better housing and the populations so deprived seek redress through social, economic and political change.

In Western Europe and North America 'low' wage economies most certainly exist while others could be described as 'high' wage economies. In the 'low' wage economies, segments of the population are relatively or absolutely deprived. Moreover, while 'low' and 'high' wages may not be characteristic of all economic segments or classes in a given society the presence and persistence of a 'low' wage segment will have serious implications for social and welfare provision. If the 'low' wage sector also persists throughout the life-cycle then all seven ages of man will remain relatively deprived.³ Poverty in old age is most often the consequence of low pay and/or interrupted employment throughout the adolescent and adulthood work experience as well as earlier childhood deprivation.

Barry (1990:524-5) has described the characteristics and consequences of 'high' and 'low' wage economics in the following terms:

Some countries (e.g., Sweden and West Germany) have a high minimum wage...and then seek to give the work force sufficient training to make its members profitably employable at that wage. In such a set-up, nobody in full-time employment will have an unacceptably low income, provided that there is an adequate scheme of child benefit. For then full-time pay will be enough for everyone to live on.

This approach has much to commend it. To insist that every full-time job should pay a "living wage" makes eminently good sense economically as a way of forcing firms to make efficient use of labor. It is also, I believe, morally obnoxious that people in full-time employment should require their pay to be supplemented to bring it up to a level that is regarded in their society as constituting a decent amount to live on. By the same token, it is also, I suggest, morally obnoxious that firms that pay low wages should in effect be publicly subsidized.

Nevertheless, some countries, such as Britain and the United States, have gone down the low-wage path. Thus, in the past ten years in Britain, the minimum wage legislation covering traditionally low-wage areas (e.g., catering) has been abolished, and the new jobs that have been created have been in precisely such low-wage service occupations, while the jobs that have been lost have tended to be semi-skilled ones with adequate rates of pay. Faced with an economy in which a substantial proportion of jobs fails to pay enough to live on, a government that accepts an obligation to avoid stark poverty (and wishes to ensure that being employed compares favorably with being unemployed) has only two choices. One is the Poor Law approach of making up household income where it falls short of the official poverty level, and this is that approach that has been followed in Britain and (less systematically through the food stamp program) in the United States.

The relationship between poverty and low pay in the United States is well-documented by a recent study by the Food Research Action Center (1991) of a survey of poor people conducted in 1989 when the Federal Government defined a family as poor if its total income was \$9,885 or less for a family of three and \$12,675 or less for a family of four. The study found that almost 12 million children (18 or under) or one in five lived in poor families. In almost two-thirds of these the 'family' (including single parent families) included at least one worker. Nevertheless, two in five poor children live in families in which the father is present.

To put the reality of low pay into clearer perspective consider the following: a single parent family headed by a female (almost 90% of single parent families are headed by a woman) with two children, one school-age, one pre-school. (Currently minimum wage is \$4.25 per hour—\$3.75 per hour in 1989). Assume a minimum wage job for eight hours per day, five days per week, 50 weeks per year.

<i>Income</i>	<i>Poverty Line: Family of Three</i>
\$8,500	\$9,885

This income, \$1,385 below the poverty line, it is suggested is simply insufficient to cover rent of a two-bedroom apartment, travel expenses to work, baby-sitting for the pre-school child and to provide a minimally acceptable standard of living. Savings for holidays and retirement would be out of the question. If this family is to avoid stark poverty, then government assistance

is essential and in the U.S. programs such as Aid to Families with Dependent Children and the Special Supplemental Food Program for Women, Infants and Children and the Food Stamp Program are in effect devices to subsidize inadequate wages, unemployment pay or social security benefits. All these programs require elaborate staffing by administrators and case workers yet the CCHIP revealed 37% of those eligible for food stamps were not receiving them, and, of those eligible for WIC, 55% were not receiving WIC benefits. Not only are these programs inefficient, they also must be serviced by batteries of administrators and case workers who apply strict tests of eligibility before these forms of relief are available to poor people.

As Woolhandler and Himmelstein (1991:1253–1256) have demonstrated, the administrative structure of the American health care system is increasingly inefficient as compared with Canada's national health program and even more dramatically expensive when compared with the administrative costs of the British National Health Service. "In 1987 health care administration cost between \$96.8 billion and \$120.4 billion in the United States, amounting to 19.3 to 24.1 percent of total spending on health care or \$400 to \$497 per capita. In Canada, between 8.4 and 11.1 percent of health care spending (\$117 to \$156 per capita) was devoted to administration." Many factors are involved, additional costs generated by the production of profit in the private-for-profit health insurance sector, the fragmented and complex payment structure, competition among insurers, and the obverse of economies of scale consequent upon the duplication of administrative costs through the multiplicity of third-party payers. Even more bizarre is the increase in costs associated with attempts to improve the efficiency with which medical care services are provided: "The United States spent 37% more in real dollars in health administration in 1987 than in 1983. The recent quest for efficiency has apparently amplified inefficiency. Cost-containment programs predicated on stringent scrutiny of the clinical encounter have required an army of bureaucrats to eliminate modest amounts of unnecessary care. Each piece of medical terrain is meticulously inspected except that between the inspectors' feet."

No study which examines the administrative overhead in the U.S. social system compared with the 'costs' for the delivery of social services to the poor, the elderly, the disabled and other disadvantaged groups has been completed with anything like the credibility, universal estimates and sophistication of Woolhandler and Himmelstein's study of the medical care system. Logico-deductive reasoning would, however, suggest that many of the factors generating waste and inefficiency in the medical care system are likely to be duplicated in the social care system. We have already noted that 70-75% of nursing homes in the U.S. are operated on a private-for-profit

basis. The costs of long-term institutional care are therefore higher than would be the case if such services were provided on a non-profit basis. Waste consequent upon administrative inefficiency and unnecessary duplication of service agencies may also apply to the social service sector. In 1987, the list of social service agencies operating in Boone County in Missouri included 180 different organizations providing services and counseling to the area's inhabitants. The total catchment area covered a population of 100,000, an average of roughly one agency for every 550 inhabitants. Many of these agencies had full time administrative and clerical staff while others used largely volunteer staff. The mix of public, quasi-public and volunteer effort in the social service arena may well represent an extremely high administrative cost per unit of expenditure on clients and services to clients. Certainly many charities including the United Way have been criticized for the high proportion of administrative and other costs deducted from each dollar before donations are passed on to private, quasi-public or public agencies involved in the amelioration or assistance of the deprived and the under-privileged. Attempts, therefore, to compensate individuals and families in the 'low' wage sector through social services seem to mirror the inefficiencies of medical care provision including Medicare and Medicaid, the latter whose purpose is to protect the vulnerable in the medical care system.

The circumstances of people in the 'low' wage sector is made even more deplorable by the absence of affordable housing. Rental units for low-income families are a scarce resource in the U.S. compared with other Western societies. In Britain, notwithstanding the sale of council housing to sitting tenants, the stock of low-rental public housing can represent 20-30% of the total housing stock. In some Scottish cities, e.g. Aberdeen, almost 50% of families are housed in rental properties owned by the local authority in which the rents are affordable to low-wage earners. A recent report by the Center on Budget and Policy Priorities entitled "A Place to Call Home: The Crisis in Housing for the Poor—Baltimore, Maryland," (one of a series of similar studies in 10 other cities, including Birmingham, Detroit, Milwaukee, San Francisco and Buffalo) found that 1) four out of five poor households (those earning less than \$10,000) in the Baltimore area pay more than 30% of their income for housing—the maximum considered affordable under federal standards. 2) 60% of poor white households and 54% of poor black households spend at least half their income on housing, and 3) many households with incomes of \$10,000-\$30,000 spend 30% or more on housing, while only 1% of those with incomes higher than \$60,000 pay that much. A spokesperson for the Baltimore Housing Authority stated that the number of subsidized housing units has remained the same over the last decade and that the number of households on the waiting list is 30,000 with

many remaining on the waiting lists for up to 10 years before they get subsidized housing. (Barancik and Sheft, 1991)

A significant number of low-cost housing units in towns and cities can contribute to the maintenance of an independent existence for elderly persons. Some units can be converted or specially designed to provide accommodations for the frail elderly who would otherwise require long-term institutional care. Such units can be grouped around day-care centers, dining rooms and staff made available to provide intermittent or continuing domestic services, social and medical care services.

The Reagan era, characterized by an enormous increase in defense spending, turned America from a creditor to the largest debtor nation in the Western world and managed to attack and reduce welfare expenditures, particularly entitlement programs. Federal support for education, never a large component of central government expenditure in the USA compared with other Western countries, was reduced and more costs shifted to the states. But of all public allocations for the common good, expenditures on public housing were reduced the most drastically. Disbursement of the sum available to support the development of subsidized housing was fraught with corruption and inappropriate use of HUD funds throughout much of the eighties further reducing the money available to build low-income housing. Retrenchment of the Welfare State was indeed a priority of the Reagan administration.

Some might object to discussion of issues such as low wages, administrative inefficiencies throughout the medical and social service care sector, inadequate public housing and the relationship between low pay and poverty in a set of readings designed to examine the plight of the elderly and the services available to them in a number of different countries. The point is, however, that resources are finite. Even Sweden, which competes with Holland for the title of the most advanced welfare state in the Western world, is beginning a process of retrenchment of its social services, although the planners argue that a reduction in standards will not be noticeable since current provisions are already most generous.

Even the brief comments presented here on the U.S. welfare system demonstrate the degree of underdevelopment of its medical and social care systems and the cut-backs of the Reagan administration (and the apparent continuation of such policies under President Bush) have made the situation even more desperate. More, rather than less, allocation of the GNP to the welfare sector is essential if the 'tail' of poverty, of real as well as relative deprivation, is to be reduced in American society. In this context it should be clear that services and support for the elderly must be viewed, not in isolation, but in relation to the total organization of welfare services and support to all under-privileged groups in American society. It is, therefore,

not sufficient to study the care of the elderly in isolation. The extent to which retrenchment or development of the welfare state characterizes service provision in different countries is important to our understanding of the ways in which geriatric care is provided now and the circumstances under which it will be supported in the foreseeable future.

In a similar vein it is also important to note the dominant aspects of economic activity which operate in the various nation-states under review. A detailed analysis of the economic system in each country to be discussed and compared would be an impossible undertaking in a single collection of readings. Nevertheless, following Offe (1984) some broad categories under which labor power is organized and rewarded may be useful, particularly in identifying those aspects of economic activity which distinguish between 'high' and 'low' wage economies. The social labor power of industrial societies tends to be distributed between different sections and rewarded differently in the various segments of economic activity.

Offe (1984) identifies four such sectors, the monopoly, competitive, and state sectors and a final somewhat differently constituted sector of residual labor power. The *monopoly sector* is characterized by a high degree of organization of the capital and labor market. Price competition is relatively minimal. Labor costs are a small proportion of total costs but wages are high since the unions are strong and labor costs can be passed on through price increases. But even here, international competitive forces are beginning to impact, mostly through international wage competition as well as varying rates of fringe benefits charged against, for example, the automobile industry in different national settings.⁴ Nevertheless in internal markets (i.e. not including imports or where imports are limited by quotas) increased costs can be passed on through price increases consequent upon the monopolistic or oligopolistic supply situation. In the *competitive sector* price competition is greater but still limited since many of the goods and services are produced and sold to the monopoly sector which can again influence prices. Trade unions tend to be less well-organized, cover fewer members of the work force and have less bargaining power both economically and within the larger trade union movement. "The competitive sector is dependent upon the monopoly sector...because the room for maneuver of small and medium-sized businesses is determined both qualitatively and quantitatively by the degree to which they are able to function as suppliers and distributors for the large corporations for whose patronage they can only compete" (Offe, 1984:37).

Apart from the absence or near absence of price competition the *state sector* has characteristics of both the monopoly and competitive sectors. In state bureaucracies and institutions civil servants or salaried employees are remunerated through sovereign political organization principles rather than those of exchange. Salaries are paid through government receipts, but to

some extent the state must take account of wages and salaries in the private sector since it must compete with the private economy for labor power. Trade unions exist but their power to operate in constraint of trade is often severely reduced or even eliminated. Nevertheless, while wage bargaining may not be conducted in accordance with the normal principles of conflict between employers and employees characteristic of the private sector, the notion of a fair wage has often influenced payments to certain categories of state workers to compensate for their loss of ability to strike. Postal workers, for example, in the United States, not only benefit from security of employment but also receive better wages than other occupational categories whose work can be described at best as semi-skilled.

In the *residual labor power sector* market mediated relationships are either eliminated or of limited and indirect influence. Work performed in this sector is virtually decommodified. The payments received by categories such as old-age pensioners, the unemployed, the disabled, college students, and drafted servicemen are transfer payments which are determined directly by political and administrative decisions rather than by economic forces. Employment in the armed forces may be indirectly affected by the broader state of the economy. During periods of depression employment in the army may be very attractive compared with no employment at all, but the amount of remuneration is still a political and administrative decision. The work of full-time housewives as feminist theorists have so ably demonstrated, is outside the forces of the marketplace.

While these distinctions in terms of the four sectors are useful they are not distinct categories. There is considerable overlap in at least three sectors, the competitive, the state sector and the residual labor power sector. In the state sector state industries and services may be in competition albeit limited, with the competitive sector. The Federal Postal System must compete with UPS and Federal Express, for example. Nevertheless the degree of competition is lessened by the need of the state sector to maintain the service component in its operation. The Federal Postal System is unable to control costs by eliminating distributions to areas either nationally or internationally "uncompetitive." The Postal Service must deliver to all of Alaska as well as to addressees in remote areas all over the globe. Federal Express can and does limit its operations to areas which are easily serviced. Many small businesses in the competitive sector and some oligopolies in the monopoly sector are dependent upon government contracts for some or even all of their profits. A good example is the so-called defense industry where all profits may be derived from tax revenues or the sale of weapons and weapons systems to overseas customers.

But it is in the residual labor power sector that Offe's analysis (1984) seems the least effective. It is probable that many service industries would be

unable to operate without the labor of old age pensioners, high school and college students and housewives. Part-time work in the last two decades is an important contributor to service industries as varied as real estate, fast food restaurants, super markets and large numbers of organizations which service the needs of the underclass in both urban and rural settings.

In the service industries an independent existence based on even full time work may be impossible. Even for a single person a gross salary of \$12,000 per annum (after taxes and other stoppages and an allowance for minimal expenses) could hardly be called a living wage and the preservation of an independent existence and lifestyle is likely impossible. In the residual labor power sector it is not surprising that we find a concentration of members of the work force in categories such as old age pensioners, high school and college students and housewives.

This introduction to the readings which follow has attempted to identify major concepts which will guide the reader through an evaluation of each country's system of care for its older citizens. The concepts outlined above may or may not be applicable to a particular society, but we suggest that the basic concerns associated with distributive justice and the extent of the welfare state and therefore service provision, are issues that are implicit or explicit in the organization of elderly care. Moreover, these issues are in turn associated with the nature of each society's social and economic infrastructure, the way in which rewards are distributed and the emphasis upon individualistic or collectivist solutions to the problems to be addressed in complex modern industrial or industrializing social systems. In an epilogue we will try to show how and in what ways each of the concepts developed here—equity, uniformity, public accountability, individualism, collectivism, institutional or residual welfare state orientation, 'high' or 'low' wage economics—apply to and help explain the variation in provisions for the care of the elderly in each of the societies represented.

Selection of Countries

Starting in the late seventies and continuing throughout the eighties a number of countries, notably the United States and Britain, began to reduce their commitments to the welfare state. In both countries reduction in the extent of welfare provision was accompanied by attacks on trades unionism possibly associated with the declining fortunes of liberal, socialist and social democratic political forces. The degree to which political conservatism increased its power base was of course not uniform and the shift to the right was muted if the welfare state was well established in the major sectors of social, medical and economic activity.

Countries were selected to illustrate the differing degrees of contemporary welfare state provision and its consequences for care of the elderly *and* to illustrate the different socio-historical circumstances under which the welfare state had developed in a variety of national settings. A focus upon European and North American nations seemed appropriate to compare and contrast the fairly extensive differences in welfare provision between societies at relatively similar levels of socio-economic development and loose but important socio-historical ties across the Atlantic. Sweden and the USA represent, if not polar opposites, nations in which the degree of welfare state development may be contrasted in terms of extensive against limited welfare provisions. France, Western Germany, Italy and Switzerland represent different points on the continuum between the advanced and limited welfare state systems of Sweden and USA. Canada, particularly in the medical care sector, leans more toward the European as opposed to the USA end of the continuum, yet its major trading partner is the United States and many Canadian industries are dependent upon American investments. In light of the above, comparisons between the various European communities, between them and the North American societies and between Canada and the USA may be particularly fruitful for exploring the relationships between the extent of welfare provision, distributive justice and care of the elderly in countries with fairly similar democratic institutions and economic systems.

The former USSR and Poland represent societies which, until recently, differed markedly from European and North American nations in their political, social and economic institutions and underlying ideologies. The USSR and Poland, although purporting to provide governments representing the interests of the working class were in fact organized as state capitalist societies. In such circumstances government determines the ways in which the surplus product is distributed. To what degree will state capitalist governments be prepared to direct scarce resources to the welfare state and elderly care?

At first sight it might appear strange to include Iceland and Japan when contrasting the development of the welfare state, care of the elderly and the ways in which issues of distributive justice are dealt with in different national settings. In the case of Iceland the rationale stems from the amazing rapidity with which a complex welfare state apparatus, particularly with respect to the elderly, was developed between 1890 and the present day which also encompassed a socio-historical transition from virtually a feudal to a modern economy over the same period. All the Scandinavian countries have well developed welfare state systems and Iceland's historic ties to the Nordic countries may have provided examples of what could be accomplished if a commitment to protect the deprived and underprivileged is accorded high priority. Nevertheless, the Icelandic experience must be nearly unique and for this reason is of interest.

In a similar way Japan is also an example of a society subject to very rapid change over a limited period—say the last 100 years. After establishing an Empire over virtually all of the Far East and the Central Pacific followed by defeat in World War II, in the 1980s Japan was one of the leading economic powers of the late twentieth century. This rapid rate of change was associated with—for a limited period—the emergence and powerful impact of a left wing movement which encouraged the development of a welfare state apparatus. Subsequently, the working class movement lost power but the initial welfare state structure remained, albeit at a less effective and less interventionist level.

The societies chosen, therefore, provide an opportunity to explore the influence of individualism vs. collectivism, equity, uniformity, public accountability, distributive justice, residual vs. institutionalized forms of the welfare state in a number of different social systems each with their own socio-historical precedents upon which welfare mechanisms were built. It is to be hoped that these comparative perspectives will help to clarify the relationships between elderly care, the welfare state and distributive justice and to indicate the extent to which further expansion, steady state, or retrenchment of welfare systems must prevail if the needs of the elderly are to be adequately met.

Notes

1. Enthoven and Kronic (1991:2533-5) state... “We have a proliferation of costly specialized services that are underutilized... in 1986, more than one third of the hospitals in California doing open-heart surgery performed fewer than 150 operations, the minimum annual volume recommended by the American College of Surgeons (Los Angeles Times, December 27, 1988) and such differences in utilization are accomplished by wide differences in charges... “For example, in L.A. in 1986 one hospital performed 44 coronary artery bypass grafts with an 11.4% death rate and median charges of \$59,000, while another hospital performed 770 coronary artery bypass grafts with a 38% death rate and median charges of \$16,000 (*Los Angeles Times*, July 24, 1988:3).

2. The notion of “state capitalism” is a more accurate description of the economics of Russia and its former Eastern European satellites than the descriptor communist. Communism implies a form of government structure in which authority is nested in the hands of organized working class groups. In the previous Iron Curtain countries a political apparatus representative of little more than its own membership constructed an elaborate state bureaucracy which controlled production, the allocation of scarce resources as well as day-to-day aspects of social, political and economic life of its populations. Throughout such societies the distribution of economic surplus was controlled, not through the mechanisms of the market place, but by decisions made by

and handed down throughout the state bureaucratic structure—a form of “state capitalism” rather than a form of distribution in which distributive justice issues were related to the broad needs of the total collectivity.

3. William Shakespeare. As You Like It. Act II scene VII

“Jacques” All the world’s a stage,
 And all the men and women merely players,
 They have their exits and their entrances,
 And one man in his time plays many parts,
 His acts being seven ages. At first the infant,
 Mewling and puking in the nurse’s arms.
 Then, the whining schoolboy with his satchel
 And shinning morning face, creeping like snail
 Unwilling to school. And then the lover,
 Sighing like furnace, with a woeful ballad
 Made to his mistress’ eyebrow. Then, a soldier,
 Full of strange oaths, and bearded like the pard,
 Jealous in honour, sudden, and quick in quarrel,
 Seeking the bubble reputation
 Even in the canon’s mouth. And then in justice,
 In fair round belly, with good capon lin’d,
 With eyes severe, and beard of formal cut,
 Full of wise saws, and modern instances,
 And so he plays his part. The sixth age shifts
 Into the lean and slipper’d pantaloon,
 With spectacles on nose, and pouch on side,
 His youthful hose well sav’d, a world too wide
 For his shrunk shank, and his big manly voice,
 Turning again toward childish treble, pipes
 And whistles in his sound. Last scene of all,
 That ends this strange eventful history,
 Is second childishness and mere oblivion,
 Sans teeth, sans eyes, sans taste, sans everything.

4. Today the power of the unions in the U.S. is limited. Less than 20% of the labor force is unionized and their bargaining power is limited by “a quirk in federal labor law under which employers cannot fire a worker who strikes legally but can give the striker’s job and paycheck to a permanent replacement (*Sun*, July 18, 1991).” In the last 10 years a number of large U.S. companies have used this tactic for breaking legal strikes—Hormel, TWA, Continental, Eastern Airlines, Phelps Dodge, International Paper and Greyhound. President Reagan was able to dismember PATCO through this legal facility which abrogates the right of working people to withhold their labor. Most other industrialized countries outlaw this practice.

On July 17, 1991 the House passed a bill which would ban the permanent replacement of workers striking over economic issues. Predictably the proposed bill

will face much stiffer opposition in the Senate where conservative forces, whether Democrat or Republican, predominate. Equally predictable, Bush has vowed to veto such legislation should it reach his desk.

In the absence of a political party that represents the interests of the working class in national politics, the only protection that U.S. workers can hope for is trades unionism. Without the ability to withhold their labor the working class is powerless to bargain effectively against the interests of capital to reduce labor cost in the pursuit of profit maximization. Clearly exploitation of the working class in the U.S. is more extreme than the situation in most other Western societies—with the possible exception of South Africa.

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