

# 4

## INVESTMENTS IN SOCIETAL FRAMEWORKS FOR ACTIVE AGEING

Ageing takes place in temporal, environmental, and societal contexts – and is shaped by these contexts (see for instance Bengtson & Cutler, 1976; Tesch-Römer & Kondratowitz, 2006; Wahl & Oswald, 2010). One of the best known examples for contextual influences on ageing is the increase in longevity which began to rise in Western countries and Japan around the turn of the 19th to the 20th century and later in the last century took place in other countries around the world as well (Oeppen & Vaupel, 2002). In addition to longer life expectancy, people are reaching old age in better health (Vaupel, 2010). Clearly, these changes in longevity and health cannot be explained by modifications in the genetics of populations, but rather by changing societal and cultural conditions. Changes in societal conditions like improved educational systems, less strenuous working conditions, enhanced health care and a cultural shift towards more adequate health behaviour explain these changes in longevity (Meslè & Vallin, 2011). Taking also self-reported health and other dimensions of subjective well-being (like life satisfaction and happiness) into account, it could be shown (in a world-wide study involving 132 countries) that societal wealth (gross national product per capita) is positively related to the extent of the average happiness in a society (Deaton, 2007). Societal wealth also attenuates the age effect in self-reported health (with age the level of self-reported health declines): In poor countries the decline in health satisfaction with age and the rise in self-reported disability with age are stronger than in rich countries (Deaton, 2007).

These societal characteristics also play a role in the discussion on investments in societal frameworks for active ageing. Despite a general trend towards longer and healthier life expectancy, there are substantial variations between societies. Differences can be seen between developed and developing countries, but also within developed countries in the UNECE region. Following a rather inductive approach, differences (and similarities) between societies will be described as well as suggested interpretations for any differences (or similarities)

found. As a theoretical approach when interpreting societies differences the typology of “welfare state regimes” will be used (Bambra & Eikemo, 2009; Esping-Andersen, 1990). In this approach various types of regimes can be distinguished, namely the social-democratic model (Nordic countries), then Bismarckian conservative-corporatist model (Central-Western European countries), the liberal model (Anglo-Saxon countries), and the still developing welfare states of the Southern European/Mediterranean model and the Central-Eastern/Eastern European model.

Among the comparative studies available in this context, two studies have been the basis for many analyses and should be highlighted here: The Study of Health and Retirement in Europe (SHARE) collects micro data on health, socio-economic status and social networks of more than 45,000 individuals aged 50 or over (Börsch-Supan et al., 2008). Depending on the data collection wave, up to 15 countries belong to this survey, representing different regions in Europe, ranging from Scandinavia (Denmark and Sweden), Central-Western Europe (Austria, France, Germany, Switzerland, Belgium, and the Netherlands), the British Isles (Ireland), the Mediterranean region (Spain, Italy, Greece, and Israel) and Central-Eastern Europe (the Czech Republic and Poland). Lately, the Generations and Gender Programme with its longitudinal Surveys covering 18 countries from UNECE region as well as Japan and Australia is also emerging as major evidence-base for the analysis of family relations in demographically changing societies. The Generations and Gender Survey comprises surveys of nationally representative samples of 18-79 year-old resident population in each participating country, with at least three panel waves and an interval of three years between each wave (Vikat et al., 2007).

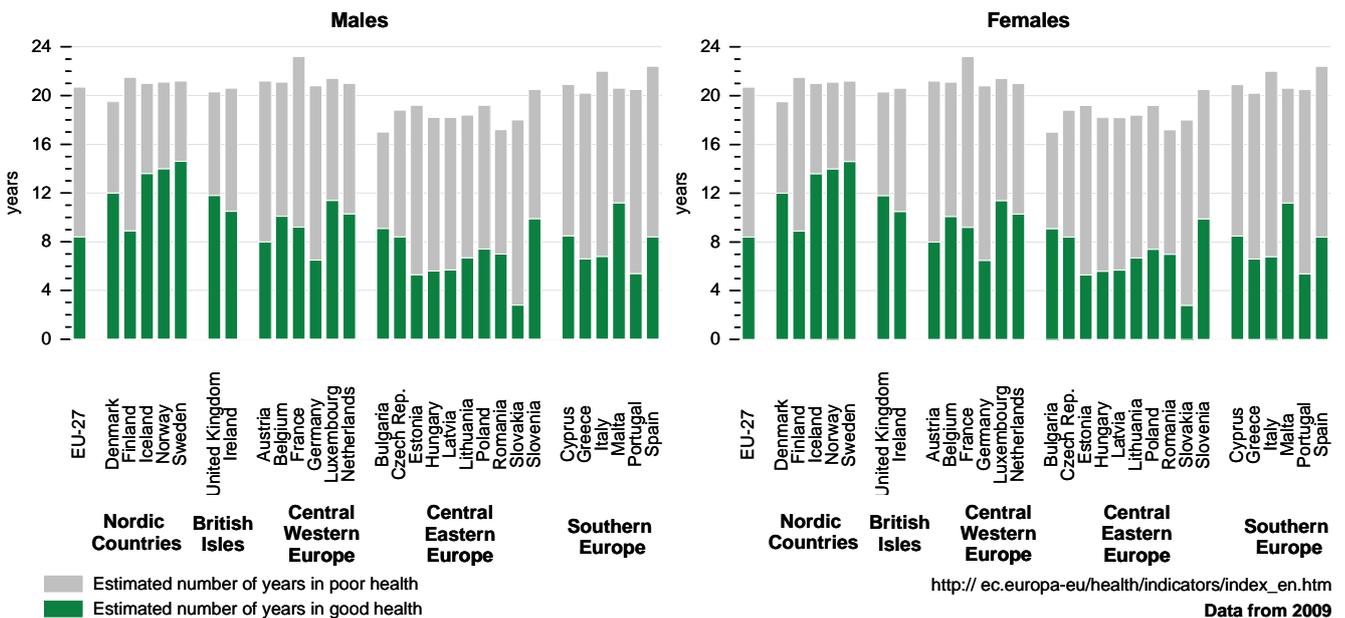
### 4.1 Health

Societies do not only differ in total life expectancy (the life expectancy estimated at birth). There are also marked differences in further life expectancy (e.g. estimated at age 65). This can be seen for the

countries of the European Union (EU27) as shown in Figure 3 (Source: HEIDI data tool). Further life expectancies at age 65 for men range from about 13 years (Baltic countries) to 18 years (Iceland, France, and Italy) and for women from about 17 years (Bulgaria, Romania) to about 23 years (France, Italy, and Spain). With respect to active ageing, even more interesting are the differences in healthy life expectancy, i.e. this part of further life expectancy which is spent without chronic diseases or functional disability. In Figure 3 the years in good health are presented in dark green while the years in illness/functional disability are presented in light grey (total life expectancy is represented by both areas of the column). As can be seen, healthy life expectancies

range for men from about 3-5 years (Estonia, Slovakia) to about 12-14 years (Scandinavian countries) and for women from about 5 years (Estonia, Latvia) to about 12-15 years (Scandinavian countries). In Eastern-European UNECE countries (like the Russian Federation) total and further life-expectancies are similar to the situation in the Central-Eastern European countries (e.g. further life-expectancy in Russia is about 12 years for men, and 17 years for women; OECD, 2011). Finally, it has to be noted, that there are not only differences between countries in the average level of health, but there also substantial inequalities in healthy life expectancy within countries (Jagger et al. 2008).

**Figure 3**  
**Further life expectancy and healthy life expectancy at age 65 in Europe**  
 (further life expectancy: total column size, healthy life expectancy: green part of columns)



There is evidence that the type of welfare state regime is related to the health of adults. Comparing older Central-Western Europeans (50 to 75 years of age) who live in Bismarckian conservative-corporatist welfare states with English and US-American adults who live in liberal welfare states, it could be shown that American adults report worse health than Central-Western Europeans and also than English adults (Avendano, Glymour,

Banks, & Mackenbach, 2009). The impact of social inequality on health was stronger in the U.S. and England as compared to Central-Western European countries (Avendano, Glymour, Banks, & Mackenbach, 2009; Banks, Marmot, Oldfield, & Smith, 2007).

In an analysis of the effect of government expenditure on life satisfaction in 12 European

countries (Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Sweden and the UK), three findings are worth considering (Hessami, 2010). (a) There is an inversely U-shaped relationship between government involvement and well-being (well-being increases with government spending up to a certain point, and then decreases again). (b) For the 12 European countries analysed, it was found that there might be scope for a further expansion of government involvement in health spending in the EU from a well-being perspective. An important condition in this respect is the high institutional quality of European countries (e.g. low corruption, decentralized spending). (c) Highly important is the sector of government spending: Allocating a larger share of government spending to education could raise the levels of well-being in the European countries analysed here.

There are, however, results which show a different pattern of welfare state effects on health. In middle adulthood, unemployment is related to worse health. Although there is a moderating effect of welfare state regimes on the effects of unemployment on health, relative inequalities were largest in strong welfare state regimes (Bismarckian, Scandinavian, and Anglo-Saxon models; Bambra & Eikemo, 2009). Analyzing gender differences in functional health, it was found that women are more likely than men to have disabling conditions, and that men more often report heart disease. These gender differences are quite consistent across different welfare state models (Crimmins, Kim, & Solé-Auró, 2010).

## 4.2 Social integration

The comparative analyses in the literature on social integration have focused on two areas: Societal influences on intergenerational family solidarity on the one hand and loneliness on the other. In respect to intergenerational family solidarity, the relationship between family and state has been discussed repeatedly. Societies can be distinguished by the degree to which care responsibilities are allocated between state and family. Hence, societies range from social democratic states with strong public welfare provisions to residualist states with rather weak public safety nets (Silverstein & Giarrusso, 2010). There is a debate on the relationship between family and state, contrasting the assumptions of “crowding-out” (a strong welfare

state tends to replace the family) and “crowding-in” (a strong welfare state strengthens intergenerational family solidarity; see also Künemund & Rein, 1999). Most studies show, however, that informal support through families and formal support through state funded services complement each other (Lowenstein & Daatland, 2006; Motel-Klingebiel, Tesch-Römer, & Kondratowitz, 2005). In strong welfare states, there is a “crowding in” of instrumental and emotional support given by adult children to their old parents, but a “crowding out” of tasks related to long-term care (Brandt, Haberkern, & Szydlik, 2009). Hence, families and services take over those tasks which they do best. Strong financial welfare state support of older people allows older parents to support their adult children financially (Deindl & Brandt, 2011).

Commonly, it is assumed that Europe is divided into a familialistic South (with strong exchange between familial generations) and an individualistic North (with weak intergenerational family support). Considering the prevalence of different family types (descending familialism: primarily help from parents to children; ascending familialism: primarily help from children to parents; supportive-at-distance: not living nearby; primarily financial transfers from parents to adult children, and autonomous: not living nearby, little contact, and few support exchanges), one can find examples of these family types across Northern and Southern European countries included in the SHARE study (Dykstra & Fokkema, 2011). However, the more familialistic types (descending and ascending families), were most strongly represented in Italy, Spain, Greece, and also in the Netherlands, Belgium, and were least strongly represented in Sweden, Denmark and Switzerland.

Finally, one could ask if social integration has similar effects on well-being outcomes, especially on loneliness. It could be assumed that societies with strong social integration (e.g. generational co-residence) will have a low prevalence of lonely individuals (and vice versa). Data from the Gender and Generation Survey show that only a minority of older adults (4-5 percent) co-resides with children aged 25 or above in Western countries, while the incidence of co-residence is more than 20 percent in Bulgaria and Russia, and more than 50 percent in Georgia (De Jong Gierveld, 2009). This stronger social integration in Eastern Europe does not lead to a lower prevalence of loneliness in these countries,

however. Mean loneliness scores are higher in Eastern European countries than in Western European countries. The protecting effects of social integration via intergenerational family support may collapse when living circumstances are inadequate, societal wealth marginal, and welfare state support weak. In this case, the existence of close family members and the strong normative demand to mutual support may even aggravate loneliness (De Jong Gierveld & Tesch-Römer, 2011). In addition, it has been shown that loneliness among older people tends to be higher in communal societies despite larger family networks in these countries (Litwin, 2010; Van Tilburg, De Jong Gierveld, Lecchini, & Marsiglia, 1998). In communal societies expectations for social contact might be higher – and therefore loneliness stronger. Hence, both social cohesiveness and social norms might influence the relationship between social integration and well-being.

### 4.3 Participation

Two main characteristics of active ageing are gainful employment and volunteering. While people are living longer (and will have a longer working life in the future), fewer young people are entering the labour market. In the future, people aged between 55 and 64 will comprise a large share of the workforce. From an economic standpoint, it makes sense to encourage older workers to stay active and to utilise their skills and experience. Employers may benefit from employing older workers because this means reduction in recruitment and training costs. For the individual, the extension of working life might be seen positive, as well (e.g. continuous interweavement with society, opportunity for self-fulfilment, and higher income relative to retirement benefits). In agreement with this assumption, there is no empirical evidence for general beneficial health effects of the transition into retirement at retirement age. In contrast, early or forced retirement seems to be connected with negative consequences for health (Tesch-Römer, 2009).

Despite encouragement for a long working life, however, there are great differences between countries in the employment rates of older workers (see Table 2; OECD, 2010). While the employment rates of older workers (55 to 64 years of age) are quite high in Northern Europe, the British Isles, and North America (the rates range from about 53 to 83 percent), they are lower in Central-Western Europe

(between 33 and 68 percent), Southern Europe (34 to 51 percent), Central-Eastern and Eastern Europe (31 to 51 percent), and Western-Asia (Turkey 27 percent, Israel 58 percent). The country specific employment rates of older workers reflect among others the combined effects of the strength of the economy and the retirement regulations in these countries. It should be noted, in addition, that there is no trade-off between the employment rates of younger people (aged 15 to 24 years of age) and older people (aged 55 to 64 years of age). It is more likely that both age groups show high employment rates (as in the cases of Sweden, Switzerland, the UK, and Canada) or low employment rates (as in the cases of France, Hungary, Poland, and Turkey). Hence, in the comparative perspective the age groups of younger and older workers do not seem to compete directly on the labour market.

Societal participation extends beyond gainful employment, however. Human capital in the ageing population, which is even growing because of better health and education of subsequent cohorts of older people, calls for expanding volunteer involvement – for the sake of communities as well as older adults themselves. Volunteering depends on the societal context: Societies differ in the allocation of social responsibilities and the expectation of engagement and participation from citizens (Anheier & Salamon, 1998). This can be seen in analyses of the SHARE data set which reveals that volunteering rates are quite high in Northern Europe and relatively low in Mediterranean countries (Erlinghagen & Hank, 2006). In the United States and Canada, too, the volunteering rates are high in older age groups (Dekker & Van den Broek, 2006; Künemund, 1997). In Central-Eastern European countries, however, volunteering rates are rather low, comparable to those of Southern European countries (Anheier & Salamon, 1999; Wallace & Pichler, 2009). Hence, there are parallels between the participation rates in employment and volunteering.

Across countries, education (higher volunteering rates in groups with higher educational status) and health (higher volunteering rates in groups with better health) are important factors which predict volunteering (Erlinghagen & Hank, 2006). This differs somewhat for the role the age of a person plays in volunteering. Two competing hypotheses predict opposite age differences: The “time-budget hypothesis” predicts that

**Table 2**  
**Employment rates by age group**  
(as percentage of population in that age group)

	Persons in employment		
	15-24 years	25-54 years	55-64 years
<b>Central-Western Europe</b>			
France.....	30.7	83.2	38.2
Austria.....	55.9	84.4	41.0
Belgium.....	26.9	80.5	32.8
Germany.....	47.2	81.0	53.8
Luxembourg.....	26.2	80.2	38.3
Netherlands.....	69.2	85.7	50.7
Switzerland.....	62.4	87.2	68.4
<b>Northern Europe</b>			
Sweden.....	45.9	86.5	70.3
Denmark.....	68.5	87.9	57.7
Norway.....	58.0	86.8	69.3
Finland.....	46.4	84.3	56.4
Iceland.....	72.1	88.1	83.3
<b>British Isles</b>			
United Kingdom.....	56.4	81.6	58.2
Ireland.....	46.1	78.0	53.9
<b>Southern Europe</b>			
Italy.....	24.4	73.5	34.4
Portugal.....	34.7	81.6	50.8
Spain.....	39.5	75.3	45.6
Greece.....	24.0	76.6	42.9
<b>Central-Eastern and Eastern Europe</b>			
Hungary.....	20.0	74.4	31.4
Poland.....	27.3	77.5	31.6
Czech Republic.....	28.1	83.8	47.6
Slovak Republic.....	26.2	80.1	39.3
Slovenia.....	38.4	86.8	32.8
Estonia.....	36.4	83.9	62.4
Russian Federation.....	37.0	84.2	50.7
<b>North America</b>			
Canada.....	59.6	82.3	57.5
United States.....	51.2	79.1	62.1
<b>Western Asia</b>			
Israel.....	27.6	73.9	58.4
Turkey.....	30.3	53.5	27.4

volunteering rates and volume should increase after the transition into retirement because there is an increase in disposable time. The “opportunity hypothesis”, in contrast, predicts that volunteering rates should decrease after the transition into retirement because opportunities for volunteering are connected to employment (and fade away in retirement). Societies may differ in the extent of opportunities for volunteering not connected to employment. However, it is too early for conclusions yet. Although cross-national differences in age effects on volunteering rates have been reported, the results vary over the different analyses. This may be due to different methodologies (Hank & Erlinghagen, 2005; Komp, Van Tilburg, & Broese van Groenou, 2011; Künemund, 1997).

#### **4.4 Investments in societal frameworks: Health, integration, and participation**

Looking over the comparative results for health, integration and participation, two questions arise: What are the causes for these differences between countries? Which implications do these results have for societal investments in active ageing? In analysing data from 92 nations, it was reported that societal wealth (gross national product per capita), strength of welfare state (extensiveness of public institutions), economic productivity, and the stability of the political system are relevant predictors of healthy life expectancy (Veenhoven, 2009, see also Veenhoven, 1996). “Citizens live longer and happier in nations where the legal system functions well, where the government is effective and where

corruption is low” (Veenhoven, 2009, p. 14). Clearly, there seems to be a pattern which stimulates active ageing in these three areas. In the context of the SHARE study, “successful ageing” has been defined as the joint occurrence of good health (no major disease, no disability), good functioning (high physical and cognitive functioning), and societal participation (being actively engaged; Hank, 2011a). Comparing the 15 European countries represented in the SHARE study, there are large differences in the rates of people aged 50 years and older who satisfy these criteria of “successful ageing” (Hank, 2011a). The rates of older people meeting these criteria range between about 20 percent of the population 50 plus (Denmark, Sweden and The Netherlands) and around 5 percent and less (Italy, Spain, and Poland). Hence, we assume that the strength of a welfare state – as can be seen in social security systems like unemployment protection, pension system, health care system, and long-term care system – might be connected to societal investments particularly effective for creating opportunities for active ageing. The results we have found reflect the differences between the “welfare state regimes” already mentioned above: the social-democratic model (Nordic countries), the Bismarckian conservative-corporatist model (Central-Western European countries), the liberal model (Anglo-Saxon countries), and the still developing welfare states of Southern European model and Eastern European model (Bambra & Eikemo, 2009; Esping-Andersen, 1990). Especially the generous welfare states in the Northern European countries might be seen as role models for fostering active ageing.