Perspectives of Silver Economy in European Union

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Abstract

The concept of silver economy*, whilst relatively new as far as terminology goes, is, actually, relatively old – at least, in the sense long-term dynamics* made*, actually, what we now know silver economy to be; also certain is the fact both silver economy and its known or obscure of its characteristics and, more importantly, long-term repercussions make up today several subjects of active debate for European Union's management, first of all for European Commission.*

One of most important subjects is the economic one, namely the requirement of an economic strategy needed, on one hand, for designing structure and content real economies around EU will have to build up in relation to *their respective social economies, if both are to work optimally (or almost), and, on the other hand, for specifically bolstering up specific sectors of EU's real economies, especially the health sector.*

Keywords: *silver economy, population ageing, care system, social equity, EU*

JEL classification: E24, H51

1. Introduction

The subject of ageing populations, that is – in plain terms – of nations around the world, and especially (if not exclusively) in industrialized states (and economies) comprising ever-larger proportions of senior citizens (e.g. men and women over 60 years old) is, without doubt, nothing new – at least, not in the second half of 20th century AD. However, until no more than a couple of decades before, *silver economy*, in the sense it is nowadays used – inclusively in this paper – was basically unknown, in fact *not yet invented*.

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One of the reasons, if not most important one, is both politicians and economists thought they knew, and, in fact, really knew how to deal with old people on an individual basis, or as the 'decent-sized' minority they constituted in the '60s, '70s and even the '80s, but, starting from the last decade of 20th century, numbers of senior citizens rose, year after year, more or less dramatically – if compared with previous increments (Popescu et al., 2015).

From this perspective, in this paper the authors undertook the task of demonstrating that, as a result, at least in European Union, *silver economy* is bound to alter, at least, or to structurally update, at most, both future labor EU policies as regards population over 50 and EU's (actual) health system, whose main strategy could very well be, in the foreseeable future, unlike today, prevention-oriented.

2. The concept of silver economy

Any analysis of present-day *perspectives* of *silver economy* in European Union must be based on a sound understanding – and, for this, outlining – of *silver economy* concept; all the more so, as *this* concept is somewhat obscure, whereas its factual substance (e.g. large throngs of old/very old men and women) is anything but.

According to an *official* definition – the definition accepted as such by the governing body[1] of European Union, that is –, *silver economy* is the amount of 'the economic opportunities arising from the public and consumer expenditure related to population ageing and the specific needs of the population over 50'.

In other words, *silver economy* is not quite a (real) economy having an autonomous existence, but a component of real economy – one whose *opportunities* are, in the same time:

- precisely defined and, more important, precisely identified and
- on a clear-cut path of (until otherwise proven) steady expansion (e.g. in size, that is in quantity – of potential customers, etc.).

Population over 50, which constitutes, for *silver economy*, its aggregate demand is *still* on the increase due to two main phenomena, who both reached peak performance, so to speak, in late '70s or early '80s: an increase in longevity and a drop in birth rate.

Nowadays, at least – i.e. in 2013 –, in European Union, on average, one of four persons aged between 15 and 64 is over 60; and, likewise, some measures are being taken for managing this intensive phenomenon (Istudor and Petrescu, 2016). That is, considering *silver economy* bleeds EU states dry – financially speaking –, every year now, up to almost 25% of GDP[2] (or *circa* half of total state (budget) expenditure), European Commission is, now, striving for enhancing specific economic sectors, activities and/or dynamics, such as (European Commission, 2015):

[1] The European Commission.
[2] And, respectively, \$7 trillion per year worldwide.

- ✓ (sustainment of) new markets such as renovation of building stock for independent living, and low-season (senior) tourism;
- ✓ sustainable long-term care systems;
- ✓ innovation at EU-scale for active and healthy ageing through;
- ✓ social investment approach to social protection systems and services.

Given this rise in numbers of (disabled) senior citizens, whose care, among other state-funded senior-oriented social and economic dynamics is, year after year, more expensive, efforts designed for *building up* a sound and sustainable *silver economy* must take into account two main challenges the existence of *silver economy* poses to real economy:

(I) a definite emerging of new consumer markets – or, more precisely, of an *extra* part of (total) aggregate demand;

(II) a rather urgent need of improving the *sustainability* of state *budgets* constituencies expect to finance this (new) state of affairs.

On one hand, this extra part of aggregate demand is or will be palpable in many an industry, main 'beneficiaries' being the following economic – and social – activities:

- health sector (especially medical devices, pharmaceuticals and eHealth);
- construction of smart homes which support independent living;
- personal and autonomous transport (inclusively actions, programs and services designed for facilitating access of aged/disabled people to public transport services);
- personal banking and e-banking services;
- tourism sector.

It is worth underlining eHealth services is a subject more important than it might seem; according to an official EU study (Eatock, 2015), the estimation is introduction of eHealth in form of ICT and telemedicine services will boost healthcare efficiency up to 20%.

On the other hand, improving state budget sustainability in every EU state as precautionary measure for a sustainable 'integration' of *silver economy* in those states is a big issue indeed; it is indeed big, since *silver economy* is less a producer than a consumer. This is why we consider *silver economy* must be – carefully, if at all – *integrated* in the real economy, for, by definition, aged (let alone ***disabled***) people are not in the least employees/workers, nor can they be. They may earn a pension – which they must use in order to finance their livelihoods –, but not much, or anything, else.

3. Financial and budgetary tools for the silver economy

Managers of real economies everywhere (at least, everywhere in European Union) cannot be very choosy in selecting their financial and budgetary tools; these tools are but a few, first one being already implemented, in Romania inclusively, and planned to be implemented, sooner or later, in every EU state:

I. maintaining in workforce – i.e. as active persons – people aged between 55 and 65;
II. making health sectors and, respectively, healthcare systems less reactive than *proactive* entities, which means, *inter alia*, focusing much more than in the present on:
    a) disease prevention;
    b) promotion of healthy living;
    c) promotion of independent living.

It must be underlined, here, the accent put on (care and mainly) healthcare systems is not a misunderstanding of the whole phenomenon; at least one reliable source[1] makes a point of how much aged people need a sound – term which should be understood, above all, as *well financed* – healthcare system, since many, or most of them are disabled – the number being quite non-equivocal:

- ratio of disabled people aged 55-64 rises to 32%
- ratio of disabled people aged 65-74 rises to 44%
- ratio of disabled people aged 75-84 rises to 60%
- ratio of disabled people aged 85+ rises to 70%.

As consequence, the real – and extensive – problem to be solved is how to *finance* such proactive – and, simultaneously, very active, in more than one sense of the word! – care and healthcare systems. Yes, it is true that, on one hand, *silver economy* growth is bound to bring important benefits to labor market, given all job opportunities it will entail. Healthcare, especially, is, in medium term and also in long term, very stimulating, in this respect: a study concludes (European Commission, 2015) health sector employment will grow, in the interval 2013-2025, much faster (+8.1%) than general (economic) employment (+3%).

But, as it happens in a market economy, at least, where *free lunch* is but a dream, these systems will undoubtedly have to subsidize themselves. Healthcare systems can function only on basis of two organizational and financial models, thus emerging only to subsidizing principles (and, as these principles are applied, strategies) (Maddala and Miller, 1989):

i. the principle to the effect healthcare insurance is compulsory (through state regulation), *and (more or less) free because it is compulsory* (free, that is *state subsidized*) – as it happens, for example, in European Union;
ii. the principle to the effect healthcare insurance is *not* state subsidized (*and* relatively expensive), be it compulsory (as, due to Obamacare regulation, it is more or less the case, nowadays, in U.S.A.) or not – as it happens, Obamacare being included, in U.S.A.

Now, the major difference between these two principles – ***in practice, not in theory*** – is, in first case, ill or disabled people benefit, in real terms, from a *state* (that is, *public*) *monopoly*, whereas in second case ill or disabled people are, also in real terms, disadvantaged by a (nominally, at least) *private monopoly*[2].

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[1] Eurostat.
[2] I.e. U.S.A.'s *Medicaid* (which is, basically, a *government insurance* program) and *Medicare* (administered by federal government, but *based on* cca. 30 private insurance companies).

The actual challenges put forth by *silver economy*, in European Union, where the said state monopoly certainly works a lot better – almost needless to say, without it being perfect or even near to perfection –, especially in terms of *social equity*, than U.S.A.'s private monopoly, but, as we will prove here, each of the two subsidizing strategies of healthcare systems has its merits.

As a consequence, it is reasonable to conclude the best subsidizing strategy for healthcare systems/sectors in a world where *silver economy* are definitely here to stay, and even to grow should be built so as to include, if possible, only the merits of the two subsidizing principles.

A private monopoly works – it must be repeated, not (only) in theory, but in practical terms –, as U.S.A. century-long practice proves it, along following lines:

(A) first thing, as in any multilateral (that is, private carted-based) monopoly, it is sure the price of healthcare insurance *will definitely rise*, compared with the situation in which healthcare insurance market is controlled by an oligopoly, or better – from consumer's point of view;

(B) also, and this is quite interesting (if not slightly unexpected), the *total consumption* of the product – i.e. *medical care* – will, also, ***rise***;

(C) being relatively, or even absolutely, expensive, healthcare insurance will not be bought – and used – by poor(er) people in need, whose consumption level, in this case, will drop sensibly;

(D) in the meantime, those who can afford healthcare services (obtainable, unless part of an emergency situation or natural disaster, through healthcare insurance) will buy, and use, as said, more of it.

A public monopoly has not many disadvantages (Radulescu, 2016), but it does possess a rather major drawback, namely the fact that, in practical terms, it tends to be, let's put it this way, less-than-lavishly financed.

This being said, this is a lesson for all components of *silver economy*, not only for healthcare sector: as *silver economy* grows, steadily, if slowly, low-season (senior) tourism, construction of smart homes and e-banking services, to name but a few of *silver economy*'s components, must be able, simultaneously, to:

1) expand as quickly as possible, as fast as the entity they are a part of – *silver economy* – or even faster;
2) fulfill all needs of aged people, be them ill, disabled or perfectly healthy;
3) finance their very economic and social activities, for which accomplishment they must *charge the right fees* (it goes without saying, without ripping off costumers – as it happens, apparently, in U.S.A., at least as far as healthcare goes).

4. Conclusions

Perspectives of *silver economy* in European Union, without being with necessity rosy, are, nonetheless, not bleak – or, not as bleak as it might seem, from a quick glance. First of all, European public and private initiative is already under way; maybe the most relevant example, from this standpoint, is European Innovation

Partnership on Active and Healthy Ageing, has the main goal of 'stimulating' stakeholders (including end-users and relevant industries) into making possible, above all, and achieving it, in the end, three main goals:

(I) making possible, for all EU citizens, the 'European dream' of ageing *happily* – e.g. by passing healthy, active and independent lives;

(II) improving, financially included, health care systems *and* the social system everywhere in EU;

(III) propping up market competitiveness (which means, without the slightest hint of irony, preventing markets ever becoming *monopolies* – anyway, *private* monopolies!), *at least* as far as innovative goods and services are to be made for the (more or less exclusive) use of ageing EU citizens.

But, symmetrically, there are (more or less) new challenges, for example that thorny issue of what can be adequately called *ageing employment* – which is no mere trifle. In other words, given that for *silver economy* the plan considered feasible, at present, is to be made sustainable by means of continuous and gradual rising of statutory retirement age – i.e. by forcing, one way or the other, ageing people to still work, instead of earning a pension, be it decent or not in real monetary terms –, the pressure (generated by the obvious compulsory derivation of needing to (re)train employees, no matter if young, old or too old) put on labor market, and, in the same time, on real economy will have to be addressed in an effective manner, which will take time and, somewhat important, will use (more) money and material resources.

Anyway, it is clear enough structure of real economy involved in producing goods and services *dedicated* to (at least) ageing people, or (at most) to ageing *disabled/ill* people is an operation not merely probable, but certain – and at least as difficult as the operation of *integrating* silver economy in every EU state' society and, respectively, real economy.

REFERENCES

1. Eatock, D., 2015. "The silver economy. Opportunities from ageing", *European Parliamentary Research Service*, July, PE 565.872.
2. European Commission, 2015. "Growing the European silver economy", *Background paper*, 23 February.
3. Istudor, N. & Petrescu, I.E., 2016. "Sustainable business opportunities in rural areas". *Quality – Access to succes*, 17(S1), 331-336, 14-19.
4. Maddala, G.S. & Miller, E., 1989. *Microeconomics: Theory and Applications*, The McGraw-Hill Companies, Inc., U.S.A.
5. Popescu, M. L., Predescu, A., & Oancea-Negescu, M. D., 2014. "Economic factors concerning development of Romania as future silver economy". *Quality – Access to succes*, 15(S1), 355-358.
6. Radulescu, C. V., 2016. "Sustainability strategies in businesses". *Quality – Access to succes*, 17(S1), 331-336.