

Support policies for dependent older adults: Europe and Brazil

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Abstract *This theoretical essay discusses long-term care policies for dependent older adults. It aims to analyze the content and strategies that guided the formulation of the so-called “dependence policies” in some European states, seeking guidance to formulate actions related to the same issue in the Brazilian case. The knowledge bases are official documents and scientific papers analyzing the institutionalized proposals. The study shows that all the countries investigated included dependence policies within their social security system framework. Some offer total protection, while others only partial protection to older adults and family caregivers. However, older adults and their caregivers never fail to receive the care they need. In Brazil, some local experiences meet comprehensive care requirements. Initiatives of Belo Horizonte and São Paulo are narrated, and while important, they are not policies. They are successful cases that can evolve to increase social awareness or simply disappear as non-institutionalized experiences. The issue addressed in this paper is very relevant, due to the inexorable fact of the accelerated growth of the long-lived population, which requires care from others the most.*

Key words *Dependent older adults, Public policy, Health services, Long term care*

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Introduction

This paper addresses public mechanisms for the protection of dependent people. It aims to understand the content and strategies that guided the formulation of the so-called “dependence policies” in the European Union, with emphasis on some countries, in search of possible guidelines for the debate and formulation of actions related to the same issue in the Brazilian case.

This is justified because, according to experts who study the consequences of increasing longevity in contemporary societies, the crucial issue today is, on the one hand, promoting active aging, and on the other, covering the care and assistance needs of dependent people, whose number is increased with the accelerated elevation of very old adults¹. The issue is social and economic, as the transformation of demographic and family structures leads to an increased proportion of older adults compared to young people and, consequently, societal aging, which presupposes new sources of expenditure for social protection systems².

The world woke up late to the issue of aging. The United Nations (UN) put this issue on its agenda only after 1956, although it paid little attention to the subject. The UN promoted the “First World Assembly on Aging”³ only in 1982, given the inexorable increase in older adults in European countries. In this event, which was held in Vienna, the milestone of 60 years was defined to consider a person as older adults in developing countries, and 65 years in developed countries. An action plan was also presented to provide economic, social, and integration security for this age group in the countries’ development process. The “Second World Assembly on Aging” took place in 2002 in Madrid⁴. The 1982 Vienna Action Plan was revised in this event, as it was found that the accelerated growth rate of the elderly population also included developing countries. Three priority recommendations emerged from this meeting: engagement of older adults in social development, promotion of their health and well-being, and a guarantee of a conducive and favorable environment for aging.

In the different UN and WHO documents⁵, the notion of old age as a vulnerability gave way to older adults’ view as an active and crucial social group for societies. This positive view persists and is expressly adopted by authors such as Gaymu *et al.*⁶, who predict an increasingly healthy long-lived people. However, there is equally a concern with dependent older adults, which

dates back to the 19th century, and in a systematic and institutionalized way, in Europe after World War II, when specific policies were formulated, in general, proposing joint actions in the health and social assistance sectors, within the framework of the social security system⁷.

Currently, the Pan American Health Organization (PAHO)⁸ has called on countries in the Region of the Americas to strengthen their health and social protection systems to respond to the long-term care demands that will triple in the next three decades, from eight million to 27-30 million by 2050.

In the same vein, the Organization of American States on June 15, 2015, had already approved the Inter-American Convention on Protecting the Human Rights of Older Persons, through a legally binding document. A specific item states that “States Parties shall adopt measures toward developing a comprehensive care system that takes particular account of a gender perspective and respect for the dignity, physical, and mental integrity of older persons to ensure that older persons can effectively enjoy their human rights when receiving long-term care⁹.” Brazil was one of the first countries to sign the Convention. However, it has not ratified it until now since its ratification implies the obligation to adopt measures to implement it. The ratification proposal has been stalled in the Federal Chamber to be taken to the Plenary since March 7, 2018.

The following topics are addressed to meet the objectives of this paper: (1) on which philosophical and normative bases, social protection and care for dependent people have been thought and regulated in Europe; (2) how care has been implemented in a sample of European countries; and (3) the Brazilian current situation.

Methods

Methodologically, this theoretical essay used secondary material and consists of a descriptive analysis on two themes: (1) European social welfare systems, bearing in mind that the dependent older adults care policy is part of their institutional framework; (2) the Brazilian situation regarding laws, norms, difficulties, and possible actions in the face of the situation of dependent older adults. The research to prepare the paper was carried out between January and May 2020.

The themes are treated within a logic that goes from general to particular: (1) the changes in contemporary society and European social

responses^{10,11}; (2) the emergence and bases of the Welfare State¹²⁻¹⁵; (3) the concept of aging and dependence according to the World Health Organization^{5,16,17}; (4) the Council and the European Commission regulation on family, aging and dependence¹⁸⁻²⁰; (5) the position of the Organization of American States⁹ on the situation of dependent people in the Region; (6) official social policies related to security, aging, rights, and services in Brazil²¹⁻²⁸. Other texts support the description of some systems in the selected countries and allow understanding the direction of the institutionalization of each. Finally, two local care experiences are narrated besides papers on aging and dependence in Brazil.

The choice of countries with specific policies for the protection of dependent older adults followed the strategic – almost teaching – objective of knowing how to inspire possible action in the same direction in Brazil. References were selected on Denmark's experience, one of the reference countries in social protection; Germany, whose origins of the protection system have inspired Europe since the 19th century; and France and Spain, as they are cultures closer to Brazil. The appropriation of documents was carried out, focusing on this paper's objective and purpose.

Welfare State and dependent people care policies

The so-called Social Welfare State as it is known today is rooted in the 19th century, but it is a Post-WWII European invention that aims to intervene in the wealth production and distribution process, protecting individuals and meeting their fundamental needs. While applied differently in each country, the proposal stresses that the care provided to any citizen should not depend on anyone's benevolence, as it emerges from solidarity and interdependence between people^{10,11,29}.

Therefore, economic and social policies are thought out in coordinated fashion, reinforcing each other, guaranteeing, at the same time, the generation of wealth and the rights of citizens. Some characteristics distinguish the European Welfare State: its uniqueness among other national security models, and its four freedoms¹⁴ (individual, goods, capital, and the social citizen). It is the idea of a social state that has allowed the tradition of democracy, solidarity, and civil and social rights. The concept of citizenship underlying this arrangement contrasts with unlimited liberalism and the notion of caring for charity³⁰

since it appears that protecting the population is to guarantee human dignity.

How the common philosophical and normative framework is organized is peculiar to each State member of the European Union, and among the typologies with which they are called are those created by Titmuss¹² and perfected by Esping-Andersen¹³. These authors consider a liberal or Anglo-Saxon model that includes Ireland and the United Kingdom; a conservative-corporate or continental one that encompasses Germany, Austria, Belgium, France, Luxembourg, and the Netherlands; and a Social Democrat or Scandinavian, gathering Denmark, Finland, and Sweden. Added to this categorization, some authors mention the so-called "Mediterranean model" composed of Spain, Greece, Italy, and Portugal, with different characteristics from the three and late, which has developed after the fall of the dictatorial regimes that marked them, from 1970^{15,31,32}.

The Anglo-Saxon model is characterized by the residual role of the State, which is restricted to ensuring that specific social groups' fundamental needs are met, notably those that are unable to survive on their own. Caring for others relies on insurance systems and State incentives, mainly through tax exemptions. In the continental regime, the State assumes a more critical role than the market and less relevant than the family. Access to benefits depends on the payment of contributions, the primary financing mechanism. The model is characterized by a high degree of labor market regulation, aiming to ensure stable employment and meet the household's needs through wages and benefits. However, no one, even outside the labor market mechanisms, is left unprotected. The Scandinavian model is characterized by the central role of the State concerning the market and the family.

Access to benefits does not depend on the payment of contributions, as taxes finance them. The regime is characterized by a high employment rate, especially for women, to reconcile family and professional life. In the Mediterranean model, the State has a more critical role than the market and less relevant than the family. The bonds of solidarity expand to the extended family. Benefits vary depending on the occupation and payment of contributions. For those at risk, care is independent of paying contributions, as taxes^{30,33,34} fund them.

As mentioned earlier, the typology helps to understand reality but does not establish it as it changes and adapts to historical contexts. For

example, while keeping its protection policies, the European Union currently faces issues that require reinforced creativity, considering that the elderly population will practically double, from 85 million in 2008 to 151 million in 2060. The number of people aged 80 and over are expected to triple, from 22 million in 2008 to 61 million in 2060³⁵. Greater longevity increasingly pressures social security systems. According to Fargues³⁶, this demographic movement calls into question size, wealth, and the social contract, as the world population will continue to increase, and the European population will stabilize or shrink. The number of workers will decrease in a movement combined with the unprecedented increase in the elderly population. *Despite reflecting a universal trend, population aging is twice as sharp in Europe than the rest of the world*³⁶.

The European continent has long been concerned with the increase in dependent older adults. A seminal document was that of the Committee of Ministers of the Council of Europe, with recommendations for all member countries of the European Union (EU), urging on the need to protect dependent people and establishing some general parameters of action¹⁸. Dependence was defined as the need for help or assistance to carry out activities of daily living, or as a state in which people find themselves, for reasons related to the lack or loss of physical, mental or intellectual autonomy, and that, for this reason, they need assistance and help in daily life, mainly to perform personal care. In this recommendation, several practical elements were established and guided countries. Many studies have been conducted on the subject by European Commissions¹⁹, among which, the one prepared by Spasova et al.³⁷, a study by “The European social policy network” called “Challenges in long-term care in Europe, a study of national policies”.

In this evaluative text³⁷, the Commission points out that the provision of Long-Term Care (LTC) in Europe is characterized by significant differences between and within member countries, mainly in the way it is organized, (whether by public, for-profit or non-governmental entities); provided (home care or institutional care); financed (in cash, benefits in kind, or direct payments); and the way resources are generated (by general taxation, mandatory social security, or voluntary private insurance). It concludes that a substantial part of the LTC is exercised by informal family caregivers. However, the extent to which this care is complemented by formal and public care varies widely and is a hidden econo-

my: the personal and domestic services sector has one of the highest undeclared work levels.

Examples of policies and actions in favor of dependent older adults

As already mentioned, the cases presented here follow a descriptive, analytical, and strategic logic. The countries mentioned fall within the classifications of Titmuss¹², Esping Andersen¹³, and Rhodes et al.¹⁵.

Denmark – The Danish public sector has an essential record in protecting older adults. Those requiring care can choose between public, private, relatives, neighbors, friends, or acquaintances responsible for assisting them. Taxes finance the social welfare policy. Administrative responsibility for care lies with the municipality that offers residential or nursing home care through professional assistance. Home care is provided as personal help and support in household chores. Being a family caregiver is an option, no one is forced. However, the subject providing care has an employment contract that guarantees payment, under certain conditions such as hourly wages. The provision of care must exceed 20 weekly hours³⁸. If necessary, the municipality may require caregivers to participate in courses or training. The municipality must find a replacement if they become ill or go on leave. It is unusual to find relatives taking care of older adults, which is more common in ethnic minorities. It is noteworthy that the commitment to social protection and the well-being of dependent older adults is defined as an investment and not as an expense, as it promotes economic stability and decreases risks of diseases and hospitalizations³⁸.

Germany – Social Law XI 1, the “German long-term care insurance” of January 1995, is part of social security and addresses the financial provision for those in need of care. This law introduced the so-called fifth pillar of social security into society, alongside the right to health, accident insurance, pensions, and unemployment insurance. This pillar finances care for older adults who need it based on their contributions in their paid jobs and private insurance contributions. The law primarily aims to enable older adults to receive home care from their relatives. Older adults must prove that they have physical needs due to illness or disability to enjoy legal rights. The level of need determines the payment for the number of weekly hours of service³⁸. The benefits received by the dependent population cover three

stages according to the degree of loss of autonomy. For each case, a report is made by the health insurance medical service to establish the value of the benefit. In Germany, the relative of a frail older adult must qualify and test his health status to become a family caregiver. The amounts paid to the family for providing care are legally fixed and depend on the care level. Critics consider these contracts very penurious: the level of remuneration is clearly below the standard salary level in Germany, and caregivers have no labor guarantees. Although they receive four weeks off, if they get sick or go on leave, they are not paid that time off³⁸.

France – In France, public policies for the social protection of older adults requiring long-term care have been in place since 1990. The “Universal Service Employment Check” allows families to seek helpers to care for older adults or perform household cleaning services in their homes. The Customized Autonomy Allocation was created in 2002 and benefited any dependent person aged 60 or over. The amount depends on the degree of dependence, the beneficiary’s income, and whether older adults live at home or in an institution³⁹. Currently, a project to assist dependent older adults is in progress in the French Senate. This proposal’s premise is investing in home care and reducing spending on long-term care facilities (LTCF) (today, 85% of dependent older adults in France stay at LTCFs). The assumption is that offering financial and care support resources to older adults at home has a positive impact on ensuring well-being, longevity, quality of life, and has significant effects on the treatment of chronic diseases, disease prevention, and health promotion⁴⁰. This bill is comprehensive and focuses on the following points: (1) create a frailty tracking program, as per the recommendations of the “Integrated Care for Older Adults”, developed by the World Health Organization¹⁷, by dependence and functional disability levels; (2) subsidize the adaptation of households to avoid falls; (3) create an application aimed at self-assessing needs and providing individualized guidance. Such measures are expected to be financed by the 0.3% pension tax, established in 2013.

Spain – The social protection model, based on local and family mutual aid, marks the Mediterranean countries, which is the case in Spain, where the issue of dependency, which has always been the responsibility of the family, has gradually changed⁴¹ and has become a matter for the State. The Law for the Promotion of Autonomy

and Care to Dependent People approved in 2006⁴² crowns a huge movement of citizens, researchers, and social and health service professionals. This law recognizes the care provided to people who are losing their autonomy as an individual right. Its most essential principles are universal access to care, the collaboration between social and health services, and participation of the private sector and the third sector in providing services. The law establishes (1) engagement at all levels of public administration (central government, autonomies, and municipalities); regulation of the service catalog by the level of dependence; (3) criteria of quality and efficiency in the provision of services; (4) professional qualification; and (5) rules and sanctions for violations against the rights of dependent people⁴³.

Services for dependent older adults are a priority and primarily provided in the municipalities. They include prevention and promotion of autonomy, home teleassistance, help with domestic chores, day and night centers, institutionalized care and economic benefits linked to the family care service, technical assistance, and home adaptation. An economic benefit can also be triggered and depends on the level of dependence and financial capacity of the beneficiary. It aims to allow dependent people to hire a caregiver for a certain number of hours to assist them in basic activities of daily living⁷. The family caregiver can also receive financial assistance and information, training, and rest periods are guaranteed. Institutional responsibility for compliance with the law lies with the “Ministry of Health, Consumption and Social Services”, through the “Institute for Older Adults and Social Services of the Secretariat of State and Social Services”⁴³.

What Brazil has done for dependent older adults: laws, regulations, and actions

The Brazilian State has essential laws and regulations for the protection of older adults. The National Policy for Older Adults²³, the Statute for Older Adults²³, and the National Health Policy for Older Adults²⁵ include all administrative and governmental spheres to guarantee the rights of the population over 60 years of age. Regarding the most vulnerable, State Health Care Networks for Older Adults were being built²⁴ even before the Health Policy²⁶ was implemented. Officially, the Health Policy²⁵ proposes that all levels of the SUS be attentive to the vulnerable elderly population defined as older adults living in LTCF, who are bedridden, recently hospitalized for any rea-

son, with diseases that cause functional disability due to stroke, dementia syndromes and other neurodegenerative diseases, alcoholism, terminal neoplasms, amputated limbs, functional incapacity to perform basic activities of daily living (ADL), living in a situation of domestic violence, and aged 75 years or older.

Within Social Assistance, the relevant National Council approved Resolution N° 109, of November 11, 2009²⁷, which defines and characterizes social assistance services, organized by levels of complexity: basic social protection and special, medium- and high-complexity social protection. The latter includes older adults and people with disabilities for whom protection is provided in a shelter, home, transit home, inclusive residence, or dormitory reception service.

The Ministry of Welfare and Social Assistance²², through Ordinance N° 73, since May 10, 2001, already established rules for the functioning of services for older adults, defining care modalities, respecting complexities and specificities. For the most vulnerable, the prescribed modalities are community center, day center, home-nursing home, home care, and comprehensive institutional care. Importantly, from the viewpoint of social protection, 84.3% of older adults receive retirement benefits, pension, or the Continuous Cash Benefit (BPC)⁴⁴. Moreover, recently, the Superior Court of Justice established the thesis that, once the need for permanent care from a third party is proven, an increase of 25% is due to all types of retirement benefits as provided for in Article 45 of Law 8.213/1991²¹.

Despite the legal and normative apparatus in Social Security, Health, and Social Assistance, most of those who suffer from the loss of autonomy live under the sole protection of their families⁴⁵. In the Pension Reform that has just been approved²⁸, nothing has been proposed to protect people who, to varying levels, lose their physical, mental, economic, and social autonomy, despite the accelerated growth of the population over 80 most vulnerable to dependence.

Camarano et al.⁴⁶ mention that at least three types of action would need to be ensured for Brazilian dependent older adults and their families, namely, day centers, long-term care facilities (LTCF), and family support. Day centers, in general, are insufficient in their responses: the number of Social Assistance Centers is negligible in the face of needs; many dependent older adults at initial levels who could benefit from this support have difficulties in accessing these places; and multidisciplinary activities that pre-

vent the loss of autonomy are scarce. Only 3,548 LTCFs are available in a continental country like Brazil, of which only 6.6% are public, and more than 60% are nonprofit and underfunded. A total of 83,870 people over the age of 60 live in them, representing less than 1% of the Brazilian elderly population⁴⁷. Now, if less than 1% of the elderly are in LTCFs, most of the dependent ones – 34.5% of the total elderly population, according to the National Health Survey (PNS) carried out in jointly by the Brazilian Institute of Geography and Statistics (IBGE) and the Ministry of Health (MS) and analyzed by Lima-Costa et al.^{48,49} and Malta et al.⁵⁰ – are under family care. This reflection leads to the conclusion about the State's omission concerning the most vulnerable older adults. A consensus among scholars is that people with functional disabilities and social problems, among them older adults, suffer the most and are victims of violence, neglect, and abandonment^{1,44,51-53}.

Some good multidisciplinary practices with a focus on dependent person care are available. However, they are specific, albeit very relevant experiences, due to their potential for universalization through public policy. We mention two cases that articulate specialized and primary care, one of which is located in Belo Horizonte and the other in São Paulo.

One of the initiatives occurs in Belo Horizonte and is called *Programa Maior Cuidado* (“Greater Care Program”). This program started in 2011 in a partnership between the Social Assistance Reference Center (CRAS) and the Family Health Strategy. Through this collaboration, dependent older adults and their families are selected to have formal caregivers on specific days and times, according to the level of need assessed technically. A care plan is built with older adults and their families for the program participants. The collaboration of Social Assistance and the Family Health Strategy ensures adequate actions with a focus on well-being and minimizing problems. The program monitors currently about 500 older adults per month and primarily serves the most impoverished ones. Assessments show that this group's demand for hospitalizations and admissions at the LTCF has decreased. The financial resources that maintain the program derive from the municipality's tax collection⁵⁴.

Another initiative is the *Programa Acompanhante de Idosos* (“Elderly Companion Program”) (PAI), promoted by the Municipal Health Secretariat of São Paulo in 2002. It includes evaluating and monitoring the specific case, elaborating a

care plan, and providing continuing education to companions. It currently has 22 joint health and social assistance teams, with specialized training in geriatrics. The proposal results from a partnership between the Family Health Association, the *Nossa Senhora do Bom Parto* Social Center, and the Superintendency of Health Care of the Civil Service of the Civil Construction, and aims at home biopsychosocial care for older adults in situations of clinical and social frailty. They receive support for activities of daily living and to meet other health and social needs⁵⁵.

In summary, comparing Brazil's situation with that of European countries regarding dependent older adults, we can conclude that there is a lack of purpose and focus. In the European case, the European Union and each member country have invested and are investing in the promotion of State policy on care, responsibilities, the definition of practices, and an indication of the sources of income to assist dependent people, mostly older adults⁷. The philosophical foundation of such postures and decisions, as Jones¹⁴ recalls, is the idea that values the "social citizen" in "a society for all ages". As the issue is addressed in Brazil, effective action that deals with dependent people and their families' real needs is almost impossible, as we conclude below.

In many cases, the initiatives of the three government departments responsible for elderly-related policies overlap. Most of them do not leave the paper or do not meet older adults' demands in their reality. In social services, most of the proposals do not have registered funding and depend on intersectoral articulation. In health services, older adults are invisible in their specificity, and it is up to them and their caregivers to compete for care. The maximum that low-income households can achieve today – except for some localized programs – is the specific care provided by the Family Health Strategy, the Family Health Support Centers, and the Social Assistance Centers. More impoverished people have to count on the community's solidarity, NGOs, and religious entities that obtain some donations, for example, of diapers and wheelchairs. Home adaptation and living conditions are precarious. There is a lack of guidance and training for families, in particular for caregivers. Few day centers or vacancies in LTCFs are available. A fundamental issue identified in a recent survey on dependent older adults and their families⁵⁶ is that there are no mobilizations of these social actors in defense of

their rights, although they are the most interested in obtaining social and state support.

Final considerations

This paper only exemplifies what the European Union and Brazil are doing for dependent older adults currently. Why is Europe targeted? It is because the Social Welfare State works in this region of the world, even with all the flaws pointed out by critics. Europe's Social Welfare Policy has been guaranteeing the aging population's rights and qualified care for dependent people by tracking weaknesses and vulnerabilities, which has generally been the result of joint work between the health and social assistance sector working with formal and informal caregivers and technical support.

The Brazilian case deserves considerations for the laws' generosity and the absence of effective measures to comply with them. The central problem is that the issue of dependence is not approached. The positive cases of action mentioned here are significant because they signal possible avenues. However, these examples are not policies. There is an urgent need to work to include the protection of dependent older adults in the Brazilian government's agenda and to ensure that it is not just a matter of family responsibility. The lesson that successful countries in providing adequate support for dependent older adults teach us is that a good policy in favor of this social group combines guidelines: a balance between public, private, social, and family responsibilities, understanding that keeping older adults in their own homes is preferable to institutionalization. However, adequate home care requires investing in family caregivers, supporting them in knowledge, practices, and financially.

In conclusion, this paper has several limitations. There has been no exhaustive search for official documents or authors analyzing and criticizing dependence policies in Europe. Also, the Brazilian bibliography on dependent older adults has not been thoroughly inspected. However, the contribution of official documents and analytical references allows the reader to make his judgment about the urgency of a specific policy for older adults depending on the care of third parties in Brazil, which is the ultimate objective of this reflection.

Collaborations

MCS Minayo coordinated and was the main responsible for the work elaboration. JMB Mendonça and GS Sousa contributed to the theoretical-methodological elaboration and analysis. RMN Mangas and TFS Pereira contributed to the literature review and to the final reading of the material.

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