Population aging in Cuba: coping with social care deficit

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Abstract: Demographic aging represents major social and economic challenges for Cuba. This paper examines the responses and coping mechanisms developed in Cuba over the past decades with regards to aging within Fassin's (2009) conceptual framework of moral economy. It demonstrates that the moral economies of social justice and homecare tend to conflict in a context of care deficit (Hochschild, 1995). The paper is based on several rounds of ethnographic fieldwork, participant observation and interviews conducted between 2009 and 2016, in Havana and other parts of Cuba,. It first analyzes the components of demographic aging, namely the increase of life expectancy, the decrease of fertility and migration. It then delves into public policies aiming to respond to the health care needs of the elderly, to foster their community integration, and to mitigate their impoverishment. Finally, it highlights how households develop strategies to cope with the care needs of aging relatives, in a context where market provision and institutional long-term care supplies are still incipient.

Although constructed as a public problem and widely documented in Cuba, the pressure aging exerts on care systems has received little attention from social scientists. In this regard, this paper contributes to comparative knowledge on aging in Post-Soviet, Latin American and Caribbean countries.

Introduction

Demographic aging is a major challenge for health care and solidarity mechanisms in Cuba. It tests the social justice principles implemented by the revolutionary regime since 1959, particularly in a context aggravated by shrinking public budgets and increased emigration. This paper deals with the intensified needs for health and social care spurring from demographic aging in Cuba, which could be considered "the burden of triumph" (Dilnot, 2017). It examines the responses and coping mechanisms developed in Cuba over the past decades and demonstrates that the moral economies of social justice, women's emancipation, and homecare tend to conflict in a context of care deficit (Hochschild, 1995).

Coping with aging in Cuba is framed within a two-level moral economy (at macro and micro levels). In this paper I adopt Fassin's (2009) re-conceptualized definition of moral economy conceived as "the production, distribution, circulation, and use of moral sentiments, emotions

and values, and norms and obligations in social space […], the former referring to judgments as to what is right or wrong (or better or worse), and the latter referring to rules, principles, and obligations (or what to do or not do). In reality, if evaluative and prescriptive statements can be distinguished analytically, the distinction is much more difficult to establish empirically and is probably irrelevant because values arise at least in part from norms, and norms depend partially on values". Fassin further adds that different realms or segments of society may have different moral economies which may conflict or generate tension. I will show how this actually occurs in the case of providing for the elderly's needs in Cuba.

Analyzing care with a moral economy perspective takes it out of the "private" realm and places it in the public and political domain. It allows us to think jointly about political economy and moral economy and to tackle the challenges of aging and elderly care separately at both macro and micro levels. This will shed light on the ways they converge in producing tensions, particularly in a context of social care deficit (Hochschild, 1995). Care deficit, in the perspective of this paper, is not a natural fact, but rather constructed by conflicting historical trends, among them Cuban women's emancipation, family solidarity, aging and public budget restrictions.

At the macro level, the Cuban Revolution was founded on social justice principles that have accompanied and provided justification for many of the sacrifices undergone by the Cuban people. These principles are at the root of social and economic policies aimed at leveling income inequality, as well as providing equal access to education, health, decent living conditions and opportunities. The elderly occupy a special place in this context, since they are the generation that actually implemented the revolution in the 60s and 70s. Public and social services developed thanks to their labor and dedication. However, the 1990 dissolution of the Soviet Union, Cuba's major ally triggered a deep economic crisis that spurred reform policies the country is still contending with today. The 1990s are thus a key period in Cuban history, marked by the deterioration of social advances, and by a series of policies liberalizing the economy. Despite the challenges that Cuba faces it has taken steps to maintain basic services (particularly education and health) and it has made significant efforts to compensate for the cumulating effects of reform and liberalization on the social condition of vulnerable groups such as the elderly.

At the micro level, Cuban society has a strong culture of solidarity and interdependence kept alive in neighborhoods and particularly within families. As I will show, it is based on necessity stemming from a shortage and scarcity economy, but also on a moral economy

based on principles, values and norms, that constitutes an ethic of care (Gilligan, 1982; Tronto, 1993). At this level, elderly-care needs weigh heavily on household resources and organization, particularly in a context of economic and housing difficulties, and outmigration of working age adults. I argue that what may be characterized as an overall social care deficit takes its toll especially on women.

This paper is the result of several years of qualitative sociological research in Cuba, mainly but not exclusively in Havana[1]. Fieldwork relied on casual relationships which began with some of my hosts in *casas particulares*, and developed with a snowballing momentum when they introduced me to some of their acquaintances, relatives, friends, and neighbors. I also provoked contact with employees and users of several social institutions involved with the elderly, whilst volunteering in some of them, which allowed the authorization for further visits, and sharing in events, trips, and activities. With these two sets of informers, I could conduct formal interviews, but above all informal conversations and participant observation. Formal institutional interviews were obtained for the most part either via former contacts, or through Cuban researchers, who agreed to introduce me to officials and professionals in areas related to my research. Finally, observation in streets and public spaces, and conversation engaged on as many occasions as possible, provided me with many elements reflecting the daily life of the elderly.

Most of my material is thus ethnographic, made of observation and conversation, recorded in numerous field notebooks, rather than formal interviews. I also made extensive use of written sources, such as academic papers, statistics, surveys, newspaper articles, blogs, and websites. Because aging is constructed as a public problem in Cuba, written sources are abundant. The Cuban statistical office and other ministerial departments (Health, Social Security) provide regular and freely accessible census and survey data on various dimensions of aging. Multilateral organizations such as the UN Economic Commission for Latin America and the Caribbean (ECLAC) or the Pan American Health Organization, also publish data on Cuba.

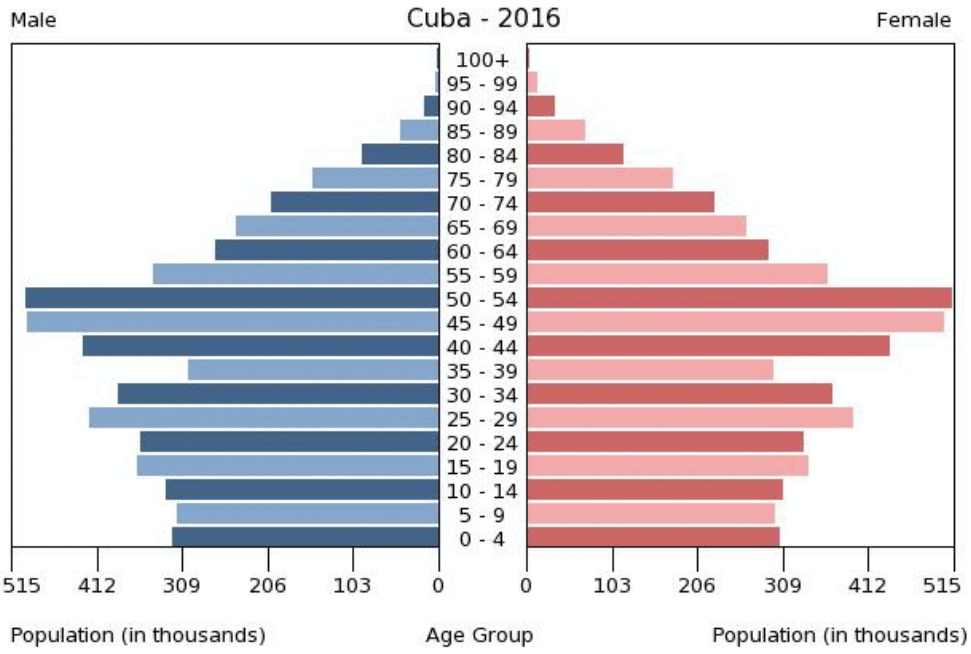
In this paper I propose first to describe Cuban demographic structure in order to underscore the intensity of the aging process and its various demographic and sociological components, Second, I present public policy responses to elderly health care, welfare, social and community wellbeing. Third I proceed to show how caring for the frail and dependent elderly

[1] From 2010-2014, this research was funded by the international project Offre institutionnelle et logiques d'acteurs : femmes assistées dans six métropoles d'Amérique latine (LATINASSIST ; ANR SUDS II).

weighs upon households and constitutes a major element of their intergenerational housing strategies.

1- A drastically aging population

The Cuban population is one of the oldest in Latin America, and its aging process, measured by several indicators, constitutes a foreseeable and preoccupying trend for years to come. As shown by the latest aging survey conducted by the Cuban National Statistical Office (ONEI, 2017), the median age has increased from 22 in 1950 to 41,1 in 2016, and is projected at 45 in 2030. The Aging Index has risen from 20,7 in 1960 to 121 in 2016 (and is projected to increase to 218.4 in 2030[3]), which means that the 0-14 age group is smaller than the population over 60, as illustrated on the pyramid below: in 2016, the group over the age of 60 constitutes 19.8% of the total population, of which two-thirds are above 65. At the other end of the pyramid, less than 17% of the population is under 15 years of age. In 2030, according to ONEI (2016) projections, 29% of the population will be over 60, and only 16.1% under 15. Some Cuban provinces and municipalities cumulate aging factors and as such, are more affected by the process than others.



Source: http://www.indexmundi.com/cuba/age_structure.html

[3] The Aging Index refers to the number of elderly individuals per 100 individuals younger than 15 years in a given population. This index increases as population ages (ECLAC, 2017).

Aging results from three sets of factors: the increase of life expectancy, the drop of fertility, and migration. Lets us examine them in turn.

Increase of life expectancy

Cuba's life expectancy at birth is one of the highest in the world. This is a direct result of the health, economic, and social policies implemented since the Cuban Revolution, These policies are founded on principles of social justice that allocate resources according to people's needs, and not to their means. Public policies endeavor to provide the whole population, whatever their standard of living, place of residence, age and type of pathology, with good quality public services, on a decommodified, universalistic, and egalitarian basis. The health sector benefits from considerable public investment[4] in buildings and equipment and has developed a dense network of hospitals, polyclinics, and neighborhood clinics. It devotes substantial resources to training doctors, nurses and technicians and it invests in research. All of these assets translate into policies, and concrete programs and campaigns that cover all dimensions of health (Feinsilver, 1993; Chaufan, 2014; Brotherton, 2011).

Many recent health indicators place Cuba at the same level as developed countries with advanced healthcare benefits. Infant and maternal mortality have dropped significantly, mortality due to infectious diseases has almost disappeared, life expectancy – at birth and at other ages – has increased to 79.6 years in 2015-2020 i.e. fourteen years above its 1960-1965 level (ECLAC, 2017). These performances are a testimony to the drastic reduction of health inequalities between classes, racial origins, lifestyles, education levels, territories, and gender (Whiteford and Branch, 2007).

[4] Health and social assistance expenditures represent 10.4% of Cuban GDP in 2015 (ONEI, 2016).

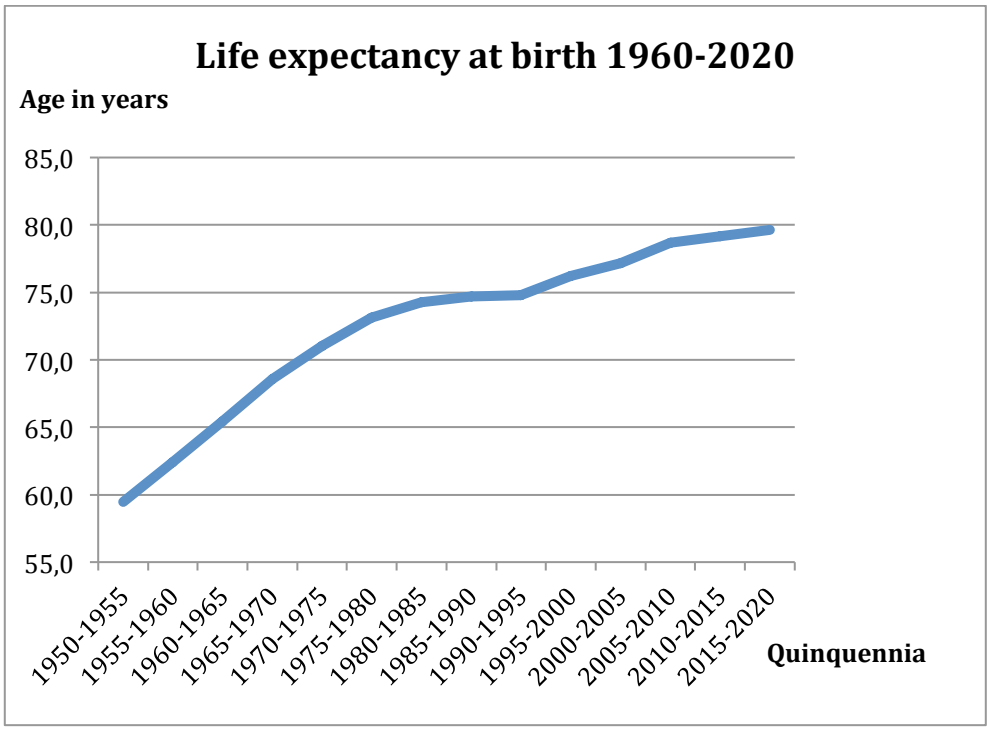


Table 1: Computed from ECLAC, 2017

It is important to note that the multifaceted healthcare investments have also resulted in a specific form of citizenship, characterized by the Cubans' acute consciousness of their health and physical wellbeing (Brotherton, 2005). The family doctor has become an archetypical figure of the revolutionary hero (Brotherton, 2013). Health is a highly politicized issue (Kath, 2010). The results and performances of the Cuban health system are widely promoted on the national and international scales. They are a flagship emphasizing the attainment of the revolutionary regime and contribute to its legitimacy. The medical industry, including services, research and pharmaceuticals has also become Cuba's primary export sector (Leleu, 2017). It is against this backdrop that health policies directed at the elderly have been promoted, as we will see below.

The decline of fertility

Fertility decline is another ingredient of population aging. In Cuba, the global fertility rate has dropped from 4.7 children per woman (15 to 49) in 1960-65 to 1.63 in 2016 (ONEI, 2016), and is the lowest of all Latin America (table 2).

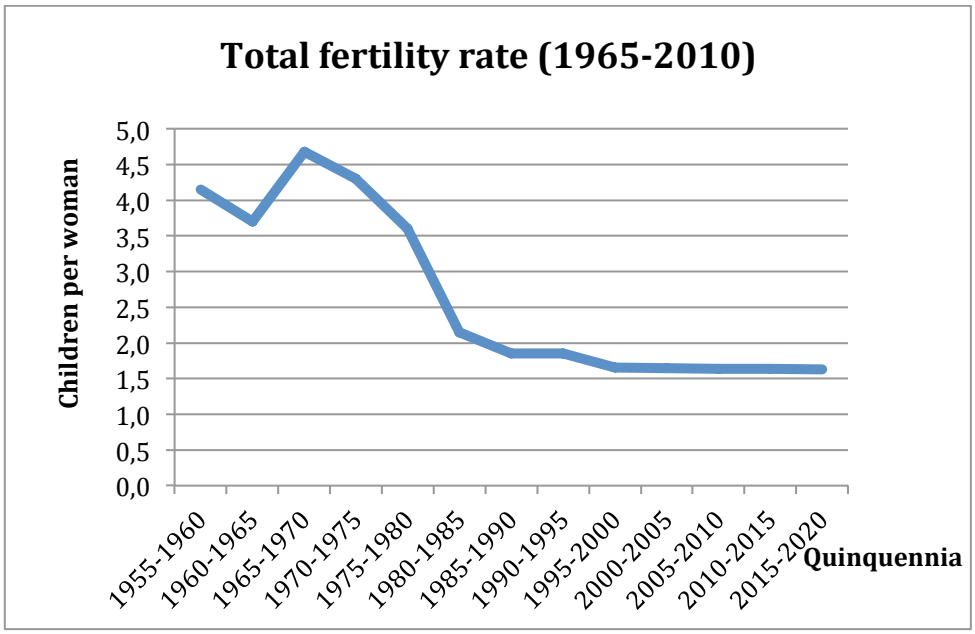


Table 2: Computed from ECLAC, 2017

This phenomenon can be explained by three major factors.

On the one hand, women have been granted individualized and equal social rights. They have benefited from incentives to attain educational and skill levels equal to that of men, and they have entered the labor market at all occupational and professional levels. Schools and care institutions have contributed to emancipate parents – and especially women – from social roles that confined them to domestic paid or unpaid labor, so that they could engage in professional careers and political activities[5]. Family planning and abortion services, freely accessible and free of charge, have helped couples or women to decide the number of children they want (Andaya, 2014).

On the other hand, birth reduction is also the result of self-limited child conception grounded in economic difficulties and housing shortages As we will see below, a large proportion of households face home overcrowding, poor maintenance, and lack of equipment, all contributing to deter child rearing. When resources are lacking – income, time, work, presence, care, and particularly space at home – couples tend to postpone, or even drop, their project to conceive a child (idem). Additionally, in spite of consistent policy adjustments over the last decades, tensions in work-life balance have not been solved satisfactorily. Women especially, find themselves overburdened and torn between their responsibilities at work, at

[5] The discrepancy between men's and women's official activity rates – about 20 percentage points – demonstrates, however, that this process has been inhibited by sturdy underlying patriarchal social structures (see Destremau, 2017a).

home, their engagement in political and social organizations, and the time required for provisioning (Destremau, 2015a; 2018). At the time of the 2012 census, 55.5% of all households above one person comprised no child under 15 years of age, and 69% of households with children had only one (ONEI, 2012).

Finally, the drop in fertility is also the result of the 1960-70 baby-boomers advancing past their conception years as they enter their 40s and 50s. Also fewer children have been born by the following reduced-in-number generations, especially since they came to fertile age in the midst of the 1990s economic crisis. This, combined with the effects of outmigration of adults in childbearing age translates into a continuous drop in the percentage of childbearing women since 1990.

Fertility indicators have remained below replacement level since the end of the 1970s with a gross reproduction rate below 1. Public authorities have addressed this issue by conducting a national fertility survey (ONEI, 2009), which analyzed the reasons and parameters of fertility drop. They have endeavored to reinforce support to infertile couples, offering them assisted reproductive technologies. They have improved the follow-up of pregnant women, to the effect that, in 2016, 56.2% of births took place within maternal homes, demonstrating constant increase over preceding years (ONEI, 2016). They also explicitly attempted to fight an alarmingly high abortion rate, which concerns, on average, as many as half of initiated pregnancies (ONEI 2009, Andaya, 2014).

Outmigration

Declining fertility combined with outmigration in reducing population growth, which has tended to be negative since 2006 (ONEI, 2016).

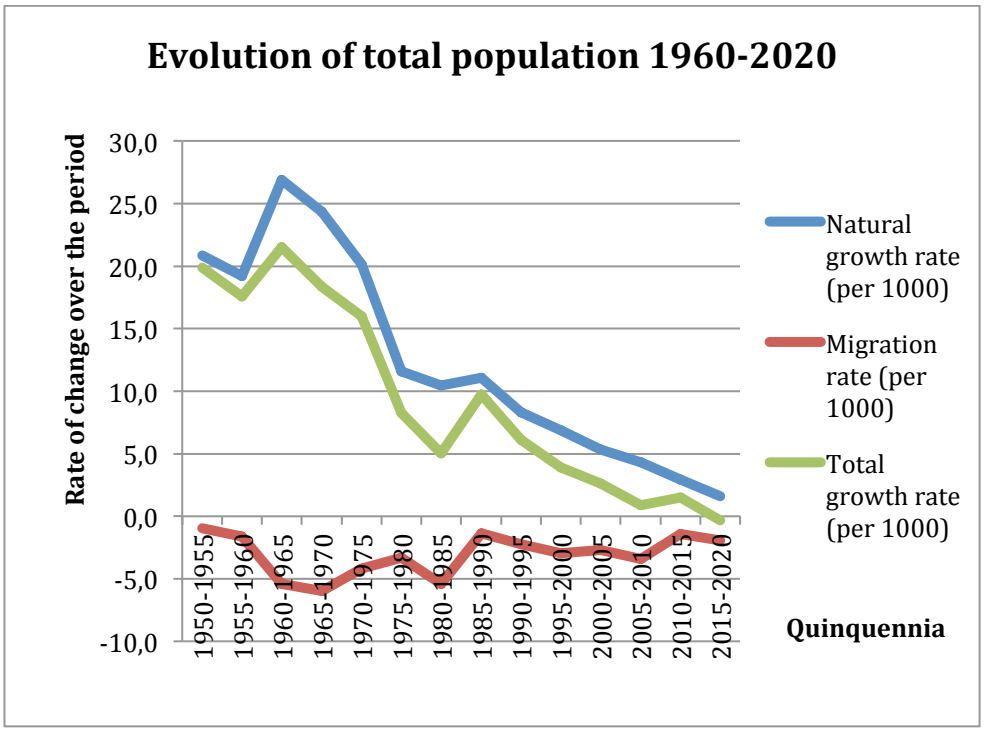


Table 3: Computed from ECLAC, 2017

Migration contributes to demographic structure imbalances. Since the Revolution migration balance has steadily been negative, except for 2013 and 2014. As illustrated in Table 3, emigration has been continuous, although its rates vary from year to year depending upon the severity of restrictions imposed by domestic policies and the relationship between Cuba and the United States. Emigration primarily affects working-age and childbearing-age adults, who may leave behind older members of the family as well as children. Impoverished rural areas are particularly subject to combined internal migration and outmigration. This phenomenon is responsible for significant population decline and consequently intensifies demographic aging.

On the other hand, immigration has been scarce and composed principally by the foreign spouses of Cuban men working or studying abroad (Cabrera *et al.*, 2016). The slightly positive balance that appears for 2013 and 2014 is an exception and can be explained by recent developments in Cuba's international relations and domestic legislative steps that constitute favorable circumstances for return and pendular migratory movements. Part of the returnees are elderly people leaving their place of residence abroad, primarily the United States, to end their life in Cuba, where they can expect to enjoy good and free healthcare, as

well as an attractive value for their retirement income[7]. With few perspectives for the return migration of working-age adults, this trend will more than likely accelerate demographic aging (García & Alfonso de Armas, 2014).

The dependency ratios

Aging affects the dependency ratio, to the point that it outweighs the effect of a diminishing proportion of children in the population. The growing weight of the elderly resulted in rising dependency ratios since 2002, which means that a lower share of economically active adults has to provide for the needs of a increasing share of aging and economically dependent population. In 2016, the global dependency ratio was at 56,4%. This means that two people of working age (15-59) support more than one dependent (child or elderly person). When considering the aged-dependency ratio separately, one remarks that the ratio of the elderly to working aged population is 30.9, higher than that of children (ONEI, 2017). If the aging trend continues as predicted, in 2030, the dependency ratio will reach 82.3%; respectively 25.9 for children and 56.5 for the elderly (ECLAC, 2017). Dependency ratios are reflected at the household level in Cuba. According to the 2012 census, 40% of all households comprised at least one person over 60 with 27% having only one elderly person, and 13% more than one; ONEI, 2012).

These statistics should however be interpreted with some caution given that the pressure on the active population is likely to be lighter than what the figures indicate. A considerable number of people over the age of 60 may not be able to afford, nor may they wish to stop being economically active. Also these figures concern only the resident population and do not take into account the number of emigrants who support their relatives back home.

Aging and its various components, has become a major preoccupation for Cuban authorities, and has been constructed as a public issue. In the following section I will focus on policies directly addressing the needs of the elderly, leaving aside migratory policies that concern them indirectly.

[7] Source : my own research and Havana Times, "El otoño de Cuba" (Jan. 17th, 2014), http://www.havanatimes.org/sp/?p=93151

2- Providing for the wellbeing of an aging population: public policies and programs

The Cuban revolutionary regime began implementing cultural, health, and welfare programs to tackle aging issues in the early 70s. The *Plan Nacional de Atención al Anciano* (National Plan for the Care of the Elderly) was introduced in 1974. It was developed in subsequent years, substantiated by studies and surveys assessing the medical and social needs of the elderly. Although it evolved in a context of economic and social crisis it came to full fruition in 1997 as the *Programa nacional de atención integral al adulto mayor* (National Program for the Comprehensive Care of the Elderly). Implementing the program requires the participation of all administrative levels i.e. national, provincial, municipal, and local and addresses not only health issues, but also social security, sports, and culture (Garcia & Alfonso de Armas, 2014).

The *Programa nacional de atención integral al adulto mayor* includes three components: Hospital Care, Institutional Care and Community Care. The first works in coordination with local healthcare institutions such as medical practitioners, and clinics and is restricted to certain cases and meant for short stays only. The second, or Institutional Care, is conceived of as complementary to family, community, and social organizations. It includes nursing homes and medical-psychological-pedagogical centers. Finally Community Care encompasses attention provided by day-care centers, as well as cultural, sports, and community socialization activities, and the services of Multidisciplinary teams for geriatric care (EMAG).

Addressing the health care needs of the elderly

A decisive step in the intensification of health care policies was taken with the implementation of the program *Médicos y enfermeros de la Familia* (Family Doctors and Nurses) in 1984. It improved elderly access to health facilities and follow-up care. Since that time outpatient offices have been set up in each « health zone" (comprising around 120 families or 600 to 700 people). They provide a general practitioner and nursing care to the neighboring population, including home and institutional care, with the support of multidisciplinary geriatric care teams, attached to the district polyclinics. These outpatient offices are the gatekeepers of a hierarchical referral system. A total of 451 polyclinics distributed over the territory attend to more complex cases offering specialized care, and medical exams i.e. lab analysis, X-rays, etc.. Furthermore local health care is coordinated

with social work. Neighboring families are monitored and receive professional and semi-professional follow-ups and assistance that are embedded in an tightly woven system of communication, relations, and collaboration between practitioners, social workers, mass organizations and more or less formalized social networks (Kath, 2010).

Health care supply has adapted with the evolution of pathologies in Cuba. While infectious diseases have been eradicated for the most part, chronic pathologies such as cancer, cardiovascular diseases, obesity, diabetes and pathologies related to deteriorated living conditions, poor nutrition, smoking and alcoholism, are on the rise. More importantly, with regards to this paper, the Cuban healthcare system has evolved so as to respond to needs related to the country's aging population.

In 2012, 80% of mortality was concentrated in the over 60 age group, with the three leading causes of death being heart disease, malignant neoplasms, and cerebrovascular diseases (Pan American Health Organization, 2012). To that end, family doctors are assisted by multidisciplinary medical teams dedicated to geriatric attention. These teams comprised of specialized physicians, social workers and psychologists are trained in gerontology. In the 1980s all general hospitals developed geriatric programs with adapted specializations and technology. In 1992, the Ministry of Health founded the *Centro Iberoamericano de la Tercera Edad* (Ibero-American Center for the Elderly) in Havana, dedicated to epidemiological research and medical assistance; One of its outcomes has been the 2005 *Proyecto Salud Bienestar y Envejecimiento de los Adultos Mayores en América Latina y el Caribe* (Health, Wellbeing and Aging of the Elderly in Latin America and the Carribbean Project; Panamerican Health Organization and University of Winsconsin). Since 2012 the Ministry of health has prioritized the "geriatrization" of its institutions so as to facilitate elderly access.

These orientations have taken place against the backdrop of severe tensions in the health sector. Investment and the coverage of current expenditures have been affected by public spending restrictions since the 1990s[11]. Buildings and equipment are decaying, facility maintenance is delayed, and supplies of consumable goods and medicines are disrupted. To face these shortages, alternative and palliative care practices develop and/or are reactivated, such as manual diagnosis, and various natural and plant-based treatment methods.

[11] Although investment in « marketable » health services and the development of clinics dedicated to "health tourism" has considerably expanded (Brotherton, 2013)

Furthermore, expatriation of medical personnel has intensified, within the framework of government cooperation programs with foreign states. The drain of medical professionals to « transactional humanitarianism» (Brotherton, 2013) interrupts the regular service provided by neighborhood family doctors, district polyclinics, and hospitals. In 2012, about 20% of medical doctors were expatriated (idem). Over the period of 2009-2015, the number of trained Cuban medical doctors continuously increased (+ 17%), but the number of family doctors drastically decreased going from 34,261 in 2009 to 12,883 in 2015 (ONEI, 2016). Although doctors and health personnel are among the more privileged of the professional branches and have seen their wages significantly adjusted over the years, they have lost much of their purchasing power. The drastic cutbacks of subsidized goods and services since the 1990s make their salaries insufficient for maintaining a decent standard of living. My fieldwork shows that many doctors are tempted to quit or reduce their service to engage in emerging and more lucrative activities such as hosting tourists.

All these factors have impacted neighborhood and local health care networks. Although the family doctor to patient ratio remains around 1:1000, dissatisfaction is rising. Criticism about limited access, long waiting lines, and deficient health and social services is increasingly heard. Budgetary constraints have led the authorities to launch a plan in 2010, aimed at reducing excess supply and adapting it to an evolving demand. To that effect, some facilities are being closed, which may imply that patients will have to travel or walk longer distances to reach a physician. The access of the elderly to health care has and will undoubtedly be affected, particularly in rural settings.

Consolidating community integration facilities for the able-bodied elderly

Cuba has developed a holistic approach to health and wellbeing, which combines biological, psychological, environmental, and social factors (Brotherton, 2013). Within this framework, the program known as *Atención Comunitaria* (Community Care) was launched for the elderly in 1978, under the auspices of the Ministry of Health. Its purpose was to coordinate various local, social, health, and academic institutions and foster cultural, educational, sport, psychosocial, and socializing activities in favor of the aging population. This program was reinforced in 1997 with the *Programa nacional de atención integral al adulto mayor* (National Program for the Comprehensive Care of the Elderly). “Senior universities” and “Senior circles” have been set up in most municipalities for aging adults that are still physically and mentally able. While the former represents a formal institution, attached to a

nearby University, which supervises the courses and the delivery of graduation certificates, the latter results from individual or institutional initiatives. Thanks to the voluntary work of a wide range of (retired and active) professionals and academics, they offer visits, workshops, debates, lectures, study seminars, physical activities, parties, choirs, trips, etc. They function on a local basis, and weave networks of sociability, support and stimulation. They aim to encourage active aging, and to offer the elderly opportunities for autonomous socializing apart from family demands and in so doing deepen their integration within their neighborhood. According to a 2010 survey half of the elderly attend them (ONEI, 2011).

Community Care Program and the National Program for the Comprehensive Care of the Elderly have also resulted in setting up *Casas del adulto mayor* (Houses of the Elderly). These day-care facilities are at the intersection of health and social care. Isolated elders, who do not have the facilities or means to cook, are subject to depression, to falling or hurting themselves are candidates who can be oriented to a *casa*. Their number has significantly grown over the past ten years i.e. +37%. Two hundred and one existed in 2005 and two hundred seventy-six in 2016 (ONEI, 2017).

Statistical scrutiny however shows that, due to the ratio between the number of aging adults and the number of available spaces in the *casas* program only a limited number actually succeeds in registering. Additionally, Cuban territory is divided in 168 municipalities some covering extended geographical areas (especially in rural zones), while others are very densely populated (in urban settings). Most *municipios* only contain one *casa*, although some host more than one. In any case, beyond the theoretical ratio, the elderly can only commute to and from the *casa* on a daily basis if they live close by, or if an effective pick-up service exists, which is only the case for a small minority of *casas*. Thus, whatever their need, in practice most elderly cannot enjoy day-care services. Also the elderly are only allowed to remain in the *casa* as long as they are mobile and do not develop a physical or mental handicap apart from those natural to aging.

All community facilities restrict their access *de facto* to able-bodied and able-minded elderly. What then occurs when an elder becomes dependent? As I will highlight below, because of cultural patterns and social norms, shaping the moral economy of care, most will remain in their homes, depending on the care of their relatives.

Reinforcing targeted welfare schemes

Public programs more specifically targeted for the destitute have also been developed. As other social categories in Cuba, the effects of the post-soviet crisis have hurt the elderly, and, on the whole, they have seen their living conditions deteriorate. Since the 1990s, the real value of retirement pensions and of public wages has dwindled. It was divided by two between 1989 and 2010 (Mesa-Lago, 2012). The reason for the considerable loss of value is rampant inflation, caused by simultaneous liberalization and marketization of goods and services such as food, transportation and clothing, combined with the parallel curtailing of public subsidies, (Mesa-Lago, 2012 & 2014; Destremau, 2015b; 2018). In 2008, the revolutionary regime undertook a reform of the pension system with the aim of securing the balance of pension schemes, while increasing the purchasing power of pensioners but these efforts did not restore pre-1990 pension levels. In fact the elderly subsisting solely with their pension are for the most part economically destitute, and their poverty has become a visible problem.

According to the survey on aging and the elderly, conducted by the Cuban Population Center in 2010 (ONEI, 2011), 60% of the elderly interviewed declare they live with deprivation and shortages. The study, however, does not specify to what extent the fact of being old is responsible for this state of affairs. In an effort to remain afloat, about 20% of respondents of retirement age declared that they continued to work, in order to keep perceiving their salary, or that they took up new jobs so as to increase their income. In any event a considerable portion of the aging population engages in economic activities either informally, or within the family business, even if that activity is limited to maintaining the household while the others members engage in lucrative occupations. Thus, the proportion of economically active elderly is certainly higher than what the statistics indicate

The luckier ones, 15% of interviewees in the same 2010 survey declare that they receive remittances from abroad. Sending and receiving remittances, primarily from the United States, has been progressively liberalized since 1993 and supported by the Obama administration as a measure of normalizing US-Cuban relations. A door-to-door survey conducted in 2015 with 1200 Cubans found that a third of those surveyed received remittances from family members abroad, with over half of them receiving less than US $1,000.00 a year. 94% of them used the money for daily expenditures and only 11% invested funds in a business[13]. Cojimar (2008; 2011) and my own fieldwork confirm that money received from abroad is used first and

[13] <https://assets.documentcloud.org/documents/1785002/cuba-final-toplines.pdf>

foremost to secure daily provisions and cover basic needs. Nevertheless, remittances regardless of their importance or quantity also remain the principal source of investment capital in Cuban market economy businesses.

In order to mitigate impoverishment and destitution, Cuban authorities have reinforced welfare mechanisms targeting « social cases » characterized by their dependency and the absence of necessary solidarity networks (Destremau, 2017b, 2017c; Espina, 2010 & 2011; Domínguez, 2008). Door-to-door neighborhood surveys led by social workers, providing measures and classifications, particularly about the condition of the elderly have been used for the development and introduction of various schemes and programs. Certain programs are targeted specifically for people living alone, in dependent situations without adequate assistance or home equipment. While others attempt to reach people suffering chronic or degenerative diseases, etc.. Between 2000 and 2010, some 40,000 "emerging" social workers have been trained to provide individual caseload follow-up and home visits to population at risk in their district (see Destremau 2017b; 2017c). These professionals, attached to the Ministry of Labor and Social Security, provide more systematic assistance than the voluntary and neighborhood networks which prevailed until then.

My fieldwork demonstrates that the elderly are the first recipients of distributed household materials and appliances such as mattresses, bed sheets, electric cookers, the worst off receiving shoes and clothing as well. While budgetary constraints have reduced social assistance, i.e. expenditures dropped by 10% between 2005 and 2010, spending has become more targeted. Although the number of beneficiaries has been cut by half, especially by limiting the number of recipients per household, the proportion of the elderly benefitting from social welfare has been consolidated: from 21,8% in 2005 to 30,2% in 2010[14]. Notwithstanding, the 2010-11 survey reported that only 2.6% of elders interviewed declared receiving financial assistance from public programs (ONEI, 2011).

Living conditions tend to degenerate when housing conditions deteriorate. In Cuba 85% of households own their homes and the rest hold long-term leases with the state. Yet neither private nor public resources have been sufficient to cope with the upkeep requirements of urban households. The construction of housing units has drastically dropped since the 1990s. The number of missing dwellings is considerable and the housing stock – for the most private – is often in a very bad state of maintenance. The need for building maintenance has been met with insufficient remittances and/or family workforce. Houses and buildings crumble at a

[14] Last data found.

recurrent rate particularly when hurricanes and storms hit the island, which results in further reducing housing supply. According to the 2012 census (ONEI, 2012), half of Cuban dwellings are in a state of dilapidation. Additionally, the building deficit leads tp overcrowding, particularly for modest families and in city centers. Welfare schemes have therefore endeavored to provide labor assistance and building materials for home repair to people devoid of necessary financial or human resources, and mainly elderly.

Welfare schemes also operate in the domain of food. The *libreta de abastecimiento*s is a ration book that every household depending on the number, age and condition of family members receives. It provides access to given quantities of food and other basic item. The elderly receive reinforced food rations, adapted to their pathologies. But since the 1990s, these rations have tended to diminish and only cover a reduced share of basic needs. Today, the elderly represent 60% of the beneficiaries of *comedores comunitarios* (community canteens), whose numbers have soared in recent years. These very inexpensive canteens serve three meals a day to those who are too poor, too disoriented, or whose home equipment is too decayed, to be able to prepare their own meals. Since breakfast and lunch are usually eaten at the canteens these places also constitute opportunities for sociability, and are a pretext to go out of one's home. In situations where an elderly person is no longer capable of making the trip to the *comedor*, a neighbor can help to carry meals to their home in plastic containers.

3- Social care deficit and family burden

Care and presence for the disabled elderly, a household responsibility

Cultural norms and moral patterns justify the fact that responsibility for care of the elderly rests on family members, especially those sharing the elderly person's lodgings[15]: Aging well, in Cuba as in many countries of the world, implies aging within one's family. Over 90% of people aged 60 and over live in independent houses or apartments. Approximately half of them live with their children[16] and this situation intensifies as they get older. A significant number share their home with siblings, or grandchildren. However, aging women tend to live more with their children than men. A 10 percent point difference (ONEI, 2011) is revealing of couple and family dynamics.

[15] The Constitution of the Republic of Cuba and the country's Family Code also establish the rights and duties of the family in a more formal way.
[16] In 2010-11, 92.5% of Cuban elders declared having living children (ONEI, 2011).

Able-bodied and able-minded aging adults represent a precious source of labor for households under time tension. They help with the work-life balance by picking up young children from the nursery or school, by preparing their meals and staying with them when they are sick. They contribute to the time consuming tasks of provisioning for food and household necessities, waiting in lines, running errands, cooking, cleaning, staying at home when e.g. fumigation brigades come by, etc. In return, they benefit from their relatives' presence and assistance with heavy chores they can no longer perform, and they experience a sense of being useful and surrounded with family.

Thus, living in a household comprising diverse age groups ideally optimizes the division of labor between genders and generations, and simplifies life for everyone. Inevitably, however, as an aging parent's autonomy decreases, so does his or her contribution of labor. Concurrently his or her need for care, presence, and support increases[17]. The elderly person tends progressively to require more of the household time and work (Duràn, 2010), which adds pressure on his or her children and relatives.

The burden of care and presence tends to become heavier as family caregivers become old themselves, resulting in several aging adults living together. This is especially true in a context of liberalized and intensified outmigration of working age adults. According to the 2012 census (ONEI, 2012), 58% of the elderly over the age of sixty who live in two to three-person households share this space with one or more aging adult. This means that small households may be composed of a majority, or exclusively consist of persons above retirement age. This ratio increases for larger households.

The elderly's need for family solidarity is not limited to care and presence. It is also, to a large extent, economic. As demonstrated above, neither pension nor welfare schemes succeed in providing the elderly with financial autonomy, particularly when they are not in adequate physical condition to perform lucrative occupations. Their survival demands forms of solidarity and redistribution of resources within families. Physical dependency aggravates economic dependency at a time when the elderly are less able to enter into reciprocal relationships, which renders them particularly vulnerable.

[17] The Health, Wellbeing and Aging 2001 Survey (*Salud, Bienestar y Envejecimiento*) conducted in Havana (where 20% of the country's elderly population lived at the time) shows that: 6,6% of the elderly face limitations to accomplish 3 or more basic activities of daily life; 12,5% face limitations to accomplish 1 or 2 basic activities; 28,5% have a close vision impairment; 24,9 % have a hearing impairment; 11,1% of the total number of elderly live alone. Another study conducted over dementia in Cuba shows that 10 % of all elderly suffer some form of cognitive deterioration (Peláez and Palloni, 2001).

Caring for the frail elderly tends to translate into a heavier demand and workload for women than for men. Research tends to show that patterns of sexual division of domestic and care labor have not been substantially modified over the decades. As in many post-Socialist countries, the state tended to transfer gendered domestic chores to women, and men's engagement has not filled the gap (Lutjens, 1995; Peciña, 2008; Proveyer, Cervantes et.al, 2010; Destremau 2015a; 2017a)[18]. The situation is exacerbated by couples' instability and migration as this leaves many households headed solely by women. Family structures are thus marked by matrifocal practices, in which women tend to gather in a single home.Thus several generations of women team together to become the backbones of the household. Adult men tend to mobility and join their current partner's household (Zabála, 2010; Vera & Diaz, 2008; Vera & Socarrás, 2008) [19].

« Cuban women's life cycle is that of care, that moves on from children to elderly », as well as to grandchildren; however, « in the conditions of a domestic economy weakened by the scarcity of goods on the market, taking care of the elderly, among whom the occurrence of diseases such as Alzheimer's increases, turns into a heroic goal » (Proveyer Cervantes et al. 2010: 65). Men, however, are not exempt from care responsibility. My research tends to show that sons share in providing care and assistance to their mothers.

Women overloaded by care obligations frequently undergo disruptions in their professional commitments, and may decide to retire early, which affects the level of their pensions (see Destremau, 2015a; 2017a for literature review). In order to supplement income they tend to engage in activities that allow for more flexible schedules. These home-based private occupations often resemble domestic chores and require few qualifications. They include work such as hosting tourists, preparing and selling food, petty production, hairdressing, manicure, etc. (Peciña, 2008 ; Echevarría & Lara, 2012; Romero Almodóvar, 2014). In the end, there is a threat that women would forfeit their professional skills and comitments to go "back to the stove front"[20].

[18] Studies underscore the fact that sexual division of domestic labor tends to be more unequal in low-income households where educational and income levels are lower, and more equal when couples have higher levels of education.

[19] According to a fertility study conducted in 2009 by the Cuban Statistical Office men between the ages of 15-54 declare to be « single » one third times more often than women (1,064 million, or 31,4% of the total, *versus* 667 020, or 20,1% ; ONEI, 2009).

[20] « Back to the "stove front": an oral history project about Cuban housewives » aims at documenting this trend (https://blog.oup.com/2015/09/cuba-oral-history-project/)

Family caregivers have become a concern for public institutions, and their burden acknowledged. In response, "schools for caregivers of elderly living in a state of dependency" are developing. Caregivers may also benefit from specialized geriatric consultation and training, psychotherapeutic focus groups, television productions and book publications. For the most part, these actions attempt to improve the quality of caregiving. They teach about degenerative diseases and the nature of aging, they suggest right gestures and attitudes, and attempt to develop caregiver's sensitivity to the condition and special needs of the elderly. They also recognize the difficulties involved in caregiving and teach participants how to avoid excessive stress, pain, frustration, depression, etc. Awareness is also being raised about the risk of elderly abuse, particularly in the context of overcrowded housing where several generations live together in small spaces. Public discourse does not, however, question the norm of family responsibility for care. Nor has it raised the issue of the patriarchal foundation of the gendered division of labor that makes caregiving weigh disproportionately on women.

Family care and housing arrangements

One central concern for Cuban families is to formulate effective intergenerational strategies with regards to the precious resources of both care and housing. These strategies tend to combine diversification with securing resources so as to meet the various needs of all family members, especially those of the children and the elderly. That is to say that income, remittances, reproductive labor and housing space are brought together to meet family expenditures, acquisitions, and possible investments.

The configuration I encountered in most of my fieldwork, which I will present as an ideal-type, is that of a continuing intergenerational and gendered family solidarity. The typical profile would be that, at forty, a woman (and possibly her spouse) has remained in (or returned to) her parent's apartment. Most likely she lives alone with her mother – her father is deceased or separated and has moved elsewhere. Her mother, recently retired and around sixty, takes care of her daughter's children after school, does part of the shopping and the cooking. Twenty years later, the same woman is herself retired or engaged in home-based self-employed activities. She is still taking care of her then dependent mother (who, by now has turned eighty), as well as helping her own daughter with her children. For these live-in family caregivers, retirement thus means the start of an intensified second career dedicated to one's parent and grandchildren. Care thus rolls on, from one generation to the next, with the caregiver remaining in the same household.

Within this archetypical pattern, upon the death of the owner, the house is transferred to the caring daughter, protected as a continuous occupier, while her siblings (if there are any) relinquish their share. This has become a widespread practice supported by successive Housing Acts aimed at eradicating real estate speculation and protecting resident rights. Until today, Cuban revolutionary laws systematically protected occupiers of any given dwelling. They had priority over legal owners when they remained living continuously in a home for ten years. This period was later reduced to five years, a period after which they were granted eventual ownership right[21]. Additionally, according to the 1960 Urban Reform Act, amended by law 48 which passed in 1984, and then by law 65 of 1988, state authorities must supervise all real estate sales and purchases, on the basis of an almost symbolic frozen asset value. Furthermore, property was limited to one residence per person, except for dwellings located in resort areas. And, until the 1990s, people who chose to leave Cuba, saw their property confiscated by the state, which allocated it as full property or granted a permanent usufruct right to families in need of housing. Thus, until recently the stakes for legal heirs of relinquishing ownership shares has been almost non-existent. In 2011 this configuration changed with the passage of law 288 which liberalized real estate purchases and sales between individuals at prices freely agreed upon between the parties [22].

When a real estate property becomes "liberated" by the death of its owner, it must be transferred to the other occupiers of the dwelling, provided they do not yet own another accommodation. In such a framework, family housing and real estate ownership strategies have been closely entangled with care arrangements. Because daughters or grand daughters are more liable than their brothers to remain or to return home as a caregiver of their aging parents and grandparents, they are also more liable to inherit the property. Male family members tend to move out when they find a partner, until the relationship breaks up and they come back to their parent's home, if it offers enough space. Matrifocality if thus the result of both social and moral norms, and legal provisions.

As I will explain below, in certain cases, occupiers that become owners are in fact non-related caregivers.

[21] http://www.cubanet.org/htdocs/ref/dis/vivienda.htm

[22] The recent liberalization of the housing market (2011) mainly benefits families receiving remittances and/or disposing of foreign funds. It is expected to have an evicting effect on poorer households living in coveted city centers.

Getting help from outside the family

Households may obtain external assistance to take on the care burden. In 2002, the Ministry of Labor and Social Security instituted a scheme according to which a destitute dependent person who is sick, disabled or elderly and who has no necessary home care may be allocated the services of a state-paid caregiver. The scheme reached a high of some 17,000 beneficiary households, before decreasing toward 2010[24] (ONEI, 2011). The figures show that existing needs are far from being satisfied, because of budgetary constraints, an also because the low wages make the occupation unappealing in the face of the parallel development of a care market. Women would tend to prefer commodified domestic employment or any other opportunity, including migration over this form of public employment.

For its part, the market for domestic services is in full expansion. This type of work was suppressed by the Revolution and domestic workers were then trained in various occupations deemed more respectable and in line with women's emancipation and dignity. Nevertheless, paid and/or unpaid domestic employment persisted covertly until 1993, when the occupation was legalized. It was designated "domestic personnel" and categorized with other branches of self-employment. Henceforth it flourished in parallel with the development of tourism, growing socio-economic discrepancies, and aging, to the point that domestic employment reaching unprecedented levels of "explosive growth" (Romero Almodóvar, 2014). Recent development of the Internet on the island has helped to expand this industry. Posting and circulating advertisements even to the United States is now a simple matter. Nevertheless hiring a home caregiver at market rate remains a luxury. It is accessible only to families receiving remittances from abroad, or conducting a lucrative activity in the new market economy. In and of itself, the development of this marketable service cannot be considered a public policy response to social care needs, exacerbated by aging and emigration. Thus, inequalities are on the rise, not only in terms of material wellbeing and consumption, but also in terms of households' capacities to hire available and necessary services.

A parallel arrangement is emerging and has apparently been widespread[25], although its frequency is difficult to assess. It typically concerns urban middle class households where children have migrated and an elderly relative is left alone in a relatively well-maintained and large dwelling. Given the very low birth rate in Cuba, it is often the case that when one child moves he/she leaves an aging parent behind to finish his or her days alone. In these cases

[24] Last estimates found.
[25] According to my fieldwork findings.

children sometimes invite a relative, or even a stranger to come and stay with the elderly parent in need of presence and care, In exchange they propose a *viager* « home for care » deal, whereby the caregiver receives an oral and sometimes legal promise in the form of a will to inherit the dwelling when the parent passes away. In these cases legal heirs relinquish their claim on the house, especially when, having migrated, they have already lost their right to property or when they already own a home and have reached the allowed quota of one dwelling per person.

During the time of my fieldwork I met several individuals, women and couples that thanks to this system moved from rural areas to settle in Havana. Some of them did this with the intervention of Church organization. Today, after several years of cohabitation, care, and service to the original elderly owner they own property in sought-after areas. In recent years, these arrangements have become less common. The commodification of real estate allowed by the 2011 law deters heirs from relinquishing an inheritance. Live-in caregivers today tend to be paid, but the risk still exists that they can claim occupiers' rights to stay in the dwelling after the owner's death.

Care tensions and the risk of abuse

The various configurations and arrangements described above may combine, not only according to household structures and resources, but also to various times of the life cycle. They are structured by crises, tensions, and turning points, such as a bad fall, a health issue, a change of job, migration, with the departure of relatives while others return home, a desire for a child frustrated by lack of living space, etc. Difficulties, disappointments and challenges of various sorts arise throughout life, and it is at those times that abuse, the dark side of care, can emerge.

Abuse of the elderly is a growing concern for public authorities and individuals. The subject is evoked in daily conversation, researched by academics from health and psychosocial fields, and discussed in television programs and internet posts. Abuse may be economic/ financial, psychological, physical, or social[26] (Rodríguez Mirandal et al., 2002, Griñan Peralta et al., 2012). Suspicion about abuse target firstly external caregivers, coming from the countryside and readily considered as opportunists grabbing to obtain housing in exchange for care, doing

[26] Social abuse includes situations such as obstacles to walking on sidewalks due to potholes and tree roots poking through the pavement, impediments to crossing streets because of poorly coordinated traffic lights, or the absence of adapted public transportation.

their job without love or genuine concern. Suspicion probably feeds on the children's absence or distance from their aging relatives, and is a well-known narrative of attitudes towards domestic workers. Interviewees recount their experience of the difficulty of finding the "right person", meaning the one who can care for their parent with filial love and attention.

But abuse is not restricted to non-family members. Stories of intergenerational conflicts in overcrowded households are increasingly recounted. The youth fight to liberate themselves from their parent's social norms so as to forge their own way, culture, and forms of consumption. Sometimes they adopt violence to do so. Elderly's abuse may also be a sign of shifting homecare moral economy.

Another kind of social and public issue that is often mentioned in the various media and collected narratives is that of the isolation experienced by aging adults that live alone

Isolated elderly: nursing homes as a residual response

According to census data, in 2012, 14% of all adults over the age of 60 were living alone, that is over 130,000 individuals with an average age of 69, and representing 39.6% of the total of one-person households[27] (ONEI, 2012). Intensified migratory movement has recently tended to exacerbate isolation. It is a complicated social issue when the elderly lose their capacity to take care of themselves, and all the more so when they are destitute. As seen above, most public policies and social initiatives concern able-bodied and able-minded individuals, and are conceived as complementary to family and/or community solidarity and sociability. Nursing homes do exist, nonetheless, to compensate for families without the means to provide the necessary care or to employ caregivers.

According to official statistics, 148 heavily subsidized public nursing homes existed in Cuba in 2016, offering 11,771 beds (ONEI, 2017)[28]. This means that less than one out of 16 people over the age of 85 may claim a place in a nursing home. At the end of the 2000s, men represented 71% of elderly individuals hosted in nursing homes. This may be interpreted- especially in a classic demographic context where women outlive men - as the consequence of their residential instability during their active life, and their relative marginalization from family solidarity and the dwelling where it is expressed.

[27] The proportion of one-person households in the total number of households increased from 13,9% in 2002 to 18,7% in 2012, according to census results.

[28] Despite contradictions between various sources and the economic challenges during the worst years of the crisis the number of beds seems relatively stable since the 1990s.

In order to qualify for a place in a nursing home a person must require permanent care and have no possibility of remaining within their community. The majority of those accepted present multiple chronic diseases and physical and mental disabilities. Those patients with degenerative diseases, particularly those affected by Alzheimer's are not accepted in nursing homes. The first specialized institution dedicated to persons affected by cognitive deterioration and dementia opened in Havana in 2014.

Nursing homes are regulated by a set of resolutions adopted at the beginning of the 1980s, in the framework of the National Program for the Comprehensive Care of the Elderly. This program understands nursing homes to be an expedient substitute for families in extreme cases. It echoes the cultural and moral norm of "keeping them at home." Nursing homes on the whole have dreadful reputations. Often heard narratives recount the shortage of qualified personnel, working there for lack of other opportunity, with no incentive or motivation and stealing food and other supplies to sell them on the black market or for their personal consumption. People speak of building decay, of lack of supply and equipment, of poor and insufficient food; of neglect of hosted persons and absence of entertainment or activities. My interviews show that taking or accepting the decision to place a relative in a nursing home is generally perceived with regret and some shame at what may be interpreted as abandonment of family.

Improving both the quantity and quality of residential nursing homes has recently emerged as a necessity. After a task force was created in 2011 the Ministry of Public Health launched an important program of rehabilitation, repair and extension of nursing homes in order to improve what is apprehended as a crucial weakness of the Cuban social system. Repair and improvement of Houses of the Elderly and nursing homes is taking place in some locations, sometimes with the cooperation of international NGOs or in the framework of a historical city center rehabilitation consortium such as the UNDP in Cienfuegos. Some experimental « protected residencies » were opened in Old Havana, with the help of international cooperation[30], in order to increase the options of isolated elderly people, or to offer alternatives to those who do not wish to stay with their family. The few religious institutions that remained during the revolutionary period are now heralded as examples of good practices. It is difficult to evaluate the perspectives of this expansion and rehabilitation program, in a context that still holds the ultimate value as that of family care.

[30] The Basque Foundation Euskal Fondoa, in this case.

Conclusion

This paper has dealt with the intensified needs for health and social care spurring from demographic aging in Cuba, which could be considered "the burden of triumph" (Dilnot, 2017). It has examined the responses and coping mechanisms developed in Cuba over the past decades and demonstrated that the moral economies of social justice, women's emancipation, and homecare tend to conflict in a context of care deficit (Hochschild, 1995).

I have shown that Cuba's population is undergoing a severe aging process, due to extended life expectancy, reduced fertility, and migration. As a result, the aged-dependency ratio has reached alarming rates, both at macro and households levels. Next, I have highlighted how public policies, particularly in the areas of health care and community integration, have developed in order to maintain the elderly in a state of physical, mental, and social wellbeing. I have also reviewed welfare schemes attempting to mitigate the impoverishment and destitution of the elderly hard-hit by the social effects of market-oriented reforms and reduction of public subsidies. The third part of the paper shows how an overarching moral economy of homecare and family love explains the configuration of intergenerational households. Most elderly adults in Cuba live with their descendants and demand increasing amounts of work and attention as they age, and become less able, more frail and dependent. Care tensions become acute when families are diminished by low birth rates and migration, when the caregivers themselves become old, and when the elderly suffer chronic or degenerative diseases.

I have chosen to mobilize Fassin's (2009) moral economy framework, to highlight a series of moral and practical dilemmas (Angel & Angel, 2018) that confront public policy and private strategies. The elderly are valued in Cuba, especially for their contribution to the Revolution. Their efforts and sacrifices have permitted the establishment of public services, as well as educational, social, political and economic achievements and social entitlements. At the macro level, however, in a context of strong budgetary constraints, reinforcing investments and redistribution in favor of the elderly has to be balanced with other competing demands. Productive sectors need strengthening and support. The youth in particular require better training, housing and job prospects, if only to encourage them not to leave the country.. Furthermore, as the new generations grow in an increasingly commodified and individualistic society, their attachment to the Revolution dwindles. Social justice and solidarity are losing ground to more pragmatic and individualistic values. Setting priorities thus emerges as a

strongly politicized issue of intergenerational justice, intersecting with gender, racial, class, and territorial discrepancies.

At a micro level, I have shown that keeping in line with cultural and moral norms and values of homecare tends to assign one or several family members to caregiving. Traditional and persistent patterns of gender labor division make it more acceptable for women to quit, or alter, their professional commitment, in order to fulfill their filial obligations. Alternatively, a homecare service market is developing, but is only affordable for the most affluent. This places women, especially, in a dilemma: keeping in line with the moral economy of homecare and engaging in a "care career" may entail jeopardizing some of their social conquests towards effective equality of opportunity and emancipation. In this regard, developing nursing homes with higher standards may accompany a shift in the moral economy of homecare. The boundary between health and social care needs to be carefully managed.

Although constructed as a public problem and widely documented in Cuba, the pressure aging exerts on care systems has received little attention by social scientists. In this regard, this paper contributes to comparative knowledge on aging in Post-Soviet, Latin American and Caribbean countries. In particular, it calls for a close examination of converging and diverging trends in aging, coping mechanisms and moral economies in Post-Soviet countries exposed to processes of economic liberalization, migration, impoverishment and growing inequalities.

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