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Three competing interpretations of policy problems: tame and wicked problems through the lenses of population aging

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ABSTRACT

This contribution presents competing lenses of population aging as policy problems and it compares their impact on the treatment of policy problems. Three lenses are analysed: intergenerational, biomedical and social gerontological. The intergenerational lens treats population aging as a new form of class conflict along age groups. The social gerontological lens claims that population aging is first and foremost a social issue and it stands in opposition to the dominance of biomedical approaches that treat aging as a pathology. The presence of these three alternative conceptions of the policy problem is indicative of the complexity surrounding population aging and the importance of having divergent definitions of policy problems. Via an analysis of informal care giving in the Canadian context, this contribution also presents a comparison of the three lenses with a focus on the roots of these conceptualisations in various disciplines, their prevalence in various public organisations, and the policy consequences of their strength or weakness.

KEYWORDS

Intergenerational; medical; social gerontology; care giving; ageism; family relationship

Introduction

In industrialised countries, population aging has rapidly become one of the policy problems *du jour*. Publications from international organisations, such as the Organisation for Economic Co-operation and Development (OECD, 2000) and the World Health Organization (WHO, 2002), leave no doubt that this demographic change is a major preoccupation for policy-makers. In many ways, population aging has become the new globalisation due to the disparate and eclectic problems attributed to it led by powerful images such as tsunamis and storms. To put it succinctly, it creates ‘messy problems’ (Ney, 2009).

This contribution provides an alternative to analyses informed by the literature on ‘wicked problems’, which focuses narrowly on specific characteristics and, consequently, targeted policy issues (see other contributions in this special issue). This paper aims to provide an overview of an approach focused on lenses followed by an illustration of its application. Rooted in the policy problems and caregiving literature, and on the basis of over 100

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interviews with senior civil servants engaged into debates surrounding policy reforms for an aging population, this contribution identifies three competing lenses (intergenerational, biomedical and social gerontological) to analyse policy issues related to population aging. Inspired by research on **problem definition** (Bacchi, 1999; Dery, 1984) and on the **characteristics of policy problems** (Peters, 2005; Rochefort & Cobb, 1993), each of these lenses possesses different problem definitions, causal mechanisms and solutions. The intergenerational lens originates from political analysis treating age as a new cleavage and from criticism over the lack of long-term perspective in the preparation of the budgetary process. The policy problems related to population aging for the biomedical lens stem from having older adults conceptualised as a population at risk, due to the prevalence of chronic conditions and disease within this age group. Finally, the social gerontological lens emphasises broad societal challenges affecting older adults and those who help to assist them.

Each of these lenses is strongly anchored within organisations in the civil service, which favours its long-term presence in ongoing policy discussions. Thus, rather than assuming that a new paradigm results in the introduction of a drastic change in policy (Hall, 1993) or a new dominant social construction emerges (Schneider & Ingram, 1993), this contribution stresses, instead, the **complexities of demographic change and the wide diversity of problem definitions it creates**. In the case of this contribution, the lenses rest primarily within governmental departments and the civil servants that engage routinely with them. The use of lenses acts as a heuristic device to facilitate the policy analysis of broad and complex phenomena, such as population aging, that **transcends policies across many sectors**. This approach also has the advantage to emphasise the importance (and the challenges) of developing better coordination mechanisms to deploy solutions that travel across lenses.

To facilitate the discussion and comparison across all three lenses, we focus on a specific challenge accentuated by population aging: Caregiving for older adults within the Canadian context. We selected this particular issue because it demonstrates nicely the diversity of treatment triggered by each lens. The growing importance of informal care giving illustrates well how these lenses produce very different problem definition and understanding of the challenges posed by an aging population. This application demonstrates the limitation of each lens, but also the consequences of embracing their respective problem representation and eventual solutions. In addition, it illustrates clearly **potential hurdles in the enactment of solutions that could travel across lenses**.

This contribution is divided into three sections. First, it **defines three lenses** (intergenerational, biomedical and social gerontological). Second, it analyses care giving across all three lenses focusing on the **context** within which care occurs, **problem definition** and **solutions**. Third, the discussion and conclusion section highlights similarities and differences with a focus on their policy consequences across public administrations.

Policy problems and the three lenses of population aging

With the introduction of the special issue already providing an extensive treatment of the literature on policy problems, this section tackles how the peculiarities of population aging make it highly interesting for policy researchers and analysts because it features so many characteristics regarding both problem definition and solutions.

Population aging has been identified by multiple organisations as representing an important policy challenge for public authorities. While there is a strong consensus on the causes of population aging, its impact and consequences are nearly ubiquitous. An in-depth analysis

of the multiple characteristics of policy problems, as provided by Rochefort and Cobb (1993) and Peters (2005) for example, would extend far beyond the limits of this contribution (but see Marier, 2017). We propose instead to analyse policy problems as lenses. The main advantage of this approach is to present a far more concise and holistic treatment of the many characteristics surrounding policy problems, focused on the identification of a core tension.

A lens represents a specific manner within which one understands a broad policy issue, including the conceptualisation of problems attached to it and its potential solutions. As such, it is somewhat reminiscent of a particular frame to tackle policy problems featuring its own discourse reinforcing the relationship between problem definition and solutions (Bacchi, 1999). The literature on policy frames emphasises the prevalence and power of ideas, arguments, and different forms of knowledge. The emphasis is on competing frames and the political power associated with them. In turn, these can be fairly malleable, at least when compared to competing theoretical perspectives, and lead to some forms of resolution (Schön & Rein, 1994).

Despite some similarities, this contribution shies away from employing the concept of a frame to emphasise the importance of institutional arrangements, the enduring nature of policy controversies and a broader understanding of problem definitions rooted in the policy design literature (Peters, 2005). Contrary to frames, each lens comes with a myriad of policy controversies even though an inherent tension is a focal point in policy analyses and discussions. Consistent with Peters (2005), we reinforce the notion that many characteristics of policy problems, such as interdependencies, scope of activity and political complexity, are prone to raise horizontal coordination issues within government. Hence, various lenses coexist and find prominence in various governmental departments.

Also, while Schön and Rein (1994) assume that the institutional dissonance is mostly between levels of government; street-level bureaucrats may have a different interpretation of the goals of a policy decision than the executive. We argue that this dissonance is as likely to occur within similar echelons of the civil service. As such, the approach has more in common with a Lakatosian view of science where research programmes continuously compete with one another without necessarily dismissing (or replacing) each other as opposed to a Kuhnian approach to policy paradigms (Hall, 1993; Schön & Rein, 1994). Each lens rests on the presence of a central tenet on the primary issue surrounding population aging. The ongoing debates within each lens surround the scope and impact of the tenet onto public policies rather than its actual existence.

The underlying basis of the lenses deployed in this article originates from the diverse public policy literature addressing the consequences of population aging, interviews with over 100 civil servants in all ten Canadian provinces on a book project centred on the development of strategies to address the challenges and opportunities of an aging population, and provincial policy documents. For the purpose of this contribution, we focus on three lenses presenting different visions related to the policy consequences of an aging population: *intergenerational*, *biomedical* and *social gerontological*.

The intergenerational lens

The intergenerational lens assumes that population aging triggers a new political cleavage consisting of generations, coexisting or even replacing older cleavages such as a religion and classes (Tepe & Vanhuysse, 2009). As such, it becomes a new source of social stratification

(Turner, 1998). The primary policy problem with population aging is the extent to which it disrupts or accentuates inequities across age cohorts or generations. This lens, assumes that, ideally, a policy should treat generations equally across time or, at the very least, public authorities should put in place mechanisms to reduce rising inequities across generations (Goodin, 1999). This lens has found credence most notably in finance departments and within some central agencies.

Two approaches illustrate well the ways in which policy problems are analysed with an intergenerational lens: generational accounting and generational politics. First, originally created as a response to the short-sighted view of the budgetary process in industrialised countries, generational accounting seeks to prolong the time horizon within which budgetary and fiscal decisions are made (Auerbach, Gokhale, & Kotlikoff, 1991). In addition, this approach provides a generational picture of what each cohort pays in taxes and receives in benefits, thus allowing cross-generational comparisons (Auerbach, Kotlikoff, & Leibfritz, 1999). Based on the assumption that the tax/benefit ratio should remain fairly static overtime, generational accounting analyses have been highly critical of the current policy structure, most notably in the United States where Kotlikoff and Burns (2012) accuse the government of 'fiscal child abuse'. Other studies, employing different methods, have also pointed to a 'senior bias' in US policies primarily because Medicare does not extend to younger populations, but such imbalance has been hard to find in other industrialised countries (Lynch, 2001).

The growing popularity of generational accounting in the 1990s has led to many critiques on its applicability, underlying assumptions and potential solutions. In terms of applicability, governmental reviews of this tool stress the uncertainty of projections. Budgetary projections performed on a yearly basis require constant revisions and involves some level of uncertainty; projecting over a long period of time accentuates these difficulties (Bonin, 2001). Others focused on underlying assumptions where, for example, all spending is counted and treated as consumption expenditure (or cash transfer) ignoring the value and effects of education or infrastructure spending, which generates benefits overtime (Haveman, 1994). Finally, the presence of a long-term fiscal imbalance does not provide solutions on how to resolve it (James & Matier, 1998).

As a result of the issues, generational accounting is not employed in finance departments and rarely mentioned in policy debates. Nonetheless, the so-called dependency ratio, an important measure in this approach that calculates the proportion of older adults (usually 65+) within a given society, has become prominently used across industrialised countries to illustrate intergenerational imbalance and to justify reforming public programmes with the OECD facilitating its diffusion (Ervik, 2005). This is occurring despite its multiple shortcomings (Walker, 1990), such as creating a false dichotomy between active and dependent population based solely on age (Robertson, 1997).

Second, rooted in political science, an increasing number of publications have emphasised the emergence of generational politics to explain both the salience of programmes benefiting older adults and the lack of reforms along the lines suggested by generational accountants (Vanhuysse & Goerres, 2011). Researchers have traditionally focused on the electoral strength of older voters with comparative studies associating the prevalence and generosity of programmes for older adults with their respective share of the electorate (Tepe & Vanhuysse, 2009). Researchers have also emphasised the affiliation to and participation

in powerful interest groups to account for the lack of reforms to the welfare state and, most notably, programmes benefiting older adults (Béland, 2005).

These studies have been challenged on multiple grounds. Studies geared towards elections have been criticised for not accounting for the actual policy preferences of older adults who still support redistributive programmes supporting children and younger adults (Busemeyer, Goerres, & Weschle, 2009). The political power and representativeness of senior-based interest groups has also come under fire for their lack of connections with marginalised older adults (Ginn, 1993) and the actual occurrence of retrenchment, most notably in pension policies across industrialised countries despite the presence of strong interest based groups (Ebbinghaus, 2011).

Biomedical lens

This lens is inspired by research on the medicalisation of human conditions (Conrad, 2008; Zola, 1972) and on the biomedicalisation of aging (Clarke, Shim, Mamo, Fosket, & Fishman, 2003; Estes & Binney, 1989). It is the lens within which health departments (mostly) comprehend issues related to population aging. For example, Estes and Binney (1989) emphasise both the social construction of aging as a medical problem and the practice of medicine that treats aging as a perpetual decline and a pathology. Even when older adults do not suffer from a medical condition, they are increasingly subjected to governmental messages and campaigns to find ways to 'age well' (Chapman, 2005), 'age successfully' (Baltes & Baltes, 1993) or to embrace 'active ageing' (Boudiny, 2013), as prescribed in the scientific literature. The medicalisation of human conditions goes well beyond the scientific enterprise to improve the well-being of individuals and to extend life expectancy with a burgeoning literature stressing other elements such as social control (Zola, 1972), the stigma associated with a diagnosis or medical condition (Beard & Neary, 2012), and the political power of both the medical profession and medical science (Estes & Binney, 1989).

Contrary to the intergenerational lens, where population aging becomes a political issue amongst cohorts or generations, the biomedical lens operates at the individual level. In this context, population aging becomes a major macroeconomic and health policy issues because of the increasing number of older adults, who are considered to be a population at risk to experience many medical conditions (Bloom et al., 2015). Within the biomedical lens, population aging is 'driving the worldwide epidemic of chronic diseases' (Prince et al., 2015). Debates are ongoing as to the extent to which future cohorts of older adults will experience a reduction or compression in morbidity, meaning the number of years experienced living with disabilities (Chatterji, Byles, Cutler, Seeman, & Verdes, 2015; Crimmins & Beltran-Sanchez, 2011). The accumulation of chronic conditions amongst many older adults is frequently cited as a cause for concern since this would imply rising health care costs at a pace faster than population aging (Denton & Spencer, 2010).

Social gerontological lens

Social gerontology 'focuses on the social as opposed to the physical or biological aspects of aging' (Quadagno, 1999). Early studies in social gerontology painted a bleak picture of the aging process with contributions focusing mostly on older citizens' loss of capacity and their gradual withdrawal from societal activities (Cumming & Henry, 1961; Riley, 1971).

Moreover, socio-economic conditions were clearly aligned with the status of dependents portrayed in the media with aging with older adults being far more likely to experience poverty and social exclusion (Walker, 1981). Population aging and improving socio-economic conditions of large segments of older adults have resulted in a shift in emphasis recently featuring, most notably, **ageism and the heterogeneity of aging**.

Ageism tends to **over accentuate differences between older and younger citizens within societies and it focuses on the impact of negative societal depictions related to older adults and the aging process**. This is hardly new with early studies demonstrating the prevalence of compassionate ageism, with older adults often presented as being frail, vulnerable, and in dire need of societal support in the media and public documents (Butler, 1969). Critical gerontologists even claim that the **state was largely responsible** for this form of ageism by actively **institutionalising dependency** via its socio-economic interventions (Townsend, 1981), such as **enacting governmental policies to encourage early withdrawal** from the labour market (Macnicol, 2006).

Recent contributions continue to reflect these issues, but they also present new forms of ageism that relate directly to the previous two lenses discussed in this contribution. This features increasing negative depictions of older adults as being **'greedy geezers'** (Quadagno, 1989), which follows from ongoing debate surrounding intergenerational equity. Fuelled by a growing number of policies to encourage active and healthy aging, 'new ageism' occurs due to an **overtly optimistic vision of ageing** where preventive measures are assumed to solve many of the health problems and difficulties associated with aging (Dillaway & Byrnes, 2009).

In contrast to both previous lenses, the social gerontological lens also stresses the **heterogeneity of aging**. While this is obvious in the case of the intergenerational lens, due to its emphasis on cohorts or generations pitted against one another, homogeneity is also present with the biomedical lens since aging is treated as pathology and distinctions are made based on medical conditions. **Older adults represent the cohort with the widest variations in terms of socio-economic conditions and health status, which is in large part due to the cumulative advantages and disadvantages accumulated overtime** (Dannefer, 2003). Yet, many public policies assume an aging path that does not coincide with the realities of many older adults. This includes, for example, fixed retirement age and standardised questionnaires to access social services and move onto long-term care facilities. The literature emphasises that underlying social conditions do not change vastly once individual reach retirement.

Applying population aging to care giving for older adults in Canada

To illustrate differences across the three lenses and facilitate a comparison, we analyse policy issues related to care giving for older adults in aging societies. This provides a succinct picture of the primary tenet of each lens and how each lens produces a different logic of problem definition and intervention. In the case of the intergenerational lens, the typical solution aimed at redressing the social policy balance across generation results in a counter-intuitive outcome. Caregiving is also a policy issue where horizontal coordination clearly comes to the fore while analyse each lens.

Our primary focus is on informal caregiving, which represents the bulk of care giving efforts across industrialised countries. Caregiving features most of the characteristics associated with the literature on policy problems and, more importantly, it provides a different problem definition that can relate meaningfully to each of the lenses under study. Caregiving

can be analysed as an intergenerational contract between family members, a biomedical tools to ensure the success of aging at home strategies, and broader societal issue due to the overreliance of women who already struggle to maintain full time status on the labour market. Still with the objective to facilitate the comparison, these are conducted within the Canadian context with multiple references to the province of Québec. It is important to note, nonetheless, that many of the issues raised in Canada are also prevalent in most industrialised countries.

Context

The relative increase in the number of older adults combined with a longer life expectancy have led public authorities to embrace 'aging at home' policies, which have resulted in a growing need for informal caregiving for many older adults. This builds upon research emphasising that informal caregiving is already predominant when it comes to assisting older adults. For example, studies have shown that 28% of Canadians aged 15 and over have provided care services to a family members with a long-term health problem, a disability or problems related to aging (Turcotte, 2013). In Québec, 75% of caregivers have stated that they have been assisting an older adults aged 65 and over (Fleury, 2013). These informal caregivers represent the backbone of the current system since they provide more than 80% of all the care needs of seniors (Lavoie, 2014). Adding to this picture, an increasing number of caregivers are part of a 'sandwich generation' since 30% are aged between 45 and 65 and provide care to both children and older adults (Sinha, 2013).

Based on recent estimates, the monetary value of informal caregiving for seniors ranges from 24 to 31 billion dollars in 2007 (Hollander, Liu, & Chappell, 2009). Albeit informal, caregivers provide the vast majority of care for those in need. The kinds of services provided to older adults by informal networks covers a large range of services ranging from basic domestic activities (meals preparation, housecleaning, financial management, etc. ...) to personal and medical care. A recent study claims that Canadian provinces only offer 8% of all caregiving needs for seniors (Lavoie, 2014).

Many older adults are themselves caregivers. Although there are fewer caregivers aged 65 and over, they are more likely to provide more hours of support. More than 25% of caregivers aged 65 and above provide more than 20 h of assistance per week for older adults (Sinha, 2013). They are also at high risk to develop health problems, as a result of providing care.

Caregiving through the prism of lenses

The intergenerational lens assumes a conflict, or at the very least tensions, between cohorts and generations, with the frequently stated belief that the current policy structure benefit older adults. With an eye towards restoring or maintaining similar benefits across various cohorts or generations, the status quo or reductions in formal services to older adults represent the logical outcome stemming from the intergenerational lens. This conclusion based on the generational accounting literature also applies to generational politics since, contrary to other popular benefits such as health care and pensions, caregivers operate at the margins and they do not benefit from strong political power.

Following the contextual discussion above, cuts to current levels of public services would inevitably result in further pressures on informal caregivers to accentuate their activities.

Considering their extensive contributions, this added pressure threatens to result in negative consequences not only for the health and economic well-being of caregivers, but also for the society in general.

First, there are also important **financial and professional consequences** attached to caregiving since 60% of caregivers are also employed. A recent public report indicates that 35% of the population on the labour market provides informal care while holding a job (Gouvernement du Canada, 2015). This twin role of worker and caregiver has important consequences. In Canada, almost 50% of caregivers who also held a formal position within the labour market have been late to work, had to leave early or had to take time off, another 15% had to cut the numbers of hours works and 10% refused a promotion or a higher position elsewhere (Sinha, 2013). Within the context of generational accounting, this has important consequences since this eventually diminishes fiscal revenues needed to sustain the financing of social programmes, which could accentuate the long-term funding gap associated with an aging population.

Second, there is a growing literature emphasising the **health consequences** associated with being an informal caregiver for older adults. A recent Canadian study states that 60% of these caregivers suffer from anxiety and stress and more than 20% mention that they are depressed or experiencing health problems (Turcotte, 2013). Since the 1980s, studies on caregivers' burden have revealed that providing care increases the risk of physical and psychological health problems for caregivers. For example, a study based on focus groups with caregivers in British Columbia stress that they remain highly invisible and that caregiver burden has risen since they are also having difficulties taking care of themselves (Lilly, Robinson, Holtzman, & Bottorff, 2012).

The importance of the **biomedical lens** in Canada is in large part responsible for the growing role of caregivers within the healthcare system. The Canadian Healthcare Act, conceived in the 1960s, assumes a **hospitalo-centric model; public funding for social services and care outside of the realm of hospitals remains marginal and highly volatile**, both in terms of coverage and quality (Quesnel-Vallée, Farrah, & Jenkins, 2012). Home care only represents 2–7% of all health care spending in the provinces (Canadian Home Care Association, 2008). While recent efforts have been made to move away from the traditional mechanisms to deliver health and social services, long-term care access continues to be a major issue for seniors with caregivers expected to attend and care to seniors while the latter wait for a place (Genest, 2012). Long-term care services remains very patchy across the country involving private, non-profit organisations and public actors along different provincial models of care (Palley, 2013).

Within the spectre of the biomedical lens, the **increasing number of older adults combined with the progress of modern medicine raises important questions surrounding the complexities of care**, most notably for individuals experiencing **multiple chronic conditions and dementia**. The rising level of complexity accentuates the difficulties placed onto caregiver in two ways. First, **coordination issues for caregivers** ranging from taking appointments to driving older adults to different sites in accordance with various medical specialties have become more frequent. Second, **caregivers are performing tasks that are more technical and complicated**, which were previously done by medical professionals (Lavoie, 2014).

Policy development in the province of Québec illustrates well these challenges. As a mean to **reduce health care costs**, an important concern in a public and universal system, the government opted to embrace an **ambulatory shift** in the 1980s with the purpose of decreasing

the length of hospital visits by patients. As a result, multiple interventions previously performed by hospitals, such as the management of medication and patient monitoring, are now being done at home. This reform even required a modification to the professional code since many of the interventions offloaded to caregivers were traditionally assigned to nurses. In the aftermath of this reform, caregivers are not only providing additional services, but also more complex ones.

Caregivers are perceived as instrument of the health care system rather than being central players with health and social services organised to facilitate their needs and those of their patients. In fact, in Canada, many provincial policies state clearly that family members are responsible to provide care to seniors (Keefe, 2011). These conclusions echo similar studies that report a shift of responsibilities from the state to families when it comes to caregiving (Martin, Le Bihan, Joël, & Colombini, 2002).

The social gerontological lens analyses population aging from a social, as opposed to a biomedical, perspective. With this lens, caregiving affects primarily caregivers and the older adults they serve, but also occur with other ongoing social issues such as gender inequality. The increasing reliance on caregivers accentuates gender inequalities because women constitute the vast majority of caregivers. Beyond gender, like the older adult population, caregivers represent a fairly heterogeneous population with regard to multiple elements such as age, socio-economic status, ethnicity, and health status. These characteristics not only influence the ways in which one provides care but also the extent to which a caregiver is likely to face social exclusion.

Other social inequalities are noticeably present when studying caregivers. For example, health and life expectancy improvements are not equally distributed within any given population. A lower retirement income or the absence of a university diploma represents important risk factors when it comes to experiencing disabilities in old age and to determining life expectancy (Institut canadien sur la santé, 2015). These kinds of inequalities have a direct impact on caregiving since older adults with lower socio-economic status require typically more assistance to fulfil their needs. With this assistance originating primarily from informal network, this implies variations in the amount of services provided by caregivers.

There is also a growing gap between the expectations attributed to caregivers by public policies, their own views on the subject, as well as those of older adults requiring assistance (Finch & Masson, 1993; Guberman, Lavoie, & Gagnon, 2005). The strong reliance on informal networks to ensure that older adults can remain in their home as long as possible clashes with the widely held values of being autonomous, which prevail amongst both caregivers and seniors (Bourgeois-Guérin, Guberman, Lavoie, & Gagnon, 2008; Van Pevenage, 2015). For example, while it remains frequently assumed that family members will act as caregiver when needed, older adults much prefer formal services since they do not want to feel as a burden onto their family and risk compromising their relationship with family members (Guberman et al., 2005).

Other important social dimensions have recently been the subjects of research and influences the ways in which one can conceptualise policy problems beyond the relationship between caregivers and older adults in needs of services in the context of population aging. First, access to social services remains difficult to achieve not only due to the lack of governmental services and the high costs to purchase them, but also because of the location of one's residence. There is, for example, an important gap between services offered in rural area, which tend to be predominantly concentrated with older adults, and urban settings

(Keating, Swindle, & Fletcher, 2011). Second, researchers have also questioned the extent to which ‘aging at home’ is truly preferable since poorer older adults may actually welcome a move in a better equipped environment to address their needs as they age (Wiles, 2010). Finally, the ways in which **immigration and caregiving intersects** is gathering increasing attention. For example, a recent survey denotes a higher proportion of immigrant caregivers experiencing health problems than other social groups, which is attributed to a ‘double discrimination’ based on their status as caregiver and immigrant (Suwal, 2010).

Solutions and consequences related to each lens

Under the **intergenerational lens**, the policy problems related to caregivers present a real catch 22. For example, if one assumes that the current structure of public policies advantages older adults at the expense of current and future generations, the prescription *en vogue* is a **reduction in the amount of services and programmes offered to older adults**. In such a scenario, public authorities would opt to reduce funding for social services targeted at older adults and, most likely, fail to provide the tools to enact a well funded ‘aging at home’ policy favouring instead programmes benefiting younger generations. However, these policy choices would have dire consequences on younger and future generations as well since they would have to increase the amount of informal care needed, which ultimately results in more precarious health and financial conditions for many. As illustrated above, this would likely trigger diverse forms of withdrawals from the labour market ranging from a reduction in the number of hours to complete withdrawals, which have important fiscal consequences for the society as a whole.

In addition, the enactment of such measures would affect primarily women. They are already far more likely to fulfil the role of caregiver. Accentuating this role would not only entrench further a stereotype, but also increase their financial vulnerability for the present and the future (Lavoie, 2014). Thus, this **intergenerational debate would quickly transform itself onto a gender debate**.

The **biomedical lens** focuses primarily on the physical and cognitive functions of older adults and how this can impact their activities of daily living. **Needs for older adults are assessed in medical terms** with social elements rarely being a concern in their own right. In the context of reforms to reduce the growth of health expenditures, caregivers are now more involved in providing services to older adults and they have accumulated additional responsibilities. However, these changes are in stark opposition to baby boomers’ expectations since they expect the state to provide health and social services to respond to their needs as they age and they also refuse to assume the identity of caregivers (Guberman, Lavoie, Blein, & Olazabal, 2012). In addition, caregivers do not have a formal status within the health care system since the medical file and the attention is geared (almost) exclusively towards the patient. Ironically, multiple studies demonstrate that a growing number of caregivers are in dire need of (medical) assistance having difficulties combining care and other socio-economic functions (Chappell, 2011). Many of these cases are underreported because **caregivers do not have a formal status** within this organisation of services and no formal mechanisms exist to calculate or assess their contributions, as is the case when a medical profession intervenes.

Caregivers’ support represents one of the many instruments deployed to maintain and sustain the health and longevity of older adults. Beyond the consequences to caregivers listed

above, this perspective also does not consider that older adults have other pressing needs even when dealing with a loss of autonomy. These include, for example, the need for personal security, social interactions, and participation in community activities (Bowers, 1987).

The social gerontological lens points towards policy issues that are more eclectic than the previous two lenses, which result in difficulties to articulate a broad policy problem. First, there exists a very diverse universe of care giving environments (social, familial, territorial, and institutional) and the needs of caregivers vary tremendously as well. With this reality in mind, the enactment of policies with universal objectives, such as 'aging well' and 'aging at home', trigger a very wide range of accessibility. Second, this succinct discussion omits to address diverse populations with specific social needs (such as homeless and LGBTQ individuals) and to discuss the importance of cumulative disadvantages (such as being a poor caregiver in a rural setting) (Dannefer, 2003).

The status of caregivers also remains precarious. For example, aging at home is an objective pursued by public authorities since it reduces health care costs, but also a desire for the vast majority of older adults. However, the viability of such a goal relies on a strong commitment on the part of caregivers. Despite the implementation of aging at home strategies across industrialised countries in the past decades, caregivers still lack support and recognition. They are notoriously absent from the policy-making process and lack political power to improve their situation (Guberman & Lavoie, 2010). There is in fact a double exclusion since this sociopolitical exclusion is added to the lack of formal role within the health and social services system, discussed in the previous section (Billette & Lavoie, 2010).

In terms of potential solutions with a social gerontological lens, an increase in the amount of formal public services offered is a quasi-universal recommendation since this would correspond more closely to the wishes of older adults while easing the amount of time and efforts required from caregivers. Also, with an emphasis on the diversity of social issues associated with population aging, the social gerontology lens requires solutions that target a wide range of specific needs and issues. However, the comparative welfare state literature is quick to point out that universal programmes tend to be far more acceptable politically, resistant to change, and more effective at resolving social problems than targeted approaches (Rothstein, 2001).

Conclusion

This contribution proposed the use of lenses to analyse and compare policy problems attributed to an aging population. As demonstrated by the multiple policy issues surrounding caregiving for older adults, the three lenses (*intergenerational*, *biomedical*, and *social gerontological*) reveal the importance of problem definitions when tackling policy issues. The ways in which these lenses compete and coexist is reminiscent of traditional horizontal issues being tackled by governmental authorities on a regular basis.

The intergenerational lens, with its focus on the budgetary process and the relative cost/benefit ratio across generations, is clearly aligned with the types of understanding found within finance departments. Although their primary concern is not with intergenerational transfers per se, they have the main responsibility to ensure the long-term sustainability of public programmes. As such, not having to spend on a service because it is provided by an informal network represents a positive outcome. The biomedical lens clearly dominates within health departments, which explain their weak prioritisation of social services and

the medicalisation of what constitutes a service (Binney, Estes, & Ingman, 1990). Issues related to older adults have traditionally been confined to health departments. Recently in Canada, strong societal pressures, most notably from age-based interest groups, have resulted in the dismantlement or displacement of seniors' divisions away from health departments in many jurisdictions resulting in the creation of semi-independent agency such as Seniors' Secretariats (Marier, 2013). This newly created agency benefited from an impetus to detach aging from being associated with a sickness. However, the resources being given to embrace a social vision on aging remain extremely marginal, especially when compared to health departments. Contrary to the analysis presented on the social gerontological lens, however, caregivers are not a core priority for Seniors' Secretariat due to its specific mandate on older adults. In fact, by linking lenses with a department or ministry the invisibility of caregivers is all the more striking by its lack of attachment to any of them ... unless they become sick!

An alternative approach to this analysis would have been to focus on the characteristics of policy problem (Peters, 2005; Rochefort & Cobb, 1993). For example, an analysis on the extent to which caregiving problems and solutions are being monetarised across the three lenses would have raised few eyebrows because of the importance of informal caregiving and how this assistance is calculated. The social gerontological lens is quick to point out the social costs of caregiving and its broader connections to gender relations and labour market participation (to name only two). However, it represents a highly appealing instrument within the confine of a biomedical lens since services are being shifted elsewhere at an extremely low cost. In the case of the intergenerational lens, a public budgetary analysis implies that formal caregiving represents an additional cost for working generations while it is a net benefit when provided by the informal sector.

Finally, a different approach could have also been to target more closely formal, as opposed to informal, caregiving. Formal social services offered by public providers face various challenges that would be well suited for a policy problems analysis based on the three lenses conceptualised in this paper. The intergenerational lens would push towards further reduction although, as suggested throughout this paper, the better solution might be the opposite to bolster the financial and health well-being of younger generations. Conforming to the biomedical lens, there is already evidence suggesting a shift towards medical services, often at the expense of the wide range of social services provided to older adults (Binney et al., 1990). Finally in line with the social gerontological lens, there remains a strong demand for better social support to assist both informal caregivers and older adults, with both groups clearly preferring formal public services to any other alternatives when facing situations requiring caregiving.

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