

Department of Economic and Social Affairs

Regional Dimensions of the Ageing Situation



**United Nations
New York, 2008**

Department of Economic and Social Affairs

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ST/ESA/318

ISBN 978-92-1-130263-9

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Printed at United Nations Headquarters, New York

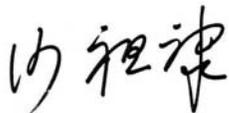
Foreword

The year 2002 marked a watershed in a policy discourse regarding older persons worldwide. The Second World Assembly on Ageing convened in Madrid, Spain, to discuss the challenges and opportunities of ageing in the twenty-first century adopted two innovative international policy documents: the *Political Declaration* and the *Madrid International Plan of Action on Ageing*. Five years later, the first review and appraisal has been conducted at the national, regional and international levels to assess the implementation of the Madrid Plan of Action around the world.

The review and appraisal exercise offered an opportunity to review various dimensions of ageing, analyze policy responses and try to assess the changes in overall quality of life of older persons in all five UN regions of the world. A bottom-up participatory assessment was proposed to review and appraise national policy action on ageing since the Madrid Assembly. This important participatory approach empowers older persons by allowing them to express their views on policies that relate to them and which could have possible ramifications for their well-being.

The present publication, *Regional Dimensions of the Ageing Situation*, contributes to the series of events, conferences and publications related to the first review and appraisal of the Madrid International Plan of Action on Ageing. It highlights priorities, as well as recent trends and policy developments, in the five UN regions of the world. The publication, which is a joint effort of UN staff and international experts, aims to assist national governments, the international community and the public at large to better assess the situation of older persons five years after the Second World Assembly on Ageing. It should better inform the debate on how to align priorities, policy innovations and technical cooperation to implement the objectives of the Madrid Plan of Action.

It is my sincere hope that the important issue of ageing will gain more attention in the international arena. Only thorough and rigorous analysis, such as that undertaken in this publication, can provide the basis for evidence-based policies aimed at building a society for all ages.



Sha Zukang
Under-Secretary-General
for Economic and Social Affairs

Contents

- Foreword
- Contents
- Explanatory Notes
- I. The Madrid Plan: A Comprehensive Agenda for an Ageing World
by Sergei Zelenev
- II. Regional Overview of Trends and Policies
by Peggy L. Kelly
- III. Ageing Trends in Asia and the Pacific
by Sheung-Tak Cheng, Alfred C. M. Chan and David R. Phillips
- IV. Ageing Policies in Africa
by Monica Ferreira
- V. Ageing Policies in Latin America and the Caribbean
by Martha Peláez
- VI. Ageing Trends and Policies in the European Region
by Bernd Marin and Asghar Zaidi
- VII. Ageing in Western Asia
by Madiha El Safty
- VIII. The way forward
by Alexander Sidorenko and Robert Venne

Figures

- III-1. Framework of a participatory approach to review and appraisal activities
- III-2. Percentage increase in population aged 60 and above between 1990 and 2025 in selected Asian and Pacific countries or areas
- III-3. Percentages of two age groups (0–14 years and 60+ years) of the total population grouping in Asia, 1950–2050
- V-1. Factors affecting policy development and well-being of older persons
- V-2. Scheme of translating global ageing priorities into national targets
- V-3. Public spending on social protection in Latin America and the Caribbean, as a percentage of gross domestic product
- V-4. Proportion of persons aged 60 and above, by sex, in major Latin American and Caribbean cities who report one or more potentially disabling conditions, in percentages

V-5. The essence of elder mistreatment

Tables

- III-1. Population aged 60 years and above in selected Asian and Pacific countries or areas and the total Asian population, in the years 2006, 2025 and 2050
- III-2. Key pension reform developments in selected countries of East and South Asia
- III-3. Labour force participation rates of older persons by age and sex in selected Asian and Pacific countries or areas, 2005
- III-4. National focal agencies and coordinating bodies on ageing, selected countries or areas
- III-5. National policies and plans of action on ageing in selected countries or areas
- IV-1. Demographic profile of the population aged 60 and above, of the five subregions of Africa, in 2005 and projected to 2025 and 2050
- IV-2. Labour force participation, sex ratios and life expectancy of the population aged 60 and above, of the five subregions of Africa, 2005
- V-1. Demographic profile of the population aged 60 and above, of the three subregions of Latin America and the Caribbean, in 2005 and projected to 2025 and 2050
- V-2. Social security in Latin America and the Caribbean
- V-3. Non-contributory pension coverage provided by Caribbean governments
- V-4. Legislation and Programs guaranteeing access to health care for older persons in Latin America and Spanish Speaking Caribbean
- VII-1. Annual population growth rate in ESCWA countries, 2000–2050, in percentages
- VII-2. Estimates of persons aged 60 years and above in the ESCWA countries, 2005 and 2050, in thousands and as percentages of the total population
- VII-3. Percentage of the oldest old population (aged 80-plus years) within the total population, and as a percentage of the population aged 60+ of the ESCWA countries, 2005 and 2050
- VII-4. Estimated total number of men aged 60+ and 80+ per 100 women aged 60+ and 80+ in the ESCWA countries, for 2005

Explanatory Notes

The following abbreviations have been used:

AARP	formerly, American Association of Retired Persons
AGFUND	Arab Gulf Programme for United Nations Development Organizations
CSCI	Commission for Social Care Inspection, UK
CIS	Commonwealth of Independent States
CFR	Council on Foreign Relations
ESCAP	Economic and Social Commission for Asia and the Pacific
ESCWA	Economic and Social Commission for Western Asia
ECA	Economic Commission for Africa
ECE	Economic Commission for Europe
ECLAC	Economic Commission for Latin America and the Caribbean
ERSAP	Economic Reforms and Structural Adjustment Programme
EM	elder mistreatment
EC	European Commission
SAGE	Global Ageing and Adult Health
GPIF	Government Pension Insurance Fund
GDP	gross domestic product
HAI	HelpAge International
IAGG	International Association of Gerontology and Geriatrics
IDS	Institute of Development Studies
INIA	United Nations International Institute on Ageing
INTRA	Integrated Health-Care Systems Response to Rapid Populations Ageing in Developing Countries
IDB	Inter-American Development Bank
ILO	International Labour Organization
UNAIDS	Joint United Nations Programme on HIV/AIDS
ALMA	Latin American Academy of Medicine of Older Adults
SABE	Latin American and Caribbean regional survey on ageing, health and well-being
LTC	long-term care
MA:IMI	Mainstreaming Ageing: Indicators to Monitor Implementation
MEAA	Middle East Association on Alzheimer's
NSGRP	National Strategy for Growth and Reduction of Poverty
NEPAD	New Economic Partnership for Africa's Development
NGO	non-governmental organization
UNHCR	Office of the United Nations High Commissioner for Refugees
OMC	Open Method of Coordination
OECD	Organization for Economic Cooperation and Development
PAHO	Pan American Health Organization
PAYG	pay-as-you-go pension scheme
RSILAC	Regional Strategy for the Implementation in Latin America and the Caribbean of the Madrid International Plan of Action on Ageing
SARS	severe acute respiratory syndrome

SCIE	Social Care Institute for Excellence, UK
SSA	Social Security Administration
SHARE	Survey of Health, Ageing and Retirement in Europe
TFR	total fertility rate
UN/DESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USCB	United States Census Bureau
WHO	World Health Organization

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Unless otherwise specified, the following regional groupings have been used:

Economic and Social Commission for Asia and the Pacific (ESCAP)

Member States (53)

Afghanistan
 Armenia
 Australia
 Azerbaijan
 Bangladesh
 Bhutan
 Brunei Darussalam
 Cambodia
 China
 Fiji
 France
 Georgia
 India
 Indonesia
 Iran, Islamic Republic of
 Japan
 Kazakhstan
 Kiribati
 Kyrgyzstan
 Lao People's Democratic Republic
 Malaysia
 Maldives
 Marshall Islands
 Micronesia, Federated States of
 Mongolia

Myanmar
Nauru
Nepal
Netherlands
New Zealand
Pakistan
Palau
Papua New Guinea
Philippines
Republic of Korea
Russian Federation
Samoa
Singapore
Solomon Islands
Sri Lanka
Tajikistan
Thailand
Timor-Leste
Tonga
Turkey
Turkmenistan
Tuvalu
United Kingdom of Great Britain and Northern Ireland
United States of America
Uzbekistan
Vanuatu
Viet Nam

Associate Members (9)

American Samoa
Cook Islands
French Polynesia
Guam
Hong Kong, China
Macao, China
New Caledonia
Niue
Northern Mariana Islands

Economic Commission for Africa (ECA)

Member States (53)

Algeria
Angola
Benin
Botswana

Burkina Faso
Burundi
Cameroon
Cape Verde
Central African Republic
Chad
Comoros
Congo, Republic of the
Côte d'Ivoire
Democratic Republic of the Congo
Djibouti
Egypt
Equatorial Guinea
Eritrea
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho
Liberia
Libyan Arab Jamahiriya
Madagascar
Malawi
Mali
Mauritania
Mauritius
Morocco
Mozambique
Namibia
Niger
Nigeria
Rwanda
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Somalia
South Africa
Sudan
Swaziland
Togo
Tunisia

Uganda
United Republic of Tanzania
Zambia
Zimbabwe

Economic Commission for Latin America and the Caribbean (ECLAC)

Member States (44)

Antigua and Barbuda
Argentina
Bahamas
Barbados
Belize
Bolivia
Brazil
Canada
Chile
Colombia
Costa Rica
Cuba
Dominica
Dominican Republic
Ecuador
El Salvador
France
Germany
Grenada
Guatemala
Guyana
Haiti
Honduras
Italy
Jamaica
Japan
Mexico
Netherlands
Nicaragua
Panama
Paraguay
Peru
Portugal
Republic of Korea
Saint Kitts and Nevis
Saint Lucia
Saint Vincent and the Grenadines
Spain
Suriname

Trinidad and Tobago
United Kingdom of Great Britain and Northern Ireland
United States of America
Uruguay
Venezuela, Bolivarian Republic of

Associate Members (8)

Anguilla
Aruba
British Virgin Islands
Montserrat
Netherlands Antilles
Puerto Rico
Turks and Caicos Islands
United States Virgin Islands

Economic Commission for Europe (ECE)

Member States (56)

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Canada
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia

Liechtenstein
Lithuania
Luxembourg
Malta
Moldova
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom of Great Britain and Northern Ireland
United States of America
Uzbekistan

Economic and Social Commission for Western Asia (ESCWA)

Member States (13)

Bahrain
Egypt
Iraq
Jordan
Kuwait
Lebanon
Occupied Palestinian Territory
Oman
Qatar
Saudi Arabia
Syrian Arab Republic
United Arab Emirates
Yemen

I. The Madrid Plan: A Comprehensive Agenda for an Ageing World

Sergei Zelenev¹

An event of major international significance took place in Madrid six years ago, in April of 2002: representatives of 159 countries gathered at the Second World Assembly on Ageing to share ideas and design policy solutions for the world's ageing population. Wide-ranging discussions at the Assembly not only focused on numerous facets of changing age distributions that have multiple social consequences, but also helped to forge an international consensus regarding the development of priorities and ways to address the challenges and opportunities of demographic ageing. The intergovernmental body at Madrid recognized that the rising median age and the shift towards older populations, owing to gains in life expectancy amid decreasing fertility rates, were a truly global phenomenon that required forward-looking policy responses.

The Assembly called for changes in attitudes, practices and policies at all levels and in all sectors so that the potential of an ageing world would be set on a positive course: to create a “society for all ages”. The emphasis on the need to harness the fruitful potential of ageing societies represented a radical shift away from the welfare approach to ageing that had generally prevailed since the 1980s.

The documents that the Assembly produced — the Madrid International Plan of Action on Ageing and the Political Declaration — vividly highlighted the largely convergent views of the international community on the need for concerted policy action at all levels to address ageing in a coherent and comprehensive manner. The point of departure was the acknowledgment that ageing represents more than just a “challenge”; it actually marks a tremendous social achievement and a milestone of human progress. The commitments made in Madrid make a compelling, practical framework for adjusting to an ageing world.

Policymaking in the United Nations usually flourishes with the opportunity afforded by “anniversaries” of major policy documents that are reviewed and appraised on such occasions. The fifth anniversary of the Madrid Assembly is no exception — Governments recently took stock of what has been achieved since the adoption of the action plan and political declaration on ageing, and will focus on issues that remain on the agenda for building a society for all ages.

A. Before Madrid: evolution in thinking

The Madrid International Plan of Action on Ageing reflects a global consensus on the social dimensions of ageing that has evolved during preceding decades through multilateral activity and work conducted at the United Nations. Pioneering efforts to

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address the challenges of ageing began in the 1940s, shortly after the inception of the United Nations. The first initiative to place ageing on the United Nations agenda was a draft declaration on old-age rights that the Government of Argentina submitted to the General Assembly in 1948. The text contained several articles that referred to rights of older persons to assistance, housing, food, clothing, health care, recreation and work as well as “stability” and “respect”.² Although it was not adopted, the issue itself stayed on the UN agenda and two years later the United Nations Secretariat produced the report “Welfare of the aged: old-age rights”.

Attention to the consequences of population ageing was renewed at the UN in 1969 when the Government of Malta submitted the topic to the General Assembly. Debate on the economic and social consequences of ageing ensued in the 1970s. In 1978, the General Assembly decided to convene the first world assembly devoted to the issues of ageing,³ as a step toward formulating an international action plan on ageing that would address the needs and demands of older persons as well as analyze relationships between population ageing and economic development. Consequently the first World Assembly on Ageing was held in Vienna in 1982 and adopted the Vienna International Plan of Action on Ageing (United Nations, 1982). The recommendations of that Plan, together with legal mandates stemming from such United Nations legislative and consultative bodies as the General Assembly, the Economic and Social Council as well as Commission for Social Development, put the range of issues of older persons firmly on the international agenda.

The Vienna Plan was the first international instrument for action on development issues of ageing. It identified three priority areas: (a) the sustainability of development in a world where the population is increasing in age; (b) the maintenance of good health and well-being to an advanced age; and (c) the establishment of an appropriate and supportive environment for all age groups. The purpose of the Vienna Plan was to help Governments in formulating their policies on ageing, by guiding national and international efforts and strengthening capacities of Governments and civil society organizations to deal effectively with demographic ageing. In its 62 recommendations for action, the Vienna Plan addressed issues of health and nutrition, housing and environment, the protection of elderly consumers, family, social welfare, income security, employment and related areas, as well as of research, data collection and analysis, and education and training.

The Vienna Plan raised awareness on ageing issues around the world. In its wake several regional plans of action on ageing were adopted, coordinated by the United Nations regional commissions. They boosted efforts to (a) analyze the existing situation in the regions, (b) identify regional priorities for improving the situation of older persons in forthcoming decades and (c) propose measures and initiatives for the consideration of the respective Governments. The regional plans generally recognized that the increase in the proportion of older persons in the population has economic, social and political ramifications that must be addressed, taking into account regional and national circumstances.

² See draft resolution A/C.2/213, dated 30 September 1948.

³ See General Assembly resolution 33/52 of 14 December 1978.

In 1991, the General Assembly adopted the United Nations Principles for Older Persons,⁴ for policymakers to incorporate into national development programmes. Underscoring the contribution that older persons make to their societies, the 18 principles were grouped under five quality-of-life characteristics:

- independence
- participation
- care
- self-fulfilment
- dignity

A year later, the General Assembly designated 1999 as the International Year of Older Persons “in recognition of humanity’s demographic coming of age and the promise it holds for maturing attitudes and capabilities in social, economic, cultural and spiritual undertakings, not least for global peace and development in the next century”.⁵ The General Assembly named the theme of the year “towards a society for all ages”, echoing the theme of a “society for all” that had been proposed earlier that year at the World Summit for Social Development at Copenhagen (United Nations, 1995a). In its resolution⁶ on the matter, the General Assembly noted that the concept of a society for all ages has four interlocking dimensions:

- the situation of older persons
- lifelong individual development
- multigenerational relationships
- the relationship between the ageing of populations and development

In that perspective, the situation of older persons cannot be considered separately from the scope of long-term opportunities that society allows them. The key is seeing the “life course” in its progressions from childhood through old age, recognizing that older people are not simply a homogenous group but individuals whose individual diversity tends to increase with age (WHO, 2002a).

Discussion of the notion of an “inclusive society” has placed it among the fundamental goals of “society for all” where “everyone, every individual, each with rights and responsibilities, has an active role to play”. By adding the age dimension to the concept, Member States emphasized the comprehensive and interdependent nature of such an approach whereby “the generations invest in one another and share in the fruits of that investment, guided by the twin principles of reciprocity and equity” (United Nations, 1995b).

Public interest in the International Year of Older Persons and its political message reverberated world-wide, generating responses to issues of ageing long after the event. The theme of a society for all ages inspired preparations for the Second World Assembly on Ageing, held three years later at Madrid. Seemingly the world was beginning to

⁴ See General Assembly resolution 46/91 of 16 December 1991, annex: “United Nations Principles for Older Persons: to add life to the years that have been added to life”.

⁵ See Proclamation on Ageing, General Assembly resolution 47/5 of 16 October 1992, annex.

⁶ See General Assembly resolution 50/141 of 21 December 1995.

recognize that “the ageing of societies in the twentieth century, unprecedented in the history of humankind, is a major challenge for all societies and requires a fundamental change in the way in which societies organize themselves and view older persons”.⁷

The preparations for the Madrid event served to bridge many gaps in the understanding of a range of issues related to the demographics of ageing. The preparatory process facilitated the exchange of information among academics, non-governmental organizations and policymakers on the development priorities of a rapidly ageing world population. Consonant with those dimensions to older people’s lives identified in the General Assembly resolution 50/141, those priorities included lifelong individual development, health and well-being; intergenerational equity, social protection and environments enabling and supportive. “Active ageing” was a guiding concept among the priorities, in bringing together agendas for “optimizing opportunities for health, participation and security in order to enhance quality of life as people age” (WHO, 2002a, p.12).

The Second World Assembly on Ageing, which was held in 2002 to mark the twentieth anniversary of the first World Assembly in Vienna, had the major task of reviewing the implementation of recommendations by the first Assembly and the Vienna Plan. The aim was to formulate a new plan of action to address the social, cultural, economic and demographic realities of the twenty-first century, according special consideration to the needs of developing countries.

Two years of negotiations brought together, in the draft of a plan document, the central themes of major United Nations conferences and summits held in the 1990s. The concerns of older persons were placed in the context of the promotion and protection of human rights and fundamental freedoms, including the right to development, underscoring the importance of achieving sustainable economic and social development in the context of an inclusive society. The active involvement of civil society organizations, including those of older persons, enriched the debate, often broadening the agenda and providing an impetus for fruitful discussions.

Differences between the Member States in their vision and approaches to ageing policies — so obvious at the beginning of preparations — were hammered out to produce a consensus. The results, the Political Declaration and the Madrid International Plan of Action on Ageing, extended and enhanced the initiatives of the international community in the Vienna Plan, taking into account new paradigms of ageing and new realities of international cooperation (United Nations, 2002a).

B. The social context

The basic premises, policy objectives and implementing actions of the Madrid International Plan of Action on Ageing are tied to the current demographic shifts in the world leading to a growing share of older persons. Data compiled by the United Nations Population Division (United Nations, 2007a) show that the number of persons aged 60

⁷ See General Assembly resolution 52/80 of 12 December 1997.

and over is expected to triple by 2050. Currently 1 person in every 10 is aged 60 years or over; by the year 2050 more than 1 in every 5 will be aged 60 years or over. In absolute terms the number of persons aged 60 years or over is estimated to be 673 million in 2005 and is projected to grow to 2 billion by 2050, at which time (for the first time in human history) the population of older persons will be larger than the population of children (0-14 years). Meanwhile, the older population is itself ageing. Currently, the “oldest old” segment, namely people aged 80 and over, represents 13 per cent of the population aged 60 and over; yet projections show that by 2050 that proportion will have grown to some 20 per cent of those aged 60 and above.

The world has experienced major improvements in longevity. Life expectancy at birth has increased by 21 years since 1950, to the current level of 67 years. Of those surviving to age 60, men can expect to live another 18 years and women an additional 21 years. As noted in the Madrid Plan, such a profound global transformation has far-reaching consequences for every aspect of individual, community, national and international life; and every facet of humanity will be affected: social, economic, political, cultural, psychological and spiritual (United Nations, 2002a).

Demographic trends showing a rising proportion of older persons create a policy imperative to integrate older persons into national poverty eradication strategies and care provision efforts. At the same time, some basic questions may need to be clarified: Does a specific age — such as 60 or even 65 — represent a realistic threshold (contrary to a purely statistical approach) for defining a certain population cohort as “older persons”? Or, are other criteria more appropriate for contemporary society, given the conditions in which people live? Such questions are important methodologically and have policy implications.

In developing countries the rate of population ageing is accelerating at a pace not seen before. The old-age dependency ratio⁸ could more than double in 50 years in some developing countries, whereas in developed countries it has doubled over a range of 150 to 200 years. In developing regions, the number of persons currently aged 60 or over is expected to increase nearly fourfold from 2005 to 2050, in comparison with a factor of 1.7 in developed regions. Not only do the numbers demand attention among the developing countries. Many of those countries must tackle population ageing in circumstances very different from those of more developed regions. Developing countries are facing acute challenges associated with ongoing urbanization and industrialization, which coincide with societal shifts in living arrangements and changing family structures.

Ageing poses a truly global challenge wherein developed and developing countries are facing the need to cope with its numerous consequences. One major difference between the more affluent and less affluent countries is that the former aged gradually and have accumulated more resources to tackle the consequences, including sustainability of social protection systems. Developing countries face multifaceted consequences of ageing while

⁸ The old-age dependency ratio is the number of persons 65 years and over per one hundred persons aged 15 to 64 years.

still being largely poor in terms of per capita income and being pressed to solve numerous other challenges of development.

The socio-economic implications of demographic ageing go beyond issues of social welfare to socio-economic development in a broad sense, including issues of human rights, societal participation and acknowledgement of the real value that older persons hold for society. Reduction of poverty, a key goal on the international agenda, has a specific dimension in the context of ageing, since poverty among older persons remains high in many societies. Special efforts are needed to address that challenge. In developing countries, the issue of poverty eradication is particularly acute and impossible to solve without social and economic development. Integration of ageing into national development in the context of the Poverty Reduction Strategy Papers and Millennium Development Goals could be particularly helpful in improving the situation of poor and vulnerable older persons.

Gender concerns are a critical subset of issues in the design of the Madrid Plan, especially because the attention accorded to them in the Vienna Plan was felt to be insufficient. Most older persons today are women. Many older women bear the brunt of the negative effects of development, advanced age and social prejudice. Growing feminization of poverty, ever present in many regions, as well as abuse and violence against older women, have made imperative a special focus on gender issues and effective strategies to remedy them. Owing to rising life expectancy among surviving older women, there are only 57 men for every 100 women aged 80 and above (United Nations, 2007a). Feminization of ageing merits special policy attention because many women in developing countries are single, illiterate and outside the labour force (Mujahid, 2006).

Another dimension of the gender perspective on ageing to be reckoned with is changes in the living arrangements of older persons: worldwide 19 per cent of older women live alone, compared with 8 per cent of older men. Generally older persons living either alone or in “skipped-generation” households tend to be an especially disadvantaged group in the less developed regions; and older women are most likely to be found in such situations (United Nations, 2005a). Not only in the developing world are women affected; for example, in the United States, at the threshold of the twenty-first century, 25 per cent of divorced, separated or never-married women over age 65 lived in poverty (Cogan and Mitchell, 2003).

C. A bold strategy for a new century

The Madrid International Plan of Action on Ageing has absorbed numerous insights and important provisions from several global summits and conferences. It has benefited most, however, from the 1995 World Summit for Social Development. A comprehensive and detailed document, the Madrid Plan provides a well thought-out basis for policy action that can guide policy formulation and implementation at all levels towards the goal of adjusting society to an ageing world while providing older persons with their due place in it — the goal of a “society for all ages”.

The Madrid Plan hinges on three interlinked themes:

- A policy approach to ageing that is integral to the development agenda
- Empowerment of older persons and full realization of their rights and potential
- Public recognition of the opportunities and challenges of an ageing society

A rich and multifaceted document, the Madrid Plan stresses the importance of enhancing (a) social protection of older persons, including adequate income security; (b) formal and informal support, as well as reduction of poverty among older persons and poverty prevention; (c) employment opportunities for all older persons who want to work, with elimination of age barriers in the formal labour market, all forms of age discrimination and removal of disincentives to working beyond retirement age; (d) development of a continuum of high-quality, affordable and sustainable health and care services; (e) promotion of “ageing in place” in the community with due regard to individual preferences and affordable housing; and (f) promotion of intergenerational solidarity as well as numerous other important themes. Demographic ageing runs like an undercurrent through society with enough force to shape the future in many respects.

The Madrid Plan outlines 18 issues of priority concern with 35 specific objectives that are to be implemented in 239 specific recommendations for action. The recommendations are organized for implementation in three priority directions:

1. Older persons and development
2. Advancing health and well-being into old age
3. Ensuring enabling and supportive environments

The three-pronged approach reflects the continuity of the Madrid Plan with intergovernmental efforts in development action. It breaks new ground, however, in broadening the range of issues to be addressed as well as the terrain and scope of its objectives and actions, in order to breach the intricacies of policymaking and contemporary realities.

The priority directions were conceived to guide policy formulation and implementation towards the specific goals of successful adjustment to the ageing world. Under the first priority direction — “Older persons and development” — the issues for action are active participation in society and development; work and the ageing; rural development, the labour force, migration and urbanization; access to knowledge, education and training; intergenerational solidarity; eradication of poverty; income security, social protection and poverty prevention; and emergency situations. Under the second priority direction — “Advancing health and well-being into old age” — the issues are health promotion and well-being throughout life; universal and equal access to health-care services; older persons and HIV/AIDS; training of care providers and health professionals; mental health needs of older persons; and disabilities. Under the third priority direction — “Ensuring enabling and supportive environments” — the issues being targeted are housing and the living environment; care and support for caregivers; neglect, abuse and violence; and images of ageing.

Empowerment, protecting the rights and ensuring the dignity of older persons are crucial issues in the context of a society for all ages. An appeal for effective participation of

older persons in the economic, political and social spheres of their societies, along with provision of opportunities for individual development of people throughout their lives, permeates the Plan. Promotion and protection of all human rights and fundamental freedoms is recognized as an essential precondition for the creation of an inclusive society where older persons can participate as equal partners without incurring discrimination and where their dignity is assured. One of the most obvious messages conveyed by the Plan is that combating discrimination based on age is one of the prerequisites of success in the quest for a society for all ages. Full realization of human rights and fundamental freedoms also appears as a major theme in that context. At the same time, a balanced yet positive image of ageing is also essential. It is detrimental for society to present a caricature of older persons as primarily weak, non-productive and dependent, a burden to society rather than an asset. It is impossible to move forward if such attitudes cannot be overcome.

The value of older persons for society was strongly affirmed at Madrid by the participating Governments in Article 10 of their Political Declaration: “the potential of older persons is a powerful basis for future development. This enables society to rely increasingly on the skills, experience and wisdom of older persons, not only to take the lead in their own betterment but also to participate actively in that of society as a whole.” Older persons thus represent a great asset of society. The protection dimension reinforces empowerment of older persons by giving them scope for individual development.

Intergenerational interaction remains a crucial characteristic. Worldwide trends in that regard, however, have been sobering. The willingness of persons of different generations to live under the same roof is clearly waning, as is reflected in a widespread trend towards independent living arrangements among older persons. While that trend has been almost universal, differences are still great, depending on the level of development. For instance in European countries, on average 25 per cent of older persons live with their child or grandchild, while the large majority (about three quarters) in developing countries live with their children (United Nations, 2005a).

Intergenerational ties, obligations and solidarity remain at the very heart of every society regardless of its stage of development. The empowerment of older persons as well as the positive images of ageing advocated in the Madrid Plan are therefore important from many standpoints and may facilitate multigenerational cohesion in society. Such relationships may be seen in different manifestations, from the intergenerational pact between workers and retirees that forms the basis of many public pension systems created on the “pay-as-you-go” premise, to the family, where most care for older persons is still provided the world over.

The recommendations are aimed at giving the Madrid Plan as much practical significance as possible, establishing a framework for national action regarding policy and programme design, but leaving enough room for particular concerns that older persons themselves may have in specific country contexts.

In setting an optimal environment for policymaking to be based on its recommendations, the Madrid Plan introduced innovative criteria of evaluation. Success was not to be

measured by technocratic or economic standards, but rather “in terms of social development, the improvement for older persons in quality of life and the sustainability of the various systems, formal and informal, that underpin the quality of well-being throughout the life course” (United Nations, 2002a). The emphasis on quality of life and the life-course dimension allows for intergenerational thinking and a holistic approach to policymaking. In that light, ageing should be viewed as one stage in the life course, not as a momentous condition apart from other interactions and trends in society.

The Madrid Plan was conceived as a practical tool to assist policymakers in focusing on their key priorities for action.

The ambitious goal of effective incorporation of ageing agendas and concerns into socio-economic strategies and policies at the national level — the “mainstreaming” of ageing — is recognized as an important policy tool and one of the key preconditions of the successful implementation of the Plan, along with national capacity-building.

At the same time, for effective implementation, the Madrid Plan calls for increased and better-coordinated efforts by Member States, the United Nations system and civil society organizations. The translation of policy design into real achievements is a well-defined goal of the Plan that links practical aspects of work at the national level with international support.

The target audience of the Madrid Plan is, firstly, Governments of the Member States that are primarily responsible for providing leadership on ageing matters, according to the Political Declaration associated with the Plan. Beyond those Governments, other stakeholders include international agencies, civil society organizations, particularly those of older persons, the private sector and other entities. The Plan itself is a result of numerous consultations among various delegations, with thousands of important contributions made by its diverse stakeholders, which reinforces its practical significance.

D. Setting the stage for implementation

The Madrid International Plan of Action on Ageing sets some general directions for Governments and international development agencies in implementing its recommendations, with two distinct layers in the implementation process — national and international. The Plan recognizes the need for enhanced and focused international cooperation, along with an effective commitment of developed countries and international agencies. The Plan also accords a key role to the United Nations regional commissions in translating its overall provisions into their respective regional action plans as well as in assisting national institutions in implementing and monitoring their actions on ageing.

Immediately following the Second World Assembly on Ageing, two regional commissions convened intergovernmental conferences and developed regional implementation strategies: the Economic Commission for Europe (ECE) in September 2002 in Berlin, Germany; the Economic and Social Commission for Asia and the Pacific (ESCAP), also in September 2002 in Shanghai, China. Then in November 2003, the

Economic Commission for Latin America and the Caribbean (ECLAC) convened its meeting in Santiago, Chile.

While the Economic Commission for Africa (ECA) has not elaborated its regional implementation strategy, the Heads of State and Government of the African Union did adopt the African Union Policy Framework and Plan of Action on Ageing, in Durban, South Africa in July 2002. Similarly, the Economic and Social Commission for Western Asia (ESCWA) adopted, in lieu of a regional implementation strategy, the Arab Plan of Action on Ageing to the Year 2012 during the Arab Preparatory Meeting for the Second World Assembly on Ageing, held in Beirut, Lebanon in February 2002. In conceptual design and content, both documents cover essential elements of ageing policies that are keyed to the Madrid Plan and at the same time envision various forms of coordination of their review and appraisal activities at the regional level.

The tools employed by regional commissions in assisting Member States differ from country to country. Technical assistance is provided on request, in designing national policies on ageing and strengthening national capacity in various areas. United Nations specialized agencies and funds also promote capacity-building at the national level according to their mandates and agendas. For example, the World Health Organization gears its capacity-building efforts to strengthening the capacity of participating countries to respond effectively to the health-care aspects of population ageing, including the promotion of active ageing. The United Nations Population Fund often combines development of capacity with advocacy, providing support to training institutions that deal with ageing matters and assistance in implementing legislation on ageing (United Nations, 2005b).

Strengthening national capacity. A key parameter of the Madrid Plan is the linking of ageing with the development agenda. That can hardly be done, however, without building national capacity to implement suitable policies. The capacity to address ageing challenges varies significantly from country to country, reflecting values and priorities in policymaking as well as particular national circumstances, including population and development trajectories. While many countries had ageing-specific policies even before the Madrid Plan was adopted, the Plan has played a very useful role as a catalyst of change, bringing ageing concerns into policy agendas and enhancing awareness. The intergovernmental process involving the Madrid Plan also facilitates exchange of best practices regarding policies on ageing, including recognition of the contributions of older persons to socio-economic development.

National capacity to implement programmes on ageing hinges on a combination of factors in the policy environment and their interaction. By definition, capacity development is based on what has been achieved by a country in creating national machinery on ageing, including the ability of people, institutions and societies to “perform functions, solve problems and set and achieve objectives” (Fukuda-Parr, Lopes and Malik, 2002, p. 8).

Within the United Nations Secretariat, the Department of Economic and Social Affairs has been designated the focal point on ageing for the United Nations. The Department

also provides substantial and continuous support to intergovernmental activities including servicing of the Commission for Social Development in its efforts to advocate a means for the “mainstreaming” of ageing at the global level.

The Department of Economic and Social Affairs helps Governments strengthen national capacity regarding ageing policies. The Department has completed the work on *Guide to the national implementation of the Madrid Plan*, geared to supporting capacity development on ageing matters. The Guide takes two broad approaches: (a) the development of effective age-specific policies and (b) the mainstreaming of ageing concerns into all aspects of development planning and policymaking. Major subsections of the Guide cover such areas as: promoting a harmonious relationship between development and demographic change; making social protection work effectively for older persons; taking account of population ageing in health policy; exploring different aspects of care-giving and service provision in different settings, and last, but not least, ensuring the social inclusion and political participation of older persons. The policy Guide for national implementation activities also incorporates the preliminary outcomes of the review and appraisal of the Madrid Plan during 2007–2008.

Accurate assessment of national capacity to design and conduct realistic policies can be a tricky exercise. The existence of the best-laid plans is no guarantee that they are going to be implemented or that the objectives in the Madrid Plan are going to be achieved. However, national commitment to ageing policies does matter. Some objective indicators do exist that can facilitate appraisal of national capacity on ageing and the prospects for success.

Essential elements. In its analysis of national efforts aimed at developing or strengthening capacity in ageing matters, the Department of Economic and Social Affairs has proposed several “essential elements” of national capacity development that Governments have addressed in designing, implementing and monitoring their implementation processes. Derived from the Madrid Plan, those complementary elements include (a) institutional infrastructure, (b) human resources, (c) mobilization of financial resources and (d) data collection and analysis (United Nations, 2006a). Each of those elements is important in its own right, but best results are achieved when they are approached holistically and comprehensively.

Institutional infrastructure includes ministries, agencies or national committees that can deal with issues of ageing, including the specially appointed national focal points on ageing within the Government. Another vital element is a forward-looking policy process geared at mainstreaming ageing into all relevant policies and programmes. That in turn would depend on the capacity to work in close partnerships with other major stakeholders, including the private sector and non-governmental organizations, particularly organizations of older persons or those representing their interests, to make sure that their concerns are adequately incorporated into national programmes and projects.

Institutional machinery matters. Many Governments have established fully fledged offices on ageing at the ministerial or similar level. Examples include the Department of

Health and Ageing (Australia), the Division of Ageing and Seniors of the Public Health Agency (Canada), the National Committee on Ageing (China), the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (Germany) and the Administration on Ageing (USA), demonstrating consistency in achieving goals of age-specific policies (United Nations, 2006a).

Qualified people who have the abilities and skills to tackle ageing issues effectively are essential. Such cadres of professionals may include specialists in gerontology and geriatric health care, providers of palliative health-care services, and other specialists who deal with older persons' requirements. Training and education often generate positive momentum, leading to the creation of schools of specialists and facilitating further training.

Equally important is the mobilization of adequate financial resources to implement age-related programmes.⁹ Building viable alliances between public and private health-care providers, as well as creating similar alliances for providing housing and transportation for older people may help improve results cost-effectively for the society at large. Ensuring sustainability of old-age support remains one of the most difficult challenges for many countries.

Finally, effective implementation of the Madrid Plan at the country level requires additional capacity development in statistical information-gathering related to older persons. Lack of disaggregated age-related data often represents a substantial obstacle in national policymaking, preventing an informed debate and decision-making in ageing matters. As a result, the General Assembly has requested the Statistical Commission to assist Member States in developing means for disaggregating their population statistics by age and sex.¹⁰ Progress so far in this area has been modest and much remains to be done.

E. Progress in the review and appraisal

The Commission for Social Development is responsible for follow-up and appraisal of national implementation of the Madrid International Plan of Action on Ageing. The review and appraisal cycle began with the forty-fifth session of the Commission in February 2007 and was concluded with its forty-sixth session in 2008.

In the Secretariat, the Department of Economic and Social Affairs is assisting Governments in carrying out the review and appraisal of their activities. To provide Governments with practical ideas for designing and conducting their own review and appraisal projects, the Department prepared *Guidelines for review and appraisal of the Madrid International Plan of Action on Ageing: Bottom-up Participatory Approach*

⁹ The economic consequences of ageing are one of the most contested and controversial areas of discourse in ageing assistance. The financial issues, including perspectives on social protection and social security funding, labour supply issues, savings and taxation options, are vitally important; however, they are not part of this chapter. For further discussion of economic and financial aspects of ageing, see United Nations (2007b).

¹⁰ See General Assembly resolution 58/134 of 22 December 2003.

(United Nations, 2006b). The Guidelines were targeted to national focal points on ageing, often single-person offices responsible for developing, implementing and monitoring national policies on ageing, including the implementation of the Madrid Plan.

The Guidelines are geared for a bottom-up, participatory approach that has been effectively applied by Governments and civil society in diverse research and policy monitoring activities. The guiding principle is that persons everywhere should be able to grow old with security and dignity while continuing to participate in their societies as citizens with full rights. The guidelines explain how to:

- Identify stakeholders (deciding with whom to work and how)
- Review national policies in response to ageing (defining challenges and priorities for action on ageing and determining what to review using a bottom-up approach)
- Review the implementation of the Madrid Plan (conducting bottom-up participatory assessment of policy impact on older persons)
- Provide for information analysis at national, regional and global levels (identifying policy-relevant implications and recommendations)
- Conduct a bottom-up review and appraisal with older people (involving discussion about collection, analysis and dissemination of policy-related information)

The analysis itself of the implementation centres around two questions:

- What has been done at the national level since the Second World Assembly on Ageing?
- What has been the impact of implemented policies on the quality of life and well-being of older people?

The policy implications and recommendations are expected to be considered and discussed with policymakers and civil society representatives at all levels, whether local, provincial or national, with older people present. The aim is to empower older persons and ensure that they have an opportunity to express their views on the impact of national policy actions affecting their lives.

The Guidelines, in summary, seek to galvanize stakeholders in reviewing and appraising national policies and programmes that address the phenomenon of an ageing society and its impacts on the whole as well as on individuals. Civil society is called upon to determine how effectively the Madrid Plan is being implemented, the extent to which all stakeholders are involved, and how well governmental departments have integrated their sectoral efforts. With the participation of older persons themselves, one of the most important outcomes may be the building of trust between older and younger groups, a dynamic that will enhance everyone's quality of life.

At the outset of the review and appraisal exercise, the record of achievement in matters of ageing has been mixed at both national and international levels. The explanation may lie in the varying acuteness of ageing challenges as well as the amount of attention accorded to them. One positive feature is a growing awareness of the various dimensions of ageing as well as apprehension of factors that make older persons vulnerable in society — exclusion, discrimination, lack of social protection — and of their overlap with other

issues on the development agenda, including human rights, participation and empowerment. To address those challenges, countries have been adopting a broad range of legislation protecting the rights of older persons. The need to give older persons voices of their own is widely recognized, but their messages are not always listened to. Undeniable achievements at the national level in various ageing-specific sectors do exist, although significantly little progress has been achieved in mainstreaming ageing into wider policy discourse and development strategies — a very important, but not easy task.

F. From philosophy to commitment

At both national and international levels, the gap between the philosophy of the Madrid Plan and translation of Madrid commitments into national programmes remains substantial.

The general assumption is that Governments are responsible for addressing the challenges and opportunities of ageing at the country level, while the United Nations has a collective responsibility to facilitate the intergovernmental process and monitor the unprecedented demographic shift, drawing attention to its long-term consequences, promoting cross-national collaboration and sharing experiences of successful policy actions on ageing.

At the international level, linkage of ageing with development goals has been challenging. Ageing continues to be on the periphery of internationally agreed goals, frameworks and policy documents, as exemplified by the absence of reference to ageing in the Millennium Declaration and the Millennium Development Goals. As a result, many of the most vulnerable groups in society, such as poor older persons, remain invisible and are unlikely to benefit from the global effort to eradicate poverty (HelpAge International, 2005a).

United Nations programme activities have been striving to facilitate a developmental response in policies geared to older persons, encouraging Member States to consider the issues of ageing in the context of related or parallel developments in the world. Apart from those challenges, urgent international response and policy action regarding older persons is required in such areas as conflict prevention, migration and health threats. For instance, chronic non-communicable diseases are becoming a major health challenge for developing countries as well as in the developed world, and are now the major cause of death among the older age cohorts. The growing disease burden inevitably strains existing health systems. Discussions of the vulnerability of older persons (United Nations, 2003) have emphasized that no social group, including older persons, is vulnerable by definition; rather, vulnerability is a result of a negative combination of various adverse phenomena in society.

Socio-economic vulnerability as well as issues of social protection should be tackled in a comprehensive way. Unfortunately, efforts remain fragmented at the national level. Integrated intersectoral policies on ageing are still the exception rather than the rule. While each social issue pertaining to older persons may have its own unique characteristics, a comprehensive approach is required to make the picture complete.

While national goals often specify that older persons must benefit from protection and social welfare efforts, it is an open question how often Governments, faced with competing priorities and resource constraints, are willing to commit themselves to treating older persons as valued members of society who possess a full range of social rights and social entitlements. A related question concerns how often national plans for older persons are part of an integrated approach and are designed to empower older persons and unleash their potential. Much remains to be done in this crucial area.

In launching the review and appraisal exercise in February 2007 at the Commission for Social Development, several key issues were raised (United Nations, 2006c). The facts reveal a very uneven picture at best. There is widespread global inequality in availability and access to social protection. Pensions, which are taken for granted in more developed regions, still do not exist in many developing countries. Progress to extend social protection schemes to old-age recipients (including such schemes as “social pensions”) remains very modest in most developing countries.

Priority-setting on ageing matters at the national level leaves much to be desired. Older persons’ priorities could and should be linked with the priorities of national development, but often are relegated to a second-class status. Priority goals for the eradication of poverty and the improvement of health-care provision, particularly if accompanied by well-focused strategies and practical actions, clearly could facilitate improvements in the standard of living of older persons. Governments in many cases need society-wide support to achieve these objectives, bringing all stakeholders together to identify goals and targets and implement policy.

Commitment costs, but non-commitment costs more. While cost may be very important in the context of social protection in general, and social protection for older persons in particular, such financial considerations cannot be viewed in isolation and taken into account without considering the social cost to society of the absence of such programmes. The success criteria at the national level is often established in a one-sided manner: the benefit to society is only seen by the introduction of cost-savings generated by proposed reforms, particularly regarding social spending in the face of present and future financial constraints.

Governments have a vital stake in achieving financial stability and sustainability, as well as ensuring that age-related programmes continue to be delivered to future generations. Considerations based on economic efficiency alone, however, cannot be considered sufficient. In a wider policy discourse, when options of social protection are weighted against other policy goals, such considerations should ideally represent a starting point in the quest for solutions that are based on equity, social justice and solidarity.

Financial sustainability, as well as the scope of insurance coverage and the capability of providing for non-contributory schemes or social pensions, obviously depends on country-level circumstances. Many countries are experiencing rampant poverty and/or are facing budgetary constraints; still others would like to avoid mounting excessive costs and the moral hazard associated with such schemes. But Governments cannot ignore the implicit need to be humane and caring towards its most vulnerable citizens. While quite

often priorities such as education or defence or debt servicing vie for the attention of policymakers, they cannot ignore the plight of millions of older persons who, without appropriate public support, would be condemned to insecurity, if not abject poverty in old age. Old-age support must always be considered a priority in all Government plans and programmes.

In economic terms, universal pension coverage is an affordable option for most countries, particularly when such a scheme offers benefits equal to the poverty line to all those above a certain age. Such an option claims a relatively insignificant share of the gross domestic product (GDP) — calculations for 100 developing countries and economies in transition in 2005 have demonstrated that in 66 countries the cost would be less than 1 per cent of GDP, while in 34 countries it would be less than 0.5 per cent of GDP. Costs of pensions could be also reduced through flexible application of eligibility criteria, improved targeting techniques or use of means testing (United Nations, 2007b). The political will to help older persons is crucial, because very often if there is a will, Governments can find a way.

Apart from its welfare dimensions, social protection for older persons can be seen in the context of human rights. The right to social security has been recognized globally as a fundamental societal right to which every person is entitled, such as in Article 22 of the Universal Declaration of Human Rights; and in Article 9 of the International Covenant on Economic, Social and Cultural Rights.

The Madrid International Plan of Action on Ageing is not legally binding on Member States and no mandatory procedure to monitor its implementation exists. Much depends on the willingness of Governments to undertake timely and concrete actions on ageing as well as to inform the Secretariat about specific efforts undertaken at the national level so that the information can be assessed and analyzed.

The ultimate commitment. The existence of international human rights instruments would be helpful in improving the situation of older persons around the world and promoting a society for all ages. Indeed, the time may have come for the elaboration of a comprehensive international convention on the rights and dignity of older persons, similar to the recently adopted Convention on the Rights of Persons with Disabilities. The initiative for any such convention must come from Governments as well as from civil society organizations.

A convention that addresses the needs of older persons and ensures the full and equal enjoyment of all human rights and fundamental freedoms by older persons could be a qualitative step forward on the road to an inclusive society. Such a new convention on the rights and dignity of older persons, based on equality, non-discrimination and equal recognition before the law, would serve not only to protect the rights of older persons but to facilitate and enhance their contributions to society as well.

The dignity of older persons is an important variable in all discussions on ageing, one that should not be overlooked. Human dignity has long been recognized as a key United Nations principle for older persons, and is at the core of all the major human rights texts

(Moon and Allen, 2006). In whatever mode society views the dignity of older persons — as a value, a principle or a right — it could and should be a true measure of progress in countering stigma, discrimination and prejudice, thus deepening the meaning of “a society for all ages”.

II. Regional Overview of Trends and Policies

Peggy L. Kelly¹¹

The global theme for the first review and appraisal of the implementation of the Madrid International Plan of Action on Ageing is the challenges and opportunities of ageing. Some of those challenges and opportunities are universal to all countries and regions, including the need for adequate income security and health care for older persons, as well as the importance of ensuring and protecting the human rights of all persons as they age. Other issues related to ageing are unique to a particular country or region, closely tied to such factors as the stage of economic development, the cultural context and the pace of demographic ageing.

To clarify the picture of ageing trends and the extent to which they either coincide or vary across different regions of the world, this publication examines the world ageing situation from a regional perspective. Each chapter reports on the ageing situation in one of the five regional commissions of the United Nations: the Economic and Social Commission for Asia and the Pacific (ESCAP); the Economic Commission for Africa (ECA); the Economic Commission for Latin America and the Caribbean (ECLAC); the Economic Commission for Europe (ECE); and the Economic and Social Commission for Western Asia (ESCWA). This chapter presents a synthesis of the major findings from those regional studies, beginning with an overview of the challenges and opportunities of ageing common to all regions.

A. Common challenges and opportunities

Demographic ageing is a global phenomenon, brought on by a combination of declining fertility and mortality rates and rising life expectancy. The older population itself is ageing in all regions, with the share of the oldest old, i.e. those 80 and over, constituting a growing proportion of the ageing population. Yet the pace at which ageing is occurring varies considerably across different regions. The ECE region is experiencing the most rapid ageing: the number of older persons already eclipses that of youth. The ESCAP and ECLAC regions are undergoing a more moderate process of ageing, although certain countries within those regions are ageing quite rapidly. Ageing in the ESCWA and ECA regions is a slower process because their populations still have large numbers of young people. Regardless of its current stage of demographic ageing, each region will experience a significant expansion in its older population by the middle of the twenty-first century.

The priority that an individual country gives to ageing issues tends to correlate directly with its current stage of demographic ageing, rather than with projections of its population in the next 20 to 40 years. Ageing issues are thus a high priority for countries in the ECE region, which already have a relatively “old” population; and of moderate, but rising priority in the ESCAP and ECLAC regions, where the median age continues to

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mount. Within the ESCWA and ECA regions, ageing holds very low priority as other issues more pertinent to a younger population, such as youth unemployment, HIV/AIDS, migration and conflict, take precedence.

While they differ in stage of demographic transition, the regions nonetheless share many commonalities with respect to the ageing-related issues they confront. Universal to all regions are concerns over (1) sustainable systems of social protection; (2) the participation of older persons in the labour market; (3) growing demand for quality and accessible health care in general and long-term care in particular; and (4) the rights and participation of older persons in society (United Nations, 2006c). Those topics are first addressed on a global level and then discussed in greater detail by region in the remainder of this chapter.

1. Social protection

Social protection programmes are an integral part of development and economic growth strategies, as they play an important role in providing older persons with basic health care and income security and, in many cases, provide assistance to their households as well. Yet widespread inequality in the availability of and access to social protection programmes persists between countries and regions. Whereas developed countries tend to offer universal coverage under social protection programmes that guarantee a basic floor of benefits and services, developing countries generally fall far short of this goal. Efforts are under way to extend social protection to a wider range of old-age recipients throughout the developing world, but progress is slow and modest.

In developed countries, the focus is on the financial sustainability of social protection systems so that they can remain viable for future generations. Initiatives include raising the retirement age, or indexing programmes to changes in life expectancy or the old-age dependency ratio. In developing countries, the main objective is to extend systems of social protection so that they reach a greater proportion of the population. In a small but encouraging number of developing countries, “social” (non-contributory) pensions have been introduced to ensure that a minimum subsistence income is paid to low-income older persons as a way of combating poverty and exclusion.

2. Older workers and labour markets

The ageing of the population has major implications for the labour force and the status of older workers. Developed countries, countries with economies in transition and developing countries with low fertility rates are feeling the effects of the ageing workforce most profoundly. Their concerns over pension liabilities, mounting old-age dependency ratios, impending skills gaps and potential labour force shortages have created a momentum towards the elimination of mandatory retirement ages and the extension of the number of working years. Previous trends towards early retirement are reversing, as older workers are gradually increasing their labour force participation rates, continuing to work as long as they want and can do so productively. Opportunities for older workers to participate in lifelong learning and on-the-job training programmes are also expanding somewhat in those countries.

Alternatively, employment often provides the sole source of income for older persons in less developed countries, as social protection schemes are rare and disease, conflict and migration may limit the availability of family support. As a consequence, upwards of 60 per cent of men aged 65 or above in the least-developed countries continue to participate in the labour force as their main means of survival (United Nations, 2007b). In such circumstances, policymakers are showing interest in building social pension schemes so that those older workers can be afforded the “luxury” of retiring with dignity and security.

3. Health care

As people continue to live longer, the challenge for public health is to increase the number of years a person lives free of disability, primarily by ensuring access to high-quality, affordable and sustainable health and care services. Policymakers recognize, however, that modern health-care systems are not always equipped to deal with the growing ageing population, because they have been set up for acute care and expediency, rather than attending to the chronic illnesses common in older patients. Particularly in developing countries, trained health personnel are in short supply, especially in geriatric medicine.

Adequate provision of health care, therefore, calls for integrating preventive, curative and rehabilitation measures within a continuum of care, including palliative care, and enhancing training and support for caregivers. Increasing the focus on preventive medicine within a continuum of care can also help to control rising health-care expenditures, as well as delay or reduce the need for long-term care.

Although family members continue to provide most of the long-term care of older persons, factors such as the shift from extended to nuclear families, the rise in rural-to-urban and international migration, and the increase in labour force participation rates of women have combined to increase the strain on such informal care-giving arrangements. In some cases, Governments have stepped in to provide home- and community-based care services to assist family caregivers, but support remains limited, especially in developing countries. Added policy attention will be needed to meet growing demand for long-term care in the future, particularly with increases in the number of very old people, who are at greatest risk of dependence.

4. Human rights and balanced images

The fight against age-based discrimination and the promotion of the dignity of older persons are fundamental to ensuring the respect that older persons deserve. In the absence of internationally agreed human rights instruments in the area of ageing, such as a convention or similar legally binding agreement, the agenda of older persons’ rights has been gaining ground primarily at the national level, through the promulgation of special rules and regulations to protect those rights, as well as through the development of advocacy, training and education programmes. Older persons are also becoming more actively involved in the implementation of policies that directly affect their well-being, sharing their knowledge and skills with younger generations and forming movements or

associations that help to articulate their concerns and affirm their rights. Yet most older persons have little voice in shaping policies and processes, even those that directly affect them.

The protection of the rights of older persons is the core element of any policy related to ageing and the most important prerequisite of empowerment of older persons. However, for the process of empowerment to become sustainable, society must ensure that older persons are recognized and appreciated as valued and welcome members. Unfortunately, that is very often not the case. Prevailing images of and corresponding attitudes towards older persons are often negative. The empowerment of older persons and the promotion of their full participation are essential elements of active ageing. To be relevant and practical, however, the concept of active ageing should be firmly linked with reality. Generalizing about ageing, from either a negative or a positive perspective, can be counterproductive. A more balanced perspective requires an approach that sees later life not as a one-dimensional experience, but as a fluid, complex and heterogeneous time, during which people can continue contributing to society in a meaningful way (WHO, 2002a).

B. Regional aspects of ageing

Although the foregoing concerns are common to all regions, some aspects of ageing are best understood from a regional viewpoint. Every region has its own character, culture and dynamics that heavily influence how older persons are perceived and treated in their communities. The state of a region's economic and social development also impacts the well-being of older persons and can determine the quality and level of care and services that they receive.

It is with a view of highlighting the regional dimensions of ageing trends and developments that this publication is written. The following provides a brief summary of the major findings of the regional studies, which are elaborated in the subsequent chapters.

1. Economic and Social Commission for Asia and the Pacific (ESCAP)

(a) Demographics. More than half (54 per cent) of the world's population of persons aged 60 or more years lived in Asia in 2005, a proportion that will rise to 62 per cent by 2050. China and India alone account for 34 per cent of the world's older population, although they are not the "oldest" countries in the world in percentage terms. Many countries in the region are ageing quite rapidly, and are likely to double their population of older persons within a relatively short period of time. Driven by its one-child policy, for instance, China can expect to see the share of its population over the age of 60 nearly double in just 20 years, from 11 per cent in 2005 to 20 per cent by 2025. The pace of ageing in the region means that many countries have little time to adapt to the consequences of demographic ageing.

Some countries in the region have among the lowest fertility rates and longest life expectancy in the world. For example, Hong Kong, China has a total fertility rate of 0.97

(compared to the world average of 2.55) and a life expectancy at birth of 82 (compared to the world average of 67). Japan has the distinction of being the world's oldest country, with more than one quarter of its population over the age of 60. Other more developed societies in the region, including Hong Kong, China, the Republic of Korea and Singapore, will catch up to Japan by the middle of the century, when 40 per cent of each of their populations will be aged 60 or above. By contrast, several developing countries in the region, among them Bangladesh, Cambodia, Lao People's Democratic Republic, Mongolia and the Philippines, have relatively young populations, with less than 10 per cent of them aged 60 or above.

Most countries in the region will have at least one quarter of their population aged 60 or above by 2050. As a whole, the region will have a greater number of older persons than children under the age of 15 before the middle of the century. Such rapid ageing raises concerns about the mounting dependency ratio, particularly in the most developed societies in the region where fewer than two adults of working age will support each older person. Another major concern is the ageing within the older population, as the fastest growth is occurring among those aged 80 or above. On average for the region, the population of those 80 or above will increase more than six fold from 2005 to 2050, raising concerns about long-term care and support for community caregivers.

(b) *Social protection.* Countries in the ESCAP region are quite diverse in terms of economic and political development, and these differences reflect varied degrees of social protection coverage. In some of the region's developing countries, many of the extremely poor are older persons living in rural areas. The lack of comprehensive and universal social security programmes in such developing countries — where only 9 to 30 per cent of the older populations receive any pension or social security benefits — means that older persons either have to continue working or rely on their families or communities for support. Even where older persons do receive social security benefits, payments tend to be too low to enable them to live decently. Moreover, many intended beneficiaries are unaware that they are entitled to benefits. A survey in Thailand, for example, revealed that only half of those aged 60 or above were aware of the social security programme, while only about 5 per cent actually received it. The very old, women and rural residents were those groups most likely to be excluded from benefits.

In most developing countries, coverage under social protection schemes is limited to people working in the public sector, State-owned enterprises, or large-to-medium-sized businesses. The majority of workers, who tend to be employed informally or in small enterprises, are unlikely to receive coverage. Workers in rural areas also have a low probability of being covered. Some countries in the region have taken steps to expand social protection coverage to rural and informal workers; but given the large numbers of people concerned, there are substantial challenges to doing so expediently. In the meantime, those living in dire poverty may receive subsidies from charitable assistance or international assistance agencies.

Even among the wealthier countries in the region, there are mounting pressures to revamp pension plans so that they will be financially sustainable in light of the rapid ageing of the population. Reforms to Japan's pension system in 2004, for example, will result in higher

contributions and lower benefits in the coming years. Other countries are following with similar measures, including a switch from defined-benefit to defined-contribution plans. Provident funds, which are compulsory savings schemes, are also becoming more common for private sector employees in countries such as Malaysia and Singapore.

(c) *Informal care system.* Traditionally, Asian countries have maintained strong family values. People have tended to live in extended family households, reflecting Confucian and other Asian philosophies, whereby the well-being of older family members depends on the devotion of their offspring. As a result, older persons tend to rely upon their children for financial support rather than on the Government. The strength of such family traditions helps to explain the lack of political support for welfare States in the region. Nonetheless, family support of older persons has appeared to be waning for such reasons as urbanization, migration of young people to the cities, the emergence of the nuclear family, rising divorce rates, and the likelihood that more educated women will enter the labour force.

Surveys in China, for example, indicate that both the younger and older generations feel less traditional about co-residence and providing their elders with financial support. Growing numbers of older persons in the region live with a spouse only rather than with their children, while fewer rely on their children as their primary source of financial support. The decrease in co-residence is most evident in the rural areas, as young people migrate to the cities in search of employment opportunities. Without a system of formal support to take the place of the family, some Governments (for example in China, India, Malaysia and the Philippines) have begun enacting policies which mandate children to support their parents. Others (in Hong Kong, China, the Republic of Korea and Singapore) are providing tax incentives to encourage adult children to live with their parents.

(d) *Gender, ageing and discrimination.* Older women are likely to be burdened with caregiving responsibilities for their spouses and sometimes their grandchildren, and are also more vulnerable to widowhood. In developing countries, older women are further disadvantaged by poor education and dependency on men for land and income, which places them at great financial risk when their husbands pass away. Widows are susceptible to discrimination as well as financial hardship; in extreme instances they may be removed from their homes to live in isolated “widow villages”.

With trends favouring urbanization and industrialization, older persons gradually have been losing their position of respect and esteem within Asian societies. Since a disproportionate number of older persons in the region are illiterate, passive and obedient to authority, they run greater risk of discrimination and exclusion. To guard against the discrimination of older persons, some countries, including Australia, Japan and New Zealand, have established legislation to protect their rights in employment and service accessibility: by providing education, training and skill upgrading to older workers so that they can continue to compete in the labour market. Other countries have initiated public education and media campaigns to promote more positive images of ageing. Having older persons serve as volunteers in their communities is another trend in the region that can encourage productive ageing as well as social and economic development.

(e) *Health care and long-term care.* Greater emphasis is being placed on the provision of primary and preventive care for older persons in the region, particularly among developing countries. As primary care is accessible, community-based and often culturally acceptable, it is generally more preferable for older persons than distant tertiary care. Many countries, however, continue to face challenges in providing universal access to health care. Thailand introduced a scheme in 2001 that gives broad access to public health care and hospitals, but critics argue that it has overburdened the public health system. Other, more established health systems, such as that in China, are undergoing changes that result in higher costs and less access to care, especially for older persons with limited means. The region can expect increasing prevalence of chronic diseases, including dementia, especially among women who tend to outlive men by several years. Yet older persons are still vulnerable to infectious diseases, as was the case with the severe acute respiratory syndrome (SARS) outbreaks. And increasingly, older persons must care for their children and grandchildren who have been affected by AIDS, especially in such highly impacted countries as Thailand.

A positive development has been the revitalization of traditional medicine in developing countries. Older persons tend to be amenable to traditional remedies, which are often cheaper and more readily available than other types. As the efficacy of traditional medicines becomes more widely demonstrated, greater numbers of older persons are likely to benefit from their use.

Long-term care presents perhaps the greatest challenge to the health-care system in Asia and the Pacific. Although families have typically provided care to their elders, such informal systems will be unable to meet the growing need for care, especially as populations become increasingly older and perhaps frailer. In a growing number of instances, family care-giving is supplemented by community- and home-based care, as well as a limited amount of institutional care. However, only Israel, Japan and the Republic of Korea have dedicated policies on long-term care, while Australia, Hong Kong, China, and Singapore have incorporated it into related policies. Much more needs to be done to finance and organize sustainable long-term care in the region, even among developed countries. Some countries have thus begun rebuilding support for family care as part of an “ageing in place” initiative, including the provision of training in caregiving skills to family caregivers. Efforts are also being augmented to create more elder-friendly environments within communities, by expanding public transportation, building barrier-free housing and installing adaptations in the home, among other interventions.

2. Economic Commission for Africa (ECA)

(a) *Demographics.* Africa is a youthful continent, as more than half of the population is 19 years of age or younger. Fertility rates, as well as infant, child and adult mortality rates remain high by global standards. HIV/AIDS, maternal deaths, tuberculosis and malaria all contribute to high mortality rates in the region. Nonetheless, the population is still ageing, as the number of persons aged 60 or above is set to quadruple: from 47.9 million in 2005 to 206.8 million by 2050.

Although population ageing is under way in the ECA region, albeit at a slower pace than in other parts of the world, few African nations have acknowledged the demographic trend and are prepared to meet its challenges. Other, more pressing issues take priority, including economic development, concerns over HIV/AIDS and youth employment. Recently the United Nations, the African Union and non-governmental organizations (NGOs) have tried to alert African Governments to ageing issues, in particular their omission from mainstream development thinking.

The well-being of older persons in Africa is affected by a range of regional trends and factors, characterized by changing family dynamics, a growing inadequacy of traditional family support, poverty and material deprivation, ill health and marginalization. Another important factor is differing concepts of age: people in Africa may reach “old age” well before reaching the chronological age of 60. As the ECA chapter of this publication notes: “Such definitions are a poor indicator of being old in Africa, especially in rural agrarian settings where chronological age may not be known and age may be defined in relation with an individual’s functioning, physical appearance and social role transitions.” Thus the region may be ageing more rapidly than is evident by statistics.

(b) HIV/AIDS and other health matters. Sub-Saharan Africa is the epicentre of the HIV/AIDS pandemic and is home to 26 million of the 40 million persons worldwide who live with the disease. The HIV/AIDS epidemic will impact older persons in two principal ways. As more people in mid-life die from the disease, older persons will be left without care and support from their children, while at the same time will need to care for and support their orphaned grandchildren. In Namibia, South Africa and Zimbabwe, 60 per cent of AIDS orphans live with their grandparents. Despite the important contribution of older persons to the care management of the epidemic, their role has been largely unrecognized and ignored in policymaking on the disease.

In general, older persons experience barriers to essential health-care services. The health-care system pays more attention to the control and eradication of preventable childhood diseases than to the treatment of chronic illnesses and the health of frail older persons. Among the disadvantages older persons encounter in the health system are an inability to pay for basic treatments, negative attitudes of health staff, and shortages of medications to treat chronic illnesses common to older persons. In rural areas in particular, access to health care is limited, causing older persons to rely on traditional healers for treatment.

(c) Migration. Both internal and cross-border migration have emerged as major trends in the region. As young people move to the cities or internationally to pursue employment opportunities, older persons are left behind in the rural communities to fend for themselves.

Migration is also disrupting the traditional multigenerational family structures and close-knit communities that used to sustain older persons. Those who follow their migrant children may encounter problems with integrating into an unfamiliar environment. As migration of the young increases, the viability of and reliance upon traditional social values and networks that had previously underpinned and reinforced intergenerational exchange and care and support may now be considered unrealistic.

(d) *Changing family structures.* Aside from migration, other factors disrupting traditional family structures include civil wars, poverty, declines in agriculture, and HIV/AIDS. In the past, older persons were the beneficiaries of support of their children and grandchildren, whereas nowadays they are likely to be active contributors, through childcare and other activities. For those receiving social pensions, much of the benefits are used to pay for food and utilities for the household and for their grandchildren's education.

Although the majority of older persons live with their children and/or grandchildren, a growing proportion live in "skipped generation" households, largely reflecting the impact of HIV/AIDS on the middle generation. Very few Africans live in residential care facilities, as culturally the concept of institutionalization of elders is rejected. At the same time, however, frail and indigent older persons are left in a very vulnerable position, especially if they cannot rely on family to provide care.

(e) *Poverty.* Acute poverty remains pervasive throughout the continent, with nearly half of the population living below the poverty line. Africa is the only region where the proportion of people living in poverty is expected to grow. Contributing to the region's high poverty levels are weak economic growth, poor ecological management, corruption, social inequalities, poor quality of governance and HIV/AIDS. Other impediments to reducing poverty are socio-political conflicts, natural disasters and rapid population growth.

Older persons are among the poorest and most vulnerable in the region, in part because their families have limited means to provide them with support. Most older persons in Africa lack any formal source of income security because social protection programmes only cover a minority of workers. Rural workers and the self-employed tend to have little or no access to pensions. A few countries have begun operating social pension programmes, but in most cases benefits and coverage are minimal. Instead, most people rely upon informal savings and support schemes, such as rotating savings schemes, credit associations, mutual aid societies and burial societies. For the most part, older persons in the region depend on families (where available) for support, as well as income-generating activities in the informal economy. For the majority of Africans, the concept of retirement does not exist, and people continue to work in the informal economy for as long as they are physically able.

Natural disasters such as droughts, floods and pestilence compound the problems of older persons in the region, who are often unable to fend for themselves or access relief in the wake of disasters. Weak governance and armed conflict, factors prevailing in a number of countries, also negatively impact upon older persons.

Older women in particular are at a disadvantage. They suffer the cumulative effects of lifelong economic, political and social discrimination in a typically patriarchal society. As a result, they are disproportionately impoverished, the most vulnerable being widowed and childless older women.

3. Economic Commission for Latin America and the Caribbean (ECLAC)

(a) Demographics. Latin America and the Caribbean have experienced major reductions in fertility and mortality rates over the past 50 years, with fertility dropping from 5.9 in the period 1950-1955 to 2.4 in 2005-2010 and life expectancy at birth rising by about 22 years over that same timeframe. As a result, the rate of growth in the older population has far exceeded that of the total population. By the middle of the century, there will be more people over age 60 than under age 15. By 2050, about 24 per cent of the population in the ECLAC region will be 60 or over, with the most rapid growth occurring among the “oldest old”, those aged 80 or above. As the oldest old are more susceptible to chronic and disabling conditions, greater planning is essential to meet the anticipated long-term care needs of that burgeoning segment of the older population.

The region is also home to an estimated 45 to 50 million indigenous persons, most of whom are concentrated in Central America and the Andean subregion. Poverty is more pervasive among the indigenous community and life expectancy is lower than for other groups in the region. Targeted efforts are needed to address the needs of indigenous older persons whose distinct language, culture and health behaviours put them outside the mainstream. Particular efforts will be needed as younger indigenous persons migrate to the cities, leaving their elders behind.

(b) Gender and cultural issues. The majority of older persons are women, and the proportion increases with age. Older women, particularly widows, are at increasing risk of poverty. Few women have access to formal pension plans, especially since they are likely to work in the informal economy or perform unpaid work in the household. Co-residence between older people and their children remains an important source of social support, as over 85 per cent of older persons in urban settings reported receiving some form of help from family members.

Culture and tradition give women the role of primary family caregivers. Daughters are still expected to be the caregivers for their elderly parents. Older women also provide care for their grandchildren, especially in cases where migration, war, disease or poverty have left skipped-generation households. One in five older persons in the region reports having provided care for a grandchild.

In general, older persons are respected and valued and typically live with the support of their children. While those traditional values remain current, sociological transitions such as reductions in family size, migration, increases in women entering the workforce and declines in extended family co-residence will affect to an unknown extent the traditional intergenerational transfers that provide older persons with a safety net. Yet for the time-being, reciprocity between generations remains prevalent: 60 per cent of older people in the cities reported receiving services or money from a relative, while one of two older persons also reported providing services or money to a relative.

(c) Migration. Because of the large-scale rural-to-urban migration over the past 50 years, most older persons in Latin America and the Caribbean currently live in urban areas. In some countries, however, up to 40 per cent of the older population continues to live in rural areas. As increasing numbers of young people migrate from the countryside to the

cities, the remaining population of older persons will have fewer family and community members available to provide support.

International migration is also a major phenomenon in Latin America and the Caribbean. Typically, younger persons choose to migrate to other countries in search of better employment opportunities. Although older persons may benefit from the money transmitted home by those migrants, it cannot substitute for the physical care and attention that many older persons need from their family members. Those who live in rather isolated areas are likely to suffer most, especially since rural areas tend not to have formal systems of care in place.

(d) Poverty and income security. Two thirds of older persons in the region have no access to basic, quality social protection. The regional survey on ageing, health and well-being (SABE) reported that 62 per cent of older persons had insufficient monthly incomes to meet their basic needs for daily living.

Many of the “younger old” in the region continue to work in the informal economy to sustain themselves, particularly since social protection programmes are not widespread. The challenge, however, concerns the increasing numbers of “older old” (age 80 and over), who are unable to work. They must rely on family support for their basic needs and are at greater risk of living in extreme poverty. The expansion of non-contributory pensions will help stave off poverty in old age. Yet less than one third of the countries in the region have implemented a social or non-contributory pension scheme covering the majority of older persons.

In some countries, including Brazil and Puerto Rico, the law makes adult children fully responsible for providing food and care to their older parents. Such laws, however, transfer social solidarity for the care of older persons to family solidarity alone, leaving the State with minimal responsibility for ensuring the well-being of older persons. For the most part, the main income for older women in the region is money from their children or other relatives. There is an informal intergenerational transfer — “a-roof-for-food” exchange. Older persons co-reside with their adult children or care for their grandchildren when the parents migrate to other locations.

(e) Access to health care. Many older persons in the region are unable to afford proper health care. Even when they can access care, health-care providers often stereotype them as burdens. Further compounding the problem, medical personnel frequently are not trained to deal with the unique health concerns of older persons. Preventable health problems such as malnutrition are widespread largely because older persons are either too poor to feed themselves adequately or cannot prepare their own food.

Since two thirds of older persons lack health insurance, health care is typically provided by publicly financed and/or publicly owned clinics and hospitals. The problem is that such services are geared towards children and women of reproductive age, and offer little or no specialization in geriatric care. Medical personnel in general have little experience in treating older persons, as only 14 per cent of medical schools in the region have geriatric programmes. Throughout the region, the quality of primary health care provided

by public clinics is poor and access to hospitals is limited, so availability of comprehensive and appropriate health-care services for older persons is a challenge. Another complicating factor is that 90 per cent of older persons surveyed in the SABE either had to make a co-payment or to pay in full for their medications. Since two thirds of older persons reported not having enough money for their daily expenses, children and relatives had to help pay for medical needs.

The Latin American Academy of Medicine of Older Adults (ALMA), a non-profit organization, was formed to address the health needs of older adults. ALMA promotes excellence in training in geriatrics in the region, with special emphasis on primary care for older adults.

(f) Long-term care. Long-term care facilities shelter those older persons who are unable to take care of themselves and have no family members able to assist them. Culturally, homes for the elderly are not looked upon favourably, and families who place their elders in such homes experience guilt over abandonment. That helps to explain why just 1 to 2 per cent of the over-60 population is in long-term care facilities, although the proportion is probably markedly higher for those aged 70 or above.

Although 80 per cent of countries in the region have some type of legislation protecting the rights of older persons, including monitoring abuse and neglect in institutions, resources are insufficient for monitoring the quality of care provided. A few countries, including Argentina, Chile and Uruguay, have begun surveys of homes for the elderly in order to monitor them and establish minimum standards of care. Among the areas most in need of monitoring are the administration of medications, the use of physical restraints, and the availability of physical, social and recreational activities for the residents.

Countries of the region are gradually instituting home-care programmes to address the needs of dependent older adults as well as their family members who are providing them care. The goal of such programmes is to improve home-based care, including support for family caregivers, in order to avoid institutionalization. Efforts are also being made to promote an “age-friendly community” where the social, physical and health environments contribute to active ageing among older persons. The World Health Organization is working to develop an age-friendly community index for evaluating how supportive urban environments are for older persons.

4. Economic Commission for Europe (ECE)

(a) Demographics. The European region is quite diverse and heterogeneous, covering countries in North America and Central Asia as well as in Europe. Countries such as Bulgaria, Hungary, Romania, the Russian Federation and Ukraine are already experiencing population decline, while others, including Albania, Turkey and the Central Asian republics are undergoing rapid population growth. Yet as a whole, fertility is low and longevity is high, making this region the world’s oldest.

The notion of ageing is relative, however, particularly as life expectancy continues to rise. So, although median ages are expected to increase in the region, people will

nonetheless have greater life expectancy upon reaching that median age. In Germany, for example, the median age is projected to be 50.6 years in 2040, compared to its current 39.9 years. But further life expectancy at that median age will be 43 years, compared to 39.9 years today — meaning that a 50-year-old person in 2040 will be relatively “younger” than a 40-year-old is today.

(b) Migration. Countries in Europe and North America are magnets for immigrants from all over the world, having become home to 106 of the 175 million people in the world who live outside their country of birth. Although migration has been mentioned as a “solution” to the ageing of Europe, the numbers of migrants required to achieve population replacement would be implausible and unmanageable. For instance, the net migration needed to keep labour force levels constant until 2050 would be twice what it is currently, and many more times higher if non-active immigrants such as dependent children and the elderly were also included.

The degree to which immigration could resolve the challenges associated with population ageing is also doubtful given that most migrants to the European region no longer come for employment, but rather for family and humanitarian reasons. The main route of entry into most countries of the region is through family reunification with dependants, relatives and spouses, as well as through student visas and refuge for asylum seekers.

(c) Pension reforms. The ageing of the population has put pressure on the sustainability of pension systems, which has led to numerous reform efforts throughout the region. Many of those reforms involve a change from defined-benefit to defined-contribution types of provisions, which are intended to enhance the fiscal sustainability of the pension systems by shifting more responsibility to current workers rather than future generations. The level of benefits is also on the decline as a result of reform efforts in some countries, which raises questions about the ability of public pension systems to reduce poverty among older persons. Women and low income earners are those most likely to suffer the adverse effects of reductions in the generosity of benefits, a factor deserving consideration from policymakers.

As pension systems begin to undergo reform, people may need to adjust their lifestyles, including by saving more and extending their working years, to adjust to these changes. Yet it is unlikely that pension reforms will have a particularly detrimental effect on the well-being of retirees, especially given the growth in the elder electorate. Reform policies must be politically and socially sustainable as well as fiscally sustainable. Aspects of pension reform that merit more attention are improved incentives for greater participation in pension savings schemes, as well as incentives for adding years of work.

(d) Extending work life. Attempts to extend working life within the European region have met with limited success, even though extra years of work can contribute to economic growth, competitiveness, prosperity and rising living standards, as well as enhance health, well-being and life satisfaction. The need to extend working life is particularly acute in Europe since the population of working age in the EU-27 will begin to shrink by 2012. A future reduction in the supply of labour could depress growth and

increase the strain on public expenditures, not to mention the sustainability of public pension plans.

Given high rates of inactivity or non-participation in the labour force, even among those of prime working age, there is considerable room for redressing the impending decline in the region's working-age population. Inactivity rates are highest among those aged 55 to 64, especially women, partly because of early retirement, as most people choose to retire upon reaching the early retirement age as opposed to the legal retirement age. Up to 91 per cent of workers in Europe retire before reaching the legal retirement age (usually age 65). Pension systems in many European countries are structured in such a way as to subsidize early retirement, while implicitly "taxing" those who continue to work beyond the earliest possible exit point.

Other factors that contribute to early retirement include the reluctance of employers to hire or retain older workers; age discrimination in the workplace; the lack of opportunities for older workers to engage in training and skills upgrading programmes; and poor, unsafe or unhealthy work environments. Poor working conditions have led to a high rate of retirement owing to work-related disability in certain occupations, with the average age of exit from the workforce being 42 in such instances. Therefore, in order to encourage workers to extend their work life, an integrated set of policies is needed that includes lifelong learning, occupational training, workplace safety and health, age-specific adjustments to the work environment and flexible options for retirement. It is also important that pension schemes should also be adjusted so that added years of work actually "pay".

(e) Long-term care. The combined factors of the baby boom generation reaching retirement age in the coming years, along with the disproportionate increase in the population of the "oldest old", mean that demand for health care and long-term care services will increase throughout the European region. Most of the demand will be for ambulant and home- or community-based care rather than residential care. Moreover, much of the care provided will probably be non-medical, including assistance with personal care services, domestic help and supported housing. Yet the capacity of current systems to meet those care needs, particularly for frail and dependent elderly, is questionable.

By far the most common form of long-term care for older persons is individual, informal, unpaid family care, accounting for about 80 per cent of all such care given. The savings in costs associated with home care as opposed to institutional care are a driving factor, as well as individuals' preferences to remain in their homes. However, inadequate support is given to family caregivers, who often have to balance competing demands from other family members, household responsibilities and employment. Aside from financial assistance, family caregivers could benefit from counselling, respite care and household help.

Funding for long-term care comes from a variety of sources, ranging from predominantly tax-financed systems to social insurance-financed schemes. All developed countries in the region operate pay-as-you-go systems. Expenditures vary from less than 0.5 per cent

of GDP in Spain to 3 per cent of GDP in some Scandinavian countries. Although the overwhelming majority of older persons are taken care of at home, 90 per cent of public expenditures go towards providing care to the 3.6 per cent of older persons in institutions. Investing additional funds in community-based and home-care services would help to expand the options for this lower-cost alternative, as well as reduce the burden currently falling on family caregivers. Other questions related to the public financing of care involve eligibility for public benefits. Many ECE countries are involved in far-ranging debates over the provision of long-term care services that encompass notions of (a) universality versus means testing, (b) whether benefits should be provided as cash transfers or as in-kind services, and (c) whether to charge user fees.

Aside from financing issues, an overriding concern with regard to long-term care is the need for quality development and quality assurances. To that end, several countries have introduced accreditation systems that set standards to measure the eligibility and performance of service providers. Once they become more fully developed, accreditation systems could regulate market access, provision levels, quality and prices. Furthermore, they could help to ensure that older persons and their families are satisfied with the level of care and services provided. Extra costs are a likely outcome of improved access and quality, however. Long-term care expenditures are also bound to rise given that the demographics indicate a growing number of people at risk of dependency. A combination of factors is projected to double spending on long-term care from 2005 to 2050, placing considerable pressure on public budgets in the ECE region.

5. Economic and Social Commission for Western Asia (ESCWA)

(a) Demographics. In Western Asia, different countries are at different stages of the ageing process. Bahrain, Kuwait, Lebanon and the United Arab Emirates are experiencing rapid ageing, since 24 per cent of their respective populations will be aged 60 or above by 2050. In Egypt, Jordan, Oman, Qatar, Saudi Arabia and the Syrian Arab Republic, demographic ageing is medium-paced, as 18 to 22 per cent of their populations will be 60 or more years by 2050. Finally, Iraq, the Occupied Palestinian Territory and Yemen are undergoing a slow ageing process, as 9 to 13 per cent of their populations will be 60 or more by 2050.

Ageing is generally given a low priority among countries in the ESCWA region. Other, competing concerns take precedence, driven by two factors of overriding consequence: economics and culture. Poverty is pervasive in most ESCWA countries and more emphasis is placed on economic development than social development, including the concerns of older persons. The culture also reflects persistent gender inequalities as women of all ages are disadvantaged, and are typically expected to tend to the needs of their older family members without additional resources or support.

(b) Culture and the role of families. A strong family culture has meant that Governments have had little to do with ageing matters, as they are believed to be the domain of families. But family structures are changing because of urbanization, labour migration and the changing role of women. There has also been a shift from extended families to

the nuclear family. As a result of these changes, older persons are losing their customary privileged position in society.

Among the major sociological and cultural factors that have impacted traditional family structures is urbanization. In rural areas, older persons are considered a blessing and source of wisdom, and are cared for within the family. Although there are problems, including a lack of access to proper health-care services in rural societies and higher rates of poverty, older persons in rural communities can still count on their families to provide them with care and support into old age. With the movement towards cities, especially among younger people, tightly woven family structures have begun disintegrating. International migration among countries in the region is another important consideration: young people, especially from Egypt, Lebanon, the Occupied Palestinian Territory, and the Syrian Arab Republic, are moving primarily to the Gulf States in search of jobs, while older persons are left behind, lacking care.

The emerging role of women in society has also contributed to the changing nature of families and their caregiving responsibilities. As increasing numbers of women begin working outside the home, they find it difficult to satisfy the caregiving needs of older persons in their families. More support will be needed, therefore, to supplement the caregiving roles traditionally performed by women within the family.

(c) *Poverty, employment and social security coverage.* Poverty is pervasive in the region, and although data are not disaggregated by age, it is evident that many older persons are poor. Social security coverage in the countries of the region, according to ESCWA estimates, does not exceed 25 per cent of the population.

The extent of pension coverage and the generosity of benefits provided vary significantly by country. Pension systems, where available, generally offer replacement rates of 60 per cent of income for an average of 30 years of service. Those employed informally, the unemployed and persons with disabilities are unlikely to be covered under pension plans. The large influx of migrant workers in some of the Gulf countries leads to further complications with regard to their integration in the health care and social security systems.

With the emphasis on youth employment in the region, there is little attention paid to providing employment opportunities for older persons. With a large youth cohort, and high youth unemployment rates, public policy is focused on job creation for young people, not the elderly. Although the Arab Plan calls for access to education and training for older persons, few programmes can ensure that it happens. Limited training in computer skills is offered by some Gulf States. Older women in particular have very limited opportunities for paid employment, although they contribute volunteer work in their communities, provide care to family members and participate in household chores.

(d) *Health care.* Primary health-care services tend to focus on women of child-bearing age and children, and no special attention is afforded to older persons. Lack of access to quality health care is thus a major concern for older persons, rather than the availability of services. The State system of health care, although provided for free or at low cost,

does not guarantee proper care owing to shortages of human and financial resources. Private health services are available which provide higher-quality care, but fees can be exorbitant, placing them out of the reach of many older persons.

Geriatric medicine is an uncommon specialization in countries of the region. In many instances, conditions such as hypertension, diabetes and cardiovascular disease are left untreated because both older persons and health providers consider them normal conditions of ageing.

(e) *Older women.* Women suffer from discrimination, which is ingrained in the culture, and older women are doubly disadvantaged. Older women are more likely to be illiterate, having had little access to educational opportunities in their youth. Rural women in this cohort have the lowest levels of educational attainment. As a result, older women tend to be either outside of the labour force or employed in the low-wage, insecure informal economy where exploitation is common.

Older women also tend to be in poor health, having lacked medical care throughout their lives. The culture puts the concerns of women at the bottom of the list of family health priorities, even at the time of childbirth. Here again, rural women in this cohort are the most disadvantaged. The chapter on the ESCWA regional study notes that the vulnerable situation of older women “is the cumulative result of a gender bias that has materialized in the form of poverty, poor health and even marginalization”. As a consequence, countries of the region have begun devoting more attention to gender issues, such as improving female enrolment in education, to redress these problems for future generations of women.

(f) *Services for older persons.* Although services for older persons are available, they remain quite limited. Nursing homes, for example, are sponsored either by the State or privately, usually by NGOs. State-run nursing homes, which are free or charge nominal fees, typically offer low-quality services. Culturally, families are still expected to care for their elders, so there is opposition to investing public funds to improve these nursing homes. NGOs fill in the gaps to an extent, and provide care, services and charity to poor older persons. These NGOs are usually faith-based or affiliated with mosques or churches.

In a few countries of the region, clubs for the ageing have been formed which resemble adult day-care centres. Older persons are provided with recreational, cultural and religious activities. For the most part, however, such clubs are available only to the wealthy among the older population. In Egypt there are plans to establish an institute for ageing that would conduct multidisciplinary studies on ageing in the areas of health care, nutrition, physical education, psychology, sociology, rehabilitation and environmental sciences. The plan also includes a hospital and a recreational club for older persons. Such services for older persons are not common throughout the region.

III. Ageing Trends in Asia and the Pacific

Sheung-Tak Cheng, Alfred C. M. Chan and David R. Phillips¹²

Population ageing has far-reaching consequences for social organization, economic activities, health care, housing, political policies and almost every area of life. What have societies in the Asia and Pacific region done to counter such impending changes and challenges? Too many sectors view demographic ageing negatively and do not acknowledge it as a consequence of great social, health and economic achievements.

This chapter reviews what countries in the Asian and Pacific region have done individually and collectively to tackle issues of population ageing. First is the historical development of the action programme on ageing under the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) and how it evolved within the broader context of international efforts. Demographic ageing is briefly described for the region, as are selected priority areas for action for issues high on the policy agendas of countries in the region. National capacity to achieve those targets is examined, as well as how synergistic efforts resulting from international cooperation can enhance the capacity of individual countries to tackle those issues. The chapter concludes with challenges in addressing ageing issues in the ESCAP region.¹³

A. International and regional strategies

The approach to a society for all ages is multigenerational and holistic, enabling “the generations to invest in one another and share in the fruits of that investment, guided by the twin principles of reciprocity and equity”. (United Nations, 1995b) The General Assembly elaborated in resolution 50/141 four interrelated dimensions of a society for all ages that would help further the ideas for action on global ageing: the situation of older persons, individual lifelong development, multigenerational relationships, and the dynamics between population ageing and social development. In Asian and Pacific societies, those four sub-themes resonate with cultural concepts of a good life for older persons. A survey of older persons in Hong Kong, China (Cheng, Chan and Phillips, 2004), for example, found that, besides health, leisure, material enjoyment and connectedness with others, older persons very much desire continuous learning and using their skills and knowledge to contribute to their society and to betterment of the younger generations.

The main role of ESCAP in policymaking for ageing matters is to: (a) assess the challenges of population ageing as well as the challenges of implementing internationally adopted plans of action in the region; (b) enhance the ability of Member States to meet the challenges of ageing, such as by disseminating success stories in specific countries and by helping them to execute their plans; (c) develop region- or country-specific

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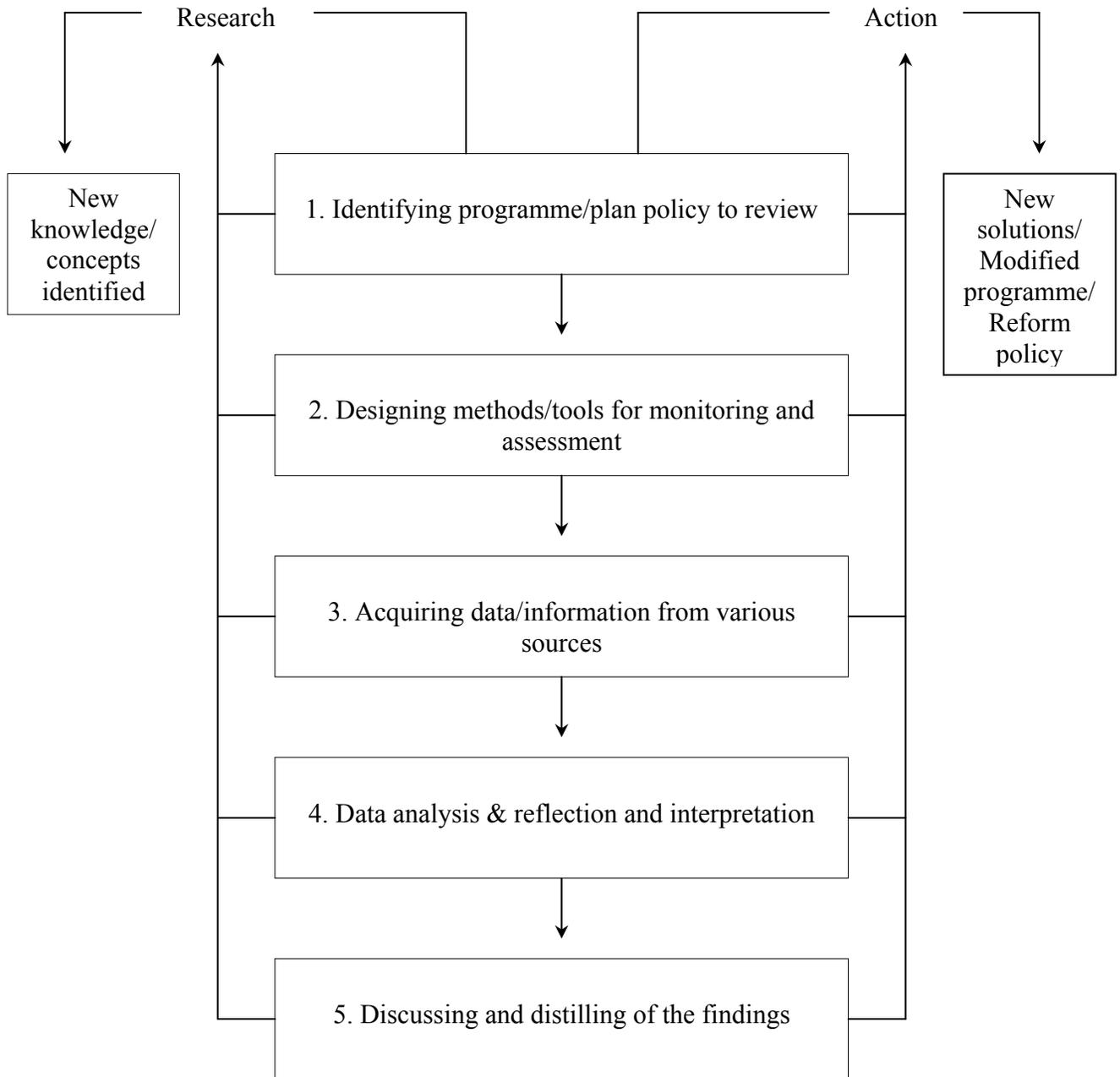
¹³ ESCAP currently has 53 Member States and 9 Associate Member States, all but 4 of which (France, the Netherlands, the United Kingdom and the United States) are located in the Asian-Pacific region.

instruments for monitoring implementation of action plans and their effectiveness; (d) conduct relevant research, including bottom-up participatory research to appraise and review the impact of measures to tackle population ageing; and (e) organize regional meetings to facilitate exchange of views and experiences across countries (United Nations, ESCAP, 2004).

ESCAP led efforts to formulate the 1999 Macao Plan of Action on Ageing for Asia and the Pacific (United Nations, ESCAP, 2000), the first such plan among the UN regional commissions. While many developing countries remain preoccupied with the social and economic development of the nation, including the provision of basic social services, the participating Governments noted that they still needed to view the issues relating to ageing and older persons within the “broader developmental context of priorities, needs and resource allocation”. The Macao Plan issued specific recommendations and guidelines centred on seven areas of concern stemming from socio-economic and demographic changes common to the region, yet providing a framework within which individual countries could set their own goals and targets. The seven areas of concern were: (a) the social position of older persons; (b) older persons and the family; (c) health and nutrition; (d) housing, transportation and the physical environment; (e) older persons and the market; (f) income security, maintenance and employment; and (g) social services and the community. The Macao Plan provided a regional platform for Asian and Pacific countries to cooperate and share their experiences in policies and programmes to meet the challenges of ageing.

Subsequently an ESCAP survey assessed the ageing situation and policy responses in the region (United Nations, ESCAP, 2002a) to provide background information for the Asia-Pacific Seminar on Regional Follow-up to the Second World Assembly on Ageing, held in September 2002 in Shanghai, China. While affirming the Madrid and the Macao Plans of Action, the Seminar produced a set of action recommendations tailor-made for countries in the region that were grouped under the three Madrid priorities, along with a fourth on implementation and follow-up. Known as the Shanghai Implementation Strategy (United Nations, ESCAP, 2003), it encouraged a bottom-up participatory approach in evaluating implementation success (see figure III-1).

Figure III-1. Framework of a participatory approach to review and appraisal activities



Source: United Nations, ESCAP (2004), p. 19.

In following up the Strategy, ESCAP members developed instrumental indicators (process indicators to identify availability, scope and coverage of programmes) and outcome indicators (policy targets or proxies, or output for same) for monitoring implementation (United Nations, ESCAP, 2004). The indicators were designed to respond to principles of the participatory approach as well as to map each priority issue with suggested data collection mechanisms. It is currently the most important implementation framework in the Asian-Pacific region. The indicators were organized along the three priority areas of the Madrid Plan to allow for comparison of results. ESCAP followed up with a regional survey in conjunction with the Asia-Pacific Institute of Ageing Studies at Lingnan University, Hong Kong, China, in 2005 to assess implementation status (Chan and Phillips, 2005). Of the 56 members and associate members of ESCAP that received the questionnaire, 21 responded¹⁴ (see table III-1 for those participating). The following report is based largely on the survey results together with individual country papers.

B. Demographic trends

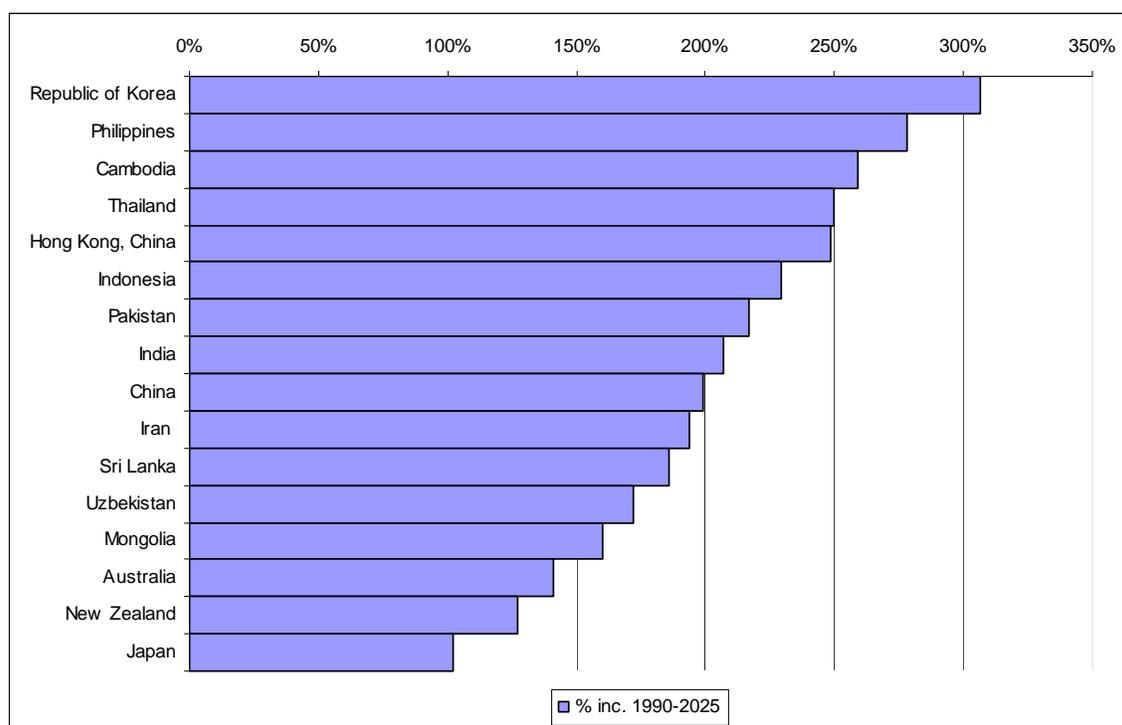
The populations of many countries in the Asian-Pacific region have shifted from high birth and death rates to low birth and death rates, with rising longevity (Phillips, 2000a; Yoon and Hendricks, 2006). Worldwide, the number of persons aged 60 and above in 2005 was 672.8 million, of whom 54 per cent lived in Asia. The ESCAP region, with its 53 Member States and 9 Associate Member States, is diverse in population composition and social development. The two most populous countries in the world, China and India, are ESCAP members. Together they accounted for 34 per cent of older persons in the world in 2005, although they are not by any means the “oldest” countries in the world in percentage terms (United Nations, 2007a). Many of the developing Asian and Pacific countries are ageing relatively rapidly; Asia is said to be the place where the impact of population ageing will be the most obvious over the next few decades. Whereas most developed European countries and the United States required between 80 and 150 years to double their older population from 7 to 14 per cent, many developing countries in the region will accomplish that within a much shorter time. Fuelled partly by the one-child policy, China, for example, is expected to nearly double its older population in just 20 years, from 11 per cent in 2005 to 20 per cent by 2025 (United Nations, 2007a; see also figure III-2). The older population in the Republic of Korea reached 13.7 per cent in 2005; that percentage will double in a matter of 20 years (United Nations, 2007a). By 2050, almost two thirds (62.3 per cent) of the world’s population aged 60 and above (numbering 2 billion) will be in Asia (United Nations, 2007a).¹⁵

¹⁴ The original publication of the 2005 ESCAP regional survey reported that 20 countries or areas had responded, a total that reflected a data coding error. Table III-1 in this publication correctly indicates the 21 countries or areas that returned their completed questionnaires.

¹⁵ For a discussion of causes of demographic ageing, see Kinsella and Phillips (2005), McCracken and Phillips (2005) and, for a specifically Asian view, Yoon and Hendricks (2006).

Some Asian And Pacific countries or societies have the lowest total fertility rate (TFR) in the world and at the same time the longest life expectancies.¹⁶ The TFRs for Macao and Hong Kong, China are 0.91 and 0.97, respectively, about the lowest in the world, while those of the Japan, Republic of Korea, and Singapore are 1.27, 1.21, and 1.26, respectively (United Nations, 2007a); the world average being 2.55 and the natural replacement rate being 2.1. At the same time, life expectancy at birth is 82.6 years for Japan, 82.2 years for Hong Kong, China; 80.7 for Macao, China; 80.0 for Singapore and 78.6 for the Republic of Korea; the world average being 67.2 years. Of the two most populous countries in the world, China is ageing much more rapidly than India, with TFR at 1.7 and life expectancy at 73, whereas the corresponding figures for India are 2.8 and 64.7. Nonetheless, the combined effects of modernization and urbanization are expected to cause fertility decline even in countries with a current TFR above the natural replacement rate of 2.1, together with accelerating population ageing (United Nations, 2007a). Across Asian and Pacific countries, women outlive men by a few years.

Figure III-2. Percentage increase in population aged 60 and above between 1990 and 2025 in selected Asian and Pacific countries or areas



Source: United Nations (2007a)

¹⁶ Life expectancy at birth is the number of years a child born in the given period would live if the age-specific mortality rates of the period were to remain constant over his or her lifetime. The total fertility rate is the average number of children that would be born to a woman over her lifetime if she were to experience the exact current age-specific fertility rates throughout her lifetime.

Japan is now ranked as the “oldest” country in the world, with some 26 per cent of its population aged 60 or over in 2005 (United Nations, 2007a). In others of the more developed ESCAP societies, such as in Hong Kong, China, the Republic of Korea and Singapore, roughly 12 to 15 per cent of the population is 60 or more years; but that will, by 2050, rise to about 40 per cent for all those societies, level with Japan. By contrast, such developing countries as Bangladesh, Cambodia, Lao People’s Democratic Republic, Nepal, Pakistan, and the Philippines are still relatively young, with just single-figure percentages of the older population in 2005, and 10 per cent or less by 2025. They have, therefore, up to 20 years of opportunity to position themselves to face the challenges of population ageing. Other developing countries, however, such as China, Sri Lanka and Thailand, have a much faster pace of ageing, with older persons occupying 10 to 11 per cent of the population in 2005, a percentage that will roughly double by 2025. By 2050, most countries or areas in the region are expected to have at least one quarter of their population aged 60 and above (table III-1). Across Asia, persons aged 60 and above are expected to outnumber those below age 15 before 2050 (figure III-3), a demographic situation unique to human history. Some countries in the region are predicted to face a population decline by 2050 (Japan, the Republic of Korea and Sri Lanka), a situation only widely experienced elsewhere in the European region.

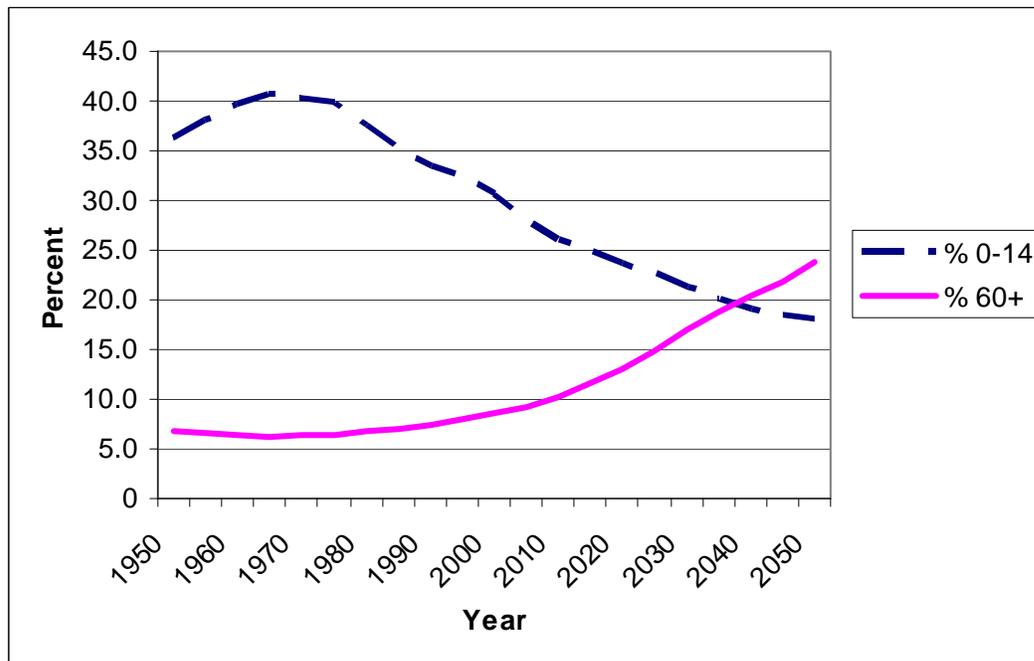
Table III-1. Population aged 60 years and above in selected Asian and Pacific countries or areas and the total Asian population, in the years 2005, 2025 and 2050

Country or area	60+ population (thousands)			60+ population of total population (%)			80+ population of 60+ population (%)		
	2005	2025	2050	2005	2025	2050	2005	2025	2050
Asia	363 378	708 829	1 249 316	9.2	14.8	23.7	10.6	11.9	19.0
Eastern Asia									
China *	144 025	289 542	437 855	11.0	20.0	31.1	10.7	11.3	23.5
Hong Kong, China *	1 087	2 507	3 534	15.4	30.2	39.4	18.3	0.2	34.4
Macao, China *	49	156	224	10.3	29.2	42.8	17.7	10.0	33.1
Japan *	33 725	43 528	45 077	26.4	35.8	44.0	18.3	29.7	35.1
Mongolia *	152	336	850	5.9	10.8	25.1	12.6	8.9	14.2
Republic of Korea	6 571	13 413	17 844	13.7	27.4	42.2	10.2	16.1	30.2
South-Eastern Asia									
Cambodia	716	1 545	3 830	5.1	7.9	15.2	6.5	7.2	9.5
Indonesia	18 869	37 165	73 595	8.3	13.7	24.8	7.3	9.8	16.1
Lao People's Dem. Rep. *	293	583	1 511	5.2	7.6	16.3	8.4	7.3	10.2
Malaysia *	1 711	4 468	8 796	6.7	13.2	22.2	8.8	9.1	17.9
Myanmar *	3 823	7 671	15 015	8.0	13.9	25.6	12.0	9.8	16.5
Philippines *	5 054	11 330	25 503	6.0	9.8	18.2	8.0	9.0	14.2
Singapore	531	1 613	2 002	12.3	31.6	39.8	12.0	12.6	37.2
Thailand *	7 122	14 782	20 071	11.3	21.5	29.8	11.5	12.4	23.6
Viet Nam	6 452	14 221	31 266	7.6	13.4	26.1	13.3	10.7	18.4
South Central Asia									
Bangladesh *	8 777	19 040	43 135	5.7	9.2	17.0	6.8	7.3	11.2
India	84 661	166 348	335 489	7.5	11.5	20.2	9.2	10.8	15.3
Iran, Isl. Rep. of *	4 438	9 566	25 658	6.4	10.9	25.6	9.2	7.5	11.4
Maldives *	17	35	102	5.6	8.5	20.0	8.5	7.7	10.4
Nepal *	1 561	3 035	7 245	5.8	7.8	14.0	7.2	7.9	10.2
Pakistan	9 323	19 246	48 112	5.9	8.6	16.5	8.7	9.5	12.1
Sri Lanka *	1 863	4 008	5 428	9.7	19.7	29.0	11.5	10.5	20.8
Uzbekistan *	1 643	3 605	8 016	6.2	10.6	20.9	11.5	8.9	14.5
Western Asia									
Armenia *	438	657	833	14.5	22.6	33.9	11.1	12.4	20.0
Azerbaijan	776	1 583	2 591	9.3	16.7	27.6	8.4	10.8	19.5
Georgia *	802	1 004	1 093	17.9	25.4	34.9	11.5	13.9	21.1
Turkey	5 971	12 371	24 230	8.2	13.8	24.5	7.2	8.8	15.7
The Pacific									
Australia	3 613	6 288	8 462	17.8	25.8	30.2	19.7	19.9	30.8
Fiji *	57	115	178	6.9	12.7	19.6	6.4	8.3	14.9
Guam *	16	35	54	9.5	16.6	22.3	10.5	10.4	22.8
New Zealand *	679	1 187	1 574	16.6	24.9	30.2	19.2	18.3	30.5
Papua New Guinea	236	539	1 246	3.9	6.3	11.2	5.6	5.7	9.8

Note: * Participated in the ESCAP regional survey of 2005.

Source: United Nations (2007a)

Figure III-3. Percentage of two age groups (0-14 years and 60+ years) of the total population grouping in Asia, 1950-2050



Source: United Nations (2007a)

As a result of longer life expectancy, one of the fastest growing population cohorts is those aged 80 or more years (Kinsella and Phillips, 2005; McCracken and Phillips, 2005). In most Asian or Pacific countries, that cohort is expected to increase six fold from 2005 to 2050, amounting to 237.8 million in the whole of Asia and accounting for 19 per cent of the older population. In the “older” societies, such as Hong Kong, China, Japan and Singapore, the very old will account for more than one third of the older population (table III-1). The immense potential need for long-term care and supporting community caregivers is glaringly obvious, especially if the economic and health status of the oldest old populations does not improve.

One consequence of demographic ageing is an increase in the number of older persons to be supported by younger adults. In Asia, the so-called old age dependency ratio, measured as the number of persons aged 65 and above per 100 persons aged 15 to 64 years, will rise from 9.7 in 2005 to 27.2 in 2050. The rate of increase varies greatly in the region. For instance, Macao, China will experience an increase from 9.8 to 59.3 in this period, Singapore from 11.8 to 58.6 and the Republic of Korea from 13.1 to 64.5. In general, the old age dependency ratio will be over 50 by 2050 in developed societies in the region, meaning that 1 elderly person will have to be supported by fewer than 2 younger adults. Japan, already leading the world (together with Italy) in the old dependency ratio, will increase from 29.8 to a staggering 73.8 during that period! Some developing countries, like China and Thailand, will experience more than a threefold increase to about 38 in 2050, whereas other younger societies, such as India and

Philippines, face more than a twofold increase to about 20 (United Nations, 2007a). The challenge for some countries to provide safety nets for their older populations is quite overwhelming, unless some transformation of the economic and social welfare systems takes place.¹⁷

Overall, because demographic ageing in much of Asia today is occurring far more rapidly, or on a much more compressed timescale, than it did in most of the West, many ESCAP countries will have considerably less time to adapt to the consequences of population ageing, especially certain countries in East Asia.

C. Regional priorities

The 2002 and 2005 ESCAP regional surveys on ageing reveal common trends and priorities in national policies and programmes on ageing as well as diversity in policy development and implementation. While ageing is a positive outcome of social, economic and medical advances, many countries in the region face challenges in crafting appropriate policies and practical measures to address these demographic changes. Countries that have already established national policies on ageing will no doubt progress in developing their strategies for dealing with population ageing in the near term. Many developing countries with a youthful population structure, however, have begun seriously to address issues of ageing only within the last decade. A national strategy on how to prepare society for the challenges of ageing is essential in ensuring that the goals of active ageing are achieved (WHO, 2002a) and to coordinate national and local policies and practices in a range of welfare, health and economic sub-fields.¹⁸

From the results of the 2005 survey, the approach to the Shanghai Implementation Strategy has been enhanced with special considerations to suit the region:

- economic and political diversities
- geographical barriers to service accessibility
- social and cultural diversities including languages

These considerations are elaborated below, according to the priority areas of the Madrid Plan to which they apply.

1. Older persons and development

(a) Social protection. Unlike many of their counterparts in the Americas and the European Union, Asian and Pacific countries are rather diverse economically and politically, especially in terms of social protection. Although a few countries in the region are advanced, many developing countries are defined by their concentrated poverty. In 1998, one fifth of the world's population was living on less than US\$1 per day; two thirds of them were in South and East Asia. Many of the poor are older persons living in rural areas. Because they have earned so little, they may not have saved enough to live

¹⁷ Experts caution that the old age dependency ratio is not a reliable measure with which to predict future needs for services and support because it would involve certain assumptions about the future health and wealth of older persons and the population.

¹⁸ For an earlier ESCAP review of critical issues in national ageing policies and programmes in Asia and the Pacific, see Phillips and Chan (2002b).

decently in old age. They must either continue working or rely on family or community for support, in the absence of comprehensive social security or even safety nets in many countries. In developing countries in Asia, only 9 to 30 per cent of the older population receives any pension or social security benefits (United Nations, ESCAP, 2004). Poverty is therefore the most urgent issue in this region.

Owing to financial constraints, social security programmes of such countries in the region as Bangladesh, India and the Republic of Korea are targeted to very poor and disabled persons only; there are simply no universal benefits for the elderly as a group. The Republic of Korea, for instance, provides the Elder-Respect Pension to those not covered by its 1988 national pension scheme (Rhee, 2006). Even with coverage, the level of payment is often insufficient for an older person to live comfortably. An encouraging development in 2006 was that India almost tripled its National Old Age Pension benefit, targeted for the destitute aged 65 years and above, to Rs. 200 per month (India, 2006). By contrast, China, with its mixed pension system, has reduced much of its guarantees for older persons, especially those in rural areas, with the demise of collective farming systems over the past 25 years. By the end of 2002, the social security umbrella covered only 14 per cent of the entire workforce, of whom almost all were urban workers. Without a sufficient pension system, families still represent the last resort for most ageing Chinese citizens today. Some 85 million elderly people in Chinese rural areas, or 65 per cent of the total ageing population, “do not benefit from the country's social welfare system, pensions and adequate medical care,” according to Xinhua, and the system is very fragmented (*China Daily*, 2006).

Part of the problem lies in the low educational level and illiteracy of current cohorts of the older population in developing countries (Friedman and others, 2003; Sobieszczyk, Knodel and Chayovan, 2003; Zeng, Liu and George, 2003). Many beneficiaries of social security systems that are already in place are simply not aware of the benefits for which they are eligible. The 2002 Survey of Elderly in Thailand conducted by the National Statistics Office revealed that only half of those aged 60 or more years were aware of social security for older persons, and as few as 5 per cent received any benefits (Knodel and others, 2005). The oldest persons, women and rural residents were most likely to be left out of the safety net. In Bangladesh, HelpAge International (2006a) is conducting an Older Citizens' Monitoring Project in villages that revealed that less than 10 per cent of eligible beneficiaries of the Old Age Allowance were receiving benefits. The project mobilizes older people to form advocacy groups that identify eligible beneficiaries locally and applies for the benefit on their behalf.

In a number of countries or societies (such as Hong Kong, China and Nepal), pension benefits are primarily limited to civil servants or employees of State enterprises (United States, Social Security Administration [SSA], 2005), senior staff in major international corporations or, in some countries, the military. Facing the challenges of population ageing, Nepal is planning to launch a mandatory pension system soon (Upadhyaya, 2004). Hong Kong, China started its Mandatory Provident Fund scheme in December 2000, although it will take many years to mature and yield benefits for older people; it is essentially an individual savings scheme that requires many decades to build sufficient funds.

In other countries, coverage may be limited to moderate-to-large-sized enterprises, if not State-owned (e.g., in India, Indonesia, the Lao People's Democratic Republic, Papua New Guinea and Viet Nam). Such a system excludes many workers employed in small businesses or informal jobs (i.e., without a formal contract). Some of those countries are taking steps to extend pension coverage to smaller enterprises and informal workers (United States SSA, 2005). Nonetheless, enforcement measures are usually lacking in developing countries, and employers and employees commonly misreport the facts in order to avoid having to contribute.

China, the most populous country in the world, has experienced tremendous challenges in providing a safety net to its retired workers, many of whom were formerly covered by State-owned enterprises and in agriculture but who today are not covered. The transition to a market economy has effectively bankrupted the pay-as-you-go pension fund of many State enterprises, resulting essentially in coverage just for civil servants and urban workers in certain enterprises. A new three-pillar system has been established, of social pooling, individual accounts and voluntary supplementary corporate schemes; but it suffers from delayed implementation, lack of incentives and inability of beneficiaries to pay for contributions (Béland and Yu, 2004; Williamson and Deitelbaum, 2005).

In the rapidly growing market economy, jobs and wealth concentrate in largely urbanized areas, attracting casual labour from rural areas in large numbers. A "floating population", they are not properly registered as workers and thus not entitled to labour protection or benefits. In the official system, defined contributions are uneven: employers are expected to pay into the central pool at an annual rate set by the provincial Government not exceeding 21 per cent of the employee's income, while the employees pay 8 per cent. Workers in wealthier provinces or cities such as Quandong and Shanghai would in theory enjoy a fair pension whereas people unable to pay or living in poorer provinces or rural villages would go without one. The pay-outs (pension benefits) are also not clearly defined. Workers will receive their benefits from their 8 per cent contribution; however, the basic pension paid out from the central pool is regulated as well by the provincial Government with a different rate each year. That provision reflects the intention to ensure an adequate basic pension for all workers including those who had made only small contributions. However, low-profit enterprises with a large number of pensioners on their payrolls would find that difficult or impossible to sustain. Adding to those issues is the almost-nil formal pension coverage in rural areas, where some 64 per cent of China's population lives. Although China has declared that improving social protection in poor rural areas is a matter of national priority, an effective pension system is extremely difficult to manage for such a large and populous country. Many other countries have experienced the same kinds of challenges.

The growing size of the older population is beginning to pose challenges for other sectors as well. For example, if transportation and medical providers in the Philippines were to honour the 20 per cent discount to seniors that is required by law, many of them would go out of business (Collado and San Diego, 2004). Economic and political realities can stifle the actual delivery of social protection in developing countries.

China, the Philippines, Singapore and Hong Kong, China, all understand the need to include individual accounts in their social security programmes, in order to address the ever-growing burden of providing for social protection for a rapidly expanding older population. In an ageing population, tax-paying workers decline in number while retirement beneficiaries grow. In 2001 in China, for instance, 100 workers supported 29 retirees; that ratio is expected to increase to 55 retirees in 30 years' time (Keran and Cheng, 2002). Even the most affluent countries in the region are already finding it difficult to formulate a sustainable pension scheme for their citizens. Japan has once again reformed its pension scheme, stipulating that the employee contribution will be raised gradually by 0.354 per cent per annum to a ceiling of 18.30 per cent in 2017; and that benefits would be reduced by 0.9 per cent per annum over the following 20 years (Sakamoto, 2005). Israel is gradually extending its pensionable age to 70 for both men and women and encourages work beyond the retirement age by raising the pension benefit by 5 per cent for each year of deferred retirement (United States SSA, 2005). Similar measures, including switching from a defined benefit to a defined contribution scheme, are being taken by other countries to deal with population aging.

Most developing countries need to deal with the challenges of population ageing before they become relatively wealthy and modernized. High unemployment or low wages can render impossible the proposition of a universal pension. Initiatives for self-sustaining projects such as the "20/20" financial support (that is, the 20 per cent contribution by the Government of the respective country is matched with the same amount from a donor country in the same region; UNDP and others, 1998) have not succeeded. People living in dire poverty in the region so far survive on extremely low subsidies given mainly by charities or international assistance agencies. Some success stories have been reported from Indonesia, Pakistan and Viet Nam, for example, on village partnership projects; one example is hiring workers from the same village where enterprises work to purify water supply. Nevertheless, whatever is gained in the transition from rural to modernized living, the family and the neighbourhood are almost always the fallback support sources.

Countries with a national policy on ageing are tending to adopt at least a three-pillar system, or to work towards building one, for social protection of older persons: (a) an attempt to provide a minimal public pension (means-tested or universal); (b) a mandatory occupational contribution; and (c) voluntary support or contribution by individuals or family savings. The relative involvement of the public and the private sector in pension schemes seems to be changing. The global consulting firm Watson Wyatt Worldwide (Charles and Collins, 2005) declares:

Across Asia, there has long been a consensus in policy making circles that public social security programmes cannot be the sole means of providing pensions. But, as in the rest of the world, pension reform is a politically sensitive issue and the role of the private sector has up to now been constrained. However, strides have recently been made. We believe that the long standing potential for a significant pension and retirement reform in Asia is now close to reality.

Some examples are shown in table III-2. A possible explanation for the historically minor development of private-sector pension schemes is that personal savings rates have

generally been high in Asian countries; and, in China, the dominance of the State in coverage.

Public-private-sector partnerships are becoming more important with respect to social protection. Some countries either cover some private-sector employees or use the private sector as a partner in public pension schemes (OECD, 2005a). The Employees Provident Funds in Malaysia is a compulsory savings scheme for private-sector employees where some of the funds are invested with outside managers. China is increasing the outsourcing of social security reserves to private industry and regulating private pension schemes in attempts to satisfy growing needs for retirement benefits in an increasingly prosperous society. In Japan, in 2001, a new Government Pension Insurance Fund (GPIF) was set up as the investment management agency. The Ministry for Health, Labour and Welfare decides the asset allocation strategy of public reserves after consultations with external experts while the GPIF is assigned with the investment and administration; the scheme has favoured passive investment but allocation to active managers is increasing steadily. In countries such as Thailand, the outsourcing of investment of public pension assets to private-sector managers is clearly a trend. Supervisory and regulatory processes to safeguard such private-sector involvement become crucial policy issues, along with the protection of investments and benefits and the maximizing of returns.

Table III-2. Key pension reform developments in selected countries of East and South Asia

Country	What's happening?	Status	Scope	Government or private sector providers?	Action for employers
China	Encouraging employers to set up pension funds	New rules effective from May 2004	Voluntary – Employers do not have to contribute but get tax benefits	Private sector providers	Review desirability of providing supplementary retirement benefits
India	New national defined contribution retirement savings system	Details awaited	Voluntary Additional to, i.e. not replacing, existing retirement system	Private sector fund management with a Government agency responsible for centralized contributions collection	Review desirability of funding mandatory and supplementary benefits (gratuity and superannuation) via group products provided by insurance companies
Republic of Korea	Option of funded system (either defined benefits or defined contribution), instead of unfunded severance payment promises	Framework legislation passed on 29 December 2004, but more details awaited	Voluntary to opt out of severance payment scheme	Private sector providers	Review likely strategy – details of the various options expected soon as the new legislation will take effect from 1 December 2005
Singapore	Opening up Central Provident Fund to private sector fund managers	Details imminent	Mandatory	Private sector fund management for first time with a Government agency responsible for contributions collection	Await details – worth monitoring closely as situation may develop rapidly

Source: Charles and Collins (2005)

(b) Strengthening the informal care system. Until recently, Asian countries characteristically maintained strong family values, with people living in extended-family households (either together or close by) and members drawing on each other's resources to meet psychological, social and physical needs. Traditionally, older persons have been looked after by the young with minimal state intervention. In Confucian societies the sense of well-being of older persons depends on the filial devotion of their children, whether they have genuine needs or not (Cheng and Chan, 2006b). In two representative surveys in Thailand carried out eight years apart, the great majority of elderly people (84.5 per cent in 1994, 77.2 per cent in 2002) received financial contributions from their children, whereas only a small number received financial aid from the Government (Knodel and others, 2005). Similarly, in the Republic of Korea, children were the main source of income of 59.4 per cent of older persons in 2001, compared with just 2.7 per cent in the United States (United Nations, 2005c).

Despite the tradition, family support for older persons in Asian societies has waned in recent years for a range of reasons (Cheng and Chan, 2006a; Oh and Warnes, 2001; Phillips, 2002): notably, urbanization, migration of young people to cities, the nuclear family as the emerging norm for young adults, and the increasing likelihood that females receive education and become involved in the labour force. Of different importance in different cultures, those factors have come to reshape the sense of children's obligation to their parents. Surveys in Chinese societies have consistently shown that both younger and older generations currently hold less traditional attitudes toward co-residence and financial support for older persons, with financial support showing greater change over time. Fewer co-residences also mean that daughters are assuming the roles traditionally taken up by the co-residing daughter-in-law (see Cheng and Chan, 2006a for a review).

The shift is similar across most Asian societies. Although it is unlikely for older persons in Asia to be living alone (just 5 per cent of men and 9 per cent of women, against the world average of 8 per cent and 19 per cent, respectively), the percentages living with a spouse only have noticeably increased (United Nations, 2005a). Similarly, over a 20-year period, the percentage indicating that children were the primary source of income declined from 78.2 per cent in 1981 to 59.4 per cent in 2001 for the Republic of Korea, and from 29.8 per cent to 12.0 per cent for Japan, compared with a flat 2.7 per cent for the United States (United Nations, 2005c). Owing to migration of younger adults, older persons live alone or with their spouse only more commonly in rural than in urban areas, where formal support is also lacking (United Nations, 2005c).

In most countries of the ESCAP region, the traditional concept of the family, living as a household in a legal or recognized union such as marriage, is still the norm. That holds important implications for intergenerational relations and the implied contract between the generations. Furthermore, the traditional stability of families in most of Asia and the Pacific cannot be assumed to last indefinitely into this century. New patterns of adult unions are emerging, divorce rates are increasing and divorce has been legalized in many countries where previously it had been either illegal or discouraged. Related changes such as loose vertical families, cohabitation, divorce and increasing voluntary childlessness (or very small families) are becoming much more acceptable and common

in some Asian and Pacific countries, changes that will likely have very profound impacts on family and informal care for older persons.

A strong safety net for older persons is therefore not the typical situation in many developing countries in Asia and the Pacific. Nor are formal social services well-developed for the older age group.¹⁹ In that context, the informal social network has a significant role. The family, along with other informal caring networks such as friends and neighbours, can provide essential help in cash or in kind to meet the needs of older persons, and could continue to do so if traditional family values are revitalized in the years to come (United Nations, ESCAP, 2003, 2004). The Republic of Korea and Hong Kong, China have used tax exemption to encourage adult children to live with their parents and/or provide them with financial assistance. Others including China, India, Malaysia, the Philippines and Singapore have legally mandated children's obligation to support their parents (United Nations, ESCAP, 2004). Aside from attempts to revitalize traditional family values, efforts to support the caregivers with, for example, the knowledge and skills to take care of a family member with Alzheimer's disease, can be especially useful (Mittelman, 2005).

Although co-residence with children is almost certainly declining in most countries, living with a spouse continues to provide mutual support for those doing so. In such households, the wife is usually the net provider of support, both emotional and instrumental, and generally outlives the husband (Allen, Goldscheider and Ciambrone, 1999; Gurung, Taylor and Seeman, 2003). Older women are therefore both burdened with caregiving and vulnerable to the consequences of widowhood. No action plan on ageing, therefore, is complete without specific attention to the issues of gender.

(c) Gender equality. Although older women are often caregivers in the (extended) family, they frequently do not receive support for the roles they play. Homemaking and informal caregiving are not recognized occupations that yield financial return. Yet women are often bound to such roles for life. For instance, among married older persons in Thailand, 71.2 per cent of men, compared with 49.7 per cent of women, nominated their spouse to be the main personal care provider (Knodel and others, 2005). Studies across cultures consistently show that women caregivers spend more hours in providing personal care and doing housework; they are more subjectively burdened than men caregivers as well, presumably because they internalize their kin-keeping and caregiving roles (Bookwala and Schulz, 2000; Chiou, Chen and Wang, 2005; Rose-Rego, Strauss and Smyth, 1998).

In many developing countries in Asia and the Pacific, women are disadvantaged by their illiteracy or lack of education, and their dependency on men for land and income (Friedman and others, 2003; Sobieszczyk and others, 2003). Especially in rural areas, women are often treated as the property of their husbands or their families without any entitlements to subsistence or basic education; abuses are still very common. They are left at great financial risk when their husband dies. Such discriminatory practices are declining in urban areas, largely because women have become better educated and better able to make their own living. As education is a major determinant of service utilization

¹⁹ For a review of trends and priorities in the ESCAP region, see Phillips and Chan (2002c).

in those countries, especially in rural areas, isolation (Sorkin, Rook and Lu, 2002) and lack of formal support increase the vulnerability of widows to health and cognitive deterioration (United Nations, ESCAP, 2002b).

In India, for example, widows are traditionally considered ill omens and are often removed from their homes to live in so-called widow villages, together with other widows and isolated from their children. They frequently live on alms and spend their time praying and chanting, until they die (Whelan, 2000). Women in other developing countries also can be victimized by deep-rooted discriminatory practices. Gender inequality not only deprives women of their right to participate fully in their society, they may even be segregated from the rest of their community.

Very few countries in the region, Israel and Japan among them, provide social insurance to homemakers that ensures access to financial security in later life for women who have no occupational history. Women may make important contributions to society yet do not fall within traditional economic categories; for example, homemakers and informal caregivers. They may also suffer inequalities in the labour market, such as women who are paid less than men for the same job, women discriminated against in recruitment for certain jobs, and women required to retire at an earlier age than men, as in China (Béland and Yu, 2004) and Mongolia (Munkhtsetseg, 2004). Only with equal status and financial security can older women participate as fully as men do in society.

Finally, although the discourse on gender issues focuses largely on the status of women in society, men also suffer from certain disadvantages as a result of their position in society. Men consistently have shorter life expectancies than women, often several years shorter. Research shows that as men advance in age, they are increasingly less likely to maintain breadth in their social network and tend to rely excessively on immediate family members, especially their wife, for emotional and instrumental support. Over time, men, having devoted their energies to occupational and financial achievements, come to depend on their wives for kin keeping, friend keeping, emotional comfort and household duties. Their role as household head in the patriarchal family structure also tends to keep them distant from their own children. As a result, men often suffer more psychologically than women, when their spouses are incapacitated or pass away (see Cheng and Chan, 2006b for a review). A gender-neutral society that distributes roles and status fairly among men and women should yield benefits for everyone.

(d) Eliminating age discrimination and promoting positive images of older persons.

Whereas gender discrimination affects primarily older women, age discrimination affects everyone in a society because it promotes segregation. Discrimination on the basis of age is a long-standing issue in virtually all societies. Ageist prejudice is deeply embedded and pervasive. Addressing those issues is not a cosmetic exercise: it has potentially huge ramifications for the well-being of older persons, families and society as a whole (Harper, 2006). Older persons may generally receive greater respect in the agrarian economies of Asia and the Pacific, but “silver power” perceptibly declines as places become urbanized and industrialized.

Although many societies in the region have historically accorded high status and esteem to older persons, age discrimination nonetheless exists, as when a person is denied a job because he is “too old” even though he is still capable and can fruitfully bring years of experience into it. Age discrimination hinders full participation by older persons and damages intergenerational solidarity, and must be dealt with on the way toward realizing societies for all ages. One obstacle to eliminating age discrimination is the negative stereotypes about older people. Unfortunately, all too often, illiteracy and low education reinforce the myth of a non-productive, dependent and frail older person.

In the 2005 ESCAP regional survey, most countries indicated that they emphasize promotion of positive images of ageing, typically in the form of public education and media campaigns. Mostly such activities are ongoing, but in some countries such as the Philippines, they are usually seasonal (say, during a national observance for older persons). Eliminating age discrimination is a task that deserves urgent implementation because of the time required to change deep-rooted cultural attitudes and practices. Education of the young also has a place in a fundamental, long-term strategy to eradicate age discrimination. Issues relating to older people in society are being included in school curricula in China, Mongolia, Pakistan, Philippines and Thailand (United Nations, ESCAP, 2004), although the scale of implementation varies among the countries. Indeed, massive education and participation by older people in social, economic and political affairs might be the best strategy to eliminate age discrimination and promote an image of successful and productive ageing.

(e) *Economic, social and political participation.* A society for all ages is one in which participation in various social spheres is not restricted to, nor skewed in favour of, certain age groups. Economic participation by older persons is going to become increasingly important in the years to come because it (a) improves the financial health of the economy and of the individual workers in their later lives, and (b) provides meaningful roles and a sense of identity to the elders (Heller, 1993). Moreover, the wider participation in the labour force by older people can go a long way toward eliminating ageism because, in modern economies, waged labour determines to a large extent a person’s social value. “Productive ageing” is an important concept to promote in this sense (Kinsella and Phillips, 2005). As people age, they can contribute to society directly, in terms of economic earnings or income generation, and indirectly, by, for example, providing family care, freeing younger people to work or taking on a wide range of voluntary or other roles and activities.

Legal reform may be necessary to facilitate economic participation by older people. Anti-age discrimination legislation protects the rights of older people in employment and in service accessibility, notably in Australia (2004), Japan (Taylor, 2002) and New Zealand (n.d.). In the absence of an anti-age discrimination law, the Republic of Korea (n.d.) promotes the participation of older persons in job markets through the Aged Employment Promotion Law, which induces businesses to hire 3 per cent or more of their employees from persons aged 55 and above, and stipulates 77 types of jobs (such as selling bus tickets and cigarettes, or attending parking lots and public parks) for which older applicants should be given first priority.

Table III-3. Labour force participation rates of older persons by age and sex in selected Asian and Pacific countries or areas, 2005

Country or province	Ages 60-64			Ages 65 or over		
	Men	Women	Total	Men	Women	Total
Australia	54.6	31	42.9	11.3	4.2	7.4
Cyprus	59.4	20.9	39.5	19.6	4.8	11.3
Georgia	81.2	58.4	68.9	54.8	42.3	47.4
Hong Kong, China	44.9	15	30.2	9.4	1.9	5.4
Indonesia	NA	NA	NA	NA	NA	NA
Iran, Islamic Republic of	62.5	4.5	36.6	40.6	4.5	23.1
Israel	56.5	29.4	41.5	16.3	5.7	10.2
Japan	70.3	40.1	54.7	29.4	12.7	19.8
Macao, China	56.9	26.3	42.6	15.7	4.3	9.6
New Zealand	70.7	49.8	60.2	15.6	7.2	10.9
Philippines	NA	NA	NA	51.6	29.4	39.6
Republic of Korea	66.7	43.4	54.6	41.3	22.5	30
Singapore	51.3	19.6	35	18.3	4.2	10.7
Thailand	NA	NA	NA	NA	NA	NA
Turkey	40.1	15.3	27.4	25.1	7.6	15.2

Note: NA = data not available.

Source: International Labour Office (2006); Singapore (2006)

Such macro measures may be more crucial for developed than for developing countries. In developing countries, agrarian labour drives much of the economy, shared among all ages in an extended family; in post-industrial economies, by contrast, workers are often expected to retire, normally at an age of 60 or above. In such places as Singapore and Hong Kong and Macao, China; the economic participation rate drops drastically after the age of 65 (see table III-3). That allegedly helps provide vacancies and a career pathway for younger workers who supposedly can master new technologies better than the retirees. The implicit intergenerational conflict is socially created but is not insurmountable. Experiences in developed economies in North America and Europe have demonstrated the value of the continuing participation of older workers as part-timers or in positions of lesser responsibility that permit their accumulated wisdom to remain in the system and provide support for younger workers. Some developed ESCAP countries (e.g., Australia and Japan) are adopting similar strategies. Older workers prove to be more reliable than younger workers in many areas, particularly in less-glamorous service work.

The skills and training of older workers is a significant issue in view of changing occupational structures. In less-developed economies or poor rural areas where age is less of a consideration in making a living, older workers may receive assistance and training by NGOs so that their traditional skills (such as arts and crafts) can be organized into

more profitable businesses or cooperatives, sometimes with support from microcredit organizations. However, training or retraining of older employees is rare in the developed countries in Asia and the Pacific; if engaged in by older persons, such activities are seen as their personal interests or pursuits rather than as occupational qualifications. As a result, many older persons tend to be relegated to unskilled or semi-skilled positions if they wish to remain working, often because of apparently outdated skills or lack of modern skills or even basic literacy (Chan, Phillips and Fong, 2003). For the vast majority of the region's older persons to continue working or compete in the labour market, they must have opportunities to upgrade their skills.

The concept of productive ageing is also reflected in the growing trend for older persons to work as unpaid volunteers. Volunteering creates social capital while at the same time it produces economic value, despite its exclusion from the conventional gross domestic product. At the personal level, volunteering compensates for role loss (Greenfield and Marks, 2004) and helps in cementing social ties (Rook and Sorkin, 2003). It clearly contributes to successful ageing and the quotient of social participation called for in the active-ageing policy framework (WHO, 2002a). With the future cohorts of older people in Asia being better educated, aspirations to volunteer and to continue contributing to society will increase (Cheng, Chan and Phillips, 2004; Chou, Chow and Chi, 2003). That will include participation in civic and political affairs: older people in the ESCAP region will become ever more politically active and influential, since they comprise a large and growing proportion of the population. Currently, however, older Asian persons who come from a tradition of submissiveness and obedience tend to accept what comes to them.

2. Advancing health and well-being into old age

(a) *Preventive and primary health care.* Preventive and primary levels of health care have become widely accepted as the best strategies for dealing with the challenges of population ageing, especially those in developing countries (WHO, 2004). Many developing and intermediate countries simply do not have the infrastructure to deliver high-quality care at the secondary and tertiary levels (such as India, the Philippines and Thailand, among others), and are moving increasingly toward a community-based model of health care. For the foreseeable future, prudence would call for concentrating resources on health promotion and disease prevention, and setting up a primary health-care system. Massive health promotion and education campaigns (particularly on healthy behaviour, e.g., on sanitation, boiling water, healthy eating) are needed in rural villages and inner cities where environmental hygiene is a problem. In the long run, a commitment toward preventive and primary health care also means extending (free) health-care coverage to all generations, a goal that might be more distant for the developing countries that are still dealing with the basic provisions. Primary health-care is often more appropriate than distant tertiary care for older persons because it provides care that is accessible, community-based and often culturally acceptable (Phillips, 1990, 2000a). A primary health-care system may also be better suited for treating older persons with chronic diseases. For example, for circulatory disorders and mobility problems, community-based long-term care and support are more appropriate than higher-level hospital technology.

Some countries have attempted to introduce forms of universal health care for all ages or for older groups. Thailand introduced a 30-baht-per-visit “gold card” health-care scheme in 2001 that gives access to public health care and hospitals nationwide. The scheme has been politically popular especially in the rural provinces, where cost previously kept many from seeking hospital care. While millions of Thais can afford regular care under the scheme, health-care professionals (public hospitals and many doctors) say it was poorly thought out and too hastily implemented, resulting in a huge debt burden for hospitals and doctors so overworked that they are leaving the public system. The 30-baht programme covers most basic illnesses, plus many expensive surgeries and treatments for AIDS and cancer, and covers almost 80 per cent of Thailand's population of 62 million. Thailand's giant step toward universal health coverage provides a safety net for many who had been largely ignored in public health policy. Critics, however, say future Governments must find the balance between serving the public and building a long-term health strategy (Corben, 2006).

Other Asian countries face similar challenges of covering basic as well as long-term health-care needs of their growing older populations. The health-care system in China, once regarded as exemplary for low-income agrarian societies, has degenerated considerably in terms of access since the early 1980s while its costs have soared (Kaneda, 2006). A system that relied heavily on public subsidies and provided egalitarian access to basic health care has shifted to a market-oriented system that relies heavily on private funding and is characterized by excessive usage fees and costs charged by local health-care facilities. Rising out-of-pocket costs prevent many Chinese from seeking care and have resulted in wide disparities in health-care access. Those trends have been of particular concern to older Chinese citizens, who may have greater health-care needs yet fewer means and who also make up a larger proportion of the rural population than do the young.

A consequence of population ageing is the increased prevalence of chronic diseases. In the Asia-Pacific region, chronic diseases account for nearly 70 per cent of all deaths across ages (WHO, 2006a, 2006b). As for older people, ischaemic heart disease, chronic obstructive pulmonary disease, cerebrovascular disease and lower respiratory infections are the leading causes (WHO, 2003). Women bear more disabling illnesses like osteoporosis, since they live longer than men. Many such chronic and non-communicable conditions are preventable or their onset can at least be delayed. For example, cardiovascular diseases, cerebrovascular diseases and some cancers are associated with diet, level of physical activity and tobacco intake. Unless greater efforts are made to promote prevention of chronic diseases, the long-term burden on the technology-intensive, curative end of the medical system will continue to be enormous (WHO, 2006b). One clear message is that many of the health promotion and preventative actions are related to life-course and lifetime risk factors. Childhood obesity, for example, a growing epidemic especially in China and other Asian and Pacific countries, does not augur well for a healthy mid-to-late adulthood. Already signs exist of early onset of some chronic conditions usually associated with middle and older age, such as diabetes, hypertension, renal and joint problems (James and others, 2001; James, 2004; Burniat and others, 2002).

In developing countries, particularly in South-East Asia, the prevalence of such communicable diseases as respiratory infections and HIV/AIDS is also high (WHO, 2006b). Older persons are particularly vulnerable to certain forms of infections (pneumonias, bronchitis), as was evident in the skewed death rates for older persons in episodes of severe acute respiratory syndrome (SARS).

Older persons can end up as carers not only of other older persons in poor health but of their children and grandchildren. Indeed, older parents have been called the “final safety net” for their children with AIDS (Knodel and Saengtienchai, 2004, 2005). A study in Thailand showed that older persons had cared for two thirds of young adults who died from AIDS and almost half of the orphans (Knodel and others, 2001). The AIDS epidemic in Thailand, as in other countries with significant numbers of HIV/AIDS sufferers, has created a major need for health care as well as material and emotional support for those infected and their families. In many countries in Asia, Governments and NGOs offer worthy but limited health and welfare services to the terminally ill and their dependents. The formal safety net leaves most of the need for care and support unsatisfied. Most needed assistance, before and after death, is provided within the family.

(b) Long-term care. The future of long-term care is arguably the major challenge in health and social care for older persons in Asia and the Pacific. Long-term care is generally developed along two main streams: (a) residential and (b) home- or community-based (Phillips and Chan, 2002a; Phillips, 2000a). Many Asian and Pacific countries enjoy the benefits of a tradition of informal care by families and friends to underpin the home- and community-based long-term care described below. Yet throughout the region, there is concern of diminished capacity of families to care for frail older members (Oh and Warnes, 2001). Under widespread directives on “ageing in place” and “community care”, older persons are encouraged to continue living in their homes for as long as possible, assisted by community support services when needs arise. Almost all such programmes rely on public finance through either general taxation or a specific budget vote (as in Australia and Japan). However, programme reviews on cost-effectiveness in recent years have revealed that the current modes and delivery of community support services often do not match the needs of the family and elderly members very well, or they are too expensive to be tailor-made to specific individual needs. Worse, perhaps, is that most of such services are provided, unintentionally, in place of informal care. For those reasons and for older persons’ preferences, developed countries have for some time advocated the bolstering of family care. With the expectation that the future population of older persons is growing older, frailer and more demanding, family care or community support services will require higher levels of skills, provided on demand, often around the clock. Thus, even those countries that want to rebuild family care in order to reduce the burden on institutional care, must restructure their approach with improved caring skills, training and support for informal caregivers.

Nonetheless, many Asian and Pacific developing countries still rely largely on families or the neighbourhood to provide long-term care; for instance, village-maintained refuges for destitute older women in India. Others may find support from missionaries or charities. Governments in many countries can at most provide emergency hospital services for free;

their older people, especially those single, frail and poor, have very little to rely on for long-term care.

In addressing the probable decline in family and community functions that provide care, some Asian countries have attempted to preserve their traditional values through policy initiatives. Examples of such initiatives include making priority allocation of public housing units or allowing tax incentives or even implementing legal requirements for the care and maintenance of parents, as has happened in Singapore.

Volunteers are helping to expand the network of caring resources for older persons, including older persons themselves volunteering, especially in more developed Asian and Pacific countries. Not only are volunteers a sign of community participation and solidarity, they are also a crucial and readily available supply of labour for home-based care (Carers Australia, 2006). Countries in the region with a developed volunteering system could initiate training programmes leading to formally recognized qualifications. In developing countries with vast rural populations, training the trainers to disseminate knowledge and skills could become especially fruitful.

A major challenge to the region will be the huge number of older persons, mostly women, with dementia (Graham and others, 1997; Zhang, 2006). In 2000, 46 per cent of the world's 25.5 million demented persons aged over 65 lived in Asia, while 40 per cent of that demented population was in China alone (Wimo and others, 2003). Dementia is often a condition that requires institutionalization (Magaziner and others, 2000; Woo and others, 2000): over 60 per cent of residents in long-term care institutions are demented (Matthews and Dening, 2002). Institutionalization is not the only option, of course, nor the best one. Early institutionalization is associated with mortality for persons with dementia: the earlier the institutionalization from onset, the shorter the survival time, except when dementia has progressed to a very late stage (McClendon, Smyth and Neundorfer, 2006). Nevertheless, care in the community is exceedingly demanding, often around the clock, for the caregivers.

Despite the recognition of an ageing community, long-term care policy still lacks coherence in many countries. Such a policy should address demands for institutional care, while supporting home- or community-based modes. Without the latter two, the rising demand for institutional care would likely overwhelm even the most affluent countries. Israel, Japan and the Republic of Korea appear to be the only countries in the region that have dedicated policies or legislation on long-term care (Lee, 2004; Japan, n.d.; Schmid, 2005). Both Japan and Israel use a social insurance model in which the programme is supported by contributions from the Government, employees (only those aged 40 and above in Japan) and employers (only in Israel), and benefits are typically in kind (e.g., home and nursing care). Other examples (Australia, Hong Kong, China and Singapore) tend to incorporate long-term care into related policies, such as for disability allowance under social security. Much needs to be done in ESCAP countries to finance and organize sustainable programmes.

In China, for example, although public funding for the long-term care of older persons is still limited, the Government has started to increase its funding at the same time that new

opportunities for entrepreneurship in the health service industry have opened up, partly the result of China's social-welfare reform since the 1990s. An increasing number of private old-people's homes as well as former Government-sponsored homes for the aged, which previously catered exclusively to older people with no children and no other means of support, are supplying an alternative to family care (Kaneda, 2006; Zhan and others, 2006). The standards, however, vary considerably and such facilities are few and often too expensive for the majority of older people and their families. Nevertheless they show how the private sector can step in to support or substitute for the public sector.

Community-based, long-term care services for older persons in China, informal and supported by local Government, have also begun to emerge, especially in urban areas (Wu and others, 2005; Zhan and others, 2006). The lack of a trained workforce in caregiving for older people is a crucial factor in the development of the Chinese system. Some local and other agencies are providing limited and basic training in long-term care for laid-off workers, yet the need remains for training programmes offering a broader and deeper range of caregiving skills. China also recognizes the need for the development of training in geriatric medicine and plans to establish more geriatric units (Kaneda, 2006).

(c) *Improving accessibility.* Geographic, economic, cultural and language disparities often bar older persons, especially women, from seeking health services. Accessibility is conditioned (a) for the would-be user, by affordability and personal knowledge of health and available services; and (b) at the provider end, by the convenience factors of locations, hours of services, user-friendliness and others (United Nations, ESCAP, 2002a). Accessibility is complicated in the Asian-Pacific region by social, cultural and political diversity as well as geographic diversity. Older persons are concentrated in rural areas: 80 per cent in India (n.d.) and 60 per cent in the Republic of Korea (Lee, 2004). The more advanced countries of Australia, Japan and Singapore would be expected to ensure their citizens reasonably fair and equitable access to health and social care, from young to old and in rural and urban areas. Regional consensus on minimum standards of health and well-being for the most deserving older persons, if not for all, seems to be evolving. What is actually provided, and how, depends on the resources and aid available to individual countries.

As standards of services improve globally, the problems in providing health and social care likewise grow in extent or complexity. Training of personnel for geriatric services is a priority item for developing countries (United Nations, ESCAP, 2004) but higher levels of training must often be undertaken in more developed countries. While training resources in the developed countries seem to be plentiful, the number of their own trained personnel is never enough to meet the demand. Hence, many developing-country professionals may not return home after training or choose to migrate to work in wealthier countries after they have obtained the qualifications.

On the positive side, traditional medicine in the region is gaining influence. Older persons tend to accept traditional remedies (Phillips, 1990), which often are cheaper and more readily available than other medicines. A trend in developed countries is to regard traditional medicines as complementary therapies to other treatments. As the evidence for efficacy of those treatments accumulates (e.g., rheumatism pain relieved with herbal

remedies or acupuncture; migraine alleviated with aroma therapy or foot massage), developing countries become better positioned to make good use of their own traditional remedies for the benefit of older persons.

(d) Health-care financing. Financing of health care is a major issue for all countries with an ageing population. In many Asian and Pacific countries, declines in fertility, together with rising life expectancies, are producing elderly populations both in absolute numbers and as a proportion of national populations. Individuals must prepare financially for an extended period of old age, including paying for their own health care if their Government does not provide for it.

Rising numbers of older persons may increase the demand for certain types of medical care. For example, facilities and staff will be required to treat conditions more commonly found in the oldest age groups: cardiovascular diseases, cancer (particularly lung cancer), chronic obstructive pulmonary disease, musculoskeletal conditions (including osteoporosis), dementia and vision problems. As people live longer, they may suffer from poor health or disabilities over long periods, increasing the general need for health care. Except in some developed countries, health-care services remain minimal and geared rather to life and death cases rather than chronic illnesses or rehabilitative needs. A worsening trend in the health status would alert Governments to review existing policies and programmes and provide at least a guarantee of basic health care.

The problem with many countries in the region is that population ageing comes before wealth can be accumulated for public provision. Rising proportions of older persons can put financial pressure on pension and health-insurance systems. Many Governments are too poor to provide more than acute care in urban hospitals. Costs of health care therefore are mostly borne by the people using the services.

The Singapore Government has a multi-layered system for financing health care mainly with adjusted allocations from its Central Provident Fund, together with varying levels of cost-sharing and subsidies in a public-private mix of health services (Dong, 2006). The Chinese have a co-payment system involving contributions from the central Government, provincial Government and employers, with the workers contributing to an insurance scheme but also sharing the cost of treatment each time. The World Bank suggests, however, a mixture of tax redistribution, savings and insurance systems for health-care financing (Gottret and Schieber, 2006). Learning from less effective strategies adopted previously in the United States or Japan, countries who can afford a health-care system currently tend to adopt a multi-pillar financing system with cost-sharing as a core value, rather than rely solely on public revenue; although what actually works for a country depends on the existing socio-economic realities (Dong, 2006; Gottret and Schieber, 2006).

3. Ensuring enabling and supportive environments

In characterizing their target group of older persons in the Asian-Pacific region (United Nations, ESCAP 2003), planners have steered their policymaking and communication compass for a population generally illiterate, politically inert, passive or submissive and

extremely obedient to authority. Thus, policies would aim at (a) ensuring a supportive environment for those frail persons who do not make demands; and (b) enabling those who can still build a supportive network for themselves, so that they can carry on living in a place of their own choice. Ageing in place has become the core of a solution for a policy that can enable independent living in a supportive environment.

Ageing in place is a policymaking concept that aims at supporting older people in their homes and communities for as long as possible (Ball and others, 2004). Ageing in place should be a matter of choice for the well-being of older people, and cannot be mandatory. In encouraging older persons to live at home, even those with some degree of frailty, the societal directives must foster family-oriented culture and caregiving, as there are no comparable services provided around the clock. For the policymakers, the option makes better sense when home care is less expensive and safer than institutional nursing care. Since Asian values for family care are still strong in many countries, ageing in place should become an explicit policy, as it has been in Hong Kong, China along with its care-in-the-community directives.

Governments have an important role in providing an environment conducive for ageing in place. Strategies include giving direct or indirect subsidies for living at home. For example, Malaysia provides low-cost apartments or rental discounts and reserves ground units for older people (Guat, 2004). The Philippines provides discounts for basic commodities, transportation and medication, although compliance by the private sector is difficult to ensure (Collado and San Diego, 2004). Most ESCAP countries need to provide for improved mobility supported by an adequate national transport system. In principle, the total environment should become more elder-friendly, including amenities such as barrier-free housing for those with disabilities and suitable appliances and adaptations in the home. At the community level, facilities for daily shopping and recreation as well as health care and social services should be available nearby and readily accessible. A safe, crime-free neighbourhood is a requisite of older persons, for they easily become the targets of abuse. For those requiring assisted living, home care services should be available, through formal provision or training of family caregivers, or both.

In such a scenario, who would provide care for older persons living alone? Informal carers (as opposed to those who are formally paid for services) in Asia and the Pacific have always been people who are either family relatives (mostly the spouse and daughters), neighbours or friends performing the caring tasks voluntarily, that is, without pay or public recognition. Carers can be described as people who provide care and support for a parent, partner, relative, friend or neighbour who is partly or completely dependent in performing daily tasks. The level of care provided by such volunteers is therefore considered basic and non-professional. In reality, however, they could be highly skilled (capable of diabetes injection or of psychosocial skills in caring for demented parents) and most reliable in providing care. In the Asian-Pacific region, Australia and Singapore have begun to work out a training system so that skilled volunteers can serve not only their relatives but also others when their skills are formally recognized. The obvious advantage for the country is that trained carers are no doubt a complementary

work force for the ever hard-to-find and expensive formal carers like nurses, occupational therapists and physiotherapists.

D. National capacity on ageing

Policy documents on ageing and national bodies for programme coordination do not in themselves guarantee success in implementing the Madrid Plan. A Government needs to allocate sufficient resources and to have sufficient political will to ensure that policies on paper are implemented in practice to the expected level (United Nations, 2006a). Given the heterogeneity of participating countries, and limited financial and human resources, implementation of the Madrid Plan is generally at a preliminary stage across the ESCAP region. Nonetheless, most countries have begun to establish the necessary institutional infrastructure for responding to issues of population ageing.

According to the ESCAP regional survey of 2005, four fifths of the 20 responding countries have set up either a focal agency or a coordinating body to oversee issues relating to ageing or older persons. Those agencies or bodies are varied in both nature and structure, ranging from established governmental structures at the ministerial level to a single agency or inter-agency committee on ageing, or a branch or function of a social welfare department. The different types of coordinating bodies in those countries reveals the different strategies used in tackling the needs of older people. Table III-4 summarizes the four main types of agency or body established by selected countries and areas, with information on certain countries not included in the 2005 survey.

Developed countries such as Japan and New Zealand have generally set up a high-level agency at the ministerial level that assumes leadership in directing and coordinating manpower and other resources in ageing matters. Countries or areas such as Fiji, Hong Kong, China, Sri Lanka and Thailand, have established national committees or commissions on ageing that coordinate the planning and development of various programmes and services. Some countries have inter-agency committees to monitor and implement their policies and programmes for older people. For example, those in China and the Philippines consist of coordinating bodies that are made up of various ministries and national NGOs. However, 45 per cent of Asian and Pacific countries have no specialized agency or body to deal with ageing matters. In such cases, usually the ministry or department of social welfare has taken on the role of providing welfare services to meet the needs of the older people. Only a few respondent countries, notably Armenia, Georgia, the Lao People's Democratic Republic and the Maldives, have indicated no focal agency or coordinating body on ageing.

Table III-5 shows examples of various national policies or plans of action and/or legislation regarding the older population. Not all countries with a focal agency have launched national policies or plans of action; many countries are only initiating efforts. For example, the Directorate of Social Services in the Social Welfare Ministry of Bangladesh indicated in their survey response that a national policy on ageing would be drafted "very soon". That provides evidence that countries in the region have recognized ageing as a development issue and are taking measures to address the needs of their expanding older population.

Well over half of the countries have a monitoring mechanism in place. New Zealand and the Philippines have plans of action for monitoring the achievement of policy targets on active ageing. The National People's Congress of China organizes nation-wide monitoring and supervision of the implementation of its law every five years. Nearly half of the Governments of the surveyed countries have undertaken a comprehensive social analysis by using participatory tools such as client satisfaction surveys and focus groups. In addition, only half of the countries have undertaken analysis of existing policies and programmes or even conducted surveys on ageing, in the past five years. Almost half of the countries have indicated that the Shanghai Implementation Strategy has been a major influence in promoting activities and programmes in ageing. Successful ageing programmes have been adopted as national policies and cover a variety of areas, including volunteer training programmes, lifelong learning and community-care service in partnership with NGOs.

However, in spite of impressive efforts in many countries, implementation often falls short of policy targets (Collado and San Diego, 2004; Upadhyaya, 2004). The political structure of a country is one determinant: in the Philippines and Nepal, for example, and especially in such a large country as China, effective implementation often relies on successful diffusion of central policies to local authorities, many of which are village or neighbourhood committees. Not uncommonly, most Government initiatives cannot go beyond city zones. Although some countries have tried mainstreaming their policies on ageing, village-level services are often inadequate because resources are lacking, coordination is ineffective because officials fail to understand policy directives at the district level, and political instability or even corruption also hamper action. More research is necessary to elucidate the roots of the problems in individual countries and to enable action plans to be improved. ESCAP can play a role in disseminating major findings so that countries can learn from each other's mistakes and good practices. Investigatory endeavours, are, however, a steep challenge in developing countries where problems of implementation, especially in rural areas, are ironically most pronounced.

Table III-4. National focal agencies and coordinating bodies on ageing, selected countries or areas

Type of agency/ coordinating body	Name of agency/coordinating body
Minister for ageing/ office for senior citizens	Aging Society Policy Council (Japan) Office for Senior Citizens, Ministry of Social Development; Older People Policy Team (New Zealand)
National committee on the ageing/Elderly commission	National Commission on the Elderly (Thailand) National Advisory Council on Ageing and the Elderly (Fiji) National Secretariat for Elders (Sri Lanka) The Elderly Commission (Hong Kong, China) National Commission on Ageing (Indonesia)
Inter-agency/inter-ministerial committee on ageing	Inter-Agency Committee for the Philippine Plan of Action for Senior Citizens (Philippines) CNWCA (consisting of 26 Government ministries and national NGOs) (China)
Ministry/department of social welfare/social justice/labour	Division of Senior Citizens, Department of Public Health and Social Services (Guam) Ministry of Women, Children and Social Welfare (Nepal) Population Development Policy and Coordination Department, Ministry of Social Welfare and Labour (Mongolia) Nuroniy Foundation, Ministry of Labour and Social Protection of Population (Uzbekistan) Elderly Service Division of the Social Welfare Institute (Macao, China) Department of Social Welfare; Ministry of Women, Family and Community Development (Malaysia) Department of Social Welfare (Myanmar) Directorate of Social Services, Ministry of Social Welfare (Bangladesh) Ministry of Social Security and Welfare (Iran) Ministry of Social Justice and Empowerment (India) Division of Elderly Welfare and Division of Elderly Health, Ministry of Health and Welfare (Republic of Korea)

Sources: Boonpraong (2006), Chan and Phillips (2005), United Nations ESCAP (2004)

Table III-5. National policies and plans of action on ageing in selected countries or areas

Type	Policy framework
National policy on ageing	<p>Article 29, the Constitution of the Islamic Republic of Iran; Article 192, Part A, Section of the Executive Bylaw of the 3rd Development Plan, 1999-2003 (Iran)</p> <p>Senior Citizen Policy and Working Policy (2002); 10th Five-Year Development Plan 2003-2007; National Plan of Action on Older People (2005) (Nepal)</p> <p>National Policy for Older Persons (1995); National Plan of Action for Older Persons (1998); Vision 2020 (Malaysia)</p>
National legislation on ageing (law, ordinance, presidential act, etc.)	<p>Basic Law on Measures for the Aging Society (Law No. 128.1995); General Principles Concerning Measures for the Aged Society (2001) (Japan)</p> <p>New Zealand Positive Ageing Strategy (2001) (New Zealand)</p> <p>Republic Act No. 7432 and Republic Act No. 9257; also, Philippines Plan of Action for Senior Citizens (Philippines)</p> <p>Older Persons Act B.E. 2546 (2003); also, 2nd National Plan for Older Persons, 2002-2021 (Thailand)</p> <p>Protection of Rights of Elders Act No. 09 (2000) (Sri Lanka)</p> <p>The Charter of Nurodiy Foundation; Law on State Pension Maintenance of Citizens (Uzbekistan)</p> <p>Law on Elderly Social Protection (1995); also, National Programme “Elderly Health and Social Protection” (1998, revised 2004) (Mongolia)</p> <p>Law on Protecting the Rights of the Elderly (1996); also, 10th National Five-Year Development Plan on Ageing, 2001-2005 (China)</p> <p>Chief Executive policy address has placed “Care for Elders” as a strategic policy objective since 1997 (Hong Kong, China)</p>
National plan of action	<p>State Plan (2004-2007), P.L. 14-139 (Guam)</p> <p>National plans of action on ageing, health and education (Myanmar)</p> <p>National Plan of Action on Ageing, 2003-2008 (Indonesia)</p> <p>Mid- to Long-term Development Directions for Elderly Health and Welfare in Preparation of an Aged Society in the 21st Century; National Long-term Care Service Plan for Older Persons (Republic of Korea)</p>

Sources: Chan and Phillips (2005), United Nations ESCAP (2004)

The guiding vision of the Madrid Plan is a society for all ages; that cannot be achieved in a top-down process. Despite widespread recognition that bottom-up participation is vital to success in action on ageing issues (United Nations, ESCAP, 2003), bottom-up participation on a broad scale is the exception rather than the norm in the ESCAP region. The emphasis on hierarchy and social order in many Asian countries conditions that outcome, not surprisingly. In socio-political systems that depend on top-down directives and are biased toward the status quo, the pace of social development and hence the mainstreaming of ageing issues have sometimes been slow. Notwithstanding, the ESCAP region was the first to launch a regional plan on ageing backed by many countries. With the expected emergence of “grey power” and the grey vote over time, and as older persons become more conscious of their rights and needs, policymakers will face increased pressure to change. For academics, careful alignment of their research objectives with policy frameworks can facilitate the mainstreaming of ageing issues.

An additional, if often-neglected, force in mainstreaming is older people’s contacts in their broader social networks: their children and grandchildren and others who might serve effectively as their advocates. The mainstreaming process becomes more interesting and dynamic when the intergenerational dimension of ageing is taken into account. In Hong Kong, China, a major policy initiative is to mainstream intergenerational solidarity into virtually all aspects of programme planning and policy decisions on ageing. By enhancing solidarity between generations, the hope is to improve the care of older persons and to create an influential mass of advocates for older persons. The mutual interest of younger generations in improving the well-being of their parents, reducing burdens for themselves in the process and improving their own prospects for old age, should also not be overlooked as an important force for social change.

E. Regional and international cooperation

Firstly, Asian and Pacific countries have developed common priorities for ageing agendas under ESCAP leadership. Since adopting the 1999 Macao Plan of Action on Ageing for Asia and the Pacific, ESCAP members have met regularly to review their strategies for action on ageing. In support of the global Madrid Plan of 2002, the Shanghai Implementation Strategy was drafted in 2004 to take action in the conviction that (a) the family in Asia and Pacific is still strong enough to provide support for its older members; (b) Governments should provide basic protection for the needy; and (c) people should be driving the policies, so a bottom-up approach in policymaking should be evident. In that perspective, “instrumental” and “outcome” indicators were developed (United Nations, ESCAP, 2004) which are becoming a common language in the region to unite and align policies for action on demographic ageing. That and many other achievements reflect the willingness and cohesiveness that characterizes the region.

Secondly, the scope of regional cooperation includes transfer of experience through exchanges among Asian and Pacific countries and globally with others, facilitated by ESCAP or bilaterally. Good practices can become models for others while negative experiences, such as unforeseen consequences of policies and problems in implementation, can serve to caution others. Experiences in developed countries can be valuable for developing countries in preparing themselves for the challenges of

population ageing. ESCAP publications also help in disseminating information and experience across the region.

Social protection, health care and training are cases in point as areas of programme action that are amenable to regional cooperation.

The developing economies of India, the Philippines and Thailand, for example, are at a crossroads in choosing suitable social protection systems. Many countries quickly learned the immense problem of keeping solvent a defined-benefit pension scheme, such as Japan experienced (Sakamoto, 2005). Just as good practices can be brought home as models for modification and implementation, other practices with known drawbacks can serve a cautionary purpose (including attempts to replace family care with public services).

Health care is an area where transfer of experience between the first and third worlds would not be one-sided. The escalating health-care costs in developed countries may eventually drive them to look for cheaper models in developing countries. A concerted effort by all Asian and Pacific countries to produce qualified care workers at lower skill levels (for older people, the chief needs being personal and psychosocial care at basic levels) would likely pay off in the long term. Such an undertaking could draw from the experience of developing countries that have done just that for years; the “barefoot doctors” of China stand out as one case. Again, ESCAP could play a coordinating role with other Governments, while NGOs could participate like HelpAge International has done with its regional base in Chiang Mai, Thailand.

In the training of informal caregivers and volunteers, advanced Asian and Pacific countries have the resources and expertise to formalize training and accreditation for this purpose. For example, Australia, Hong Kong, China and Singapore have begun to develop skill-based qualifications (versus academic knowledge-based programmes) by mapping the route from core skills to higher levels of care; say, from personal care to pre-nursing care. Those countries are likely to lead in developing international accreditation bodies for programmes that provide flexibility in training of informal as well as formal carers. Curricula can be standardized and teaching materials disseminated across countries. In addition, an internationally recognized qualification or recognition might draw more people into voluntary work.

The potential of international volunteering remains underexploited. For example, developed countries could provide valuable technical aid and manpower by sending doctors, public health experts and medical students to developing countries. Volunteers from neighbouring or wealthier countries could engage in “adopt-a-granny” programmes to serve older persons during their school or work breaks. In one instance, school pupils are required, as part of their curriculum, to serve older persons in need. If such initiatives become more prevalent, more sustainable support to older persons in dire need might become possible. ESCAP and other organizations could play important roles in coordination and exchange of expertise and resources.

Finally, international aid in the form of expertise and materials will remain crucial in parts of the region. Some countries will continue to need assistance and support from regional and international sources, until their economic and social development permits them to afford basic welfare and health care for their people. The Indian cataract programme sponsored by the World Bank is a case in point (Sandhu, 2004). Financial and material help is just part of the story. Agencies such as HelpAge International are major coordinators in the region, providing an umbrella for many relevant NGOs and liaising with Governments and intergovernmental groups such as ESCAP. They have done much to raise awareness among senior citizens about their own rights and fostering sustainable resources within the community, especially income generation and microcredit, that helps improve care for older persons. The need for regional and international aid will continue until the distribution of wealth can be better balanced.

F. Conclusion and future challenges

Demographic ageing in the ESCAP region has its positive as well as negative considerations. Unfortunately, the negative are often emphasized and strong concern, verging on moral panic, can ensue about increases in older populations. For example, the Chinese Academy of Social Sciences has reported research that shows that the ageing population will slow economic growth and affect social development (*South China Morning Post*, 2006). Some have suggested that China could see the end of its decades-long advantage of a low-cost labour market, “especially after 2030, when the demographic dividend is set to end”. (*China Daily*, 2007). By taking a positive perspective, however, authorities could as well report that the increasing older population could be helped in preparing to cope with its rising life expectancy by being shown how to adopt healthier lifestyles. Another issue, the numbers of people with dementia to be cared for in very populous countries, could be discussed in the context of improving planning for service provision.

Balancing the needs with the available resources often seems daunting; the challenges of demographic ageing can appear to outweigh the opportunities. However, the potential of positive achievements from increases in life expectancy and social well-being must never be discounted. The potential of older people to continue offering their wisdom and material contributions to society should be celebrated. Their potential inputs into the economy should never be underestimated.

Forward planning by Governments could help older people realize their potentials and prevent them from being perceived as a burden. If social pensions could be developed, for instance, especially for the poor, the possible problems of elderly poverty could start to be alleviated. Health-care provision and especially accessible and affordable primary health-care for older persons, in their communities, need to be established and could be made affordable. The coming elderly cohorts will be more educated and possibly better off financially, but will also expect more from social services and health care. Higher aspirations from older persons should feed into the surer development of societies for all ages.

Developed countries are relatively few in Asia and the Pacific. The ESCAP region holds very diverse economies, political systems, religions and languages. Hence, transfer of resources including wealth, information and technologies, and staffing strengths may not be mutually agreeable. Differences in socio-economic development and the forces of globalization can often become barriers to uniting countries for resource-sharing, despite the benign intention of some developed nations to lend a helping hand to poorer ones. Market forces shift the loci of economic activity around the region. In the next rounds of international investment, China might be the one to suffer and India and South Asia to gain; whatever the outcomes, they would be very difficult to predict. They will, doubtless, have huge impacts on the future economic growth of specific countries and impact their ability to build and maintain social protection for all age groups, not only the elderly. International aid is experiencing the same effects. But with rising economies, in particular of China, India, the Republic of Korea, Thailand and parts of the Russian Federation, greater resources could be generated within the region for poorer countries. The 20/20 funding initiatives may become viable possibilities in the foreseeable future (UNDP and others, 1998).

Individual poverty is arguably best eradicated with education. Barriers to resources and opportunities for doing so may be structural, related to opportunities provided by the economy and society; that would be as true for the older population as for the young. In the industrialized economies, without skills and knowledge, even the able-bodied can become financially dependent. In a changing economic structure, older people may have to keep learning new, marketable skills in order to make a living. That capacity looms especially important as fewer younger workers remain to support the older population in each society. Lifelong learning brings other benefits in later life, notably keeping people engaged in activity that interests them, socializing with new friends, adapting to new living styles to suit the changing environment, keeping pace with technological changes such as information technology, and learning new skills in caring for relatives and friends (Leung, Lui and Chi, 2005; Purdie and Boulton-Lewis, 2003). However, systems or infrastructures for lifelong learning are not readily found in Asian and Pacific countries, excepting Australia, China, Japan and New Zealand where the concept of “U3A” (university of the third age) is widely accepted.

In putting into practice the wisdom of continuing education, the case for ageing nations to abolish the compulsory retirement age, or to apply it with flexibility, needs to be considered. Elimination of compulsory retirement would help in eliminating age discrimination and would free up a large work force that could bring back valuable experience accumulated over working lifetimes. For the able, retirement should be an option rather than compulsory. Of course, the imbalances in youth employment opportunities that could result in some sectors should be addressed as well.

Involuntary retirement has been found to be detrimental to social adjustment and well-being (Gallo and others, 2000; Shultz, Morton and Weckerle, 1998). Flexible working conditions should be allowed; for example, job sharing and part-time employment. The case is especially compelling as economies shift from labour-intensive to knowledge-intensive operations. The prospects for fostering productive ageing become brighter with greater flexibility in the retirement environment (Kinsella and Phillips, 2005).

Last, but not least, the emergence of a “silver market” has profound ramifications for many economies. The silver market for the consumption needs of older persons has become a major, growing sector of many economies. The commercial sector is already reacting much more quickly than are Governments. For example, in May 2006, nearly 200 Chinese and foreign enterprises held an international fair in Harbin, China to showcase products in health, food, beverages and entertainment for older people. Some 100,000 seniors visited the fair on the first day alone. The value of the silver market in China alone has been estimated to be US\$37.5 billion (*Sina English*, 2006). The Elderly Commission of Hong Kong, China, hosted a silver-market exhibition in November 2006 to highlight the importance of this growing sector of consumers and their contribution to the economy. The silver market will be fuelled even further by successively more financially secure cohorts that are better placed to remain economically active into later life. In Japan and other countries with substantial older populations, the silver market for goods, services, travel and recreation is well recognized as a burgeoning sector of the economy. By the year 2000, those aged 65 and above are estimated to have accounted for 21 per cent of the consumption expenditure in Japan, which will rise to 27 per cent by 2010 (Hong Kong Trade Development Council, 2001). Hopefully, Governments will match the response of the private sector in meeting the range of consumption needs of their older persons.

IV. Ageing Policies in Africa

Monica Ferreira²⁰

A. The context of ageing in Africa

Africa is the world's second largest and second most populous continent and economically the poorest. The continent is characterized by diverse geographic and climatic features, ranging from deserts to tropical rainforests, from drought to floods. Geopolitically, it comprises 56 countries, including adjacent islands (United Nations, 2007a).²¹ The continent is divided into five subregions: Eastern Africa, Middle Africa, Northern Africa, Southern Africa and Western Africa. Historically, many African countries have been colonized but the majority gained independence beginning in the 1960s (Council on Foreign Relations [CFR], 2006). European languages introduced during the occupations remain by and large the official languages of the formerly occupied countries,²² although many indigenous languages are spoken in each country.

The continent may be further divided between Northern Africa and sub-Saharan Africa, with the latter incorporating the other four subregions. A rationale for a separation of Northern and sub-Saharan Africa are population differences, with sustained high fertility in sub-Saharan Africa (where women bear almost 5.5 children, on average) and significantly lower fertility in the Northern African subregion (a rate of 3.2 births per woman, on average; United Nations, 2007a). Although the percentage of the population aged 60 and above in the total population of Northern Africa and sub-Saharan Africa differed moderately in 2005 (at 6.8 and 4.8 per cent, respectively), by 2050 it is projected to increase to 19.6 per cent in Northern Africa, compared with 8.8 per cent in sub-Saharan Africa, reflecting more rapid demographic transition in the northern subregion (United Nations, 2007a). A separation of the subregions based on population differences for analytical purposes may be spurious because the subregions have common social and economic features. Therefore, in this chapter the situation of older persons in Africa is considered for the continent as a whole.

The continent's diversity is evident, moreover, in a plurality of cultural heritages, traditions, beliefs, religions and value systems, as well as modes of production, levels of economic development, and types of social and political structures and national and social contexts (Cohen and Menken, 2006). Thus, Africa's people grow old in a variety of settings, which differ in urban areas and rural areas and for nomadic pastoralists (Makoni and Stroeken, 2002), as well as across countries and subregions. Nevertheless, within the diversity are cross-cutting trends that shape older persons' situations and

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²¹ There are 53 countries that are Member States of the Economic Commission for Africa.

²² African countries may be grouped subregionally as anglophone (in the Eastern and Southern subregions and some countries in Western Africa), francophone (mostly in Middle Africa and Western Africa), lusophone (the PALOPs [*Países Africanos de Língua Oficial Portuguesa*] are Angola, Cape Verde, Guinea Bissau, Mozambique and São Tomé e Príncipe) and Arabic-speaking (mainly countries of Northern Africa).

experience of ageing, and present challenges for policy and research and opportunities for older persons and societies.

Population ageing is under way, albeit at a slower pace than in other developing regions (Velkoff and Kowal, 2005; Kinsella and Phillips, 2005). Few African nations, however, have acknowledged the demographic trend and have prepared to meet its challenges. With more than half the population 19 years of age or younger (United Nations, 2007a), national priorities are issues of the young rather than concerns of the old — among numerous other priorities, such as macroeconomic development and coping with the effects of HIV/AIDS. Nonetheless, a series of recent documents of the United Nations, the African Union and international NGOs has drawn attention to the situation of older persons as well as the contributions they make, and has highlighted their omission from mainstream development thinking. Essentially, the agencies argue for Africa's need to address the welfare and capacity of the older population as an integral part of development efforts (see several sources from the NGO HelpAge International [HAI]).

Globally, the Second World Assembly on Ageing in 2002 generated momentum for the support of governmental action on population ageing and ratified the Madrid International Plan of Action on Ageing (United Nations, 2002a), which recommended a broad framework for policymaking. One year later the African Union countries adopted the African Union Policy Framework and Plan of Action on Ageing, which they had prepared together with HelpAge International (African Union/HAI, 2003). Few Member States, however, have since adopted their own national policy framework or action plan on ageing; several have adopted policies to address the situation of older citizens (Nhongo, personal communication, 2006).

Meanings of ageing for Africans. Attempts to define “older persons” in Africa are at variance with international definitions, which are typically chronological and currently use a cut-off age of 60. Such definitions are a poor indicator of being old in Africa, especially in rural agrarian settings where chronological age may not be known and age may be defined in relation with an individual's functioning, physical appearance and social role transitions (see, for example, Kinsella and Phillips, 2005; HAI, 2002a; Apt, 1997; Tout, 1989). Nonetheless, a statistical definition of older persons has come to be recognized as the official retirement age of a country, although this may range from 50 to 65 years (see United Nations, 2006d; Velkoff and Kowal, 2006; Apt, 1997). Such a definition is incongruent with African life experience, as fewer than one tenth of individuals are ever employed in the formal economy and may “retire” from employment (Ferreira, 2005a). For most Africans, the concept of “retirement” does not exist and they continue to work in the informal economy for as long as they are able.

Several trends and factors that are features of the African regional and ageing contexts go against the well-being of older persons and opportunities for successful ageing. Their dynamics, interplay and effects are not well understood, partly because of a paucity of credible scientific evidence and the underdeveloped state of research on ageing. Understanding of the older persons' situation has been hampered, moreover, by a reliance on past studies of modernization (Cowgill and Holmes, 1972) that contend that changes wrought by modernization render older persons vulnerable and their situation “abject”

and “worsening” (Aboderin, 2004; Ferreira, 2005b; Sagner, 1999). Overly deterministic and overused in African settings, that perspective has simply resulted in a reiteration of stereotypical “problems”. Few studies have focused on older persons as human agents, invested with motives and awareness, whose experience of ageing is changing (Ferreira, 2005b; Sagner, 1999), nor on their contributions, although the number of anthropological studies has increased in recent years (for example, Makoni and Stroeken, 2002).

A dearth of knowledge on ageing may have constrained African Governments in developing new policy and programmes. Recent international instruments, including the Vienna and Madrid plans of action (United Nations, 1982, 2002a), have fostered a new developmental vision and approaches that aim to promote active participation of older persons in society and mainstream them in development frameworks. However, there is no appreciable evidence of such approaches being incorporated in policies and strategies in the region.

A need for a political and societal “mindshift” may be required for the approaches to be adopted and employed in expanded policy action. Similarly, in order to harness older persons’ capacities and encourage their contributions, regional trends and factors that impinge on them must be bridged with policy and programme development and implementation that are suitably informed and guided by research evidence. To achieve those goals, national capacity on addressing ageing issues needs to be built or expanded.

Thus, a set of three broad and interlinked priorities may be identified, in forging comprehensive and inclusive responses to ageing that are aimed at enhancing the older persons’ situation and facilitating the adjustment of African societies to ageing realities. The priorities are elaborated in the following three major sections of this chapter.

B. Trends, older persons’ situation and priorities

The situation of older persons in the African region is shaped by the mosaic of features unique to indigenous societies and the continent’s economic, social and political landscape, as well as an interplay of multiple trends and factors, some of which may have intensified and increased older persons’ vulnerability and worsened their situation. Regional trends and factors combine to affect the well-being of older persons, and their situation may be characterized as one of changing dynamics, a growing inadequacy of traditional family support, poverty and material deprivation, ill health and marginalization.

Economic and social change is purported to have weakened traditional social values and networks that previously underpinned and reinforced traditions of intergenerational exchange and care and support systems in Africa (see Cohen and Menken, 2006; Kinsella and Phillips, 2005; Apt, 1996, 1997). Continued reliance on those support arrangements may be an unrealistic proposition, given the trend of the young to migrate to cities out of economic necessity.

Multiple regional trends and factors bear directly on older persons and exacerbate their vulnerability, constrain opportunities for successful ageing, and go against social and

economic development. While trends and factors may be identified, evidence-based knowledge of older persons' situation is relatively sparse. Neither are the effects of social and economic change well understood, nor are other trends and factors that impact their situation.

1. Factors governing older persons' situation

Environmental factors that impact the older persons' situation include drought, floods and pestilence, among other natural disasters, the consequences of which include food insecurity, famine, forced migration and displacement. Older persons and their households may consequently experience losses of livestock, farmland, habitat and other assets. Eastern Africa is the subregion hit hardest by drought and floods, where famine puts people at greatest risk of starvation, related illness and death (HAI, 2006b). Older persons affected by natural disasters are often unable to fend for themselves and less able than younger kin to flee or access relief (HAI, 2006b, 2002b). Government responses to disaster are often inadequate and uncoordinated and do not target older people (HAI, 2006c). In addition, ecological factors contribute to the region's burden of disease — in particular, a high prevalence of communicable diseases such as malaria, waterborne disease and malnutrition (CFR, 2006; Lopez and others, 2006).

Political factors include weak governance and armed conflict. Post-independence, in some countries a weak administration and pervasive corruption have hampered delivery of basic health services, education and financial management, while failures of policy and governance may have affected food production and created food shortages. Civil wars in certain countries have taken a terrible toll, causing numerous deaths and wide displacement (HAI, 2005b, 2006c; UNHCR, 2006; CFR, 2006). Social and ethnic tensions, discrimination and economic hardship associated with conflict cause people to flee, or, where unable to flee, older persons are isolated from family and support (HAI, 2005b, 2006c).

(a) Demographics. Rates of population ageing vary within the region (USCB, 2005). In sub-Saharan Africa, fertility rates and adult, child and infant mortality rates remain high by global standards and the age structure is changing only gradually (Kinsella and Phillips, 2005; Velkoff and Kowal, 2006). HIV/AIDS together with maternal deaths, tuberculosis and malaria contribute to high mortality (WHO, 2006b; UNAIDS, 2006; UNAIDS/WHO, 2005). Nonetheless, the absolute number of persons aged 60 and above in Africa is projected to increase from 47.9 million in 2005 to 206.8 million by 2050, when they will constitute 10.4 per cent of the total population (United Nations, 2007a). Demographic features of the region's older population are shown in tables IV-1 and IV-2, by subregion, for 2005 and projected to 2025 and 2050.

Table IV-1. Demographic profile of the population aged 60 and above, of the five subregions of Africa, in 2005 and projected to 2025 and 2050

Sub-region	Number of those 60+ (thousands)			60+ population of total population (%)			80+ population of 60+ population (%)		
	2005	2025	2050	2005	2025	2050	2005	2025	2050
Total Africa	47 940	89 171	206 811	5.2	6.4	10.4	8.0	8.9	10.6
Eastern Africa	13 106	23 941	59 275	4.5	5.1	8.6	7.8	8.7	9.2
Middle Africa	5 050	8 546	21 001	4.5	4.5	6.7	7.0	7.7	8.0
Northern Africa	12 930	27 149	60 656	6.8	10.7	19.6	8.2	8.9	13.3
Southern Africa	3 625	5 881	8 662	6.6	9.7	13.3	8.1	11.5	15.5
Western Africa	13 229	23 654	57 217	4.9	5.6	9.3	8.2	8.9	9.3

Source: United Nations (2007a)

Table IV-2. Labour force participation, sex ratios and life expectancy of the population aged 60 and above, of the five subregions of Africa, 2005

Sub-region	Percentage aged 60+ in labour force		Sex ratio (men per 100 women)		Life expectancy at age 60	
	Men	Women	60+	80+	Men	Women
Total Africa	64	32	82.9	69.6	14.6	16.7
Eastern Africa	78	52	81.0	69.1	14.2	16.3
Middle Africa	74	41	79.0	63.2	13.9	15.6
Northern Africa	39	6	86.4	71.6	16.3	18.4
Southern Africa	40	15	69.2	41.5	13.2	17.5
Western Africa	76	37	87.3	80.1	14.4	15.8

Source: United Nations (2006d), (2007a)

Life expectancy at birth in Africa is approximately 52 years, being 12 years below the average in all developing countries and the lowest among the world's regions (United Nations, 2007a). Life expectancy at age 60 is about 15 years for men and 17 years for women (United Nations, 2007a). In sub-Saharan Africa, life expectancy is rising very slowly, mainly because of AIDS-related mortality, but also from poor access to health

care, low living standards, economic oppression, civil unrest and violent conflict (United Nations, 2007a; Velkoff and Kowal, 2006). In the period 2000-2005, 22 sub-Saharan countries had a life expectancy below 50 years, while in half of these countries it was less than 45 years (United Nations, 2007a). The effects of the HIV/AIDS epidemics have significantly impacted older populations: the associated morbidity and mortality in the middle generation have resulted in a loss of care and support for older parents and an increase in the number of vulnerable and orphaned children, which has far-reaching effects on grandparents who become caregivers to the children. In some affected countries, the mortality may contribute to premature population ageing, yielding a significantly expanded older population (Kinsella and Phillips, 2005).

(b) Migration. A major subregional trend is internal and cross-border migration. Sub-Saharan Africa is currently the most rapidly urbanizing subregion in the world (Kinsella and Phillips, 2005). Migration is expected to contribute to destabilization of traditional African values that sustain elders in closely knit communities (Cohen and Menken, 2006; HAI, 2002b; Apt, 1997) because of changes in family structures and support systems. Rural-to-urban migration of able-bodied younger kin for work and study removes support for older persons. If elders follow migrant kin, they may feel disorientated or alienated at the destination. Forced migration to displacement camps following emergency situations, such as violent conflict or natural disasters, renders older persons especially vulnerable in terms of personal safety and access to food and health care in the camps (HAI, 2005b, 2002b).

(c) HIV/AIDS. Sub-Saharan Africa is currently the epicentre of the HIV/AIDS pandemic. In 2005, some 26 million of more than 40 million persons living with AIDS worldwide were estimated to be living in Africa (UNAIDS, 2006), the majority in their prime reproductive and economically productive years (Velkoff and Kowal, 2006) and the principal sources of financial and material support for older persons (UNAIDS, 2006). The Eastern and Southern African subregions have the highest prevalence of the disease; infection rates continue to climb in some of the countries. Each year, almost 2 million people in Africa die from AIDS and 3 million become infected. Few countries, notably Senegal and Uganda, have succeeded in containing the spread of the virus (UNAIDS, 2006; CFR, 2006; Velkoff and Kowal, 2006; Asamoah-Odei, Garcia Calleia and Boerma, 2004); the future course of the epidemics in the subcontinent is unfathomable.

HIV/AIDS is one of Africa's most acute health challenges, and costly and complex to manage. The epidemics adversely impact development, social cohesion, political stability, life expectancy and human dignity, and impose a huge social and economic burden on the whole continent. National economies are damaged, communities undermined, household livelihoods destroyed, poverty worsened and traditional arrangements for the care of orphans overwhelmed (African Union, 2006a; CFR, 2006; Subbarao and Coury, 2004; UNICEF, 2004; Nyambedha, Wandibba and Aagaard-Hansen, 2003). The epidemics have profound effects on older persons, older women in particular, through morbidity and mortality of adult children, which thrusts them back into the role of primary caregivers and surrogate parents to vulnerable and orphaned grandchildren (Velkoff and Kowal, 2006; Kinsella and Phillips, 2005; Moore and Henry, 2005; Dayton and Ainsworth, 2004; HAI/International HIV/AIDS Alliance, 2003;

Mwape, 2003; HAI, 2002b; WHO, 2002b; Williams and Tumwekwase, 2001). In Namibia, South Africa and Zimbabwe, more than 60 per cent of AIDS orphans are estimated to live with their grandparents (Monasch and Boerma, 2004; UNICEF, 2004; HAI/International HIV/AIDS Alliance, 2003). Studies in South Africa, Uganda, United Republic of Tanzania, and Zimbabwe show how older carers face a range of material, health and emotional problems and lack formal support (Dayton and Ainsworth, 2004; Williams, 2003; WHO, 2002b; Williams and Tumwekwase, 2001). Older persons' contribution to the care management of patients and their families has been largely unrecognized and they have not been included in national policies dealing with HIV/AIDS (Help the Aged/INIA, 2005; United Nations DESA, 2004). Nor is their growing risk of infection with the virus well recognized; they are excluded from routine screening and thus from opportunities for detection, diagnosis and treatment (UNAIDS, 2006; UNAIDS/WHO, 2005; HAI, 2005c; Help the Aged/INIA, 2005).

(d) Poverty. Apart from the key demographic trends of population ageing, migration and AIDS-associated mortality that shape the situation of older persons, their endemic and deepening poverty is the condition that defines their lives most singularly. Nearly half of Africa's population lives below the poverty line and more than 140 million people are unable to provide their family with a sustainable livelihood (African Union, 2006a). Other sources estimate that half of the sub-Saharan population survives on less than US\$1 a day and up to 500 million people survive on less than US\$2 a day (World Bank, 2006a, 2006b; CFR, 2006). Africa is the only region of the world, moreover, where (a) the proportion of people in poverty is expected to grow; (b) slightly more than half the population has access to clean water; and (c) the number of malnourished has risen in the last decade (CFR, 2006). Weak economic growth, poor ecological management, corruption, social inequalities, the quality of governance and HIV/AIDS contribute to and exacerbate poverty in the region, while population growth, socio-political conflicts, and man-made and natural disasters impede efforts to reduce poverty (CFR, 2006). African countries have lagged sorely in efforts to achieve the Millennium Development Goals (United Nations, 2000; African Union, 2006a), the first being to halve extreme poverty by 2015.

Apart from poverty on an individual level, scarcity as a function of widespread poverty limits the capacity of Governments and civil society to respond to the needs of the poorest and most vulnerable older people. Younger kin are increasingly unable to provide support for elders, because of poverty and high unemployment (Aboderin, 2004). Hence, older persons are among the region's poorest and a link between ageing and poverty is evident (Ogwumike and Aboderin, 2005; HAI, 2002b). In that context, ageing should be understood as a development issue and in relation with issues of gender, participation, employment, social protection, food security and human rights (United Nations, 2003b).

(e) Social protection. The majority of Africa's older people lack a social safety net (Kakwani and Subbarao, 2005; Ferreira, 2005a; HAI, 2004, 2002b; Bailey and Turner, 2002; Kasente and others, 2002; Mukuka, Kalikiti and Musenge, 2002). Few African countries have even a barely adequate system of social protection. Only 10 per cent of the mainly urban population is ever employed in the formal economy, typically in the civil service or military. These are predominately males in urban areas, who may access a

small occupational pension after retirement; however, the schemes are often dogged by problems of maladministration, so payment of benefits is precarious and may cease (Ferreira, 2005a; HAI, 2002b; Mchomvu, Tungaraza and Maghimbi, 2002). Rural workers, mainly in agriculture, and self-employed workers have little or no pension coverage. A few countries operate a social pension programme — Botswana, Lesotho, Mauritius, Namibia, Senegal and South Africa (Save the Children UK/HAI/IDS, 2005; Ferreira, 2005a; Barrientos and others, 2003; HAI, 2002b) — where typically the benefits and coverage are minimal. The exceptions are Botswana and Lesotho, where all citizens aged 65 and over and aged 70 and over, respectively, are eligible for a social pension (Save the Children UK/HAI/IDS, 2005; HAI, 2006d; Bailey, 2004); and South Africa, whose pension programme is near universal and comparatively generous (Ferreira, 2005a; Barrientos and others, 2003).

A range of informal savings and support schemes provide a measure of income security, based on African traditions of shared support and kinship networks; they include rotating savings schemes, credit associations, mutual aid societies and burial societies (Ferreira, 2005a; Save the Children UK/HAI/IDS, 2005; Kasente and others, 2002; Mukuka, Kalikiti and Musenge, 2002; HAI, 2002b; Mchomvu, Tungaraza and Maghimbi, 2002; Kimunyu, 1999). Members benefit through small-scale capital accumulation and savings to meet various welfare objectives and contingencies, or to start a small business or acquire assets.

The majority of the region's older people rely on family, where available, for support, or on personal livelihoods in the informal economy, where they engage in a variety of income-generating activities, ranging from small-scale subsistence farming to home industries to petty trade (Ferreira, 2005a; Apt, 1996, 1997; several HAI sources). Rates of participation of older men and older women in the labour force, both formal and informal, are shown in table IV-1. However, those rates may underrepresent older women's economic activity because it is often underreported or not captured in data surveys and censuses, and their participation in informal economy activities is poorly documented (Cohen and Menken, 2006).

(f) *The family: gender divide and structural change.* African society is typically patriarchal and has deep gender divides. Women are discriminated against in virtually all political and social arenas, so in old age they suffer the cumulative effects of lifelong economic discrimination (Ferreira, 2004; HAI, 2002b; Apt, 1996, 1997). In countries without social pensions, most women are disproportionately impoverished in old age; widowed and childless women are the most vulnerable to poverty (Cohen and Menken, 2006; Apt, 1996, 1997). Older women are especially disadvantaged in matters relating to widowhood, succession, inheritance and land ownership, often through associated harmful traditional and cultural practices (HAI, 2002b; Apt, 1996, 1997). In addition, older women may experience abuse, neglect and violence; in certain sub-Saharan countries they may be branded as a witch and ostracized, their assets seized and themselves killed (Ferreira, 2004; HAI, 2002b; WHO, 2002b).

Changing family structures are a key trend in African societies. For generations the extended family provided support and care of older persons, but families have come

under increasing pressure from social change, civil wars, poverty, agricultural declines, migration, HIV/AIDS and other factors, and their capacity to care for elders may have diminished (Kinsella and Phillips, 2005; Kasente and others, 2002; Mukuka, Kalikiti and Musenge, 2002; Williams, 2003; Apt, 1996, 1997). Changing family structures contribute, moreover, to new roles and responsibilities for elders, altering traditional relationships of interdependence and reciprocity (see Cohen and Menken, 2006). Traditionally, older members were largely inactive recipients of financial and other support from children and grandchildren; contemporary elders are likely to be active contributors to the well-being of their family and household, through childcare, home management, resource sharing and other activities (HAI, 1999, 2002b; Apt, 1996, 1997). In countries where social pensions are provided, female beneficiaries are likely to use a major part of the income to pay for food and utilities for the household and grandchildren's education (Ferreira, 2005a; Barrientos and others, 2003; HAI, 1999). Ironically, as the older members' need for support increases, the number and capacity of family care providers may decrease inversely and leave elders vulnerable.

Changing family structures have implications for the living arrangements of older members. Although some 74 per cent of Africa's elders co-reside with children and/or grandchildren and benefit from and contribute to household resources, about 9 per cent live alone with a spouse, 8 per cent live alone and a similar percentage live with other relatives or non-relatives (United Nations, 2005a; cf. Zimmer and Dayton, 2005). The proportion of elders who live independently may reflect a changing pattern in household structures. More than 10 per cent of all older women in most sub-Saharan countries live in "skipped-generation" households (households in which the middle generation is absent); 21 to 25 per cent of all older persons in Zambia and Zimbabwe and 30 to 34 per cent in Malawi and Rwanda live in such households (United Nations, 2005a). An increase in the number of skipped-generation households in rural areas may be a result of the high prevalence of HIV/AIDS (United Nations, 2005a; Zimmer and Dayton, 2005) and highlights the vulnerability of households in which older members are carers of orphaned grandchildren (Kinsella and Phillips, 2005). Very few older persons live in a residential care facility; few such facilities exist (United Nations, 2005a). While the concept of institutionalization of elders is rejected culturally in Africa, a lack of care shelters exacerbates the vulnerability of very frail and socially indigent older people.

(g) Public health resources. The generally poor health status of older persons and inadequate health-care service delivery in African countries augment their vulnerability. Not only do older persons suffer the cumulative effects of poor health over their life course; in old age they may experience access barriers to essential health-care services. Public health-care programmes face a huge burden of disease (Lopez and others, 2006) so they focus on the eradication and control of preventable childhood diseases. Far less attention is paid to the treatment of chronic illnesses and management of the health of frail older clients. Barriers to health care for older persons include lack of affordability of basic treatments, depersonalizing attitudes of health-care staff, a lack of medications to treat chronic disease, and marginalization of older clients in health services (HAI, 2002b; WHO, 2002b). In rural areas, health-service infrastructure is sparse and often inaccessible through a lack of transportation (HAI, 2002b; Darkwa, 1999). Older persons often rely on traditional healers for treatment (Cohen and Menken, 2006; Darkwa, 1999), because their

access to biomedical treatment is limited or they feel sceptical about its efficacy, especially its ability to treat age-associated chronic illness.

Very little formal care, if any, is available to older people in Africa; the majority rely on NGOs and volunteers, or relatives, friends and neighbours when they need care (Kinsella and Phillips, 2005). The family is the main provider of informal care to its members. Older women are commonly carers of their spouse, adding to their other burdens (Apt, 1996, 1997). Much of the instrumental, emotional and personal care provided to African families comes from the older female members; but the burden of care is growing, partly owing to the AIDS pandemic (United Nations, 2003b; HAI, 2002b).

2. Status of knowledge and research possibilities

The information presented here was garnered from recent situational papers and policy analyses, the scientific literature and international NGO bulletins to describe regional trends and older persons' situation broadly. Gaps in knowledge of Africa's older population are evident in this review and undoubtedly impact policy development. Accurate statistics on basic demographic events to inform national health and public policy are one such gap (Velkoff and Kowal, 2006). Others include a lack of reliable data disaggregated by age and sex, epidemiological information, data from longitudinal studies to indicate major change in older persons' situation over time (Cohen and Menken, 2006; Aboderin, 2005) and knowledge established from an actor's perspective (Aboderin, 2004; Ferreira, 2005b; Makoni and Stroeken, 2002; Sagner, 1999).

Research on ageing in the region is relatively underdeveloped and has been constrained by inadequate research capacity and infrastructure, a lack of co-ordination and non-availability of funding, all of which go against the production of credible scientific evidence. The extant body of research is uneven and limited in accessibility. Several studies have methodological shortcomings, the majority being cross-sectional and subnational, with attendant problems of generalizability and comparability of their findings (Cohen and Menken, 2006; Aboderin, 2005). In addition to gaps in knowledge, the constraints and shortcomings of research therefore confound understanding of ageing and older persons' situation.

Nonetheless, critical areas of their situation warrant attention and evidence is needed to inform policy and responses. Areas of vulnerability identified in this review are corroborated as priorities for research on ageing by international agencies and organizations in consultation with African researchers for the region. In addition, the collective agendas have indicated how a dynamic research endeavour may be promoted and achieved.

- (a) The United Nations and the International Association of Gerontology and Geriatrics compiled their Research Agenda on Ageing for the 21st Century in 2003 and made a separate agenda for sub-Saharan Africa; both were revised in 2005 (United Nations/IAGG, 2006). The sub-Saharan agenda identifies priority areas for research as chronic poverty, changing family structures and functions, access to health care, HIV/AIDS, income security and urbanization.

- (b) The research agenda of the African Research on Ageing Network, a partnership between the Council for the Development of Social Science Research in Africa and the Oxford Institute of Ageing in the United Kingdom, identifies four broad priority areas: poverty, HIV/AIDS, health and family (Aboderin, 2005).
- (c) The research agenda of the United States National Academy of Sciences identifies priority areas for Africa as income, wealth and expenditure; health and well-being; the nature of family support and social networks; changing roles and responsibilities of older people in an era of AIDS; and formal and informal forms of social protection (Cohen and Menken, 2006). The agenda incorporates a temporal dimension that provides for the measurement of change over time. Specific details of priority research areas are provided in each agenda.

Priorities to foster an expanded and relevant research endeavour identified in the three agendas include: (a) establishing indigenous solutions, tailored to specific socio-economic, cultural and demographic situations; (b) addressing fragmentation of past and present research through cohesive approaches to define strategies and link priorities; and (c) strengthening linkages between research and policy in order to improve communication between policymakers, research institutions and researchers (United Nations/IAGG, 2006; Cohen and Menken, 2006; Aboderin, 2005).

The priorities are supported by a minimum data set on ageing and older persons in sub-Saharan Africa to be constructed in a multi-country project coordinated by the World Health Organization (WHO) (see Ferreira and Kowal, 2006). Intended as a tool for the provision of baseline evidence to African Governments on the health and well-being of the older population, the minimum data set comprises core and expanded sets of indicators that correspond broadly with priority areas in the agenda.

Priorities for knowledge production to inform policy development on ageing in Africa correspond with the areas of risk and vulnerability for older persons considered earlier. Nonetheless, uncertainties abound regarding future directions that regional trends might take, and improved understanding is needed of causal processes of social and economic change as well as effects of an interplay of many factors in their situation. Such an understanding could be achieved through improved knowledge and relevant research, which may be viewed as a first regional priority to advance the well-being of older persons.

C. Opportunities, approaches and best practices

The Second World Assembly on Ageing of 2002 approached ageing primarily as a development issue; older persons were both contributors to and beneficiaries of development. The challenges of population ageing may thus be viewed as opportunities for Governments and civil society to harness older persons' energy, wisdom and capacity, and to engage them as agents of change in the achievement of national and regional development goals.

Essentially, the new developmental vision is aimed at the liberation and empowerment of older persons through changes in governmental and social attitudes, primarily through an acknowledgement of the many roles they play and the numerous contributions they make to family, community and society. Incorporation of the new approaches in policies and programmes and engagement of older persons' contributions in development initiatives may help older persons to avoid marginalization, improve their visibility and reduce their vulnerability. Adoption of an intergenerational approach in policy responses may also help to foster older persons' integration, by enabling them to continue to engage in intergenerational exchange and reciprocity as is customary in African societies (Apt, 1996, 1997). Indeed, identifying and exploiting opportunities to support and empower older persons in order to enhance their situation may be effected best within an intergenerational framework. Equitable allocation of resources to older people, advocacy of their needs, and enablement of their contributions to social and economic life and development will help sustain intergenerational cohesion.

Examples of intergenerational programmes and opportunities for empowering older persons in certain African countries are reviewed here briefly. First, individual international instruments are considered in terms of how they might support appropriate and inclusive policy responses.

1. Recent international instruments

Some recent international instruments may have only indirect relevance to ageing in Africa, as they are aimed primarily at poverty reduction and macroeconomic development broadly. Their thrusts and approaches are largely intergenerational and their action plans can benefit older persons equitably.

At the threshold of the new century, the General Assembly adopted the United Nations Millennium Declaration in its resolution 55/2 of 2 September 2000 which included a special commitment to support Africa's development needs. Subsequently, the Millennium Development Goals (United Nations, 2000) took into account the social and economic implications of demographic ageing; the instruments suggest implicitly that older persons' concerns may be mainstreamed into development agendas (United Nations, 2005; Aboderin, 2005).

The Madrid International Plan of Action on Ageing (United Nations, 2002a) has broad macroeconomic goals that include key and emerging issues in the continent, such as poverty reduction, social development and human rights. It fosters engagement of older persons and emphasizes mainstreaming them into national development frameworks and poverty eradication strategies (United Nations, 2002b, 2005).

The African Union Policy Framework and Plan of Action on Ageing (African Union/HAI, 2003) takes specific account of social, cultural and environmental realities and how they shape contexts of ageing in the region. It identifies multiple, critical areas of ageing in need of policy responses. The concept of active ageing and related policy framework (WHO, 2002a) combine concepts of successful, productive and healthy ageing and promote older persons' continuing participation in social, economic, cultural,

spiritual and civic affairs. The framework shifts strategic planning away from a needs-based approach, which implies older persons are passive recipients of care, to a rights-based approach in which they deserve opportunities equal to those of other citizens (Kinsella and Phillips, 2005).

The African Union focuses on the vulnerability of its older population in its new Mission, Vision and Strategic Plan (2006a). The primary goal is to reverse pervasive and persistent poverty, largely through a reduction in unemployment among the youth. At the same time it stresses programmes to promote social development: improved living standards, quality of life and social security, especially for vulnerable groups such as older persons, who should be included broadly in national development plans and intergenerational activities. The conjoint Declaration of Commitment undertakes to empower poor and vulnerable individuals, especially in rural communities and informal urban settlements, to ensure equal opportunities for marginalized groups and to improve the living conditions of the old, through improved social protection services that include pensions, and through health and other social security schemes.

The Commission for Africa has not singled out older persons for programme action and focuses notably on youth. It has, however, fostered collaboration between regional bodies such as the African Union and the New Economic Partnership for Africa's Development (NEPAD), through subregional organizations and the United Nations regional economic commissions that are committed to meeting shared political and development challenges.

An evaluation of national and regional policy action on ageing following the Second World Assembly are awaiting outcomes of the review and appraisal process conducted in 2007–2008 (United Nations, 2005b, 2006a). Responses from specific individual Governments, often in partnership with international and national NGOs, are noteworthy and are considered below, together with interventions in some countries that exemplify best practices.

2. National, regional and international responses

In general, responses of national, regional and international agencies in different African countries have addressed specific areas of older persons' vulnerability in policy, legislative and developmental areas. In Guinea, the Ministry of Social Affairs established a unit for matters relating to older persons that investigated their situation and elaborated a national policy on ageing. The Government of Mauritius established a national coordinating committee and sub-committees to oversee implementation of recommendations of the Madrid Plan. The Government of Nigeria formulated policies to integrate older persons in social and economic development processes. The Government of Senegal committed itself to the integration of issues of ageing in national development programmes and drafted a national plan of action on ageing (United Nations, 2005).

Intergovernmental agencies have also produced noteworthy results. In Tunisia, the Ministry of Social Affairs requested the United Nations International Institute on Ageing (INIA, in Malta) to prepare a 10-year plan of action on ageing. In Egypt, the United Nations Department of Economic and Social Affairs (UN/DESA) provided technical

assistance to the Government to integrate issues of ageing and older persons in national development plans and policies (United Nations, 2005). In Benin, the United Nations Population Fund (UNFPA) helped in formulating a national plan on active ageing and supported the development of a database of census information on older persons. In Uganda, UNFPA worked closely with the Government to formulate and promulgate a population policy that includes a section on older persons (United Nations, 2006a).

National workshops, in partnership with intergovernmental agencies and NGOs, have deliberated policy action needed to address specific issues and to call for action. In 2003, UN/DESA collaborated with the Government of Tanzania and HelpAge International in holding a workshop at Dar es Salaam to explore the nature of the ageing–poverty relationship in Eastern Africa and Middle Africa, and to determine measures needed to incorporate a focus on this relationship in poverty policies, strategies and action programmes (United Nations, 2003b). Older persons were subsequently included as targets in a revised strategy for growth and poverty reduction (United Nations, 2004). In 2004, UN/DESA in partnership with the Government of Namibia convened a workshop at Windhoek to develop a policy framework to mitigate the effects of HIV/AIDS on family well-being in Southern African countries. The framework encourages programmes to target the needs of infected and affected individuals in different generations, including older carers, simultaneously and comprehensively (United Nations, 2004).

In 2006, the Government of Zambia in collaboration with the African Union and HelpAge International hosted a multi-country workshop in Livingstone to discuss measures to protect very poor older persons and how Governments could support them. The Livingstone Call for Action (HAI, 2006e, 2006f) encourages African countries to share experience and information on social protection and cash transfers, including pensions for older persons and transfers to vulnerable and orphaned children, to commit to social protection, and to integrate social transfer plans in national development plans and budgets. Finally, in Uganda, HelpAge International collaborated with the NGO Uganda Reach the Aged Association and various ministries in a project to mainstream older persons in policies, which resulted in their inclusion in national plans on poverty, agriculture and health (HAI, 2006g).

3. NGO responses and best practices

NGO projects in certain African countries reflect best practices that may be replicable elsewhere. Most were initiated and overseen by HelpAge International in partnership with other international, national or local organizations and groups. While some address specific areas of vulnerability thematically, such as a lack of social protection, the majority address poverty, development and cross-cutting issues jointly, aiming to help older persons uplift themselves and their community and to benefit all. Generally, the projects aim to support and develop local groups and thus enhance national capacity (see United Nations, 2006a).

The Older Citizens Monitoring Project was conducted initially in Kenya and the United Republic of Tanzania (and three non-African countries as well), and later in Ethiopia, between 2002 and 2006 (HAI, 2006a). The project supported groups of older persons to

develop locally relevant indicators and benchmarks in the implementation of policies that affect them, and to promote dialogue with local and international development agencies. Groups of older citizens collected information and used it for their empowerment and to advocate for improvement of service delivery. Results showed improved access to services and enhanced skills and increased self-confidence.

A programme aimed at poverty alleviation and economic development was implemented in Mozambique, South Africa and Sudan to support older women as carers and increase their visibility (HAI, 2005c). In Mozambique, groups of older persons designed and implemented a strategy to increase the economic support of older carers of sick persons and orphans through activities aimed at reducing the cost of care and increasing income through selling crops and handicrafts, rearing animals and brewing traditional beer. Capital was made available through community credit schemes to enable groups to start small businesses. The money was deposited in a fund run by older-person committees, from which payments were made for family members to be transported to distant HIV testing centres and antiretroviral therapy clinics. In South Africa, older carers were helped to access governmental services and entitlements, such as a pension, child-support grants and disability grants, and antiretroviral treatment for persons living with AIDS. In Sudan, groups improved the dissemination of information on prevention and care relating to HIV/AIDS among older carers who were excluded from HIV prevention campaigns. A similar project was aimed at supporting older carers to children and grandchildren affected by HIV/AIDS in South Africa, with support from the Government and the private sector, by the NGO Grandmothers Against Poverty and AIDS. Support groups empowered members through information, skills training and emotional support, while members engaged in income-generating activities to increase household income and activism to fight the spread of the disease in their community.

HelpAge International in partnership with Help the Aged UK has initiated a programme to bring disaster relief to an estimated 1 million poor and vulnerable older people and their families in Eastern Africa at risk of starvation as a result of drought and floods (HAI, 2006b). The programme ensures that older people are included in relief efforts, and restocks cattle and goats, strengthens breeding stock and improves access to water for affected households.

4. Research and intervention

Several projects to enhance older persons' situation have had a dual purpose of (a) gathering information to empower them and (b) promoting awareness and evidence-based policy formation. Participatory research methodology (HAI, 2002a) has been employed in the majority of projects. It encourages the involvement of older persons and other stakeholders in project design, data collection and analysis, and dissemination.

The methodology was pioneered by HelpAge International in a project in Ghana and South Africa in 1998–1999 (HAI, 1999) that involved poor older persons in an analysis of their situation and formulation of strategies to reduce poverty. Outcomes were disseminated and dialogue was facilitated between older people and other stakeholders, including policymakers. Key areas for action and policy implications were identified:

unmet needs for health care, nutrition, clothing and self-esteem; perceived inadequacy of health care; and a need for intersectoral approaches to develop policies and programmes to alleviate hardship and enable older persons to contribute to family and community. The project was seminal in identifying contributions made by older persons in the region, such as caring for vulnerable and orphaned children affected by HIV/AIDS and minding grandchildren. Their contribution enabled young adults to engage in economic activities, generated household income and nurtured families and communities.

More recently, the Food and Agriculture Organization of the United Nations undertook a study in Ghana on rural ageing and its effects on food security and rural poverty, gender equality, patterns of farming and management of productive resources. Older persons were involved in data collection, taught skills and helped to cope with HIV/AIDS, and their access to services and production resources was improved. They improved their own nutritional status, followed good dietary practices and took steps to improve their food security, while advocating their human rights, especially access to adequate food (United Nations, 2004, 2005b, 2006a).

The WHO is undertaking the multi-country research project Integrated Health-Care Systems Response to Rapid Populations Ageing in Developing Countries (INTRA) that includes Botswana, Ghana and Kenya. INTRA aims to assess the preparedness of primary health-care services to respond to population ageing and to make recommendations for improving service delivery for older persons, in partnership with Governments, research institutes and NGOs. Care-seeking behaviour of older persons is mapped; and roles, needs and attitudes of service providers are assessed. Information and good practice models resulting from the project have been shared and comprehensive policy recommendations are being formulated for the development of a continuum of care for older clients within the primary health-care sector (United Nations, 2005b, 2006a).

Another project aimed at evidence-based intervention to improve health care and service delivery to the older population is being overseen by the International Federation of Ageing. The project involves NGOs working with older persons in Cameroon, South Africa and Uganda and is linked with organizations in Australia, Israel and the United Kingdom. The capacity of NGOs within the countries is being strengthened, in order to facilitate older persons' access to health care and service delivery. The health and well-being of older persons are being improved through realistic planning and exchange of expertise among the partner organizations (United Nations, 2004, 2005b).

The projects reviewed here demonstrate how small-scale and low-cost grassroots solutions can empower groups of older persons and enhance their situation. Numerous other projects have addressed pertinent areas of ageing, ranging from elder abuse, neglect and violence (see Ferreira, 2004), to older people's rights (see several HAI sources), to human capacity-building to care for older persons.

5. Rethinking attitudes and policymaking

The review of regional trends and factors has sought to aid understanding of their influence on the African older persons' situation. The review of responses, best practices and research interventions has provided insights into types of information and models needed to guide the development and implementation of sound policy on ageing in the region. Essential to future policy formation and action will be sharing of experience and consultation of evidence by policymakers, employment of new approaches to ageing, and engagement of stakeholders in review and appraisal of policy action.

Given a lack of systematic monitoring and evaluation of progress, some governmental efforts to modify policy approaches and implement the plans may be sketchy or variable. Realization of their commitment to implementation may be limited, or Governments may not sustain interest or political will or funding. They may need to be encouraged anew to act on policy on ageing, as well as conduct reviews and appraisals. A policy and societal "mindshift" at regional and national levels may be required to overcome constraints that retard progress in policy action. Changes in attitudes, policies and programmes are clearly required, beginning with the view of ageing as a development issue.

Current regional development and poverty eradication initiatives have focused on achievement of the Millennium Development Goals. They are concerned overwhelmingly with human development and poverty challenges relating to younger age groups. International NGOs working on ageing in the region argue that older persons should be mainstreamed in poverty eradication and development efforts, benefits of which have been demonstrated in best practices reviewed here. Older persons' integration in consultative processes and concrete actions to effect development at local and national levels would represent a policy shift away from an emphasis on care and benefits needed to support an older population (United Nations, 2003b). Continuing the policy dialogue with older persons, and their participation in advocacy for responses in areas that they say are critical, should constitute other components of a shift in thinking and policymaking.

Rethinking of attitudes towards older women is especially needed so that they may become integrated into economic, political and social decision-making and achieve gender equality in policies and programmes (United Nations, 2003b; Apt, 1996, 1997). Ultimately, a rethinking can help stimulate societal adjustment to ageing.

D. Bridging trends, older persons' situation, opportunities and policy

A third regional priority to advance the well-being of older people may be for stakeholders to bridge the landscape of current trends, older persons' situation, emerging opportunities and policy options. An initial step might be for regional and international agencies to reinforce advocacy campaigns to remind Governments and civil society organizations of their commitment to implement the plans. A subsequent step might be to inform all stakeholders of planned regional and national reviews and appraisals of policy action and invite them to participate in the processes. Thereafter, steps could be taken to bridge knowledge of trends, factors and the older persons' situation, with the outcomes of review and appraisal as well as opportunities to mainstream older persons and optimize their contributions in new policy development.

Hence, possible action could include: (a) placing challenges of ageing and opportunities for older persons' integration on the social development agenda; (b) planning for utilizing their capacity and ensuring their participation in development; (c) formulating, adopting, coordinating and harmonizing policies to support older persons; and (d) developing policies simultaneously on extended families and health and social security for older persons, that reduce their vulnerability and optimize their contributions (Kinsella and Phillips, 2005; United Nations DESA, 2004). Steps for review and appraisal should be included in the process.

1. Review and appraisal

Outcomes of review and appraisal of regional and national policy action on ageing will contribute to an understanding of older persons' situation and an evaluation of policy responses to date. Continuing and emerging areas of risk and vulnerability and new responses that may be required will also come out of the review and appraisal exercise.

The United Nations Economic Commission for Africa (ECA) will convene and oversee review and appraisal of implementation of the Madrid Plan within the region. No plans exist for review and appraisal of implementation of the African Union Plan, nor does it have a regional implementation strategy, pending the setting up of an Advisory Council on Ageing (African Union, 2006b, n.d.). Nonetheless, commonalities in the ideology, priorities and substantive content of the plans indicate their compatibility (Aboderin, 2005) and suggest the feasibility of harmonization of their implementation, review and appraisal.

The United Nations Commission for Social Development is responsible for global follow-up of implementation of the Madrid Plan and has provided modalities for its review and appraisal (United Nations, 2003c). Governments are responsible for related activities and outcomes at the national level, while regional and international NGOs, national research institutes, university centres, the private sector, and older persons and their organizations are to conduct the processes nationally or cross-nationally. The modalities recommend the use of a "bottom-up" participatory approach (United Nations, 2002b), similar to the participatory research methodology pioneered by HelpAge International with governmental bodies in Ghana and South Africa (HAI, 1999, 2002a). The approach ensures inclusiveness of stakeholders, affords flexibility, and allows for the use of national and local experience and expertise, including that of older persons and their organizations (HAI, 2006h), as well as the identification and sharing of good practices. Generally, Governments and citizens can engage in dialogue to improve their understanding of older persons' situation, in order to promote important areas of action. Specifically, the approach focuses on an evaluation of the results of policy intervention from an action perspective.

Given resource constraints in Africa, steps needed to carry out review and appraisal and achieve goals might include: (a) strengthening regional, subregional and national capacity for the purpose; (b) ensuring capacity to lead the processes subregionally and nationally, and to co-ordinate them at a regional level; (c) accelerating the processes through partnerships with stakeholders and within regionally integrated strategic frameworks; and

(d) strengthening capacity to mobilize external resources. An entry point for the processes may exist in such mechanisms as the United Nations ECA and NEPAD that provide a platform for Africa's engagement with the international community and a strategic framework for partnerships aimed at encouraging people-centred development, initiatives and programmes (African Union, 2006b, n.d.). A clear political endorsement by Governments of their capacity and willingness to undertake review and appraisal will be a prerequisite. International involvement in the form of technical co-operation and financial assistance will also be critical to the success of the regional exercise.

Understandably, regional implementation of the plans is an evolving process (United Nations, 2003), but an evaluation of Africa's progress thus far is appropriate, before more time elapses while inaction continues. Governmental participation in review and appraisal may indeed reinforce official commitment to implement the plans. However, stereotyped images of the poor economic and social situation of older persons, views that they constitute a vulnerable, resource-dependent and non-productive group, as well as assumptions that families will care for elders, are likely to continue to prevail and impede progress in policy action (United Nations, 2004) regionally and nationally. Thus the evidence of their real situation is needed from older persons themselves.

2. Evidence for policy, implementation, review and appraisal

Improved knowledge and reliable evidence of older persons' situation and contributions upon which to build and forge policy action may be achieved through comprehensive, diversified and specialized research (Cohen and Menken, 2006; United Nations/IAGG, 2006; Aboderin, 2005). The production and sharing of evidence-based knowledge has been identified as a principal component of review and appraisal (United Nations, 2003b, 2005) — as indeed was research identified as essential to implementation of the plans of action (United Nations, 2002a; African Union/HAI, 2003).

Africa has a small and fragmented research community. Research capacity and infrastructure need to be built to produce high-quality evidence with political and scientific relevance. Ideally, research strategies and data collection efforts should be forged and coordinated by African research organizations and guided by a common regional research agenda. To such ends, the African Research on Ageing Network offers a mechanism to foster research, research collaboration and research capacity building, as well as advance African scientific discourse on ageing (Aboderin, 2005). Specifically, the network could examine the relevance of prevailing concepts and theories for understanding ageing in the region; develop new Africa-based interpretations and critical perspectives; help to foster the development of baseline data that tracks changes in several key variables over time; and through dissemination, facilitate an intermittent flow of information to relevant government authorities for action and serve as an early warning system of areas of high risk and vulnerability for older persons.

A short-term, regional research priority must be the re-visioning and harmonization of several research agendas and the use of a consolidated agenda to promote relevant and coordinated research. The research should include age- and gender-sensitive data collection and analyses and be suitable for cross-country comparisons. The availability of

adequate funding to support the generation of data and the production of evidence may be a major impediment to a vibrant research endeavour. Hence, both national allocation of resources and access to external funds for the purpose will be essential to bridging the regional trends, older persons' situation, opportunities and informed policy and action.

3. Societal and regional adjustment to ageing

An overarching goal of processes outlined here is to guide and support African nations in adjusting to challenges and taking advantage of opportunities of population and individual ageing in a timely manner, appropriately and prudently. Given the magnitude of developmental and institutional needs yet to be satisfied, the current trends and factors will continue to impact older persons' situation negatively.

Signs of positive change in the region are evident, however, as "Afro-pessimism" gives way gradually to optimism among its people and institutions as well as in the international community (see, among others, CFR, 2006). In 2005, development partners in global fora (for example, the Gleneagles G8 Summit and the campaign "Make Poverty History" of British-based NGOs, trade unions and faith groups) made commitments of new or additional resource allocation, debt relief or cancellation and increased foreign investment, aiming to redress debilitating poverty, poor economic growth, underdevelopment and other crippling social and institutional burdens. The African Union, NEPAD and the African Peer Review Mechanism have set a continent-wide agenda to forge development goals and regional integration. African leaders and regional and subregional institutions are making genuine efforts to achieve democracy, uphold constitutional rule, resolve remaining conflicts, foster good governance and develop sound economic policies (Council on Foreign Relations, 2006; African Union, 2006a). Hence, while the current ageing context may remain one of deepening poverty and weakening human resource development, there are positive changes, progress and concrete local and international initiatives that are setting African nations on a course to achieving sustainable development and a better life for all.

At a societal level, the region's nations must continue to cope with multiple burdens and crises while they prepare to meet the challenges of ageing, with neither a comprehensive social security system nor a well-functioning traditional care system in place (Cohen and Menken, 2006). At the individual level, unmet livelihood and health-care needs will continue to strain older persons' capacity to sustain themselves and to contribute to family, community and society (Aboderin, 2004, HAI, 2002b, 2004). Such constraints and other priorities may diminish governmental capacity to enhance critical areas of older persons' situation comprehensively in the short term.

Three focal areas may be identified, depending on a country's conditions and resources, as areas of opportunity to adjust to ageing: (a) income security, including expanded social protection and social assistance, and livelihood security; (b) health care, including improved accessibility and delivery of comprehensive health care for older clients; and (c) support of older persons in households affected by HIV/AIDS. Indeed, attention to social protection and health care for older persons will contribute to the support of older carers in AIDS-affected households. The areas are described here briefly.

(a) Social protection and social security. Neither the introduction nor expansion of such programmes, linked with poverty reduction, development and economic growth strategies, has received considerable international attention recently. Instead, debate has ensued on the merits, feasibility and costs of providing universal, basic, social pensions in African countries (UNAIDS, 2006; Kakwani and Subbarao, 2005; United Kingdom, 2005; Beales and German, 2005; Barrientos and others, 2003). Small, regular cash transfers in the form of social pensions and other grants have been shown to improve the well-being of older beneficiaries' households significantly and to be a vital safety net for vulnerable populations (Kakwani and Subbarao, 2005; HAI, 2006d&e, 2005d&e, 2004; Bailey, 2004; Barrientos and others, 2003). Social pensions not only reduce individual and household poverty, but redistributive effects can help in achieving the first Millennium Development Goal (HAI, 2006i, 2005d, 2004). Similarly, regular cash payments to older carers in AIDS-affected households can help to preserve livelihoods and foster human development, as can cash subsidies provided to children affected by AIDS help older carers to cope and nurture the grandchildren's healthy growth and development (UNAIDS, 2006; HAI, 2006i, 2005c). Better access to antiretroviral therapy can provide substantial economic and social benefits not only to infected persons but their carers and family as well (UNAIDS, 2006; Ferreira, 2006; HAI, 2005c; Help the Aged/INIA, 2005; Save the Children UK/HAI/IDS, 2005).

(b) Health care. The problems in delivering health-care services for older people in African countries warrant substantial policy and research attention. Health-care systems must be improved to respond better to the care needs of a growing older clientele, especially in rural areas. Better information is needed of older persons' health status, changing patterns of morbidity and disability, patterns of service utilization and unmet care needs in order to inform policy and improve service delivery. A knowledge base must be built through ongoing data collection in longitudinal surveillance projects such as the WHO Study on Global Ageing and Adult Health (SAGE) under way in Ghana and South Africa (WHO, 2006a). Availability of reliable data on health and ageing in countries of the region will enable monitoring of patterns of ill-health and disability as well as of changes in physical and cognitive functioning, and the implications thereof in terms of the demand for health services (see Cohen and Menken, 2006).

(c) Support for AIDS caregivers. AIDS-associated morbidity and mortality will affect how growing numbers of older persons age in sub-Saharan African countries. Most countries are ill-equipped to meet the challenges of ageing in the first place, and will be hard pressed to meet the support needs of older persons affected by AIDS who lack kin support, assume new roles and may themselves become vulnerable (Velkoff and Kinsella, 2006). Older persons' considerable contribution to the care management of the subregional epidemics is hardly recognized; it must be acknowledged and supported in policies and they should be helped in practical ways (HAI, 2005c, 2005d). Older persons' own growing risk of infection with the virus must be addressed similarly. They must be included in prevention education and routine screening and treatment programmes (Ferreira, 2006; Help the Aged/INIA, 2005; United Nations DESA, 2004).

Finally, expanded and relevant education and training to build human capital for addressing ageing issues is another area in need of attention at national and regional

levels. Cadres of professionals, para-professionals, practitioners, educators, researchers, policymakers, planners and administrators must be trained in multidisciplinary gerontology and geriatrics appropriate for the region, to equip them to meet social and health challenges of an ageing population and to facilitate older persons' realization of opportunities. UNFPA conducts training programmes to build national capacity for data collection and analysis on ageing in several African countries and supports training institutes such as the United Nations International Institute on Ageing, in Malta (United Nations, 2006a, 2006b). INIA has offered training programmes in Egypt, Ghana, South Africa and Tunisia, and also trains individuals from Africa in Malta. INIA has also developed training programmes for senior officials and other stakeholders to engage in review, appraisal and follow-up (United Nations, 2006a). Through its African Regional Development Centre, HelpAge International has been training older persons in human rights and how to exercise them, in literacy, numeracy and health literacy, and in skills development to foster livelihood security and to cope with the vicissitudes of ageing in the region (see several HAI sources). Other institutional players must be encouraged to offer similar regional and national education and training programmes.

The foregoing examples show how the older persons' situation may be improved and specific hardships alleviated. They show how older people can be empowered, their well-being enhanced, and their contributions to family and community sustained — thus helping African societies to adjust to ageing. A road forward for African nations and their institutions may therefore be to build on evidence from research and best practices, adopt the new approaches and achieve goals progressively.

Resource constraints are likely to continue, however, and international assistance may be needed to enable Governments to build national capacity and effect policy action on ageing as well as conduct review and appraisal. But, where financial and technical assistance is accepted from abroad, attempts to transfer and impose external models and strategies intended to help the country adjust to ageing should be resisted (Apt, 1997). Indeed, Africans strongly contend that they should determine and apply African solutions to remedy their own situations (Ferreira, 2005b; Apt, 1997), based on pan-African values, indigenous knowledge systems and local practices. African countries must be supported in addressing the critical areas themselves.

E. Conclusions

The challenges of population and individual ageing in Africa and ways to face them require understanding of the trends and factors that shape older persons' situation, impinge on their well-being and constitute obstacles to growth and development broadly. Recognition is needed similarly of roles that older persons play and contributions they make, and how opportunities may be exploited to facilitate and support their contributions and enhance their integration into the mainstream of society.

New approaches to ageing and older persons that are espoused in international instruments offer encouraging directions for inclusive policy formation and mainstreaming of older persons in development efforts. Adoption of the approaches and their employment in national policies and programmes will serve to empower older

persons and reduce their vulnerability, as well as help to ensure intergenerational equity and promote economic growth and sustainable development, from which older persons may benefit equitably.

Meeting the challenges of ageing and improving older persons' situation call for the long-term commitment of Governments and civil society to expand national agendas to include ageing and to develop relevant policies and implement them through well-designed strategies and programmes. However, information is needed to forge policy action, which should be established through relevant and coordinated research as well as the review and appraisal exercise.

Planning and implementation of responses to older persons' current and projected situations must be accompanied by broad-scale adjustments across the life course and within social, economic and political institutions (United Nations, 2003b). As African countries engage in policy action on ageing progressively, a stronger link will evolve between ageing, the older population and global agendas on poverty eradication and economic growth. Ultimately, macroeconomic development will improve African capacities to support older persons and enhance their situation. Similarly, new policy approaches to children and youth that include intergenerational issues, as well as approaches to the advancement of women that include issues of ageing in rural areas, will benefit older people.

For processes to be effected successfully, information on the older persons' situation and their roles and contributions must be improved. Development of a vibrant research endeavour within the priority areas identified for the region, as well as national and international investment in that endeavour, is crucial to spearheading other processes. Finally, strong partnerships between policymakers and researchers, and indeed among numerous other stakeholders and older persons as the primary and core stakeholders, are needed to enhance dialogue and to help ensure that research evidence is consulted and translated into appropriate policies and responses.

Despite the enormity of inherent challenges, African societies and settings offer unique opportunities to discover indigenous solutions and implement best practices, through which individual capabilities may be enhanced and societies helped to adjust. The concepts of successful ageing and societal adjustment in the African context embrace a dual need to enable older persons to cope and society to facilitate their contributions. It behoves Governments and civil society therefore to take the opportunities to respond to these challenges — in timely and prudent ways, effectively and inclusively.

V. Ageing Policies in Latin America and the Caribbean

Martha Peláez²³

The countries of the Latin American and Caribbean region face many challenges and opportunities in implementing the Madrid International Plan of Action on Ageing (United Nations, 2002a). This chapter describes the most significant of them and recommends action for regional cooperation in the priority areas of the Plan. The chapter also seeks to assess national capacity to address issues of demographic ageing in the region, based on an analysis of existing legislation, policies, plans and programmes as a proxy for the capacity of the region to respond to the needs of older persons.

A. Population characteristics and trends

Latin America and the Caribbean include 46 countries with a total population of 558 million, of which 9.0 per cent is 60 years of age and older.²⁴ There are vast differences in age, gender and ethnic composition among the various countries. The population data presented here, unless otherwise noted, are drawn from the 2006 revisions of the United Nations studies of world population prospects (United Nations, 2007a).

1. Age composition

While the momentum of demographic ageing in the region is a significant driving force that shapes public policy, the age composition of the older population is a significant consideration in establishing priorities for policy decisions and resource allocations.

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²⁴ The 33 countries of Latin America and the Caribbean are Member States of ECLAC, together with several North American, Asian and European nations that have historical, economic and cultural ties with the region, reaching a total of 44 member States. Eight non-independent territories in the Caribbean are associate members of the Commission.

Table V-1. Demographic profile of the population aged 60 and above, of the three subregions of Latin America and the Caribbean, in 2005 and projected to 2025 and 2050

	LAC	Caribbean	Central America	South America
60+ population (thousands)				
2005	50 228	4 511	11 468	34 249
2025	101 677	7 853	24 103	69 721
2050	186 721	12 410	48 540	125 772
60+ population as % of total				
2005	9.0	11.1	8.0	9.2
2025	14.8	16.7	13.4	15.1
2050	24.3	24.6	24.0	24.3
80+ population (thousands)				
2005	6 939	705	1 560	4 674
2025	14 955	1 248	3 603	10 104
2050	40 252	3 012	10 105	27 135
80+ population as % of total				
2005	1.2	1.7	1.1	1.3
2025	2.2	2.6	2.0	2.2
2050	5.2	6.0	5.0	5.3
80+ population as % of 60+				
2005	13.8	15.6	13.6	13.6
2025	14.7	15.9	14.9	14.5
2050	21.6	24.3	20.8	21.6
% increase in 60+ population				
1975-2005	139.3	107.4	165.2	136.4
2005-2050	271.8	175.1	323.3	267.2
% increase in 80+ population				
2005-2025	115.5	77.2	130.9	116.2
Sex ratio of 60+				
2005	82.2	87.4	86.0	80.3
2025	81.5	82.0	85.6	80.1
2050	79.2	82.1	78.0	79.4
Sex ratio of 80+				
2005	65.9	74.0	69.6	63.5
2025	64.0	64.9	72.1	61.1
2050	61.6	62.9	65.8	60.0
Distribution of population 60+				
2005				
60-69	54.4	53.2	54.1	54.6
70-79	31.8	31.2	32.3	31.7
60-79	86.2	84.4	86.4	86.4
80+	13.8	15.6	13.6	13.6
2025				
60-69	54.2	53.1	53.7	54.5
70-79	31.1	31.0	31.3	31.0
60-79	85.3	84.1	85.1	85.5
80+	14.7	15.9	14.9	14.5
2050				
60-69	45.3	43.5	44.5	45.8
70-79	33.1	32.2	34.7	32.6
60-79	78.4	75.7	79.2	78.4
80+	21.6	24.3	20.8	21.6

Source: United Nations (2007a)

Table V-1 compares each of the three subregions (the Caribbean, Central America and South America) in a number of measures of population ageing. It provides a quick reference of the age distribution of the older population, the percentage increase of the older population and of the cohort of older persons referred to as the “oldest old”. The Caribbean subregion has the highest proportion of older persons, at 11.1 per cent of the population. By 2050, the Caribbean will have 24.6 per cent of the population at 60 years of age or older. South America is the second oldest subregion. Central America had the highest percentage increase in the population group of age 60 and older from 1975 to 2005.

The rapid growth of the population at ages 80 and above, in particular, will become an important factor in the selection of priority areas within countries. Latin America and the Caribbean will experience a 115 per cent increase in the oldest old population from 2005 to 2025. The proportion of older persons who are aged 80 and above among those already aged 60 and above exceeds 13 per cent in the region. By 2050, more than 1 in every 5 older persons will be 80 years old or older.

The population data shown in table IV-1 is quite revealing. In each of the subregions, the rapid growth of the older population is impressive; policymakers will want to give careful attention to the numbers involved. Latin America and the Caribbean need to prepare for the projected increase in the number of older persons. For example, in 2005 South America had 34.2 million persons 60 years of age and older; by 2025 this number is projected to jump to 69.7 million older persons and by 2050 that cohort is projected to become an impressive 125.8 million persons. What policies, plans and programmes can effectively respond to such massive growth?

Although the prevalence of chronic and disabling conditions rises steadily after age 60, most of the chronic disease programmes are not yet targeting older persons for prevention. Life expectancy at 60 is approximately 20 years in the region, so it is evident that chronic and disabling conditions will accelerate rapidly among those aged 75 or 80. Therefore strategies for chronic care in “younger old” persons (60 to 79 years old) must be designed and implemented, and simultaneously care must be planned for the large proportion of older people reaching the age of 80 with poor access to quality services. Similarly, pension and social welfare programmes need to recognize that while a large proportion of the younger old continues to work, it will rapidly decline with age. Therefore, with increasing years, the proportion of older people living under the poverty line will increase.

2. Gender composition and cultural values

Ageing in all countries in the region is, above all, a gender issue. In all countries, men have 10 to 20 per cent lower probability of surviving to age 60 than do women. Table V-1 shows that by 2025 the sex ratio in the region will be roughly 82 men for every 100 women aged 60 and above. Among the oldest old, the majority will be women living without a partner or spouse. In the 80 and above cohort, the sex ratio in Latin America

and the Caribbean is currently about 66 men per 100 women. And to the extent that older women are less likely to have participated in the labour force, their access to income of various sorts is severely reduced with a high proportion of them living near or below the poverty line.

In Latin America and the Caribbean, daughters are still expected to become the caregivers of older parents. Older persons are generally respected and valued and are expected to live with the support of their descendants. Those traditional values have changed during the last decade because of migration, urbanization and the rising cost of living, among other reasons. However, sufficient evidence is lacking to determine exactly how the role of family caregiving has changed.

3. Ethnic composition

The region has a complex ethnic composition. The total indigenous population is estimated at 45 to 50 million, of which 90 per cent is concentrated in Central America and the Andean subregion. The countries with the highest indigenous population are Bolivia, Ecuador, Guatemala and Peru, where it constitutes from 40 to 70 per cent of the total population (Pan American Health Organization [PAHO], 2002a, p. 101). The indigenous population is characterized by a high level of heterogeneity across linguistic, religious and regional boundaries; however a common denominator among all groups is poverty. Life expectancy at birth and at age 60 is lower than for other sub-groups; distribution of resources and services are generally inequitable with the rest of the population and the role of older people within the community is changing as younger people migrate and move to the city. Therefore those countries will need to target their indigenous older persons who, owing to language, culture and health behaviour, are likely to remain outside mainstream services and require programmes and other tailored forms of support.

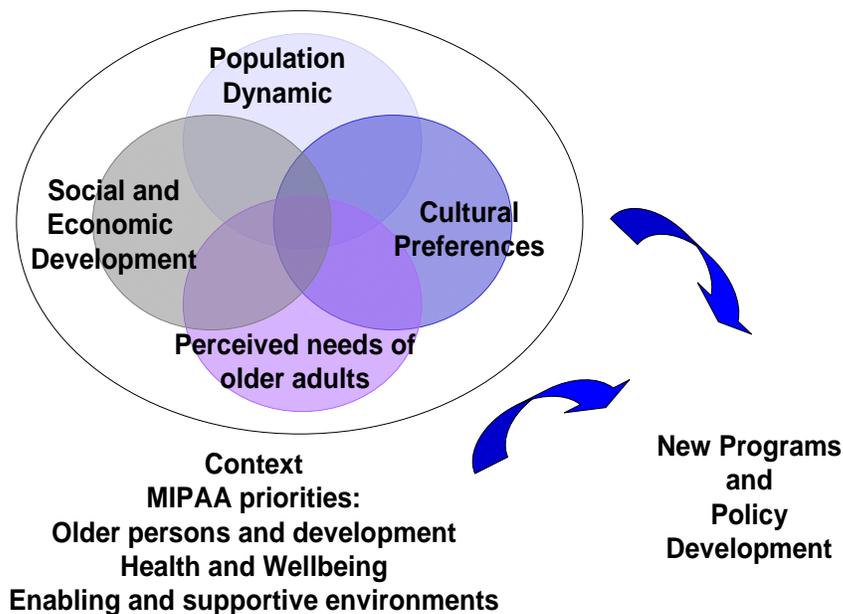
The total population of African descent is approximately one third of the region's total population, or 200 million. The countries with the largest population of African extraction are Brazil, Colombia, the Dominican Republic, English-speaking Caribbean countries, Haiti and Venezuela. They constitute the majority of the population only in English-speaking Caribbean countries and in Haiti; they are the largest minority in Brazil and Colombia. The role of ethnicity in health and in access to social goods is also a special consideration in those countries where the population of African descendants is a minority.

B. Ageing policy development: setting the stage

The development of policies and programmes that affect older persons is, generally speaking, guided by population dynamics, cultural preferences, perceived needs and economic resources. Figure V-1 illustrates the broad dynamics of those elements at work. Within each country the speed and magnitude of population ageing guide the movement towards change in policies and the development of new programmes, which in turn are largely shaped by cultural preferences, perceived needs and economic realities. The priorities of the Madrid Plan (United Nations, 2002a) provide the context for change: (a)

older persons and development; (b) health and well-being in old age; and (c) enabling and supportive environments.

Figure V-1. Factors affecting policy development and well-being of older persons



How ready are Latin American and Caribbean countries in preparing, adapting and implementing national policies to respond effectively to the needs and interests of older persons?

In November 2003, the Economic Commission for Latin America and the Caribbean (ECLAC) and the Inter-Agency Group on Ageing²⁵ held the first intergovernmental meeting on ageing in the region. The ECLAC Member States adopted the Regional Strategy for the Implementation in Latin America and the Caribbean of the Madrid International Plan of Action on Ageing (RSILAC), identifying three goals corresponding to the priority areas of the Madrid Plan and defining specific objectives for implementing each of those priority areas (ECLAC, 2004a). Individual countries agreed to establish, according to their particular circumstances, specific targets to be met under each of the objectives of the strategy, together with mechanisms for following up implementation of the policies and programmes, as illustrated in figure V-2. During 2004 and 2005 three intergovernmental, subregional meetings were held to discuss the national priorities.

²⁵ Comprising ECLAC, the United Nations Population Fund (UNFPA), PAHO, the International Labour Organization (ILO), the Inter-American Development Bank (IDB), the World Bank and the Programme on Ageing of the United Nations Department of Economic and Social Affairs (UN/DESA).

Figure V-2. Scheme of translating global ageing priorities into national targets



The processes for establishing national targets and determining mechanisms for the follow-up of policies and programmes have been extremely difficult. An important achievement is that every country in the ECA region has identified a focal point for the follow-up of the Madrid Plan. Only 8 of 20 countries in Latin America and 2 out of 22 countries in the Caribbean, however, have established multisectoral commissions with full responsibility for coordinating national action and the capacity to develop national targets in all three of the Madrid Plan priorities. No country has yet set up targets at this time. Baseline analysis and country-defined targets are, of course, essential in any meaningful evaluation of successful implementation.

Legislation and basic rights for older persons. Issues of the aged are not a high priority in most Latin American and Caribbean countries. Older persons are included within the broad category of vulnerable populations such as children, women and the disabled. Provisions for those vulnerable populations include State responsibility for their protection and welfare, with little if any guarantee of their right to a minimum, decent standard of living or specific guarantees for health-care services. Few countries include provisions of benefits for indigent older persons such as food and free health care; some include special discount programmes for persons 60 or 65 years of age or older.

A central theme of the Madrid Plan is the promotion and protection of all human rights and fundamental freedoms in a society where older persons can participate fully and without discrimination and on the basis of equality. Those rights are part of the international human rights protocols; older people could refer to the international instruments for protection of their rights. However, social and economic rights that are included in the basic human-rights declarations are defined by each country on the basis of its economic development. Therefore the specific rights must be understood as they are recognized in each country's legislation; that is, the protections that enable older persons to participate fully and without discrimination in society.

In a comparative study of legislation on behalf of older persons, in Latin American and Spanish-speaking Caribbean countries, only 10 countries (Brazil, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Paraguay, Puerto Rico, the Dominican Republic and Uruguay) have legislation that guarantees specific fundamental rights to older people. Two countries (Chile and Panama) have created a Government institution responsible for overseeing and coordinating services for older people. Bolivia, Colombia and Uruguay have laws establishing specific benefits or discounts for older persons (Villarreal, 2005; Morlachetti and Huenchuan, 2006). Among English-speaking Caribbean countries, Belize, Dominica and Jamaica have adopted a national policy on ageing. Other Caribbean countries have either started writing a policy or have a draft policy pending approval. Antigua and Barbuda, Bahamas, Barbados, the Netherlands Antilles, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago have

national councils on ageing that serve as advisory committees in drafting a national policy. Jamaica is the only Caribbean country with a National Council officer holding a Cabinet appointment.

In addition to specific legislation or policies on ageing, several countries have constitutions that include broad provisions giving the adult children full responsibility for providing their parents with food and care. For example, Article 220 of the Brazilian Constitution of 1988 states: “Parents have the duty to care, nourish and educate their young children; and the adult children have the duty to help and protect their parents in old age, in need or in illness.” In 2000, Puerto Rico passed Amendment No. 168 to legislation to “Improve the support of older people in Puerto Rico” in which the primary responsibility for food and support of older parents lies with their descendants. Such provisions are double-edged: on the one hand they confirm the cultural values of family solidarity, but on the other hand the State is able to replace social solidarity with family solidarity, leaving many families and older people in desperate situations and the State with minimal responsibility for older persons.

This section of the chapter reviews specific legislation on social security, health and supportive environments in institutional care, that fall within the three priority areas of the Madrid Plan.

1. Priority Direction 1: Older persons and development

Representing an important shift in paradigm, the first priority direction calls for social protection of older persons on the basis of human rights and recognizes older people’s right to participation in all dimensions of the social and economic life of a country.

The regional strategy calls for action in six areas: (1) incorporate the rights of older persons in policy, legislation and regulations; (2-3) promote access to decent employment and inclusion in the formal-economy workforce; (4) expand pension schemes; (5) strengthen the exercise of active citizenship; and (6) promote equality of opportunity for lifelong education. Both contributory and non-contributory pension schemes are considered essential in ensuring that older persons can access the benefits of development.

The biggest problems and challenges in social protection facing Latin America and Caribbean countries may be characterized as follows. One, they start from woefully inappropriate schemes. Approximately two of every three people in the region do not have access to basic, good-quality coverage for the most common social risks, such as illness or loss of income owing to old age, disability, unemployment or the death of the main provider. Thus it is very difficult, although not impossible, for countries to make significant changes in expanding access and improving quality of pensions. Two, the present schemes tend to perpetuate — or even exacerbate — inequality. Thus any meaningful reform will have to eliminate regressive financing mechanisms and develop an income source to subsidize a non-contributory safety net for the poor and near-poor who are unable to contribute to a pay-as-you-go scheme. Three, not only are more people surviving to old age, but more are living longer than at any other time in history. Those

who have lived most of their lives in poverty and with poor access to health care will tend to live longer with more disabilities and therefore be forced out of the informal or formal labour markets by premature frailty and disability.

(a) *Dimensions of the problem*

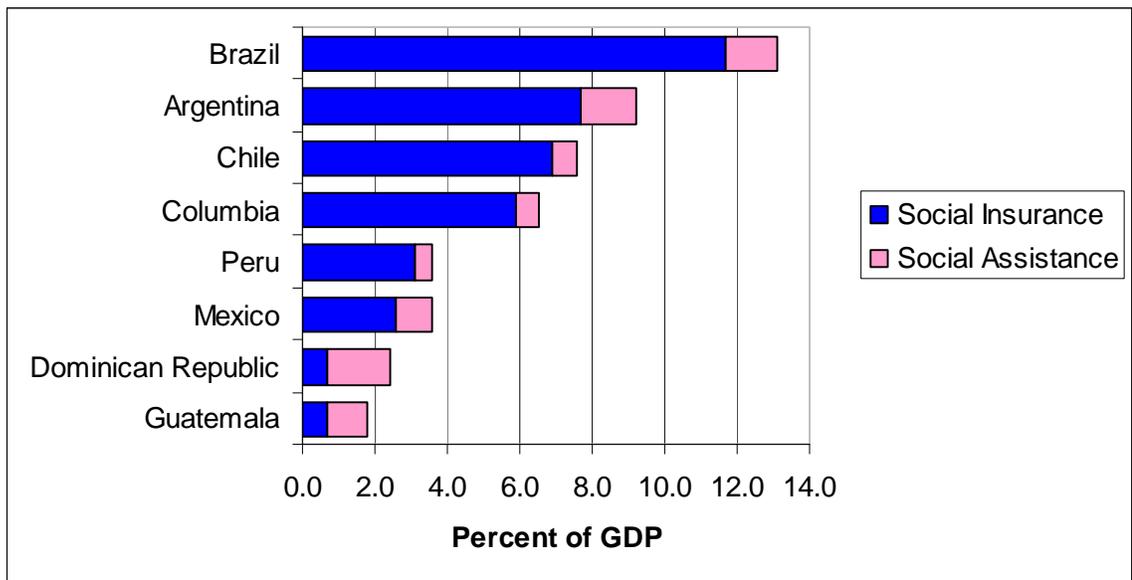
The regional survey on aging, health and well-being (SABE) is a key resource for reliable information on the issues of ageing under discussion here, taken from a sample of 11,000 persons in 7 cities of Latin America and the Caribbean (Albala and others, 2005). The SABE survey was coordinated by PAHO and conducted in each city by a team of university-based researchers. SABE reports that 62 per cent of older persons believe that their monthly income is insufficient to meet the basic needs of daily living.

A social protection plan for older persons should go beyond pension programmes; it should present a basket of integrated schemes and programmes designed and coordinated so that older persons receive a minimum, decent income that prevents them from falling deeper into poverty because of their age. Two formal approaches to income security are described below.

Social security: pension for old age, disability or death for those who have participated in a plan based on a pay-as-you-go scheme. Since 1981 most countries in Latin America have introduced both structural and non-structural economic reforms. Several studies by Mesa-Lago and Bertranou (1998) have developed typologies characterizing the different types of retirement and pension systems in Latin America. In Bolivia, Chile, the Dominican Republic, El Salvador and Mexico all contributions go to fully funded individual accounts. Colombia and Peru have a mixed scheme in which workers may choose to pay into individual accounts or the pay-as-you-go scheme. Argentina, Costa Rica and Uruguay have a complementary pension scheme in addition to the pay-as-you-go system.

In Latin America generally, many systems incorporate a significant public-sector role in tandem with the trend towards privatization of social security. Figure V-3 compares levels of public spending on social protection as a percentage of gross domestic product. Public spending will have to increase with demographic ageing in order to make up for the woefully inadequate coverage throughout the region that is currently available.

Figure V-3. Public spending on social protection in Latin America and the Caribbean, as a percentage of gross domestic product



Source: K. Lindert, E. Skoufias, J. Shapiro, The World Bank (2006)

What proportion of older persons benefits from the social security system? Table V-2 provides an overview of certain features of social security systems in terms of the stage of the population ageing process, level of coverage, type of pension system, and poverty rate of the population over 60 years of age. Countries of moderate-to-advanced ageing in Latin America, like Argentina, Brazil, Chile, Cuba and Uruguay, have the best pension coverage; while moderately ageing and incipient countries have the worst coverage, in some cases with only 1 out of every 10 older persons receiving a pension. The main message of table V-2 is to suggest that as the population grows older, higher priority in resource allocation is given to the economic security of older persons and new policies and programmes are implemented. Also, low coverage appears to be the norm; in countries where most of the work is performed in the informal economy, a contribution-based social security system always suffers from enormous disparities in coverage.

Table V-2. Social security in Latin America and the Caribbean

Stage of the population aging process	Country	Pension coverage among older persons (a)	Type of pension system	Poverty rate of over-60 population (b)
Advanced	Argentina	High	Mixed-integrated	0.48
	Chile	High	Mixed-private	7.89
	Cuba	High	Public	8.67
	Uruguay	High	Mixed	
Moderate to advanced	Brazil	High	Public	10.33
Moderate	Bolivia	Very low	Mixed-private	36.59 (d)
	Colombia	Low	Mixed-parallel	29.20 (d)
	Costa Rica	Medium	Mixed	30.38 (d)
	Ecuador	Low	Public	38.39 (d)
	El Salvador	Low	Mixed-private	30.35
	Mexico	Low	Mixed-private	30.50 (d)
	Panama	Medium	Public	21.71
	Peru	Low	Mixed-parallel	18.32
	Venezuela	Low	Public	20.85 (d)
Incipient	Guatemala	Low	Public	45.90 (c)
	Haiti	Very low	Public	24.27
	Honduras	Very low		18.25
	Nicaragua	Very low	Public	24.35
	Paraguay	Low	Public	38.09 (d)
	Dominican Rep.	Very low	Mixed-private	

Source: F. M. Bertranou, International Labour Organization (2005)

- (a) Coverage: High: over 50 per cent; medium: 30-50 per cent; low: 15-30 per cent; very low: less than 15 per cent.
- (b) The poverty rate in old age is defined as the proportion of the over 60 population whose per capita household income is equivalent to less than 50 per cent of the me median income. Source Gill and others (2005), pp.202 and 203.
- (c) Poverty rate for Guatemala is for 65+
- (d) Denotes that the poverty rate is higher in the over 60 population than in the population as a whole

Social Security systems in the Caribbean were established mostly after independence in the late 1960s and early 1970s (Paddison, 2006). The oldest was founded in Jamaica in 1966; the most recent were founded in 1987 in Saint Kitts and Nevis and in Saint Vincent and the Grenadines. All social security systems in the Caribbean are publicly managed pay-as-you-go schemes. About one third of all Caribbean older persons are receiving social security pensions.

Social assistance: financial and/or non-financial contributions to people based on age and on an income test. Non-contributory pension programmes and social assistance pensions have become the most important tools for meeting the basic needs of the region's growing older population. In the period 2001–2002, non-contributory pension programmes in Argentina, Brazil, Chile, Costa Rica and Uruguay, the five Latin American countries with the most advanced social security systems, had 8.8 million beneficiaries (Bertranou, 2005). The programmes use targeting and an income test in order to protect the most vulnerable members of the older population. A special case is that of Brazil's rural pension scheme and Bolivia's Bonosol programme.

Table V-3 presents an overview of various initiatives in the Caribbean to enhance coverage of pension schemes through non-contributory plans (Cuevas, 2006). The level of coverage and the amount provided varies greatly among countries; nonetheless, those schemes provide benefits for older persons who are not included in the traditional social security systems.

Table V-3. Non-contributory pension coverage provided by Caribbean governments

Anguilla	SS Act of 2001 provides non-contributory pensions for persons 68 and over.
Antigua and Barbuda	In 1994 a non-contributory pension scheme is provided to indigent older persons.
Aruba	Has adopted an officially regulated old-age pension designed to ensure a minimum income for older adults.
Bahamas	Has established non-contributory pensions for those excluded from the contributory scheme.
Barbados	Universal pension coverage for all elders through contributory and non-contributory pensions paid to all persons 65 and over.
British Virgin Islands	Universal basic pension to all older persons.
Grenada	Since 1995 has been able to double the number of persons receiving old age pension.
Guyana	Universal basic pension to all persons 65 and over.
St. Kitts and Nevis	Non-contributory pension scheme for indigent older adults. In 1997 introduced a compulsory contributory scheme for self-employed to ensure coverage for retirement.

Source: United Nations ECLAC (2005)

Across all countries, money from their adult children or other relatives is the main source of income for the majority of older persons. The informal intergenerational transfer occurs in the “roof-for-food” exchange that happens in cases of co-residence with their adult children or when they provide a home and care for the offspring of their adult children who have migrated to work elsewhere.

Another source of income is employment, the second most important source of support, especially for men 60 to 69 years of age.

A fundamental component of older persons’ quality of life is their economic security, defined in RSILAC as “the capacity to independently have and use an adequate quantity of economic resources on a sustained basis so that they can live with dignity and achieve quality of life in old age”. Currently, the economic security of older persons is insufficient and inequitable, especially for older women and the rural, indigenous and ethnic minorities.

All countries fail to acknowledge the complex nature of vulnerability in old age. Older women are outside the labour market after a lifetime of unpaid productivity. Older women who have dedicated a lifetime of caregiving for children, grandchildren, older parents and older spouses become vulnerable as older persons without a safety net against their own needs. Also, older persons with chronic health conditions and disabilities are severely limited in participating in the labour market and become vulnerable and poorer for lack of sufficient social assistance. Non-contributory pensions are recognized as helpful; but they tend, in most cases, to be too small or too restrictive to sustain older people and their families above the poverty line.

(b) *Key areas to be monitored*

What, during the next decade, could create or improve conditions of economic security, social participation and education that could satisfy older people’s basic needs and promote their full inclusion in society and development?

Any expansion of social security coverage put in place now will be subject to the pressures of a growing older population, increases in survival at older ages, and future changes in the age composition from disability and adverse health. Also, both the pay-as-you-go schemes and private capitalization mechanisms are designed to serve a population that participates in the formal labour force. They both omit the needs of informal and marginal workers who constitute the majority of the labour force in many countries.

The intra-family transfer system could continue to operate to some extent either via co-residence or through actual exchange of money and services; but as more people live longer and their care needs increase, the family will experience pressures and tensions that they are not prepared or able to cope with.

Measuring the economic well-being of older persons is complicated in the traditional cultural context. A high proportion of older people live with their children; their minimal income may be all that the entire family has to live on. The other complicating factor is

the difficulty of measuring the sufficiency of basic income in relation with expenditures for medical and personal care, rather than in relation with a national poverty level.

In order to integrate older persons as full partners in development; older people must be considered in all poverty eradication strategies in the region, not only in pension reform. Social assistance pensions need to be evaluated to ensure that they target the most vulnerable and that the coverage is sufficient to provide older persons with a basic minimum to support their needs. In implementing the activities of the Madrid Plan and RSILAC, the region should gain the requisite experience in evaluating the real economic well-being of the older population and become equipped with targets and programmes that can reduce poverty in old age.

2. Priority Direction 2: Health and well-being in old age

The second priority direction calls for access to health-care services adapted to the needs of older persons in order to maintain their quality of life and preserve their ability to function independently. RSILAC calls for action in six areas: (1) promotion of universal access for older persons to health-care services; (2) establishment of comprehensive health-care services that meet the needs of older persons; (3) promotion of healthy personal behaviours and environments; (4) creation of legal frameworks for the protection of the rights of older persons who use long-term care services; (5) implementation of a national gerontology and geriatrics training plan for existing and future health-care providers; and (6) collection of information on the health of older persons and setting of health targets and indicators to monitor their health.

(a) *Dimensions of the problem*

Each country has the primary institutional responsibility of promoting and protecting the health of the population. The ministry of public health is the basic institution that should interpret the health needs of a society, respond to them, and work to meet them in the most effective way possible (PAHO, 2002b, p. 63). At a minimum the public health institution in each country should be able to monitor, evaluate and analyze the health status of older persons. How well is the region responding to such responsibilities?

The ECLAC region does not have the first requirement in assessing the state of public health service delivery: a set of indicators for health surveillance of older persons that is accessible, population-based and appropriate for analyzing the performance of services for older persons. The minimum requirement for a database on trends of health and ageing would include the following types of indicators by sex and such age cohorts as 60–69, 70–79 and over 80 years.

Indicators of health and ageing for surveillance of health status of older persons

Self-reported health status	Other health problems
Chronic transmissible diseases	Falls
Tuberculosis	Nutrition
Malaria	Ocular health
Chronic non-transmissible diseases	Oral health
Risk factors	Functional status and disability
Hypertension	Physical performance
Diabetes	Performance with activities of daily living
Cardiovascular disease	Performance with instrumental activities of daily living
Stroke	
Arthritis	Access and utilization to appropriate health services
Cancer	
Memory loss	
Depression	

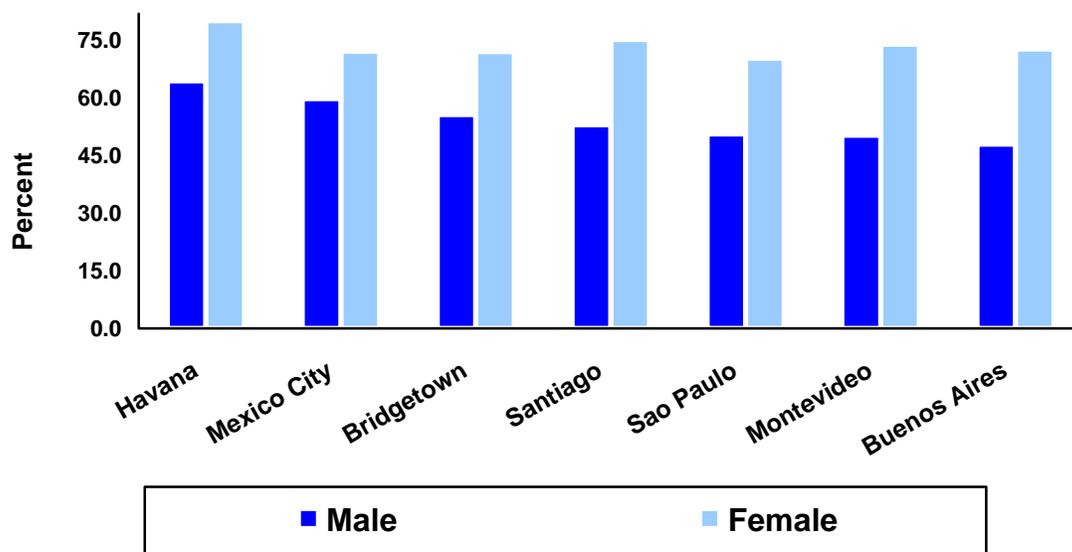
The information provided in the list of indicators would enable public health authorities to (1) establish a baseline on morbidity and disability for persons 60 years and older; (2) analyze tendencies and changes in the health and functional capacity of that population group by age cohorts; and (3) develop national goals or targets for improving the health of older persons.

Lacking morbidity and functional performance data from official registries in the region, the only source currently available is SABE, the cross-national survey on ageing and health. Almost half of older persons in urban settings in Latin America and the Caribbean reported, when asked about their health, that they had fair or poor health. That is a very high percentage of persons reporting not having good health, in comparison with self-reports in the United States and Canada, where only about 35 to 40 per cent of people 70 years or older claim to have fair or poor health.

The tragedy in Latin America and the Caribbean is that (a) most older people are unable to afford proper health care; (b) doctors and nurses are not trained to deal with their unique problems; and (c) older people are stereotyped as a “burden” by the people who are meant to be the providers of health care.

Figure V-4 reports the prevalence rates among older persons of one or more of three potentially disabling conditions (arthritis, incontinence, vision problems). The three were selected because they would generally be readily apparent to an older individual for their characteristic symptoms, so they would likely not be underreported by those with limited access to a knowledgeable health-care provider. The data show that women in all countries have a higher prevalence of disabling conditions than do men. At least three quarters of women in all cities for which data are available report suffering from one of those conditions.

Figure V-4. Proportion of persons aged 60 and above, by sex, in major Latin American and Caribbean cities who report one or more potentially disabling conditions, in percentages



Source: SABE 2000 – Pan American Health Organization (2005)

Vision impairment in old age leads to functional decline as well as to falls, hip fractures and depression. But the out-of-pocket cost of ophthalmology visits, eyeglasses, eye treatments and surgery are beyond what the majority of older persons can afford. The SABE survey reports that 35 per cent of older persons had difficulty seeing with or without lenses. Chronic pain from arthritis and isolation because of urinary incontinence lead to decline in physical activity and productivity which in turn could lead to further decline in function and the immune system. The failure to diagnose and treat such conditions is unnecessary. Even such a basic health problem as malnutrition is widespread, partly because many older people are too poor to feed themselves properly, partly because of depression or because they are unable to prepare their food and have no one to do it for them.

Diseases associated with old age are in some cases preventable, can almost always be delayed, and are most certainly treatable. Of the physical decline that occurs with ageing, 70 per cent has been found to be related to modifiable risk factors and failure to use preventive and screening services (Taylor, 2002).

The science and technology for preventing, delaying or treating chronic conditions and diseases of older persons are available. Also available is the evidence for public health interventions to improve the health conditions of older populations. In general, the possibilities for good health in late life have become much brighter in recent years for those who have access to trained health-care providers and the appropriate medications and technology to treat potentially disabling conditions. Lack of access to appropriate care translates into increasing years of disability.

Global access to public health services. Generally, universal coverage can be extended through one or a combination of the following: (1) universal access to a public health-care system or a publicly financed health system; (2) health coverage for beneficiaries of the social security system; and (3) private insurance schemes.

Most Latin American and Caribbean countries have been implementing health sector reforms. Colombia and Chile, among others, have set up a solidarity fund to offer public coverage to those unable to be covered by an employer or retirement programme. Jamaica has set up medication pools to provide a defined package of free medications to older persons suffering from chronic diseases. However, the vast majority of older persons receive health services from publicly financed and/or publicly owned clinics and hospitals. For the most part they have access to general programmes, run by health-care providers with little or no training in geriatrics, with little or no coordination with social services and with no clear targets for interventions.

The SABE survey found that 78 per cent of older persons were able to visit a doctor in the 12 months prior to the survey any time they needed one. However, they lacked access to (a) eye care: over 35 per cent had problems seeing with or without glasses; and (b) dental care: approximately 65 per cent had fewer than half of their teeth and of those without teeth, 35 per cent had no prosthesis. Over 69 per cent had no flu vaccine. Over 70 per cent of older women had not received a mammogram during the two preceding years. Over 90 per cent had to make some co-payment or had to pay in full for their medications. With two thirds of older persons not having enough money to cover daily expenses, clearly most of them cannot meet their medical needs without support from their children and relatives. Adherence to any chronic-care therapeutic regime is thus compromised by lack of access to affordable medications.

Table V-4 summarizes legislation and programmes providing some guarantees to health care for older persons in Latin America and the Caribbean. Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Puerto Rico, Uruguay and Venezuela appear to have better coverage in access to medical care, some medications and some diagnostic procedures appropriate for the health conditions of older persons.

Table V-4. Legislation and Programs guaranteeing access to health care for older persons in Latin America and Spanish Speaking Caribbean

Argentina	<ol style="list-style-type: none"> 1. Universal access to limited public health services available to the population 2. Various social security health schemes covering 77% of older population 3. Specific health services guarantees for persons 70+ receiving social non-contributory pensions
Brazil	<ol style="list-style-type: none"> 1. Universal access to health care through a uniform health system 2. Older Adult Legislation (Estatuto do Idoso) provides explicit guarantees to universal access to health services and medications
Bolivia	Legislation No. 1866 (1998) establishes the Universal Free Medical Insurance for all older adults. However funding has never been available for the implementation of the law.
Chile	<ol style="list-style-type: none"> 1. Universal guarantee to health care for 16 health problems common in older persons through the national program AUGE. 2. Access to health care guaranteed by FONASA for older adults with freedom of choice in selection of provider 3. Private insurance provided by ISAPRES to those who can afford it
Colombia	Universal access to older adults guaranteed by Legislation 100 (1993) (Social Security legislation) Private/public mix system with freedom of choice in selection of provider.
Costa Rica	<ol style="list-style-type: none"> 1. Universal access to public health services available to the population 2. Legislation 7935 with Regulation No. 30438 defines the rights of older people including to health services adapted to their needs.
Cuba	Universal access to health services available to the population
Ecuador	<ol style="list-style-type: none"> 1. Universal access to limited health services available to the population 2. The Ecuadorian Social Security and other Social Security schemes serving the military and police
El Salvador	<ol style="list-style-type: none"> 1. Universal access to limited health services available to the population 2. Legislation No.717 (2002) with Regulation No. 78 defines the rights of older people to health services 3. The Salvadoran Institute of Social Security provides health care for beneficiaries 60 years old and older
Guatemala	<ol style="list-style-type: none"> 1. The Guatemala Institute of Social Security provides centralized health care in the Social Security hospitals 2. Access to public hospitals for the population at large
Honduras	<ol style="list-style-type: none"> 1. Honduran Institute of Social Security provides access to health care services to beneficiaries 2. INPREMA, Social Security Institute for Teachers, provides access to health care to over 11,000 retired teachers
Mexico	<ol style="list-style-type: none"> 1. Universal access to limited health services available to the population 2. Mexican Institute of Social Security (IMSS) guarantees health services to beneficiaries as well as to older parents of eligible beneficiaries 3. Mexican Institute of Retired Government Employees (ISTEE) guarantees health services to beneficiaries 4. Mexican Institute of Petroleum (PEMEX) guarantees health care to beneficiaries
Nicaragua	Legislation 423 includes older adults in the category of vulnerable populations for access to health care services available in the public health system
Panama	1. Social Security Institute of Panama guarantees access to beneficiaries
Paraguay	Universal access to limited health services available to the population
Peru	<ol style="list-style-type: none"> 1. Universal access to limited public health services available to the population 2. Peruvian Institute of Social Security (ESSALUD) guarantees access to beneficiaries
Puerto Rico	<ol style="list-style-type: none"> 1. Health insurance (Medicare) for everyone receiving social security income 2. Free health insurance (Medicaid) for all older people with income below the poverty line
Dominican Rep	<ol style="list-style-type: none"> 1. Universal access to limited public health services available to the population 2. Dominican Institute of Social Security (IDSS) guarantees access to beneficiaries
Uruguay	<ol style="list-style-type: none"> 1. Universal access to limited public health services available to the population 2. Various social security health schemes (Mutualistas) covering the majority of older population
Venezuela	Universal access to health services available to the population

Source: Unpublished reports from Country Reports and literature review done by ECLAC

In English-speaking Caribbean countries, the public health system provides universal coverage for the population. Private service providers are available to those who are dissatisfied with the public system and are able to afford the private fees. Some countries in the Caribbean have set up programmes for training health-care workers and dispensing chronic-care medications free of charge. However, the poor quality of health-care systems in all countries in the region, and the limited access to overburdened hospitals in general, makes access to comprehensive health-care services that are suited to older persons a significant challenge.

Access to services designed to meet the health needs of older persons. Historically, public health clinics used to be maternal and child health centres; now they are responsible for the health care of most older persons in Latin America and the Caribbean. Two of every three older persons lack any health insurance and therefore rely on public health clinics for their care; those clinics have failed to foresee the dramatic changes occurring from population ageing and are unable to provide appropriate care for their older clientele. Drastic changes are necessary to reorient public health functions to include an ageing dimension and to reform primary health care in the region in order to accommodate the new clients: people 60 years of age and above. Life expectancy at 60 in the region is approximately 20 years. The challenge for public health is not only to prevent premature death, but also to increase the years a person can live free of disability.

The adequacy of existing programmes for meeting the needs of the older population is a critical issue. Older persons overwhelmingly receive health care from a primary health-care provider. In the SABE survey, over 80 per cent of the population had seen a primary health-care doctor when they were ill during the previous six months. Therefore the main problem seems not to be access to a health centre, but the quality of care received from health professionals. Research has shown that during the last decade, 60 per cent of mortality in older persons can be attributed to the poor quality of health services and to the poor quality of medical care.

For instance, a favourite assumption in public health is that in order to prove the cost-effectiveness of health promotion, young adults must be targeted in all health promotion activities. Actually, older people have more to gain than younger people by engaging in physical activity because they are at higher risk of developing problems that regular physical activity can prevent. No national health-promotion plan in the region, except in Chile, has been identified that sets targets for improving the health of older persons through proper nutrition, exercise, smoking cessation and counselling for healthy behaviour.

Another essential function of public health is human resources development and training. Most health-care professionals have little experience in treating older people. Doctors often rely on treatment rather than prevention, and many physicians mistakenly believe that chronic disease, pain and disability are inevitable in old age. Moreover, most countries lack specific, up-to-date and patient-centred guidelines and training for management of chronic conditions and care of geriatric patients. That is an important

barrier to good-quality health care for older persons and a major failure of the public health system.

A good indicator of quality of care is the number of physicians providing care to older persons who are trained in the medicine of ageing: geriatrics. Only 14 per cent of medical schools in Latin America and the Caribbean have geriatric programmes. Less than 2 per cent of baccalaureate nursing programmes have full-time faculty trained in geriatric nursing. A mandatory geriatrics rotation in all medical schools would be a wise practice to prepare the future workforce. The continuing education of practicing health-care workers is another intervention that should be reinforced.

A review of national policies on ageing reveals that the issue of training of human resources for the care of older persons is actively considered in the majority of such policies. More difficult to find, however, is any human resource plan with funding to bring health-care professionals up-to-date in the care of older persons. In addition, the continuing education of health professionals will not succeed in changing the behaviour of doctors and nurses unless the approach is comprehensive and not simply limited to delivering lectures or printing manuals or pamphlets on caring for older patients. An integrated approach to changing practice should include a variety of tools that are designed to enable and support physicians and nurses in adapting their practice to the needs of older persons.

(b) *Key areas to be monitored*

Priority areas to be monitored within-country and regionally are:

- Appropriate resources and budgets for the promotion of healthy lifestyles for older persons
- Health promotion plans with measurable targets for older persons and committed budgets to promote evidence-based health promotion and protection programmes
- Access by older persons to necessary and appropriate health services for their health needs
- Definition by Governments of the basic basket of services needed to promote and care for the health of older persons
- National, regional and local health programmes for older persons with a budget designed to support the implementation and monitoring of the basic basket of services
- Definition of quality indicators to measure outcomes of services for older persons

To ensure that all working health-care professionals develop the necessary knowledge and techniques to address the complexity of delivering care to the older population, countries must support and monitor:

- Numbers of medical and nursing schools that include knowledge of geriatrics in their

basic curricula

- Numbers of professionals who have participated in lifelong training in medicine and health care of older people

3. Priority Direction 3: Enabling and supportive environments

The third priority direction calls for the creation of physical, social and cultural environments that are conducive to the exercise of rights and duties during old age.

The physical environment as well as the social, political, economic and cultural settings can either facilitate or impede realization of a satisfactory quality of life by older persons. The priority concerns action in four areas: (1) adaptation of the physical environment; (2) strengthening of social support systems; (3) elimination of discrimination and mistreatment; and (4) promotion of a positive image of old age.

Residential arrangements. Historically, homes for the aged were created as shelters for indigent persons without family support. Homes for the aged became the orphanages at the far end of life. Due to increasing longevity, such institutions are changing and offering shelter and care for frail older persons who are unable to live by themselves and have no available family member to provide assistance with daily living. Nine out of ten of them are for-profit, targeting all income levels. They can be found in all sizes and in all types of neighbourhoods; with few exceptions, they are administered by untrained personnel. They are often not officially registered or monitored.

Older people view the move to a home for the aged with fear, as though going to the “waiting room of death” with no family and no recognition of personal identity or personal history. It is a form of depersonalization or stripping of a lifelong accumulation of personal history and values, in order to face the final exit. Families who are unable to care for their older parents interpret the placement of a family member in an institution as “abandonment”, in many cases doing so with guilt and regret but with perhaps no other option.

(a) *Dimensions of the problem*

The public tends to consider all residential facilities for the old under the term “homes for the aged”. A distinction must be made between (1) the few geriatric hospitals or homes run by federal, state or municipal Governments; (2) homes sponsored by religious or philanthropic organizations, which are non-profit and voluntary; (3) private micro-enterprises targeting middle and low-middle class families; and (4) other for-profit institutions for those who are able to pay for professional care. Estimating how many such institutions exist and how many people live in each type of institution is an impossible task because of the extent of “unofficial” or clandestine operations in all countries.

The prevalence of institutionalization among the over-60 population is relatively small. It varies with countries but probably amounts to 1 to 2 per cent of the total. However, the proportion of persons aged 70 years and older who are cared for in group homes or

institutions is unknown. In the SABE survey, 1 of every 4 persons 70 years old and above reported having difficulty with at least one activity of daily living. The real question is, therefore, how many of the almost 10 million people who are 70 or more years old in Latin America and the Caribbean are being, or will be, taken care of in group homes or facilities run by untrained personnel? Since the proportion of the oldest old will be growing at a faster rate than any other population cohort, understanding the reality of care options for that cohort is essential in public policymaking.

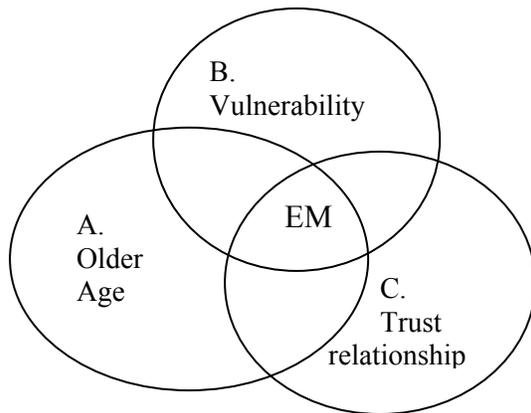
A review of legislation in the region shows that at least 80 per cent of the countries have some form of legislation or policy that protects the rights of older persons, including training and/or monitoring of abuse and neglect in institutions. However, there has been very little experience with effective legislation or regulation for quality of care in such businesses. There has definitely been no experience or resources available to conduct regular monitoring of the care provided in them. The mere existence of legislation or rules is not sufficient to guarantee supportive environments free of abuse and neglect in long-term care facilities.

In addition, no Government office responsible for enforcing legislation and rules for those establishments has sufficient trained personnel to provide realistic surveillance. Inspections are conducted without appropriate criteria for basic quality of care and by personnel not trained in the care of older persons. Moreover, the non-registered homes fall outside the radar screen of any regulatory personnel. The shocking reality is that guest houses and hotels are better monitored than homes for long-term care of older persons.

A few countries are beginning to keep registries of licensed homes for the aged and to monitor them with minimum standards of care. Argentina, Chile and Uruguay have completed representative surveys of homes for the elderly with support from Inter-American Development Bank (IDB) and technical cooperation from PAHO. The results will provide an excellent profile of the situation of older persons in institutions as well as insights into the physical, social and cultural environments of residences for older persons from different socio-economic levels.

In every country some facilities are well organized and run by competent and caring individuals, but the majority can accurately be described as “storage places for people waiting to die”. An understanding of the extent of elder abuse and mistreatment in long-term care institutions may begin with an illustration of the essence of the problem in figure V-5 (Bonnie and Wallace, 2003).

Figure V-5. The essence of elder mistreatment



The essential components of elder mistreatment (EM) are intentional acts or failure to provide care to an older person (A), who is unable to care or protect him- or herself (B), by a person in a relationship of trust, or caregiver (C). The result of such acts is injury or unmet basic needs.

At the centre of concern is the trust relationship. Three areas of action in particular involve trust and the dependency of the vulnerable person, where failure to provide adequate and basic services to vulnerable elders can lead to significant abuse or neglect. Such failures are endemic to long-term care institutions. The three areas are: (1) administration of medications; (2) use of physical restraints; and (3) lack of physical, mental, social or recreational and spiritual activities.

Administration of medications. Older persons in long-term care settings usually suffer from multiple chronic conditions and illnesses. They depend on a variety of medications that need to be kept in safe storage and administered according to physicians' orders; yet the caregivers in many cases are hardly able to read or write, poorly trained and in most cases not supervised. Although family members are often responsible for purchasing the medications, the institution should be able to provide for the safe handling of medications and the coordination with family and health-care provider to avoid medication abuse.

Use of physical restraints. The unnecessary use of restraints is a violation of human rights. The problem lies in clear definition of what is a necessary restraint, for whom it is necessary and who is qualified to determine its necessity. Restraints are commonly misused (a) to substitute for lack of sufficient personnel to provide care; or (b) because there is no safe environment for free ambulation of residents; or (c) to replace properly therapeutic interventions. No regional study is available that shows the extent of the problem. However, a study on social exclusion of persons with physical and mental disabilities who are institutionalized in Latin America and the Caribbean has been supported by the IDB in Argentina, Chile and Uruguay. Up to 73 per cent of the surveyed facilities report that the reason for restraining residents was to protect them from falls. Evidence in the United States and Canada has shown that the risk of falling in institutions

has been greatly reduced by prohibiting physical restraint of residents, except in rare cases where it is allowed for a circumscribed period of time.

Lack of physical, mental, social or recreational and spiritual activities. To promote active ageing, the following would be necessary components of caregiving: providing opportunities to be physically or mentally active; encouraging and assisting older persons to have social contacts with family and/or others such as community volunteers; and providing recreational activity and spiritual support.

On the other hand, the following actions or omissions would constitute mistreatment of older persons in institutional settings: not doing range-of-motion exercises; not providing strength-building exercises; not offering social activities or spiritual support; not training staff how to maximize the autonomy of residents; not keeping residents hydrated and well nourished; restricting visiting hours; and restricting the participation of residents in community events.

(b) *Key areas to be monitored*

Vulnerable older persons receiving long-term care services in group homes or institutions are at risk of abuse and neglect. Their rights are periodically violated and the State has a responsibility to protect them.

In order to assess progress in implementing the priority direction of “creating an enabling and supportive environment” in each country, assessment must be made of the capacity to enforce regulatory measures that protect the rights and dignity of persons with disabilities.

Within the next five years, there should be an accurate evaluation of the countries that have regulatory frameworks, and how many of those regulations address specific issues related to the quality of basic care needed by the population being served. In addition, older people and their families should know the range of options available to support caregiving.

A survey of mistreatment in homes for the elderly may be needed in order to create sufficient public awareness of the problem and strong advocacy for change in the design and development of a continuum of community-level, long-term care services.

C. Regional cooperation in response to the challenges and opportunities of ageing

The ECLAC offices in Santiago de Chile and in Trinidad and Tobago, with support from UNFPA, are coordinating the follow-up of the Madrid Plan and RSILAC in Latin America and the Caribbean, working closely with Member States in drafting a system of indicators to serve as a frame of reference for follow-up and evaluation of the situation of older persons at national and regional levels.

PAHO is providing technical assistance to the Member States in assessing how well the essential public health functions have included the health needs of older persons.

The intergovernmental Latin American network of technical cooperation with Spain, RIICOTEC, has collaborated in developing indicators for use in the follow-up of the Madrid Plan.²⁶

The Caribbean Symposium on Population Ageing, the first such meeting at the subregional level, was held in Port of Spain in November 2004. It provided Caribbean Governments, civil society and academia with an overview of existing policies and programmes. The main purpose of the meeting was to facilitate efforts by Governments and other stakeholders to translate frameworks on ageing at the national level into policies and programmes (ECLAC, 2004b, 2005).

Significant amounts of technical and financial resources are still needed, but not available, to assist countries in the definition of realistic and sustainable targets in each of the following priority areas:

- Extending social protection through poverty eradication strategies and non-contributory social assistance
- Providing a guaranteed, basic package of health services designed with evidence-based research to prevent, delay when possible, and treat disabling conditions associated with old age
- Guaranteeing an abuse- and neglect-free environment for older persons in need of long-term care services because of their frailty, disability or terminal illness

ECLAC Member States are supposed to promote the actions necessary for the development and implementation of national targets and establish mechanisms for follow-up, evaluation and review. However, they lack potentially their best ally in that endeavour: an active movement of older people who understand their power to produce change.

Being old is considered too often to be a synonym for resignation and powerlessness. Many older people resist identifying with others of their own age group because of ageing stereotypes. Well-organized groups of older people, those belonging to trade unions and receiving pensions from social security, tend to demand benefits for their group rather than social changes for the improvement of the conditions of all older people, present and future.

As a result of the implementation of the Madrid Plan and RSILAC, attitudes and political actions of older persons will hopefully soon be seen in Latin America and the Caribbean. The most important outcome of the Madrid Plan should be the unleashing of an older people's "liberation movement" that is concerned about establishing a society for all ages and sophisticated enough to aim at producing change by participating in the political process.

²⁶ For further information please refer to: <http://www.seg-social.es/imserso/internacional/i0_ibered.html>.

VI. Ageing Trends and Policies in the European Region

Bernd Marin and Asghar Zaidi²⁷

A. Demographic trends and coping capacity

The United Nations region under the auspices of the Economic Commission for Europe (ECE) is undoubtedly the most diversified and heterogeneous of all. The ECE currently includes 56 member countries on three continents — Europe, North America and Asia — and a population that is projected to grow almost to 1.19 billion people by 2025. The region comprises a great range of political and socio-economic contexts as well as population trends and coping capacities in implementing policies that are designed to address the challenges of demographic ageing.

The critical questions concern the specifics of demographic transition in the ECE region, their pace and social impact. Rapid ageing takes place everywhere on the globe, in developed and developing countries alike, notwithstanding the popular conception that rich countries started to age after having become rich, while poor countries will age before they become rich. The ECE region presents both scenarios, since it comprises the very rich countries of North-Western Europe and North America as well as the poorer South-Eastern European, Central Asian and Caucasian countries. The extent and nature of the challenge is such that even countries among the richest nations are seemingly unable to build sufficient capacity and political will to cope with the most acute ageing challenges, despite having known about those demographic challenges for decades and, for the most part, having the resources, including the knowledge and tools, available to solve them. Alarming, the absence of mainstreamed ageing policy and sustainable old-age security systems, as well as health care and long-term care for the elderly, have become serious concerns, as many countries have as yet to come up with a clear and convincing perspective on possible solutions. That is a quite remarkable state for a region whose core continent claims a special “European Social Model” as a major element of its collective identity.

Demographic measures such as life expectancy at birth and at later ages, disability-free life expectancy and mortality rates, reflect demographic differences within the region with a low to non-existent tendency to converge, and sometimes even a growing divergence — the latter especially with respect to differences in number of deaths from traffic accidents and violence (Chesnais, 2003). For instance, the relationship between already achieved levels of life expectancy and additional gains in life expectancy turned around from negative to positive, thus shifting from convergence during the 1960s to growing divergence in the 1990s and into the new century. Although the post-1989 rise in death rates in many but not all “transition” countries may have been temporary, the gap between some Central and Eastern European countries and neighbouring ones was significantly increased and does not seem likely to close again in the foreseeable future.

²⁷ Bernd Marin is Executive Director and Asghar Zaidi is Director of Research at the European Centre for Social Welfare Policy and Research, Vienna. The authors are grateful to Manfred Huber, Kai Leichsenring, Alexandre Sidorenko, Willem Stamatou and Sergei Zelenev for valuable contributions, comments and editorial support.

Baltic people, for instance, gained up to 6.8 years of additional lifetime during the last decade only, whereas life expectancy is decreasing for men in Belarus and Ukraine, and the Russian Federation remains 20 years behind Sweden and Switzerland.

Within the region, population is declining in countries such as Bulgaria, Hungary, Poland, Romania, the Russian Federation and Ukraine, while increasing in others, such as in rapidly growing Turkey, as well as in Albania, Ireland, Israel, Tajikistan, and Uzbekistan. More general and persistent population growth takes place in North America — the United States and Canada — where immigration levels are perpetually high and the population significantly younger than in Europe (2.6 years lower than the median age in Europe and 6.6 years lower than in Japan) and fertility rates are higher as well. The populations of all Eastern European and former Soviet countries grew over the past 50 years, but a good majority of them will shrink between 2000 and 2025. The population of that subregion (not including Turkey) is projected to decline by about 23.5 million. The largest decline (in millions) will be observed in the Russian Federation (17.3), followed by Ukraine (11.8). In contrast, during the same period, the Central Asian republics will experience gains in population (in millions): most notably Uzbekistan, at 9.3; followed by Tajikistan, 2.6; Turkmenistan, 1.6; and Azerbaijan, 1.5 (World Bank, 2007).

Thus population development within the region is highly diverse, with first natural and later overall decline in some but not all countries, more so than in expanding North America. The imbalances highlight the potential of a higher internal and external immigration within neighbouring countries and surrounding regions, which must be managed so that the challenges of shrinking population are not aggravated in some of those countries. The population growth in North America is parallel to that of neighbouring Mexico and countries in South America, representing a stark contrast to population decline in Southern Europe vis-à-vis the population multiplication in neighbouring Northern Africa. Similarly, population growth in the Central Asian republics and Turkey brings the population size in those countries closer than ever to that of the Russian Federation and Ukraine, which face a sharp decline.

There clearly is a demographic marginalization in a global context, but even more so of Europe itself than of the ECE region. The ECE region is shrinking from 34 per cent of the world's population in 1950 to an expected 17 per cent in 2050. The continent of Europe's share of the global population has been shrinking from 22 per cent in 1950 to the current 12 per cent, to a projected 7 per cent in 2050. In 2000, for the first time in history, Europe's 25 closest neighbours from Northern Africa to western Central Asia, whose total population was less than half the population size of Europe in 1950, reversed that trend. By 2050, their population is expected to reach 1.26 billion (2.4 billion including Africa), or three times the population of the 25 countries of the European Union (EU-25),²⁸ thus changing the demographic relationship between EU-25 and its 25 closest neighbours from 1:6 to 1:12 within one century.

²⁸ The EU counted 25 Member States as at its enlargement of 2004. Two more countries joined the EU in 2007, making the updated acronym "EU-27".

Uneven population growth between Europe and its southern neighbours can be illustrated vividly with many examples. The Egyptian Nobel Laureate Najib Machfus was born in 1911, when the size of the Cairo population was one third that of Vienna; when he died in 2006, Cairo numbered 15 million people, 10 times more than Vienna. Egypt, until the 1990s smaller than Italy, will soon be bigger than the most populous European country (Turkey, which will overtake Germany in the near future). Cairo alone will have more inhabitants than Beijing, or more than Paris, London and Berlin combined. Pakistan, which was smaller than the United Kingdom until the 1960s, may reach the population size of the United States within one or two generations. And nobody will remember Belgium as having the same number of people as the Philippines (which currently has 85 million inhabitants, but soon will have 128 million), Iraq being smaller than Denmark, or Saudi Arabia smaller than Ireland. Uganda, in 1950 having the same population size as Switzerland, by 2050 will have more inhabitants than the Russian Federation (Coleman, 2007). Clearly, in terms of sheer population size, Europe is rapidly losing out in comparison with the rest of the world.

The low fertility experienced over the last decade in the ECE region has changed the proportions so that currently 83 per cent of all newborn children are born in Africa and Asia and only 8 per cent in North America, Europe and Oceania (outside the ECE region). Whether and how fast the European or Western pattern of fertility restrictions will diffuse around the globe will be most important. Whereas the one-to-two-child family has appeared in Bangladesh, China, and southern India, as well as in Brazil, Columbia and other Latin American countries, and even Muslim countries such as Algeria, Tunisia and Iran (having the same birth rate as the United States), that has not (yet) been the case in many parts of neighbouring Africa, Asia and the Middle East, including Israel (as a country within the ECE region). But the level of fertility decline, which took 200 years in Europe, may be speeded up to only 20 years in the neighbouring developing countries. While the fertility rate in the Maghreb²⁹ in 1960 was that of Europe around 1750, the Maghreb in 1995 corresponded to Europe from 1900 to 1950; and only a decade later, in 2005, several Maghreb countries had the same birth rates as France.

Transformation of the “second demographic transition” (characterized by an increase in cohabitation rather than marriage, and by single parenthood and childbearing outside of marriage) to a more universal and irreversible trend in itself does not empirically result in low birth rates, as the concerned countries themselves are highly heterogeneous. China, currently having fertility rates close to the lowest-lows in Europe, shows nevertheless that for several decades a population “overhang growth” of more than all European inhabitants since the times of Mao Tse Tung is compatible with a one-child policy and low fertility, leading to accelerated ageing from 2015 onwards. In comparison with population growth in the United States, low fertility in many European countries, such as the Czech Republic, Germany and Italy, has become so drastic that they could totally disappear by around 2250 without massive immigration and turn-around in birth rates (cf. Chesnais and Chastelande, 2002). After a continuous decline in fertility, the Russian Federation as well as many countries of the former Soviet Union (in particular Ukraine

²⁹ The Arab Maghreb Union consists of the Northern African countries of Morocco, Algeria, Tunisia, Libya and Mauritania.

and Georgia) and the western Balkans (in particular Croatia) will also be facing shrinking populations. Their challenges to mitigate the consequences for economic growth and public expenditures are much greater as they are still going through reforms to develop their political systems and institutions.

Neither higher immigration rates, nor return to higher birth rates, present themselves as a solution to challenges of population ageing faced by Europe. The shrinking population and its consequences require a package of policy reforms covering adjustments in labour and capital markets, health and education sectors, migration and social security systems, or else the region runs the risk of becoming demographically unsustainable. Replacement migration alone cannot be expected to offer a panacea to prevent population ageing or to mitigate negative consequences on economic growth and public expenditures associated with population ageing. As shown by the United Nations Development Programme (UNDP, 2001), an implausible and socially unacceptable — and unmanageable — level of immigration would be required. It is well understood that immigration is easy to start but hard to stop and most difficult to manage in its daily routines.

According to World Bank calculations (Holzmann and Palmer, 2006), the net immigration “required” to keep labour force levels for EU-27 constant till 2050 (at currently rather low levels in Europe compared to North America) would have to be about twice as high as today. Correspondingly, the gross immigration, including non-active migrants, dependent children and elderly, as well as returning and circulating migrants, would have to be about between 4.5 and 9.5 times, respectively, higher than projected by the European Commission (EC; formally known as the Commission of the European Communities) for the decades to come — between 3.7 and 7.5 million per year as against 850,000 projected and 1.3 million currently — and far above the all-time high in 1992 of 2.7 million gross immigration. According to model calculations, the economic benefits of an immigration rate of 1.3 million people annually correspond to an increase of only 7 per cent in the labour force participation rate (EC, 2006a). An alternative view is that adopted by the World Bank (2007) in which migration within the region (from younger to ageing societies) could ease some of the pressure of the shrinking population, although that might not be possible politically and proper management of such migration would be essential.

At least four core problems appear to be related to the immigration issues in the ECE region.

1. Predominance of non-discretionary immigration; that is, migratory flows over which the receiving country has no or very little control, such as asylum seeking or family reunification as against labour migration
2. High stocks (several million both in the United States and Europe) and flows (several hundred thousand both in the United States and Europe annually) of illegal migrants, who make no formal contribution towards the development of the economic system
3. Failure of social integration of immigrants, especially in Europe, with social

consequences

4. A conspicuous gap between immigration realities and self-conception as well as the prevailing mentality of European countries as constituting a supposedly “non-immigration” continent, as opposed to the United States and Canada

In Europe and North America, most inbound migration (up to 90 per cent in France and Austria, for instance) is no longer taking place for work reasons; rather it is for family and humanitarian reasons. Family reunification with dependents, relatives and spouses, for marriage, university studies, as well as asylum-seeking have become the main routes of entry even into the United States and many countries of North-Western Europe. The very few, but important, exceptions are Canada, Portugal, Switzerland and the United Kingdom, which resemble Australia in that labour force migration remains the main purpose of immigration. Widespread endogamy (i.e., the practice of marrying within a social group) and marriage migration in ethnic minority populations, such as, for instance, Turkish and Moroccan people into the Netherlands, has become the single most important route of entry in some countries for some populations. Failure of socio-economic and cultural integration is being reinforced by chain-migration and in-marriage patterns. Asylum seeking has become a process of mass population movement (Coleman, 2005), with 6.6 million asylum claims into Europe since the 1980s, which, while mostly rejected, seemed to enable most claimants to stay nonetheless. If migration within the region is to become a reality, some useful lessons from past migration practices will need to be drawn. If “labour” migration is to be pursued effectively, such migration patterns must also offer good outcomes in terms of social integration.

One more consequence of massive immigration is that 106 million out of 175 million people in the world living in a country other than their birthplace are in the ECE region, 56 million of whom are in Europe and 35 million in the United States. But 24 million out of 56 million Europeans living in countries other than where they were born are residents of countries of the Commonwealth of Independent States (CIS; the alliance of 11 former Soviet republics) which, with the dissolution of the Soviet Union, were turned overnight in 1992 into residents with foreign-born status. For the rest of Europe, Austria, Luxemburg and Switzerland come close to the United States (12.4 per cent) and Canadian (19 per cent) levels of foreign residents. Figures are difficult to compare across countries as the number of “foreigners” is being reduced by millions through naturalization, but with some differences in naturalization practices from easy (Belgium, Netherlands) to rather difficult (Denmark, Switzerland). As a result, the foreign-born population which has not acquired citizenship varies from less than half (the Netherlands, United Kingdom) to an overwhelming majority (92 per cent in Denmark, 64 per cent Norway and Sweden), again displaying the great divergence within the ECE region.

Demographics unique to Europe. Three more Central and Western European demographic specificities contrast with demographics in the United States and Canada. First, the biggest demographic developments have been triggered by unique historical events, such as war and State collapse, for instance, in Central and Eastern Europe in 1989, the Soviet Union in 1991, and in the former Yugoslavia from 1992 to 2006, to date. Secondly, even within the small European territory, there has been quite a differential in

historical “timing” regarding, for instance, the rises and declines in fertility rates, which consequently translate into differences in ageing pace and ageing peaks. While Finland, for example, had its “baby boom” immediately after World War Two in 1945/46, the same happened in Germany in the mid-1960s and in Spain only in the mid-1970s, after the collapse of the Franco dictatorship. Correspondingly, ageing pressures have been building up — and had to be resolved — much earlier in Scandinavia than in Continental or Latin rim countries, and the strongest cohorts will age at quite different times. Ageing, for example, will peak in Austria decades later than in Norway, the Netherlands or Greece. Similar differences exist between Eastern European countries, which have been ageing rapidly, and the Central Asian republics, which will continue to experience gains in population over the next two decades. Finally, very high — but also highly differential — internal demographic labour-market reserves through non-employment can be observed throughout the region, with Europe, again, displaying both the highest (Scandinavian countries) and lowest (Mediterranean countries) values in activity rates compared to the United States and Canada.

Within the ECE region, the Eastern European, Central Asian and Caucasian countries have additional challenges, principally because they continue to experience transitions in their political systems (towards democracy) and in their economic systems (towards a market economy) and they also face the demographic transitions of a shrinking labour force and higher public age-related expenditures. However, there are important differences across those countries. The countries of Central Asia and the Caucasus region (Azerbaijan, the Kyrgyz Republic, Tajikistan, Turkmenistan, and Uzbekistan,) as well as Albania and The former Yugoslav Republic of Macedonia will experience population gains during the next decades, so they may be considered “young” societies within the region. Countries such as Belarus, Bulgaria, Poland, Romania, the Russian Federation and Ukraine will, in contrast, undergo serious shrinking of their labour force during the same period. The latter countries will face the greatest challenge, and they need to design and implement a series of reforms to counterbalance the negative effects of not only the shrinking labour force but also a growing economic dependency. The countries of Eastern Europe, in particular those who have joined the EU, offer some useful policy experiences in that respect.

Almost half a decade after the Madrid and Berlin conferences and the adoption of the Madrid International Plan of Action on Ageing and the ECE Regional Implementation Strategy in 2002, the United Nations Secretary-General’s observation “that ageing has not been seen in its ‘revolutionary’ terms, restructuring the entire life course and the socio-economic and cultural landscape”, still holds true for the ECE region. That is principally because, in many countries, no comprehensive response to the ageing process has yet been found and no encompassing measures to mainstream ageing have yet been implemented. There appears to be a degree of mismatch between the challenges ahead and both the policy responses given and public awareness of the issues involved. They can simply be illustrated by the recurrent debates on raising the eligibility age for early retirement and the legal retirement age. There is unanimity among all experts that a kind of lifetime indexing or factoring of increases in (residual) life expectancy into the pension formula and, thus, raising of the retirement age automatically with rising life expectancy, are not only necessary for financial sustainability, but also fair; together with reinforcing

of old-age welfare. But policymakers in many countries have remained shy of implementing such measures, and if they do so without adequate explanation, they meet strong public resistance against such reforms. The latest such example is the German opposition to raising the official retirement age from 65 to 67 between 2012 and 2029; ironically, people would probably gain 5 to 6 years of additional life expectancy during the phasing-in of the proposed measure, thus ending up with 3 to 4 years of more leisure in retirement by the year 2029 despite the higher retirement age.

New concepts of prospective age and standardized median life expectancy (Sanderson and Scherbov, 2005) need to be adopted, to enable recalculation of age not chronologically from birth, but biometrically from the end of life, being the years remaining until death. Such a reframing would permit conceptualizing the paradox that ageing societies like the ones in the ECE region might nevertheless grow “younger” at the same time, if residual life expectancy at median age rises despite a simultaneous increase in the median age. For example, the median age for a German in 2040 would be 50.6, as opposed to the median age of 39.9 years as it is today. The life expectancy at the median age of 50.6 would also rise to 43 years in 2040, as against 39.9 years today at the present median age of 39.9 years. Accordingly, the person aged 51 in 2040 would be significantly “younger” when judged in terms of years of life remaining, than would a 40-year-old today. And if a 73-year-old in 2050 would have as much remaining life as a 65-year-old today, how could freezing of eligibility and reference retirement ages be considered fair, meaningful or sustainable? Such logic is necessary in promoting changes in retirement age and other ageing-related policy reforms.

Such changes in old-age dependency ratios and the corresponding adjustment of the retirement age would require a continuous upward adaptation of the legal, standard and conventional reference retirement age of up to several months each year. Several countries have already done or intended to do some partial adjustments in that direction, but mostly rather arbitrarily and automatically. The term “lifetime indexing” is applied to this intervention of automatically adjusting both the first pension eligibility age as well as pension reference age to rising life expectancy or to disability-free, healthy life expectancy. Such a measure marks the threshold of coping with ageing issues and must become as accepted as mechanisms of inflation-proofing in wage negotiations or pension up-rating through indexation.

Significantly enough, both the United States (with a life expectancy lower than that observed in more than 20 European countries) and Japan (with a life expectancy somewhat higher than in the highest European countries) have been successful in adjusting their formal and actual retirement ages to the longevity enjoyed by their respective populations. Normally retiring up to a decade later than their European and North American counterparts, the Japanese only slightly outlive the people within the ECE region.

Paradoxically, Europe and the ECE region are growing together and drifting apart simultaneously, not just regarding demographic challenges, but also in coping strategies and outcomes. In measuring welfare across time and space throughout the region, using hundreds of indicators from mortality and healthy life expectancy to happiness and life

satisfaction, the Europe of 27 to 56 countries is simultaneously growing together and drifting apart. In recent decades, current social trends and developments increasingly reflect growing disparities and segregation in conditions of participation in social security arrangements. Such growing gaps between social groups and generations even in the most “hard core” lifetime, welfare, health, wealth and poverty indicators may well prevail over forces working to move Europe towards convergence in terms of sustainable livelihood.

B. Key regional priorities in ageing policy

1. Financial and social sustainability of pension reforms

The size of the older population and the length of retirement have created considerable pressures on sustainability of public pensions throughout the ECE region. In response, many pension systems in European countries have recently been reformed or are considering introducing reforms. In some cases, the implemented pension reforms will lead to a significant decrease in pension spending compared to originally projected trends. For instance, the recently released assessment of ageing-related public expenditures by the EC Economic Policy Committee (EC, 2006a) suggests that public spending on pensions over the next 50 years is expected to decline in Austria, Estonia, Latvia, Malta, and Poland and remain relatively unchanged in Italy and Sweden. Comparison of the projections of pension spending made in 2001 and 2006 by that EC Committee reveals that reforms made in the past five years have managed to reduce by more than one third the projected impact of ageing on public expenditures. Downward revision of pension spending in EU countries was achieved despite projections of a sharper acceleration in ageing.

It comes as no surprise that the current period of pension reforms is driven by the concerns for the impact of population ageing on public spending and a need for fiscal consolidation. Many of those reforms have changed the nature of pension provision from the defined-benefit to defined-contribution type. In general, such a change is likely to enhance the fiscal sustainability of the pension systems in shifting more responsibility and risks to the current workforce, and, consequently, reducing the social burden on the State and future generations.

Although pension reforms are expected to have significant social impacts, most of the studies have only focused on their effect on fiscal sustainability. That emphasis, in part, confirms that there has been very little assessment of the potential impact of reforms on the relative economic position of pensioners. Hence, the World Bank’s Independent Evaluation Group (2006) concluded that “there was insufficient attention on analysing the living conditions of the aged and exploring options for expanding the safety net for those outside of the formal pension system” and that “Bank involvement in pension reform was often prompted by concerns about fiscal sustainability...yet, in doing so, there often was a neglect of the primary goal of a pension system: to reduce poverty and provide retirement income *within* a fiscal constraint”.

A common economic effect of the reforms has been a decline of pension benefits drawn from the public pension system; consequently, the average public-pension benefit ratio (the ratio of average public pension relative to output per worker) has dropped in most countries (Zaidi, Marin and Fuchs, 2006). Many EU countries are projecting a decline in State generosity. The magnitude of the decline in the new EU Member States (particularly Estonia, Latvia, Malta, Poland and Slovak Republic) and in Austria, France, Germany, Italy and Sweden is quite worrisome.

As for other Eastern European and former Soviet countries, the pension reforms already implemented in Albania, Georgia, Kazakhstan, Romania and Serbia will also reduce public pension expenditures induced by demographic changes. Scope for two types of pension policy changes remains in many countries: (a) raising and equalizing the retirement age between men and women and (b) using price indexation for pension benefits instead of wage indexation. Georgia is the notable exception, which has already instituted both inflation indexation and a retirement age of 65 for both men and women. Additionally, for many of those countries, there is scope for introduction of social pensions, which are defined as non-contributory pensions available to all who reach retirement age. That kind of social pension is expected to be the most effective in reducing the risk of poverty among the retired population, according to experience in other countries (particularly in Finland, the Netherlands, and Sweden).

Theoretical replacement ratios provide useful indications of how the income adequacy of a pension system is evolving, although they are derived from the replacement of income for specific classes of individuals – full-career males, with average earnings and contributions to first- (and in some cases second-) pillar schemes and retiring at 65 (EC, 2006b). Based on that indicator, public pension benefits are set to decline in a number of countries, ranging from a massive 61 per cent in Malta and 44 per cent in Poland to 2 per cent in Finland and the Netherlands. Net replacement rates have declined significantly in eight countries; the changes have been moderate in others. Some countries have experienced an increase: 35 per cent in Cyprus, 17 per cent in Austria and 10 per cent in Belgium.

A comparison of gross replacement ratios before and after the reforms also highlights the likely impact of pension reforms. According to calculations provided by the Organization for Economic Co-operation and Development (OECD; and reported by Zaidi, Marin and Fuchs, 2006, p. 23), the effect of reforms in six countries has differed substantially for individuals who had earnings of half the average, average, and twice the average throughout their working life. In France, Germany, Sweden and the United Kingdom, the reforms had a redistributive effect because they made low-earning individuals better off compared to those with average or high earnings. That differential effect is much stronger in the United Kingdom and Sweden. In contrast, the reforms in Poland and Slovakia appear to have reduced the redistributive effect in those formerly socialist systems. The same pattern of reduction in redistribution appears to dominate in reforms implemented in South-Eastern European countries and in countries of the former Soviet Union. Reduction in redistribution is consistent with the policy trend in the reformed systems to link benefits with the contributory record of the pensioned individual.

These results indicate one fundamental and frequently ignored impact of the reforms enacted in recent years — their effect on redistribution. While defined-contribution systems offer clear incentives to individuals to work and save more for their retirement, redistribution cannot be achieved without fundamentally reinforcing the concept of a defined benefit for certain groups (through, for example, minimum thresholds). For instance, the link introduced between contributions and benefits increases the importance of how the pension system credits work absences (such as those due to sickness and disability, and those for childcare). Contributors to the personal accounts system in Hungary contribute 6 per cent of their childcare benefit to the pension system instead of having credits as under the old system (Fultz and Steinhilber, 2003). Since that benefit amounts to much less than wages, carers in Hungary will be worse off. Poland pays a subsidy based on the minimum wage, but it is much less generous than it was before. By contrast, Sweden gives extra pension rights to parents with children under the age of 4, though its National Strategy Report of 2005 states that while “in principle, the national pension system gives everyone the same possibilities of building an adequate pension...many women still devote more time to unpaid work and less time to paid work than men, which results in lower average pensions for women” (Sweden, 2005; pp. 26-27).

One particular challenge faced by former countries of the Soviet Union and the Yugoslav Republic has been that a good number of working-aged persons do not formally contribute to the system. Since a vast majority of older people are receiving pensions, the pension system dependency ratio (calculated as the ratio of pension beneficiaries to contributors) in those countries is rather high: on average, the ratio is more than three times higher than the population dependency ratio. The anomaly is so great that even in those countries where population ageing has not yet become serious (such as Albania, Azerbaijan and the Kyrgyz Republic), the pension system dependency rate is close to six times the population dependency rates (World Bank, 2007). By contrast, the system dependency ratio in OECD countries is, on average, less than twice the population dependency rate. The comparison reflects the continuing high level of employment in the informal economy, and continuing labour-market transitions in the former socialist countries.

Pension adequacy. The traditional goal of a pension system is to provide adequate resources to pensioners and to keep the risk of poverty at a relatively low level; if it fails to do so, it is deemed to be not “socially sustainable”. That consideration will foreseeably become a serious issue for many countries of the ECE region. For some Eastern European, Central Asian and Caucasian countries, the policy option of introducing social pensions should be seriously considered, since they do not have well-functioning contributory pension systems to keep pensioners out of poverty. Many countries, for example Serbia, are currently considering introducing such a policy reform; one of the main challenges is the affordability of such a universal provision of pension benefits. Studies by the World Bank and strong advocacy by HelpAge International show that in very many of those countries a social pension (which is equal to 10 per cent of per capita GDP) can be made possible by spending between 1 and 2 per cent of annual GDP. The costs are lower for those countries that already have a social assistance system.

Since EU and OECD work on pension adequacy has clarified the effect of reforms on “pension generosity”, reforms that improve the social sustainability of both the current and future generations must be given a fresh review. The effects on specific groups, such as women and low-income earners, have not been assessed in great depth. For such reforms to have a lasting effect, and to ensure both fiscal and social sustainability, they need to be accompanied by changes in saving and working behaviour, unless European societies are prepared to accept a substantial decrease in the living standards of older people and a significant increase in income inequality during retirement. Similarly, the reduction in overall generosity increases the importance of ensuring the presence of an adequate safety net, possibly in the form of minimum income guarantees.

The United Kingdom policy experience over the past two and a half decades provides some lessons for other European countries. The linking of the basic State pension to prices only was leading to an ever-falling level of State pensions. The drop in public pensions has been halted in recent years with measures such as the introduction of pension credit and the State second pension; coincidentally, pensioner poverty in the United Kingdom declined significantly in the same period. The United Kingdom experience may serve as an example of how pension reforms that focus solely on fiscal sustainability may require further policy changes to ensure social sustainability, once the effects on pensioners’ benefits and poverty risks become more apparent. Similarly, European policymakers must strive to ensure that reforms aim at both sustainability and adequacy of pensions in order to minimize pensioner poverty.

Three further questions merit attention:

- (a) How aware is the public of the impact of changes in the pension system, and whether working individuals are trying to adjust to the changes by extending their career and (possibly) adding to personal savings?
- (b) Without positive changes in behaviour, can certain groups, particularly low-income earners in poor health and with low skill levels, make sufficient adjustments to maintain their living standards in retirement?
- (c) In light of the reduced generosity in annual pension benefits and likelihood of further reductions as longevity increases, will the reforms remain politically viable in the face of growing elderly electorates?

The pending questions call for reassessing the reforms and clarifying the incentives for extending working lives in parallel with gains in life expectancy. For instance, the French reforms link the number of contribution years required to qualify for the State pension with longevity, so theirs may be a socially less risky policy than the German policy of linking the value of pension benefits with the dependency ratio. The policy sends clear signals to individuals that they need to work longer to qualify for the same benefit; it does not simply give them a smaller benefit. Similarly, the administrative structure adopted with the multi-pillar reforms in the Central and Eastern European countries needs to be reformed in order to reduce administrative costs and reduce the burden on low-income earners. Moreover, policymakers must (a) ensure that individuals understand the options

before them, particularly the longevity risk (the risk of outliving one's material means by living longer than anticipated) and (b) increase the incentives for enlarged participation in pension savings schemes and for extended working life in tandem with longer and healthier lives.

Countries that are currently reforming their pension systems, especially those among the Central Asian republics, should learn from the pension policy experience of other countries. Each country needs to account for the particular circumstances that govern its own system and prepare a reform package that provides for lasting fiscal sustainability as well as pension adequacy.

2. Active ageing and the failure of “extending working life”

Since the end of the twentieth century, extending working life has become a major and almost unanimous political objective in national and intergovernmental policymaking. Working up to retirement age and possibly beyond has been accepted as a key response to longevity gains. The principle has been recognized but not yet practically implemented through policy reform.

While goal formulation has advanced, policy formation has been delayed and confused. As a result, outcomes in terms of extension of working life have countered declared intentions and objectives in almost all ECE countries. While most countries have initiated a small turnaround with respect to increasing their labour force participation of older workers and the actual retirement age, all of them are still below the activity levels of the 1980s or 1970s for persons aged 50-plus.

Within the EU, for instance, “older workers’ employment” is the only dimension of the so-called Lisbon, Stockholm and Barcelona employment targets (that ask for higher than 50 per cent employment rates and a rise in the effective retirement age of five years by 2010) in which relatively little general progress has been made and, moreover, in which the gap between goals and objectives is greatest. It is the only dimension where the opposite has occurred during the past decade in some countries, in that already low rates of labour force participation among persons aged 55 to 64 and the actual retirement age have both declined even since the turn of the century — and have risen significantly and sufficiently in very few countries only. Where progress in terms of greater participation of older workers is observed, it is often restricted to more educated workers and those who already had a fuller work history (see Zaidi and Fuchs, 2006).

In some EU countries, a number of public policy initiatives have been undertaken to encourage an extension of working years and later retirement among older workers. In some cases, steps have been taken to raise the official age at which State pensions become payable. In others, the possibility of taking early retirement through such means as being declared disabled has been restricted. In some countries, changes in the pension system have brought about actuarial adjustments that encourage later retirement. Moreover, the actuarial terms for delaying retirement have improved, for example in the United Kingdom, where the receipt of both the basic State pension (SERPS) and the

supplementary pension (S2P) can be deferred up to age 70 with a gain of 10 per cent per each year deferred, instead of 7.7 per cent as before.

Although many of the changes in the official retirement age have already been made into law, their effect on actual retirement ages will occur at a much later date. Recent data on labour force participation suggest that the policies may be working, albeit slowly, putting the brakes on the trend towards early retirement in the future. Nonetheless, for a sizeable majority of European workers, withdrawal from the labour force is still happening at an early age; some individuals can retire more than five years earlier than the official retirement age.

Unless European policymakers start to find ways to induce older workers to remain in the labour market longer, the demographic pressures of a shrinking workforce and growing life expectancy will generate severe fiscal and social problems for most welfare systems. The required policy agenda is one of “flexible later retirement”. Additional incentives in the system can help achieve that by enabling people both to move between jobs in later working life and to work part-time without losing their entitlement to benefits (such as early retirement pensions). Such policy incentives should encourage older workers to avoid the cliff’s-edge fall from full-time work into full retirement that many of them often face.

Mainstreaming ageing in rapidly ageing societies is deeply ambivalent: even when well-intended programmes to raise the retirement age are followed, their outcomes appear not to meet the challenge. However working lifetime is measured, its absolute and relative size have been reduced significantly over decades throughout the ECE region — with very few, minor exceptions, which may or may not be temporary but certainly will prove to be largely insufficient in coping with the challenges ahead.

Even good practices in countries such as Finland and the Netherlands so far have not generated a full and sustained turnaround yet. While the decline in middle-aged labour force participation may have ceased, the turnaround that happened in 1993 in the United Kingdom and in 2001 in Germany and Italy (a full swing back to activity rates at the level of the 1960s or 1970s) is still not in sight for the region as a whole. There has been some slight convergence of working longer with living longer in countries such as Australia, Denmark, Iceland, Japan, New Zealand, Norway, Sweden and Switzerland, as well as in Hungary, Italy and Spain. Yet whether they are moving towards a middle ground is still uncertain.

Labour slack and economic growth. Massive labour slack (inactivity or non-employment, unemployment and long-term unemployment, long-term sickness and invalidity) is among the main barriers to European economic growth, competitiveness, prosperity and rising living standards. Labour inactivity also impedes progress in health, mental health and well-being, happiness and life satisfaction. After 2012, when the EU-27 population of working age is expected to shrink, and even more so after 2017, when the ageing effect will dominate throughout the region, economic growth will be driven by productivity growth, innovation, research and development alone. These factors will not, however, be able to compensate for the decline in the working-age population.

After 10 to 12 years, only a highly improbable and radical increase in labour market participation, a radical extension of working life in response to extended, healthy, life-expectancy, and steep productivity increases, would prevent economic growth and social prosperity from declining as well. Otherwise, the contracting labour supply would depress growth and the growing proportion of older persons will make public expenditures fiscally unsustainable, undermining pension security. Every 1 per cent decrease in economic growth corresponds to an approximate 20 per cent decrease in pension entitlements or an additional five to six years extension in the work requirement, reinforcing the view that if the performance with respect to economic growth falters, a vicious cycle of economic and social decay could result.

Current inactivity or non-employment — not unemployment — is the single most significant component of labour slack: non-employment in the EU-25 is 92 million, five times as high as unemployment (19 million persons). One in five adult men of working age is currently outside the labour force, and unemployed males make up less than one third of the male non-employed in Europe. The proportion of women out of the workforce is six times greater than those who are unemployed. Above the age of 50, the ratio of the non-employed to the unemployed increases to 8:1 for both men and women, and rises even more sharply with age, as the risk of disability and other forms of early exit increases while the risk of unemployment decreases (Marin, Meulders and Snower, 2000).

As a result, non-employment for those aged 55 to 64 is on average 30 times higher than unemployment. It is 10 times higher for men, and up to 90 times higher for women. Unemployment, in contrast, is only erroneously considered to be a major problem among so-called “older workers”, because with very few exceptions, such as in Germany, it is normally disproportionately low in that age group. According to data from EUROSTAT, in countries such as Austria, Belgium, Hungary, Italy and Slovakia, between 80.6 and 88.9 per cent of the women in that age group are non-employed as opposed to the unemployment rate of 0.3 to 1.5 per cent. In many countries, three in four (of Spanish) or four in five (of Austrian, Belgian, Bulgarian, Hungarian, and Italian — more so than Turkish) middle-aged women, who have more than three decades of additional life expectancy, are still excluded from the world of work. The opportunity exists to unlock the enormous potential of that silent labour reserve, and a reform package to enhance work capacity is thereby imperative in many countries.

Aggravating the problem, but also improving the potential for a solution, the 50-to-65 age group is rapidly growing in absolute and relative size, with baby-boom generations making it the largest age group in the labour market, for the present and for decades to come. Whereas Nordic and other early baby-boomers are already approaching a pension-eligible age within the next few years, in Germany and elsewhere, persons aged 67 will not be the most populous age group until at least 2030. The only relevant question is whether or not the current reforms will encourage people to continue working up to that age more regularly than is currently the case.

Retirement: policy versus popular preferences. Contrary to widespread belief, no universal “iron law” exists of a five-year gap between the legal and actual retirement age

in Europe. Such a gap does not exist in Denmark, Iceland, Portugal or Switzerland, for example; rather, it varies between 0.8 years for males in the United Kingdom to 6.4 years for Austrian men. Austria, Belgium and Luxembourg have larger than five year gaps, while Germany, Hungary, Norway, Spain, Sweden and the United Kingdom have gaps much shorter than five years. In such countries as the Czech Republic, Greece and Turkey, persons may work until or beyond the legal retirement age, but eligibility can be as low as 58 years (as in Greece).

If there is an iron rule regarding early retirement, it is that people will always or normally exit at the earliest retirement age or age of first eligibility, for whatever pension benefits are offered (the so-called “first exit opportunity habit”), regardless of different (up to five years) legal retirement ages between men and women. Spain is a perfect illustration of the iron law: the earliest possible “*jubilación anticipada*” is 61 years of age, and according to EUROSTAT data, the average effective retirement age is 61.3 for women and 61.6 years for men.

Hence, regarding the “normal” legal and the “exceptional” early retirement age, almost everywhere in Europe, early retirement has become the rule and remaining at work until the legal retirement age has become rather the exception: up to 91 per cent of the working population retires before the official retirement age of 65 in a country like Austria. One major explanation, accounting for most of the variance, is that with very few exceptions, working beyond the prime age (50-plus years) simply does not pay in Europe (Gruber and Wise, 2004; Wise, 2007); nonetheless, that effect has been diminished in several countries through adjustments in a shift towards actuarial fairness (see Queisser and Whitehouse, 2006). Continuing to work beyond the earliest possible exit point, and especially beyond the legal retirement age, is implicitly “taxed” more heavily in many European countries while early retirement continues to be heavily subsidized. If such a subsidy is not being provided, as in a few ECE countries like Switzerland and Sweden, there are fewer incentives and a lower propensity to exit early from the labour market.

In many European countries, citizens and residents have declared their preferences for early retirement in Eurobarometer surveys and other public opinion polls. The “body language” of actual behaviour displays an even stronger preference for leisure as against an extended working life — as long as it pays, or more precisely, as long as it does not cost too much to retire early. Any policy that does not take into account that preference for the earliest possible exit is doomed to fail. Likewise, any policy that does not account for the preference of significant minorities to extend their working life will also fail.

Examining public opinion through a great variety of Eurobarometer and other sources offers a coherent image of public perception — and misperception — regarding challenges, policies and preferences with regard to extending working life. Perceptions include: (a) a vague sense of problems and doubts about the future viability of mandatory systems; (b) little confidence in Government policies; (c) largely unchanged attitudes regarding current retirement practices and little popular support for increasing the retirement age; (d) widespread belief in the notion that older workers “should give up work to make way for more younger and unemployed people” (see Kapteyn, Kalwij and Zaidi, 2004). In countries such as Denmark, Finland, Ireland, the Netherlands and the

United Kingdom, public awareness and sensitivity have been raised by (a) governmental campaigns; (b) a growing opposition to forced retirement at a fixed age (with great differences between North-Western to South-Eastern Europe); and (c) support for the views that later retirement should lead to a higher pension and that pensioners should be allowed to earn freely on top of their pension.

Apart from financial disincentives to work longer and hidden or revealed preferences to exit early, there are other determinants of early retirement, including: (a) the reluctance of employers to hire or retain older workers; (b) negative attitudes toward older workers and age discrimination; (c) steep age/wage profiles in which labour costs outpace productivity increases over the working life; (d) strict job protection that perversely functions as an employment barrier; (e) insufficient training to compensate for “de-skilling” and inadequate placement services, both weakening employability; and (f) a poor, unsafe and unhealthy work environment and demoralizing working conditions. Those factors seem to play an even greater role in the decision to retire early than do low economic rewards.

Policy options. The general direction of policy conclusions from the analysis is quite clear. The policy options include: (a) making work pay through actuarial neutrality or even increasing pension rights with age and lifetime-indexing (a concept explained earlier in the first section of this chapter); (b) increasing opportunities and choices for flexible retirement practices; (c) repealing early retirement options and pathways; (d) combating age discrimination; and (e) changing employer attitudes and practices by eliminating employment barriers and improving employability through training, re-qualification and better working conditions, among other means. Empirical evidence from the Survey of Health, Ageing and Retirement in Europe (SHARE) database suggests that a focus on improving the work environment is more important than on employment, on employment more than on unemployment, and on retirement rules and work satisfaction more than on health. Evidence also supports the conclusion that health matters much less than expected for determining the length of working life, whereas working longer may actually improve health and mental health in particular.

While the policy direction is generally agreed upon, a long series of difficulties emerge regarding the hard choices to be made and with respect to the technicalities of policy design and its implementation. The following questions hint at the complexities involved. (a) How, for instance, should eligibility ages of earnings-related pensions and guaranteed minimum pensions be differentiated fairly and effectively? (For example, the latter is available in Sweden at age 65, only four years later than the former.) (b) How can work/retirement decisions be made more flexible and corridors (age spans in which workers are entitled to retire) be widened without simultaneously encouraging an even earlier exit? (c) How can collective bargaining agreements be prevented from fixing an age lower than the legal retirement age (such as the age up to which employment protection is provided) as the mandatory retirement age for whole occupations such as pilots, military personnel or opera singers? (That practice was outlawed by the Swedish Parliament in 2001 but is quite frequent in most other European countries.) (d) Who should be supported in order to create the most effective work incentives, and how can simple age-targeting avoid missing its goals? (e) How can age discrimination legislation be made more effective?

Finally, although some quite robust recommendations are available, policymakers still regularly fail to implement those evidence-based proposals that would promote good practices or avoid entrapments. The principles of work first, of making work pay and of raising general and, in particular, post-prime age employment rates are rarely accorded high priority as guiding principles. The wide range of good practices available for adoption to improve workers' lifelong education, occupational training, work safety, health promotion, professional rehabilitation, job rotation, upgrading and enrichment, late career measures, mobility support, age-specific adjustments of the work environment, personal time-off and lifetime banking account systems, including partial pension and phased, flexible retirement schemes, and so on, are not systematically evaluated and widely shared (see Marin, 1998).

Experiments and systematic, rigorous evaluations are rare. For instance, social security contributions could be age-risk-rated over the whole life cycle, making the compound non-employment and unemployment risk-by-age the yardstick for differentiating all social security contributions according to age-specific, out-of-work risks. Tax credits or subsidies for recruiting and retaining post-prime-aged workers may be experimented with and rigorously evaluated. But worse than missed opportunities, corroborated knowledge is widely unknown or ignored in practical policy implementation. For example, the suggestion that pension rules should follow notional defined-contribution schemes, or that defined-benefit systems should be actuarially neutral in order to avoid setting perverse incentives for early retirement, is often not followed. Automatic adjustment or "lifetime indexing" of early, normal and reference retirement age to rising survival rates, prospective age, and residual life expectancies, though indispensable in the long-term, is almost never implemented. Many countries allow for a minimum "guaranteed" pension not only at a regular, reference retirement age, but at the earliest possible eligibility age, instead of permitting only the collection of earnings-related or supplementary pensions and savings at early retirement age. Age discrimination and forced retirement have not yet been effectively banned, and in fact continue even in the OECD and the United Nations, where people must retire at ages (60 or 62) below the legal retirement age of many of their Member States.

Many Governments within the ECE region still dismiss large-scale early exiting as either irrelevant or inevitable, instead of taking effective action to block early exit pathways. Consequently, if a critical share of the middle-aged population retires early, and if that is socially accepted for whatever reason, even more people will choose to do so for their own reasons, regardless of whatever weakened opposition to that trend exists. Meanwhile, it is well-known and shared by all expert institutions, from OECD, the World Bank and International Monetary Fund to research centres, that a Government should never permit special pension schemes to appease special interest groups, regardless of how strong the pressure or how noble the causes underlying their claims. Rather, pension rules should be universal and fully transparent, avoiding privileges for special groups. Apart from being costly themselves, such privileges tend to demoralize the working population and reinforce and legitimize widespread resistance to any change or reform. In short, pension justice must not only be done, it must also be seen to be done. A lack of fairness and its transparency is actually among the major obstacles to pension reform. And while different retirement ages for women and men have been outlawed by the

European Court of Justice as fundamentally unjust, several countries within the EU and within the ECE region have kept this illegal and costly pension rule and will phase it out over periods of up to 40 years, if they have started to do so at all.

Policy failures. A series of basic policy failures such as the following explain the lack of success in extending working life. When it comes to early exit from the world of work, basic social safety nets, old-age security (which by definition can only apply beyond the working age) is regularly confused with unemployment, accident, sickness or invalidity insurance, disability benefits and the like. Instead of being explicitly generous to the poor, to sick people, to persons with disabilities or to other disadvantaged groups in a focused way, a generalized generosity benefiting the greatest number, namely early retirees, forces authorities to be “non-solidaristic” to all others in need. A price is being paid for failing to fully integrate foreign residents and citizens who may differ significantly in their labour market participation and retirement behaviour. The same applies to low self-employment rates, as the self-employed, small shopkeepers and professionals tend to work for several years longer, up to more than a decade, than do waged workers and employees. Assisting the transition to self-employment for middle-aged employees could be a major step towards effectively extending active working life.

Another succession of failures has emerged around widespread “invalidity pensions” that need to be reorganized (see Prinz, 2003; OECD, 2003; Marin and Prinz, 2003; Marin, Prinz and Queisser, 2004). Despite outflow rates of close to zero, disability “pensions” are still frequently awarded as lifelong instead of temporary benefits, even at early ages. Today, significant parts of the working-age population, almost one in two men in some countries such as Hungary and Austria and up to a majority of persons in some occupations and professions in some countries in the region, retire as “invalids” at an average “retirement” age of 42 (the Netherlands).

From such a diagnosis, the remedies are the following: if about one in eight adults “retires” for reasons of ill-health or disability in the richest, healthiest, and longest-living societies, the very concept of “disability pension” may have to be reconsidered and replaced. Work injury and long-term sickness insurance will have to be clearly disentangled, institutionally differentiated and psychologically distinguished from unemployment insurance, on the one hand, and from old-age security on the other. Receiving disability benefits should have nothing to do with working or not working, nothing to do with labour market problems, and nothing to do with old-age entitlements. Awarding old-age benefits should be restricted to demographically adjusted age thresholds, and/or to actuarial adjustments, such that the overall lifetime pension entitlement will not be increased by adverse retirement behaviour such as early exiting.

According to a global survey of the Oxford Institute of Ageing in 2006, 72 to 80 per cent of respondents want to scrap mandatory retirement and freely choose their preferred age of leaving work with actuarial adjustments. Yet policies providing flexible retirement-age corridors and protection against forced retirement are still rare exceptions. Similar policy misfits may also be identified with respect to popular preferences for home care as a mode of long-term care, which is under-financed compared with residential care, or with respect to various modes of terminal care. In all those areas, public opinion polls and

surveys that document the views of younger and older persons on what they consider important for their own well-being show important mismatches between the policies offered and the programmes demanded, between real social conditions and normative expectations.

3. Quality services in long-term care in Europe and North America

The development of high-quality, equitable, affordable and sustainable health and care service structures, in particular for long-term care (LTC), is a crucial challenge for rapidly ageing societies. Demographically, in addition to ageing in general, the “ageing of the aged” progresses as the number of very old persons will increase three to four times within two generations (see United Nations, 2006c). That reflects the disproportionate increase of the oldest old population (of 80-plus years) and the historically unique factor of the baby-boom generation approaching retirement age, and then — within one more generation — the broadest oldest age cohort in human history will have reached age levels with increased risk of dependency. Consequently, a much greater absolute number of the oldest old within the ECE region will be at risk of dependency, even under conditions of significantly improving health status and decreasing disability prevalence.

In discussing quality services, the fluid character of emerging LTC patterns in countries of transition and the corresponding lack of adequate data preclude an even coverage of the entire regional situation of 56 countries, but do permit a focus on two thirds of the countries — the EU-27, Norway and Switzerland, North America (Canada and the United States) and Israel. Older persons are found to be dependent on support from other people in three types of situations (Leichsenring and Billings, 2005):

- (a) Those living alone in ordinary houses or apartments, needing a range of different services, showing functional incapacities after illness and disability
- (b) Those discharged from the hospital with LTC needs, who suffer from geronto-psychiatric and/or geriatric diseases
- (c) Those with chronic/degenerative diseases and at risk of losing their autonomy

Many such situations become visible and/or occur only at short notice.

The growing demand for care services, together with a shift in preferences away from residential care towards ambulatory and home care (or community-based care, more generally) puts care needs at the centre of current and future ageing policy. The demand for care will be predominantly non-medical — with personal care services covering a wide range from nursing to domestic help, from informal family care, mobile and community care and supported housing to institutionalized residential care, and from prevention to rehabilitation and palliative care.

But more than in any other dimension of social protection and health care, LTC — both financial allowances and personal services — does not yet seem sufficient to meet the needs of frail and dependent elderly persons as well as the needs and expectations of their

families and informal caregivers. Currently, the elderly and their relatives are frequently disappointed with the LTC services offered. Many have had high expectations of social security, hoping that it would provide fully fledged protection against the risk of chronic dependency, much like the way it protects against the risks of accidents, illness and disability. For such reasons, the aims of developing LTC systems are complex and multifaceted. In particular, four aspects seem to be of outstanding importance: (a) managing adequate care provision by developing a continuum of care; (b) enhancing support for family care-givers; (c) creating a sound and sustainable financial basis for LTC to guarantee a defined quality of services; and (d) providing terminal care for a dignified end of life.

Regarding the last point, dying and death currently take place mostly under conditions that most people – especially those in the most “advanced” and prosperous subregions of the ECE – find unsatisfactory (European Centre, 2001). In too many cases, “dying with dignity” is not possible because it requires a substantial reorganization of current health and care provision, with tailor-made, individualized services.

Several peculiarities arise when reviewing LTC experience in the region (see Leichsenring and Alaszewski, 2004; Leichsenring and Billings, 2005; and World Bank, 2007). Firstly, the issue is more complex in comparison with the issue of pensions (even if old-age security often appears to be difficult and politically controversial). While LTC is less salient an issue, it poses serious dilemmas, difficult choices and life-altering decisions. It allows for no quick-fix solutions in any of its dimensions.

Private care savings plans and privately pre-funded insurance schemes, for instance, are (in contrast to pension policies) either non-existent or in their infancy in most countries. Recourse to private care as a simple fallback is therefore unavailable. Even in countries that otherwise rely heavily on State aid and public schemes such as the Scandinavian countries, the predominant forms of LTC for older persons are individual, informal, unpaid care by family, kinship and friends. Around 80 per cent of all such care, involving some 16 to 44 per cent of all families within the EU Member States, is given by informal family caretakers (EC, 2002). The predominance of informal care applies to all LTC approaches, whether market-oriented, family-oriented or welfare State-centred; a remarkable similarity for otherwise radically different systems, philosophies and practices of LTC provision.

Most LTC in Eastern Europe and the former Soviet Union is provided in hospitals or informally by family members. That reflects cultural preferences and also the very limited availability of institutional LTC services in those countries. Most of them have not completed the reforms that address deep-rooted structural faults in the design of their health-care systems. For example, countries need to shift from expensive inpatient care to less expensive outpatient care; otherwise, they will experience drastic increases in the costs of health care and LTC. At current benefit levels and using the constrained, constant morbidity scenario (which assumes that morbidity during additional years of life would remain at current levels and that all additional years of life would be lived healthily), public spending on health will increase significantly between 2005 and 2020 in Uzbekistan (1.35 per cent of GDP), The former Yugoslav Republic of Macedonia (1.06

per cent) and Tajikistan (0.53 per cent). The increases will be more modest in Belarus, Bulgaria, Estonia, Poland, Romania and the Russian Federation (World Bank, 2007).

There is no empirical evidence that an increase in paid and formal, publicly funded home-care results in a reduction in home-based care from families. Often public services are viewed as substitutes for home-based care, not complementary to it. Informal family care should be a necessary means to fill the gap between public services and patient need. Informal care is often misunderstood by policymakers as a “free” resource available in abundance, and with no significant hidden costs to the public, which is a serious miscalculation. Such a presumption places the burden on the caregivers, who often find themselves unable to meet all the needs of their loved ones. As a result, the needs of caregivers themselves, such as counselling, respite care, and other support services, are pushed aside. Their propensity to provide care has been overexploited and in many cases has demoralized the potential carers that may already be under other social and economic pressures from general demographic and social changes.

As with all other dimensions of LTC provision, countries within the ECE region greatly differ in their political and cultural preferences with regards to family-based or more formal care arrangements. Austria, Canada, Germany and the United States all advocate individual and family responsibility, while Denmark, the Netherlands, Norway, Sweden and partly the United Kingdom lean towards a marketing or formal delivery of elderly care, viewing it rather as primarily a social responsibility. Countries of Eastern Europe and the former Soviet Union also lean towards informal family care, although that rather reflects a lack of formal and affordable services available to care users.

In making such basic choices, countries also take sides in latent conflicts between the interests of the oldest old people and their caregiving families. Whereas care allowances enable and empower the recipients of cash benefits (the “patients” or dependent elderly), in-kind services or vouchers as well as institutionalized care tend to reduce the burden on families and caretakers. But often the main or sole driving force behind a governmental preference for informal care is simple cost-saving expectations, assuming cash payments are lower than direct service expenses — and discounting externalities such as the work time interruptions and employment-reducing effects associated with widespread informal care.

A strategy recently employed throughout the ECE region has been the hiring of undocumented care workers from neighbouring or surrounding countries inside or outside the region. Taking advantage of great differences in income and living standards between countries within close geographical proximity, various sectors of the LTC industry (above all, private households) recruited informal caregivers from countries in Eastern Europe, Central Asia, Northern Africa and Latin America to replace family caregivers in the home.

Informal care by “illegal” migrants from poorer countries is widespread. It supports and partly replaces family care in richer countries — where irregular caregivers may match the numbers of formal nurses and home helpers. That happens above all with community-based home care, almost monopolizing, for instance, around the clock services at home

either not offered at all legally or supplied at prices unaffordable except by the very rich in several ECE countries. While it strongly increases the purchasing power capacity of people in need of care or with disabilities in receiving countries, it has quite contradictory employment and income effects in the sending countries.

LTC funding approaches. In funding of LTC, a great variety of mostly public approaches prevails, ranging from predominantly tax-financed systems (such as in Scandinavia, the United Kingdom, the United States or Austria and France) to social insurance-financed LTC schemes in Germany, Luxembourg and the Netherlands. No developed country relies on private savings or funded schemes alone, as all of them operate pay-as-you-go (PAYG) systems, and some of them have even introduced insurance schemes in order to overcome limitations of savings-based arrangements. Private insurance itself, apart from the usual risks of market failure, requires public subsidies, tax exemptions or concessions, partnership arrangements or even mandatory LTC insurance for some groups in order to maintain affordable rates, as in Germany, the Netherlands or the United States.

Funding and spending levels for LTC differ even more than funding approaches, ranging from around 0.5 per cent of GDP in countries like Spain, of which 0.15 per cent is public spending, and a number of countries in Eastern Europe; to levels of between 2 and 3 per cent of GDP in some Scandinavian countries (Huber, 2005). Those numbers suggest that other than demographic challenges, above all income elasticity in care demand play almost as much of a role in determining LTC expenditures as ageing itself does. In the non-EU Eastern European countries and in the countries of the former Soviet Union, the rise in health expenditures can be managed mainly by completing the reforms to improve fiscal discipline of their health systems and by developing strategies to ensure that the elderly spend increasingly more years in good health.

Many other factors are crucial in explaining differences in spending levels: for instance, the density and quality of services offered or the individual and collective choices taken regarding the mix between residential and domestic care services. Whereas the latter are strongly preferred and faster growing, domestic care services remain a minor budget item with respect to public spending categories throughout the EU. In Austria, between 80 and 90 per cent of all public support for services are spent on the 3.6 per cent of persons aged 65 and above in institutionalized care. The remaining 10 to 20 per cent of funds for in-kind services are allocated for the 96.4 per cent of elderly people living independently and receiving home care. There is no country among the EU-27 and among the European countries of OECD where more than 8 per cent of LTC recipients are in institutional care; in some countries they amount to as few as 1 to 2 per cent. The dependent elderly cared for at home therefore compose between 92 and 99 per cent of all dependent older persons. Only in Denmark do more than 20 per cent of persons living at home receive home-care services. Public expenditures still predominate in institutional service delivery in all countries within the domain outlined above, despite the marginal percentages of the population that require care (OECD, 2005).

Although the explanations for the persistent paradox described here seem to differ widely across countries, lessons learned from Denmark show that a great transformation from

institutional to community care would probably take a generation or more, even though the shift to community-based care has shown that it can produce desirable outcomes. The Danish experience since the late 1980s shows that a rigorous policy prohibiting the construction of new local nursing homes by municipalities and shifting resources to home care and community services can actually reduce LTC costs over long periods. Will such experience induce a paradigm shift and institutional change in other parts of the region as well? So far, signs are still lacking.

Changing structural public choices away from institutionalized towards community-based and home care would result in superior results in shorter times, provided that older persons are offered individual choices between lower cash allowances and higher-valued services in kind. The German care insurance that offers such a choice between types of benefits at each level of care-dependency experienced a tripling of options for home-care services from originally 12 per cent in 1995 to 35 per cent in 2002, once the supply shortages of the initial period were overcome and the purchasing power from care allowance benefits helped to create a service market with more, broader and better services. If, on the other hand, home-service supply shortages prevail such as in the Netherlands or Austria, the personal budget scheme, known as LTC allowance (*Pflegegeld*), is used to bypass long waiting lists or other formally inaccessible services in kind — or to buy care on a well-functioning market. Actually in Austria, for instance, the only currently existing market for around the clock home-care services, and a well-functioning one, is the informal or “illegalized” one.

Choices may also be restricted for public provision and on the regular care market itself. In most ECE countries, a conspicuous gap still exists between the rhetoric and the realities of “choice” for service users. Older persons dependent on help and support usually have very restricted choices. Even the rich are confronted with limited choices and supply shortages. The great majority of the non-rich, even in many rich countries, face even fewer choices because of a limited scope in supply.

Clients can choose between different providers only to the extent that competing organizations actually exist and operate in their neighbourhood. Alternative local providers are all too frequently not available, for many reasons; and even if they are, they may not offer any choices.

Restriction in choice for service users may be caused by many reasons: (a) scarcity of public funds and supply of services; (b) open or hidden rationing and long waiting lists; (c) complexities of contractual arrangements that regulate access, commissioning or reimbursement between clients, providers and funding agencies; (d) lack of transparency in eligibility criteria and other regulations; (e) uncertainties about quality and quality assurance; (f) entrapment incentives into premature admission to institutionalized care with few or no return options; (g) rigid care management policies that eliminate potential user choices in social care markets by disempowering clients; and (h) distrust of informal care recipients regarding care managers who often are not independent advisors but collude with the care providers who employ them, thus rendering them suspect of control and policing functions.

Policy may target the poor instead of providing LTC universally to the needy, regardless of their income. Nonetheless, in such an environment, even low-income dependent people in need of help may simply be excluded from access to care by means-testing, if they have not “spent down” all of their remaining assets or resources.

Not surprisingly, then, equity issues are of primary concern and are most controversial in public debates on LTC. A sample range of questions would be: Should LTC welfare be universal or provided only to older persons with low income and no assets? Should there be cash transfers or in-kind-service offers, or general social rights or individualized needs assessments? Should funding come exclusively from the public purse or should it be mixed? Should user charges be levied or not? And if there are charges, should they be flat-rate or income-related co-payments? If co-payments, how much for the residential component versus care services within residential care homes, and how much for home nursing as against home care in mobile services? Should housing (and other) assets be taken into account in income-testing and wealth eligibility criteria, in determining access to publicly subsidized care or user charges, such as with Medicaid in the United States? Who should be responsible for meeting regular and inherent shortfalls between the public transfers meant to cover — partially — the care expenses and the actual costs of services?

The questions here are a few of those most intensively debated on equity issues of primary concern. They are only some of the starting points for further queries to be answered with hundreds of decisive, detailed regulations impacting on the fairness and equity of resource collection as well as resource allocation. While most of the distributional consequences of the choices, constraints and incentives being offered are difficult to understand, even for experts, the obvious inequities of administrative and financial treatment that stem from different diagnoses are troubling for the patients concerned. For example, why would someone with one medical condition (say, cancer) have free access to personal care, whereas someone with another medical condition (say, Alzheimer’s disease or dementia) receive no care service unless he or she were poor — or hospitalized?

Differentiation of health and care systems with separate funding streams and sets of rules and regulations may have many advantages, but there are also risks of establishing artificial dividing lines between health and social care, costly trans-boundary transactions and useless disputes over domain competences, opportunistic cost-shifting, and co-ordination problems. These regulations may burden the clients instead of helping them through the bureaucratic jungle of entitlements, implementation practices and feedback on satisfaction and/or complaints. Regular assessments and quality control of services being offered require client and advocacy feedback and a shift of evaluation focus from unit costs to the outcomes and overall value of services for stakeholders. The cost/benefit analyses and evaluations of unit costs and overall resource allocation, its effectiveness and efficiency are indispensable instruments in responding to basic queries.

Care spending generosity — and its effectiveness — is most difficult to determine. The neighbouring countries of Belgium, Germany and Austria, for instance, because of different eligibility criteria, entitle respectively around 2 per cent, 2.5 per cent and 4.8 per

cent of their overall population for LTC allowances (“*Pflegegeld*”). When it comes to their respective populations aged 65 years or over (or 60; strict data comparability is not given), Germany entitles 6.4 per cent as against Austria’s 20.5 per cent of the elderly, despite quite similar health conditions and age structure between the two countries. The broader eligibility of the Austrian system may either be a waste of scarce resources by spreading them over too many people with low-level needs, or a wise strategy of prevention where small amounts of extra money could be highly cost-effective by preventing a deterioration of conditions that would otherwise qualify for higher and much more expensive levels of care (known as “*Pflegestufen*”).

Countries of otherwise comparable wealth and welfare standards differ dramatically regarding generosity of coverage (from 6.4 per cent of older persons in Germany to 19.3 per cent in the United Kingdom and 20.5 per cent in Austria) and best-payment standards (from €125 in Belgium to €450 in Italy, €1,100 in France and €1,562 in Austria) in care (cash or attendance) allowances. From another angle, Sweden allocates 0.1 per cent of its spending on care allowances but is actually no less generous than Austria, since Sweden spends twice the amount that Austria does for LTC — Sweden concentrates on resources for home services and residential care as against income support for family care-giving, thus displaying the predominantly service-orientation of the welfare State (focusing on quality, in-kind services) as against a transfers-oriented regime (focusing on cash benefits).

In improving LTC provision, the system’s rationality and effectiveness are crucial and must be advanced. Showing consideration towards enhancing client welfare, well-being and satisfaction is equally important. Whereas a public policy perspective aims at optimizing welfare gains through improved LTC governance and management structures, a consumer protection view raises a different series of queries. Above all: in services designed for the elderly, why are such aspects as quality standards and systematic monitoring so often ignored? Or more specifically, why should services for the elderly appear to be systematically inferior in quality and less well monitored than other sectors; for example, the cleanliness of public transport or washroom facilities, the quality of minimum health standards of restaurants, hotels, sport or education facilities, not to speak of kindergartens or hospitals? Whereas those facilities are regularly visited, controlled and publicly evaluated, this is not the case with old-age nursing homes (not to speak of home services) even in some of the most developed ECE countries.

Quality improvement and quality assurance are, therefore, an utmost priority issue for the coming decades. Recently, traditionally implicit codes of practice have been slowly replaced by more explicit guidelines, regulation and quality management; and traditional inspection and bureaucratic controls have been replaced by professional accreditation. New policy initiatives such as the Commission for Social Care Inspection (CSCI) and the Social Care Institute for Excellence (SCIE) in the United Kingdom are examples of the search for improved quality management by benchmarking and models of excellence. Increasing numbers of accreditation systems and standards for measuring the eligibility and performance of service providers have been introduced in several countries and subregions. Accreditation mechanisms could become powerful instruments in regulating

market access, provision levels, quality and prices; especially if they include client satisfaction as a crucial dimension of evaluation.

Any improvement in levels of supply, quality and prices would surely generate additional costs. Whatever the assumptions about future challenges, needs and developments, there are no scenarios that do not project significant increases in LTC spending levels — far above the rises expected for health expenditures and expenses on pensions (Oliveira Martins, de la Maisonneuve and Bjønerud, 2006; Scherer, 2006). Great uncertainties prevail, above all, not regarding the demographic projections, but those of future health conditions. Whereas there will be a much greater absolute number of the oldest old and of those at risk of dependency even under conditions of significantly improving health and decreasing disability, recent evidence shows that improvement in the health and functional status of the oldest old persons cannot be taken for granted. The records show periods of disability rates falling (in Sweden, 1980–1996; Denmark, 1987–2000; Finland, 1980–2000; Italy, 1994–2000; Netherlands, 1991–2003; Switzerland, 1992–2002; and the United States, 1984–2004), remaining stable (in Canada, 1996–2003; and the United Kingdom, 1995–2001) and rising (in Belgium, 1997–2004; and Sweden 1996–2004; see Scherer 2006). In short, there is inconclusive evidence on the alternative hypotheses of a contraction in or expansion of disability, perhaps leaning towards a hypothesis of contraction.

The most probable demographic effect on LTC spending — roughly doubling from 2005 to 2050 — may not be significantly reduced by a contraction in disability. Non-demographic drivers are expected to be more important than population ageing and health status: improved quality of care services; at times unsustainable remuneration levels of care personnel and corresponding staff shortages; catch-up costs for upgrading service levels and quality standards to those prevailing in other ECE countries; and declining family-care potentials despite its continued prime role. All of those factors may serve to increase cost pressures on LTC expenditures far beyond the growing demographic challenges. Depending on whether cost containment succeeds or cost pressures dominate, LTC costs will at least double or triple their share of GDP within the next two generations, outpacing age-related cost increases in general and health-care cost increases by about four to six times (OECD, 2005). Central and Eastern European countries and countries of the Caucasus and Central Asia, as family caregiving erodes and formal care expands to fill people’s new needs, will probably have to multiply their LTC expenditures many times as well.

C. National policy responses in implementing the Madrid Plan

1. Why is there no interaction between the Madrid Plan implementing activity and national ageing policymaking?

As a working hypothesis, it is assumed that the heterogeneity of the ECE region as well as the predominance of the EU and the EC in political action within the strictly European part of the region (in other words, excluding Canada, the Russian Federation and the United States) makes the so-called “Open Method of Coordination” (OMC) the major if not the only coherent, but soft, tool of transnational cooperation available.

Some particulars of OMC may serve as examples here. Policy co-ordination within the EU is considered indispensable, as Member States are highly interdependent economically and, consequently, strategically. The creation of larger economic and employment growth as well as social cohesion have been accorded unanimous EU priority since the new millennium. The OMC was developed at the Lisbon European Council in March 2000 as a new approach to policy synchronization; it works through the definition of common goals and objectives as well as agreement on indicators and joint assessments to measure their achievement. Member States are asked to present national policy strategies to address common goals within their domestic constraints and given their country preferences. National Strategy Reports describe how the Member States intend to meet those common objectives. Joint Reports adopted by the EC and the European Council call on Member States to ensure the implementation of reforms and the continuous application of OMC in the field.

Recently, OMC has been applied to achieving sustainable and adequate pensions together with reforms of health and LTC systems. Most national approaches concerning issues of ageing (inside and occasionally outside the EU) refer to either the EU or the OECD policy frameworks. But they do not, as yet, seem to refer to the Madrid International Plan of Action on Ageing and the (ECE) Regional Implementation Strategy as the framework for their policy orientation. Such a limitation in the implementation process is slowly disappearing, as the ECE secretariat is becoming involved in training and capacity-development matters and in preparation of the conference in León, Spain in 2008 that will mark the first five years of the Madrid Declaration and Plan.

In the OMC policy field of pensions, the adequacy, sustainability and modernization of pension provision has been emphasized. Joint Reports and studies by the Social Protection Committee offer an evaluation and synthesis by the EC on national experiences to facilitate mutual learning and promote sharing of success stories. Within the EC, the Employment Committee and the Economic Policy Committee work together with the Social Protection Committee to meet common policy challenges. While there is limited evidence that countries actually learn from each other, generating intergovernmental European legitimacy for difficult choices at home may be a significant if latent OMC function.

The Madrid Plan and the Regional Implementation Strategy, in contrast, have so far been less binding at the procedural level. Whether or not they are nationally implemented, whether they are institutionally followed-up at country level, and whether capacities are built — all of that is currently far less certain. Therefore, it is difficult to know, for instance, whether effective organizations of older persons are being established; educational, training and research activities on ageing are being offered; national data collection and analysis are being undertaken; and whether all that is being done in a synchronized, internationally comparative way throughout the ECE region. Comparable resources are neither available nor mobilized. The independent development of achievement indicators and the monitoring of progress in implementation that are completed within the broader ECE region are not comparable with the equivalent indicators developed within the EU-27.

While the promotion of training and capacity-building on ageing in countries in transition is of highest priority, neither capacity-building in the most advanced States, nor exchange of experiences and good practices and the dissemination of information throughout the region, are being done in ways that match the OMC within the EU. The first cycle of review and appraisal of the Madrid Plan could come to the conclusion that an integration density for the ECE region of 56 countries for the next cycle (2008–2012) should not be much less ambitious than the degree of synchronization achieved for the EU-27. Whereas ageing-specific and LTC policies seem to be taking-off slowly, mainstreaming of ageing may slowly become a priority item on policy agendas throughout the region, but it is still not fully understood and implemented. The ECE could play a significant role in making that possible. It would be better accomplished by collaborating closely with the EC and institutes working for them.

In the next phase, 2008–2012, when the new EU Member States from Central and Eastern Europe will be fully integrated within the EU, both the future candidate countries and the majority of non-candidate countries from South-Eastern Europe and Central Asia as well as from the Caucasus, Belarus, the Russian Federation and Ukraine should, quite justifiably, wish to move their ageing policies closer to policy positions of the EU-27 and North America. The role of the National Focal Points and their networks may come closer to that of members of the respective EU Social Protection Committee or others. Regional activities orchestrated by ECE and other regional agencies could help to bridge the Europe of 27 with the economically and socially diverse ECE region of 56 countries.

2. National capacity in ageing policy

Capacity development for national ageing-related policies with respect to the Madrid Plan and Regional Implementation Strategy within most ECE countries is quite weak, apart from a few notable and quite impressive exceptions. About half of the ECE countries have nominated Focal Points on Ageing (United Nations, ECE, 2006) and between 24 (second questionnaire of 2006) and 29 countries (first questionnaire, 2004) have responded to the ECE questionnaires on the Plan and Implementation Strategy follow-up; 14 countries have adopted their National Action Plan and in 8 countries such a document is under preparation. Some countries have not replied, including new EU Member States, and fewer than one third (18) of the countries have responded both times. Thus, undoubtedly, greater commitment from Governments is required in future activity.

While the priority areas fully correspond with the priority areas highlighted in the two core documents at the global level (United Nations, 2002a) and regional level (United Nations, ECE, 2006), participatory activities (corresponding to Commitment 2 of the Regional Implementation Strategy) seem to be much more developed than capacity building. Education and training programmes are in place in most of the responding countries, yet they are mostly available for professionals working with older persons rather than geared towards strengthening the skills of older persons themselves or their family caregivers, who are providing most of the informal care work. Even the training of elder-care professional personnel is frequently done for medical and non-medical staff in specialized courses and training modules, instead of devoting the resources to mainstreaming ageing and all ageing-related issues into existing curricula. Thus an

institutional preference for geriatric specialization as against mainstreamed ageing for a “society of all ages” is revealed.

One aspect of mainstreaming ageing has been considered more than others, namely the integration of population ageing and concerns of older people into national development plans, including poverty eradication or alleviation strategies. But even here, while political consciousness and sensitivity regarding old-age poverty may have grown, most pension policy-reform measures legislated or foreseen to take place will most likely increase the risk of poverty for older people (Zaidi, Marin and Fuchs, 2006).

Given the rapid — and rapidly accelerating — future aging trends within the ECE region, especially between 2011 and 2017, the current status of national capacities on ageing will have to be upgraded significantly if future requirements are to be met and coping with growing burdens is to succeed. Three critical test cases can serve the purpose here:

- (a) Balancing out fiscal and social sustainability, financial balance and sustainable livelihood in indispensable pension reforms
- (b) Enabling older persons to work longer while living longer and healthier lives
- (c) Creating quality LTC services

Those three cases in point can serve in checking to what extent national capacities on ageing policies actually match or do not match mid-term adjustment and long-term sustainability requirements — and the basic human needs of the persons concerned.

3. Indicators for monitoring progress in implementation

There was consensus at the Second World Assembly on Ageing in Madrid and at the Ministerial Conference on Ageing in Berlin, both held during 2002, that systematic review by the United Nations regional commissions would be essential for successful implementation of the Plan and its regional implementation by the Member States. Through the project “Mainstreaming Ageing: Indicators to Monitor Implementation” (MA:IMI), the European Centre for Social Welfare Policy and Research at Vienna collaborates with the ECE in monitoring implementation of the Regional Implementation Strategy throughout the 56 ECE countries.

In the absence of major ECE players beyond the EU in implementing the Madrid Plan, outstanding examples of good practices may not be easily found in the majority of countries; also, the exchange of experiences about overcoming persistent obstacles to regional cooperation cannot be done within an ECE context as easily as it could be within the EU framework. Exchange of experience in ageing-related policies throughout the region, data collection, research and analysis, and networking with organizations active in the field has been as much a task as the development of a set of agreed-upon indicators of achievement. That is being done in close co-operation with an international task force, the National Focal Points on Ageing, and a non-governmental organization, the Network on Monitoring RIS, as a counterpart to the governmental structure. A monitoring website,

technical workshops with key partners and publications are among the most notable MA:IMI tools.

Above all, the main objective of MA:IMI has been the development of indicators designed to translate the 10 commitments of the regional strategy and a great number of special objectives into a coherent set of clear, operational, measurable goals; and to monitor and measure to what extent countries are living up to those commitments. Whether the goals as well as the monitoring of their achievement can be accomplished is not yet clear. Apart from any success in attainment of the goals, the systematic monitoring of goal achievement would itself be an interesting signal of real ambitions at work, and a form of success. As much as goal realization and outcome impact, the systematic review and appraisal of implementation (or a lack of it) would already be a good sign of progress (or failure) in coping with ageing challenges within the ECE region.

VII. Ageing in Western Asia

Madiha El Safty³⁰

This chapter addresses the situation of older persons in the 13 countries of the United Nations Economic and Social Commission for Western Asia (ESCWA) from the perspective of the age group of 60 years and above, considering that 60 years marks the legal age of retirement in most countries of Western Asia. In certain instances, reference may be made to the Arab States, since the situation of older persons does not exhibit significant variations in the whole Arab region, and hence available data in many cases lump the countries together under an Arab umbrella.

The report starts with an overview of the demographic indicators in the ESCWA countries, highlighting changes as they reflect the situation of older persons, especially future projections. Variables relevant to the issues of ageing in the region are reviewed: poverty and employment, health, gender issues and services for older persons. Selection of particular variables has been based on their relevance to the situation in the region and their impact on ageing issues. Primarily, poverty constitutes a serious problem in most ESCWA countries. Secondly, the culture reveals persistent gender inequalities, to the disadvantage of women. Scarcity of resources is yet another significant factor, reflected in the lack of availability of quality health and social services.

This chapter also looks critically at the Madrid International Plan of Action on Ageing, examining how its different components relate to action plans and strategies in the ESCWA region. The conclusion spotlights those areas of priority that merit action if the issues of ageing are to be met as older people in Western Asia and their Governments would want them to be.

A. Introduction and overview

Countries of the ESCWA region have witnessed increases in their older population, despite the youthfulness of the population pyramid in most of those societies. The young segment of the population remains fast growing because of the high birth rates in the region. Youth aged 19 and under represent approximately one quarter to one half of the population in each country, with Iraq, the Occupied Palestinian Territory and Yemen having the highest proportion of young people. By contrast, the share of the population aged 60 years and above stands at about 5 per cent in the region, ranging from a low of 1.8 per cent in the United Arab Emirates to a high of 10.2 per cent in Lebanon (United Nations, 2007a).

While the growth of the older population is a global phenomenon, it is not monolithic and disparities cut across regions and individual countries, not only with respect to growth rates but also in the structure of the older population. The situation of older persons in any society is made up of a multitude of conditions. The cultural specificities in each society leave their impact on the whole ageing “problematique”. Attitudes are shaped

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according to norms and values of their respective cultural settings; the hardware, the availability of physical facilities provided in response to ageing issues, is likewise conditioned by the cultural base. A major determinant in each country is the economic resources that necessarily condition the scope and extent of different measures and policies targeting the older population.

A starting point in gaining an understanding of the situation of older persons is the mix of demographic changes taking place in the region. The growing proportion of older persons is a result of the improved public health situation: the expansion in health facilities and eventual rise in life expectancy, coupled with a decrease in infant and child mortality. The improvement in health conditions can be seen especially in the case of women's health, with the positive outcomes of reduced fertility and maternal mortality rates. In that context, technology transfer has played a significant role in the upgrading of health services and facilities.

A low level of policy concern. The demographic transition to an ageing society does not receive sufficient attention in most ESCWA countries. Policies and strategies concentrate on other priorities, probably underestimating the future impact of the changing situation in the population structure. With increasing social, economic and political problems on the horizons of policymakers, the ageing situation unfortunately does not occupy a prominent position on the lists of national priorities.

The increase in the older population is paralleled with other changes in their situation. In a tradition-dominated culture, ageing has been a guarantee of a privileged status, especially within the family structure. The extended family has allowed for the provision of care for older persons, not only as a service, but as an obligation. Religious values in the region, both Islamic and Christian, highly emphasize the caregiving role of the family. That may partially explain the relatively low concern of policymakers with ageing issues. The older segment of the population has traditionally been considered outside the Government domain, lying within family boundaries. Changing conditions in society have, however, led to shrinking family functions, including those related to care of older persons. Urbanization, labour migration and the changing role of women are major influences as well.

Urban and rural influences. Societal shifts towards urbanization have contributed to changes in the situation of older persons, often for the worse. The rural population retains its traditional value system, whereby care of older persons remains a family function. An older person in the rural family, according to cultural beliefs, is considered a source of blessing and wisdom. The demographic structure in the villages is likely to exhibit variations when compared with that of the city because of the tendency to have higher birth and death rates. Likewise, there may be differences between the two subcultures with respect to life expectancy. Yet, whereas the rural family position in caring for older persons remains unchanged, the urban milieu feels pressures that lead toward changes in those values and practices.

Although the rural family remains responsible for caring for older persons, their changing socio-economic situation still needs to be addressed by policymakers. The highest

proportion of older persons is in the rural areas of the region. Even if the culture provides for the care of elders within the family structure, their needs may not necessarily be properly covered. Health care is usually inadequate in rural areas. In addition, attitudes toward ageing may not be conducive for the provision of health care, since, in most cases, older people's health problems are attributed to their age. Furthermore, poverty is more prevalent in villages than in cities.

Labour and gender influences. Economic, social and political conditions have stimulated movement of labour between countries. Such labour-exporting countries as Egypt, Lebanon, the Occupied Palestinian Territory and the Syrian Arab Republic experience migration outflows, normally to the Gulf States, where better economic opportunities prevail. The youth migrate in search of jobs while the older members of the family remain in the mother country, frequently in need of care.

Another variable is the changing role of women, who are now permitted educational and employment opportunities. Traditionally, women have been mainly responsible for looking after the older persons in a family. Female employment outside the home has, however, made it difficult for women to cope with their many family obligations, care of older persons being among them. That responsibility might come last on the list of a woman's domestic chores, hence the rising concern for the situation of the older population in families where women are working outside the home.

Changes in society. As a result of these societal conditions, families are finding it difficult to retain their caregiving role, particularly as the patterns of extended family life have given way to the lifestyle of the nuclear family. Family values have been changing in line with changing social and economic conditions. The result is a culture that has shifted the position of the older family members from one on top of the family hierarchy to a lower one, in tandem with a change in attitude toward them, especially with respect to their care.

Gradually society in the region is coming to recognize the need to address the issues of ageing, at both community and national levels. Yet in the area of social security, for example, the needs of older persons are treated as part of a package for several target beneficiaries, including the poor, persons with disabilities and other marginalized groups. In the case of such a vulnerable segment as older persons, the bureaucratic and practical constraints interfere with their utilization of social security benefits and they find themselves thus in an increasingly disadvantaged situation.

Demographics of the aged. Reference to the older population must distinguish between the variations that cut across the ESCWA region. Older persons cannot be treated as a homogeneous group, but as a collection of different categories of people that must be taken into account when designing policies, programmes or any other form of action.

First, there are differences based on age, between the "oldest old" aged 80 years and above and the "young old" aged 60 to 79 years. Second, there are variations in physical ability, as older persons may develop functional limitations, including physical, mental, intellectual and sensory limitations, resulting from disabilities acquired later in life which

can impact their degree of independence. Third, there are differences in financial status, which determine both the needs of older persons as well as the resolution of those needs, especially when the individual may be living in poverty. Fourth, the gender issue reflects disparities with respect to social status, needs, and attitudes toward each sex, based on culture. The distinctions here cut across social class, differentiating among women in the different social strata.

Lastly, the rate of growth of the older population is different in different countries. Countries undergoing a rapid rate of ageing are Bahrain, Kuwait, Lebanon and the United Arab Emirates. Those with a medium rate are Egypt, Jordan, Oman, Qatar, Saudi Arabia and the Syrian Arab Republic. A slow rate of growth in ageing characterizes Iraq, the Occupied Palestinian Territory and Yemen (United Nations, 2007a). Variation in the rate of ageing is a determining factor in assessing priorities for action.

B. Demographic changes

The demographic transition among the 13 ESCWA countries is marked by a declining population growth rate. Between the years 1950 and 2000, the annual growth rate was 2.6 per cent. Based on current population estimates, annual growth is projected to decline to 1.99 per cent in the first quarter of the new millennium and decline further to 1.67 per cent in the following 25 years to 2050.

Among the various countries, however, disparity among annual population growth rates yields differences in the projections for the first half of the millennium (see table VII-1). Egypt, with the largest population of the ESCWA countries, is expected to maintain an annual growth rate of 1.0 per cent. Estimates for the United Arab Emirates and Lebanon, with the lowest rates in the region, are 0.7 per cent each. The highest rate appears to be that of Yemen at 3.4 per cent. The annual growth rate for the entire Arab region between the years 2000 and 2050 is estimated at 1.5 per cent (United Nations, ESCWA, 2004, pages 3–5).

Table VII-1. Annual population growth rate in ESCWA countries, 2000–2050, in percentages

Country	% Annual population growth
Bahrain	0.9
Egypt	1.0
Iraq	1.7
Jordan	1.7
Kuwait	1.5
Lebanon	0.7
Occupied Palestinian Territory	2.6
Oman	2.5
Qatar	0.8
Saudi Arabia	2.2
Syrian Arab Republic	1.6
United Arab Emirates	0.7
Yemen	3.4

Source: United Nations ESCWA (2004; adapted)

One of the key demographic changes among the 13 ESCWA countries is the rise in life expectancy. The average life expectancy at birth for the region reached 66.5 years in the years 2000 to 2005, having risen from 42.7 years only 50 years earlier. In another 50 years, life expectancy is projected to be approximately 77 years. Kuwait is expected to witness the highest rise in life expectancy, reaching 81.9 years by 2050 (United Nations, ESCWA, 2004, p.9).

In the year 2005 Egypt ranked highest in total population; including the highest number of older persons, those aged 60 and above, at 5.2 million or 7.2 per cent of the total population. In the rest of the region in 2005, the proportion of those aged 60 and above ranged from 1.8 per cent in the United Arab Emirates to 10.2 per cent in Lebanon.

Almost all countries are expected to witness major increases in their older population by the year 2050. (See table VII-2.) And in Bahrain, Kuwait, Lebanon and the United Arab Emirates, those aged 60 and above are projected to constitute nearly one quarter of the population by 2050.

Table VII-2. Estimates of persons aged 60 years and above in the ESCWA countries, 2005 and 2050, in thousands and as percentages of the total population

Country	Number of those 60+ (thousands)		60+ population of total population (%)	
	2005	2050	2005	2050
Bahrain	33	284	4.5	24.3
Egypt	5 247	23 432	7.2	19.3
Iraq	1 284	7 950	4.6	12.8
Jordan	281	1 928	5.1	19.0
Kuwait	84	1 306	3.1	24.9
Lebanon	411	1 236	10.2	23.7
Occupied Palestinian Territory	168	1 113	4.5	10.8
Oman	107	947	4.3	20.4
Qatar	22	300	2.7	22.5
Saudi Arabia	984	8 127	4.2	18.0
Syrian Arab Republic	894	6 916	4.7	19.8
United Arab Emirates	76	2 041	1.8	24.0
Yemen	789	5 440	3.7	9.4

Source: United Nations (2007a)

In discussing the demographic changes in the region, this chapter focuses on the two main age groups in the older population: the “young old” (those individuals between 60 and 79 years old) and the “oldest old” (those aged 80 years and above).

The proportions of these two age groups of older persons within the total population show wide variation at the beginning of this century and are projected to change dramatically by mid-century (see table VII-3). In the year 2005, the share of the oldest old within the population of those aged 60 and above ranged from 4.9 per cent in Qatar to 11.2 per cent in the Occupied Palestinian Territory, meaning that for every 100 people aged 60 or above in the territory, 11 of them were aged 80 and above. Similarly, projections indicate further variation for mid-century: from 8.0 per cent in Yemen to 20.2 per cent in Bahrain by 2050. Projections for the other countries lie within that range.

Furthermore, estimates indicate that both the percentage and size of the oldest old in the total population are expected to increase. By the year 2050, it is estimated that the percentage of the population aged 80 years and above will exceed 3 per cent of the total population in five of the 13 ESCWA countries (United Nations, 2007a).

Table VII-3. Percentage of the oldest old population (aged 80-plus years) within the total population, and as a percentage of the population aged 60+ of the ESCWA countries, 2005 and 2050

Country	80+ population of 60+ population (%)		80+ population of total population (%)	
	2005	2050	2005	2050
Bahrain	9.4	20.2	0.4	4.9
Egypt	7.7	13.1	0.6	2.5
Iraq	6.8	10.1	0.3	1.3
Jordan	7.8	14.5	0.4	2.8
Kuwait	5.4	17.8	0.2	4.4
Lebanon	9.5	16.9	1.0	4.0
Occupied Palestinian Territory	11.2	12.9	0.5	1.4
Oman	7.4	14.5	0.3	3.0
Qatar	4.9	14.6	0.1	3.3
Saudi Arabia	8.9	14.5	0.4	2.6
Syrian Arab Republic	8.9	12.6	0.4	2.5
United Arab Emirates	9.6	12.0	0.2	2.9
Yemen	7.7	8.0	0.3	0.7

Source: United Nations (2007a)

Gender issues in regional demography. The distribution of the oldest old population in the region reflects a gender imbalance in favour of women (see table VII-4). In the year 2005, the ratio of women to men among individuals aged 80 years and above in all the ESCWA countries averaged approximately 10:8, meaning that for every 100 females, there were 80 males (United Nations, 2007a). That is an illustration of the term “feminization of ageing”. Only 2 ESCWA countries were exceptions with respect to the gender ratio, Bahrain and Qatar, where men 80 years and above outnumbered women in 2005.

Table VII-4. Estimated total number of men aged 60+ and 80+ per 100 women aged 60+ and 80+ in the ESCWA countries, for 2005

Country	Sex ratio (men per 100 women) in 2005	
	60+	80+
Bahrain	101.9	101.1
Egypt	85.0	69.5
Iraq	88.0	73.2
Jordan	103.2	77.5
Kuwait	145.4	81.2
Lebanon	92.6	80.0
Occupied Palestinian Territory	75.1	69.0
Oman	110.2	61.4
Qatar	243.8	128.3
Saudi Arabia	108.1	76.3
Syrian Arab Republic	86.8	75.2
United Arab Emirates	176.5	80.9
Yemen	89.2	74.4

Source: United Nations (2007a)

An explanation of the variation in the gender gaps among countries may be found in cultural factors affecting female life expectancy. Furthermore, the gender bias in receiving health care may provide another explanation.

C. Ageing, poverty and employment

The ageing of populations raises many questions about the feasibility of providing health facilities and social security measures for the growing numbers of older persons. The challenge is great, especially for those countries that are already unable to provide adequate services to the older population. The high incidence of poverty aggravates the situation in many ESCWA countries, with older persons constituting a high proportion of the poor.³¹ Poverty is a major roadblock to the publicly declared attempts at development in the region. Whether defined in terms of per capita income or access to basic services such as education and health care, the incidence of poverty is visible in most countries in the ESCWA region. (See Van Eeghen and Soman, 1997; and Shaar, 2004.)

³¹No age-disaggregated data could be found about poverty rates of older persons in the region. However, other indicators point to higher incidence of poverty among older persons compared to that of the general population.

With the heightened concern over poverty generated by the World Summit for Social Development in Copenhagen in 1995, Governments have been designing programmes and strategies to reduce poverty. The United Nations Development Programme (UNDP) has been supporting ESCWA countries in formulating national strategies and action plans to fight poverty. Among their principal efforts have been the Poverty Strategies Initiative and its successor programmes that have been adopted in Egypt, Jordan and Lebanon. In Jordan, the National Aid Fund has been established with a pro-poor focus. In Yemen, efforts are under way to develop the National Plan for Poverty Eradication. The Syrian Arab Republic has incorporated the Strategy to Eradicate Poverty in its Ninth Five-Year Plan, as Law No. 54 of 2002. The objectives for those efforts have included increasing the awareness of policymakers about the necessity of making poverty eradication a major component of national plans.

Older persons should constitute a natural target for policy reforms that benefit the poor, since reduction in income is usually a consequence of old age, leading to limitation of access to basic services. Pro-poor initiatives fall short of a clear, direct approach to the aged. Older persons are lumped with other vulnerable groups as target beneficiaries. That may help explain why specific information about poverty rates of older persons is not available.

The official definition of poverty in Lebanon is a “condition of inability to meet those human needs than can be identified and structurally determined, and whose satisfaction is possible through economic resources”. The definition, in fact, refers to poverty of opportunity that indeed characterizes the life of a great proportion of older persons in the ESCWA region.

HelpAge International considers the condition of older persons as one of “chronic poverty” that entails a number of risk factors. Most significantly, chronic poverty is accompanied by poor nutrition and even hunger which can lead to poor health. When coupled with lack of health care, whether for financial reasons or otherwise, the combined conditions of old age reduce the capacity for work, adding to the factors that increase the likelihood of older persons becoming poor, and remaining poor. Moreover, poor health conditions may require special care far beyond the limited financial capabilities of older persons, in which case adequate treatment may be inaccessible.

Characteristically, poverty reduction programmes exhibit an obvious lack of coordination between the involved agencies that leads to fragmentation of policies and programme measures, and, in some cases, redundancy and reduced efficiency. Moreover, some of the policies of the different actors may conflict with each other. Civil society, including NGOs and other groups, participates in efforts to alleviate poverty through the adoption of programme activities and new technologies. However, coordination is also lacking here among the different components of civil society — NGOs constituting a major part — and between civil society and Government.

Poverty among older persons has the further dimension of invisibility: ESCWA countries lack accurate information about the incidence and distribution of their poverty. Poverty

reduction efforts require proper mapping of poverty. Its absence does not facilitate efforts to address the problems, especially in identifying poor older persons.

Effective approaches. Addressing poverty among older persons must be part of a comprehensive approach that includes a plan involving all Government agencies, in collaboration with civil society. However, the major provider(s) of services for the poor tend to be the ministries of social development or welfare, since such services fall under social welfare programmes.

Different measures are adopted in the various countries with no specific plan for covering older persons. In general, social welfare systems for older persons provided by Governments in the region appear inadequate in serving the target beneficiaries.

Social assistance for the poor in general, and older persons in particular, has traditionally been in a cultural context, mostly in the form of charity within the framework of society and family obligations as dictated by cultural norms and religious instructions. Charity towards the poor constitutes a basic part of the culture. Older persons are recipients of charity from individuals, but more so from NGOs whose major role is channelling assistance towards vulnerable groups.

Egypt is one example where social security laws of the State provide different types of pensions for older persons. Apart from retirement pensions for State employees, Law No. 30 on Social Security for the year 1977 is meant to provide for all people above the age of 65, as explicitly defined in the document, aiming to serve those workers who are not covered by pension laws or social security as well. Women who are eligible for benefits are single — never married, widowed, or divorced. For the never-married woman, eligibility starts at the age of 50.

The welfare system in Egypt may be adequately serving older persons, although a gender bias appears with respect to eligibility for the pension, since married older women are excluded from that benefit. In addition, the actual situation reflects an obvious gap between relevant laws and their utilization by the target beneficiaries. A major constraint is the bureaucratic procedures required to qualify for the pension. Women find it especially difficult to succeed in applying for their legitimate benefits, sometimes even impossible, because of the unavailability of documents in most cases. Another setback is lack of awareness among the target population about available social security schemes, either because of low educational levels, which render them ignorant of the key information, or because of inadequate or unhelpful publicity about those benefits.

Another factor discriminating against older persons in Egypt is their exclusion from programme measures in efforts to alleviate poverty. The Social Fund for Development was based on new policy, together with the Economic Reforms and Structural Adjustment Programme (ERSAP) adopted in the 1990s. It concentrates on development of youth, since Egypt has a multitude of problems related to the condition of youth — unemployment and low wages are typical examples. Moreover, the young dominate the age pyramid, hence attracting greater public concern compared with that of older persons.

The situation in other countries of the region does not differ from that of Egypt, considering the general conditions of social security schemes, as well as the situation of older persons. Social security and assistance laws may target older persons, as in the case of the Syrian Arab Republic in Article 46 of its Constitution: “The State insures every citizen and his family in cases of emergency, illness, disability, orphanhood, and old age.” Moreover, the Strategy to Eradicate Poverty has been incorporated in the ninth five-year plan (Law No.54 of 2002). The question here is how comprehensive is the coverage of older persons, especially those most in need. ESCWA estimates show that social security coverage in the region does not exceed 25 per cent of the population. Historically, Iraq was the first country to establish a social security programme, but current conditions in that country are definitely not conducive to the implementation of such schemes.

In general, pension systems in most countries provide 60 per cent of income on average for 30 years of service. There are, however, some important differences in the region. Retirement pensions are given as regular payments for employees covered by the social security laws in most countries. Lebanon and Yemen provide payments in lump sums at the termination of employment. Kuwait has one of the most generous social security schemes for retirement in the region. On retirement, employees are given 65 per cent of their last monthly payment, in addition to an extra 2 per cent of the last wage multiplied by the number of years of service beyond the first 15 years. That privilege can be granted before they reach the age of 60; or, if they so choose, starting from the age of 50. They can also receive a lump sum of 25 per cent of the total benefit (United Nations, ESCWA, 2004, p.26).

Some Gulf countries offer higher benefits than others. However, the beneficiaries of those schemes are limited to employees covered by the system. The problem arises with those above the age of 60 who are not covered by the laws, which presumably constitutes a significant proportion. Some people may be employed informally or not working at all, either because of inability to find work or, for the most part, because of disability. Interestingly, in some Gulf countries the law makes no reference to the retirement age for women (United Nations, ESCWA, 2002, p.7).

Because of limited coverage of social security for older persons — even lack of it in some sectors — older persons may continue to work beyond retirement age, sometimes under conditions of hardship, even when their health is poor. Job opportunities for both men and women are available in the informal economy in most developing countries. Workers in the ESCWA region are exposed to different sorts of exploitation, since labour laws do not protect them. In many cases older persons are employed in hard, tedious jobs that are far beyond their physical capacity. Examples here can be seen in construction, transport and delivery jobs. The situation of women is more drastic, since they represent the more vulnerable gender group. Older women may be found performing such jobs as cleaners and food vendors, sometimes even sharing with men the physically tedious work in the construction industry.

Workers in the informal economy in the Gulf region, however, are generally not drawn from the native population. They come from a range of labour-exporting countries,

mostly other Arab countries and South-East Asia. Migrant workers in general include older persons; their integration in the local health care and social security systems varies with their employment status, subject to labour regulations in the respective countries. The distribution of migrant worker types covers a wide range, from university professors to different levels of employees in the Government and private sector, to workers in all sorts of menial jobs. Workers in the informal economy fall in that latter group.

D. Ageing and health

The ageing of the population has given rise to new needs in health care. Countries are expanding their health services, especially in primary health care. National health programmes for immunization, infectious diseases, reproductive health, children's diseases and especially oral rehydration therapy have been launched in Egypt, Jordan and Yemen, for example. Expansion of services in reproductive health in particular is a priority in the region. State-provided services, for the most part, cover primary health care and are offered free or at nominal cost. Funds for primary health care may include varying proportions from foreign sources in the low-income countries, which have budgetary deficiencies in the health sector, as is evident in Egypt, Iraq, Jordan, Lebanon, the Occupied Palestinian Territory and Yemen. The health needs of older persons receive no special emphasis in the provision of primary health care services, however.

The Gulf States rank highest in availability and quality of health services. Kuwait and the United Arab Emirates are highest-ranked. Jordan provides another example of good health services. Yemen is one country in the region where efforts are being made to expand and upgrade available health services because of the currently low level of health indicators. In Egypt, religious institutions are additional providers of health-care services, as mosques and churches frequently include clinics where services are offered free or at very low cost.

Older persons have nonetheless benefited from the situation, although geriatric medicine is not commonly practiced; geriatrics is selected neither as a specialization by physicians nor as a service by target patients. Introducing geriatrics to address the health situation of older persons as a specialized branch of medicine is a positive step that has been taken in several countries. Egypt, Jordan and Lebanon have established geriatric departments in some faculties of medicine, leading to a relative increase in that specialization by physicians, followed by a relative increase in its practice.

The importance of geriatric medicine can be appreciated in relation to the general health condition of older persons. Ailments associated with ageing receive no special medical attention because of the widespread belief that they happen to be "normal" at that age. Hypertension, diabetes and cardiovascular, kidney and chronic renal diseases, Parkinson's disease, and even poor memory can go untreated, as a result. Also, older persons commonly suffer from multiple chronic diseases, in many cases resulting from lack of health care at younger ages. An older woman suffering from health problems usually blames the situation on her age, although the reason may lie in neglect of her health earlier in her life.

Specifically, there is growing concern about Alzheimer's disease. In Egypt the Alzheimer Society has initiated efforts to raise awareness about the disease, handling of patients and appropriate advice to give family members about dealing with the situation. The Middle East Association on Alzheimer's (MEAA), which is headquartered in Tripoli, Lebanon, has as its objective to expand education, stimulate research as well as its application, and train personnel, in the treatment of Alzheimer's disease.

The major dilemma in the health situation of older persons is not the unavailability of health care — although specialization may be lacking — but rather its inaccessibility. The State system, which is available either free of charge or at low cost, does not necessarily guarantee access to proper care, especially where resources are short, both human and financial. The rural sector, in particular, is highly disadvantaged. Moreover, the common prevailing attitude is that free services are of poor quality. On the other hand, the parallel private system is, for the most part, beyond the reach of the majority of older persons, considering their limited financial means. Providers in the private system include clinics and hospitals that charge different fees, some exorbitant. The health status of older persons is highly correlated with their economic condition. The two variables constitute a vicious circle that is closely linked.

E. Older women: their marginalization in an ageing society

The vulnerability of older persons is intensified by gender issues, as older women tend to be greatly disadvantaged. Old age can lead to the marginalization of individuals in a society where ageing issues are not addressed as matters of concern. An old woman is therefore doubly disadvantaged in a male-dominated culture where gender inequality still exists.

Legislation in most Arab countries guarantees equality of treatment to all citizens irrespective of gender, as explicitly stipulated in their constitutions. Moreover, the religion of Islam is an all-inclusive, comprehensive, worldly faith that grants women their human rights. However, gender inequality persists in ESCWA countries and women may still be underprivileged in many respects.

Illiteracy is higher among women than men. The adult literacy rate for Arab women is 51 per cent, compared to 73 per cent for men. Jordan, however, boasts the highest female literacy, at 86.6 per cent. School enrolment likewise reflects a gender disparity. The same situation appears with respect to employment, where female participation in the labour force is far lower than that of males. Arab female participation in the total labour force is only 10.6 per cent (United Nations, ESCWA, 2005).

An obvious illustration of women's disadvantages is their high numbers in the informal economy, where they are not guaranteed minimum wages, maximum working hours, environmental protection, sanitation, social security or health insurance. The high proportion of women engaged in informal work is attributed to their low educational qualifications and training. Although legislation does not officially discriminate against women in hiring practices and wages, equality is not reflected on the ground, where a gender bias characterizes hiring opportunities. The underlying factors have to do with the

prevailing cultural values and traditional norms of gender stereotypes that determine gender roles. The boundaries exclude women from public life, hence affecting their cultural image, which invariably extends to hiring opportunities. Women often have no other choice than to resort to work in the informal economy.

Where does the older woman stand? In the first place, women's generally low educational qualifications and training deny them good employment opportunities. The high illiteracy rate is more apparent in older women, who were not exposed to educational opportunities at a time when tradition was in greater control of their lives than it currently is, leading to their seclusion and hence denial of the right to education. The older women of today missed the expansion in educational opportunities that came at a later period. Especially in the rural sector, where traditional culture is most conservative, the issues of gender discrimination are very apparent, as exemplified by the low educational levels of rural older women.

The vulnerability of older women is also apparent in health matters. Health problems in older age are often the result of poor health care — or the lack of it — in earlier periods, especially for women. Females come at the end of the list of family members in receiving health care in the region. They have the same problem with respect to nutrition, even during pregnancy and breast-feeding periods. The situation of the girl child is yet another example of gender inequality in health. The traditional practice of female genital mutilation is still practiced in Egypt, in spite of intensive and extensive campaigns against it. Its incidence is not precisely known, but considered still high. Complications arising from that ritual usually appear later in a woman's life.

A cultural attitude in the region with a negative impact on women's health, especially in old age, is the perception that pregnancy and childbirth are natural phenomena that need no medical intervention. Consequently, a woman does not receive health care during this period, irrespective of ailing symptoms or complications. Most women seek help from providers of folk medicine, the traditional midwife being the most common source. In both cases, whether the woman receives no care or she resorts to folk medicine, the probability of exposure to health hazards is high, the complications of which may last until old age, or at best appear during that stage of life. Again it is the rural woman who is most likely to experience the worst of such problems.

A common health problem that appears in older women is deterioration of urinary and fecal control. Incontinence among older women, as a result of "intrinsic" or natural age-related changes, is undoubtedly a source of embarrassment and discomfort to them, as much as it is a source of inconvenience and effort to their care-providers, who therefore need to have an understanding attitude.

However, with the trend in upgrading health services and expanding them in countries of the region, female health status has been improving, albeit slowly. Reduced maternal mortality is a case in point, although significant disparities remain between countries, ranging from a low of 5 women per 100,000 live births in Kuwait, to a high of 350 women per 100,000 live births in Yemen, for the year 2000 (UNDP, 2005). Iraq has been affected by long years of international sanctions, followed by still-persisting conflict.

Maternal mortality is high, having almost doubled since the 1980s: current estimates are 250 women per 100,000 live births, compared to 117 in the earlier period (Save the Children, 2006).

The vulnerability of older women, in light of the foregoing discussion, is the cumulative result of a gender bias that has materialized in the form of poverty, poor health and even marginalization. Consequently, countries of the region are focusing on gender issues in order to redress the problems. Policies to expand female education have been implemented, with positive impacts being seen particularly in Bahrain, Jordan, Kuwait, Qatar and the United Arab Emirates, where female enrolment in education has increased and female illiteracy has declined. Egypt has channelled its policy actions towards improving women's status through a national campaign for female education, among other programmes.

F. Services for older persons

The social and demographic transformations in ESCWA countries that affect the situation of older persons have led to the establishment of services in response to emerging needs. The creation of nursing homes is one such development. Nursing homes fall under two categories: State-run or privately sponsored, in the latter case mostly by NGOs. State-run services are either offered free of charge or at a nominal fee. Private nursing homes require fees, which in some cases are exorbitant. Some NGOs, however, offer free services. Nursing homes affiliated with religious centres such as mosques and churches are a growing trend. In most cases they offer essentially free services and are meant to cater to the needs of the poor, in line with their religious values of social cooperation — mosques and churches play a major role in providing help for older persons, as charity work. Muslim and Christian institutions provide such services in Egypt, Jordan and Lebanon, among other countries.

Public- and private-sector nursing homes vary in the quality of services they provide. State-run homes are usually of a low quality, in terms of both service and general condition, whereas private institutions usually deliver a superior quality, based on the costs involved.

While nursing homes are not widely available and the shortage of homes constitutes a problem, a more serious concern remains the persistently negative cultural attitude toward them. Despite changes in society, nursing homes are perceived negatively, not in relation to quality, but in terms of general acceptance of the concept itself. Families whose elder members have been placed in such institutions are socially stigmatized as having neglected their elders and discarded a family obligation of great value in their society.

Another type of service that is provided for older persons in countries such as Egypt is “clubs for the ageing” that are actually like day-care centres. They provide daytime facilities for such activities as playing backgammon and cards, and watching television; reading materials are available and in many cases religious seminars are held, a service

highly valued by older persons. The clubs also organize social events such as picnics and trips to visit theatres, museums and cultural places, at relatively low cost.

Services offered to older persons reflect class distinctions, and clearly benefit the well-to-do. Private nursing homes that require high fees are definitely beyond the reach of poor and even middle class families. Clubs are a luxury that underprivileged people cannot afford, not only because of the cost of membership, no matter how low, but because they are already preoccupied with worries related to their basic needs. Participating in such activities would be far beyond their lifestyle. Moreover, such services are not advertised properly and are thus not widespread.

Another service for older persons in Egypt has come to be known as “elderly sitters”, analogous to babysitters. They are arranged by NGOs, among other community sources, and hired by the hour according to need. The service is also not widespread, in part because it is not properly advertised. Secondly, it reflects a social class bias, since it entails cost. The cost, however, varies. Some NGOs ask relatively low fees, although still out of reach of the majority of the target beneficiaries. Other NGOs charge relatively high fees because their services are of high quality and given by highly trained caregivers.

Egypt also provides an additional privilege for older persons known as “the gold card”. The owner of such a card must be aged 60 years or above, and he or she is accorded a number of privileges that include reductions in transportation charges, including airfares, and cultural activities, among other facilities. Helpful as such a service would appear, it entails many bureaucratic procedures, not only in issuing the card, but in processing the privileges it grants. Consequently the actual gold-card beneficiaries are few in comparison with the size of the target population.

A pioneering experiment in the region is at an embryonic stage: the Egyptian Government has initiated a plan to build an institute of ageing, an academic centre for multidisciplinary studies on ageing and for the broad concerns of older persons in Egypt. Health care, nutrition, physical education, psychology, sociology, rehabilitation and environmental sciences are on the institutional agenda. The objective is to create a pool of personnel qualified to assist older persons and address their diverse needs. In addition to academic matters, the plan includes an attached hospital, well equipped for relevant services, a club and recreational activities. Such an ambitious project, although in its very initial phase, is promising and could very well provide support for the lives of older persons. It could also serve as a model for other countries.

G. The Madrid Plan and ESCWA countries: the relevance of international priority directions

Population ageing presents a major challenge to countries in the ESCWA region, especially since awareness of the demographic changes is not yet strong enough to encourage adoption of policies and strategies that address the situation of older persons with its multifaceted dimensions. In addition, cultural and economic constraints interfere with implementation of such policies.

Countries of the ESCWA region have committed themselves to implementing the Madrid Plan and have also formulated the Arab Plan of Action to the Year 2012, based on their respective national reports and programmes on ageing (United Nations, ESCWA, 2002). The Arab Plan was adopted just before the Madrid meeting in 2002 as a follow-up to the Vienna International Plan of Action on Ageing of 1982. Much of the document came from the draft text that was negotiated by Governments and later adopted in Madrid. The Arab Plan focuses on achievements in the area of ageing, identifying the challenges and highlighting the mechanisms that can help improve the situation.

The following section of the present chapter addresses the relevance of the three priority directions of the Madrid Plan, and correspondingly the Arab Plan.

Priority direction 1: “Older persons and development.” A major challenge in implementing the recommendations of the Madrid Plan lies in the economic conditions in most of ESCWA countries. The region includes a wide range of rich and poor countries. The per capita income in the Gulf States of Kuwait, Qatar and the United Arab Emirates ranks high on an international scale, whereas in Yemen it occupies a very low slot.

The poorer countries of the region are at a disadvantage in allocating job opportunities to older persons. The Economic Reforms and Structural Adjustment Programmes (ERSAP) that most of these countries are implementing create economic bottlenecks, especially where employment opportunities are concerned, and unemployment remains a serious problem. Under such conditions, older persons stand no chance in participating in the labour force when youth are already experiencing serious unemployment problems. Beyond public opinion that gives youth priority over older persons in being gainfully employed, legislation considers youth to be the main target for the labour market. ESCWA countries may, therefore, hardly be able to guarantee older persons “access to equal opportunities”, as well as “take action to provide older persons with employment opportunities”, as is also stipulated in the Arab Plan of Action on Ageing to the Year 2012, in line with priority direction 1.

The situation in most ESCWA countries with respect to the concerns of ageing and development is well described in the Madrid Plan, which states that: “developing countries face the challenge of simultaneous development and population ageing”. In that light and considering the foregoing discussion, action to provide employment opportunities for older persons in most ESCWA countries is difficult to implement.

Volunteer work is a possibility that could have a role in keeping older persons active in society, but that would be limited to the well-to-do, those who could afford to work without pay. Volunteer work could help in supporting the psychological well-being of older persons, but would be no solution for those who need income.

The broader contribution of older persons to society “reaches beyond their economic activity”, as stated in both the Madrid Plan and the Arab Plan. Their family-based role in caring for other members, especially children, in participating in household chores, especially where the younger women are overburdened with responsibilities, and in undertaking subsistence production, are all examples of their possible contributions in

situations where paid employment is not available as an alternative. Although such contributions might not be financially rewarding for individuals, they would have indirectly positive impacts on the community level.

Issue 6 of priority direction 1 in the Arab Plan addresses “Access to education and training” for older persons. Policies that guarantee that right are generally absent in the region, although sporadic efforts may be seen. Some Gulf States offer educational and training opportunities for older persons by providing special programmes in computer skills and other studies, preparing them for productive work (United Nations, ESCWA, 2002, p.5). Insufficient information is available, however, on what use is made of such opportunities, whether on the individual or State level.

Issue 6 also deals with “eradication of poverty”. With the increase in poverty in the region, in combination with the increasing proportion of poor older persons, there is an urgent need to guarantee that programmes to alleviate poverty specify older persons as target beneficiaries. Even though charitable organizations currently make significant contributions to reducing poverty among the elderly, the responsibility of the State to assist poor older persons must not be forgotten. Coordination with civil society is likewise necessary.

Even more important is the need to guarantee that the social security system reaches older persons throughout all sectors of society — especially workers employed in the informal economy, the rural population, the non-working segment, and the large proportion of persons with disabilities.

The Arab Plan acknowledges that despite “earnest endeavours” by countries to address poverty among older persons, “few have the capacity to alleviate the suffering” of that group (United Nations, ESCWA, 2002, p.15). A major explanation is that policies of those countries inadequately address poverty among older persons. Ageing must therefore become incorporated as part of a package addressing the needs of marginalized groups.

Priority direction 2: “Advancing health and well-being into old age.” An increase in the health and well-being of older persons in the region has led to an expansion of health services, as well as an attempt to upgrade those services. Rural areas, earlier neglected in the provision of health care, have become better served by Governments. Consequently, older persons are expected to benefit since good health is an achievement of lifelong care, and neglect in the earlier years can lead to health problems later in life.

Even though both the Madrid Plan and Arab Plan emphasize the need to train health-care professionals in geriatrics, other health priorities prevail. Thus geriatrics is a branch of medical practice that is not yet widespread enough among ESCWA countries. There are also issues concerning accessibility of services, as well as access to safe drinking water among certain segments of the population. Caregiving facilities needed for persons with disabilities are mostly inaccessible, aggravated by the absence of a proper social security system.

Adopting a “comprehensive health insurance system” without any form of discrimination, as is stipulated in the Arab Plan, has not been implemented in all countries of the region. The Gulf States have generally provided free health care of good quality to the older segments of their population. Other countries of the region that have health insurance systems, however, do not guarantee universal coverage for older persons. Moreover, mental health problems among older persons may often be neglected and go untreated.

Priority direction 3: “Ensuring enabling and supportive environments.” Proper facilities to accommodate older persons are not always available in most countries, and when found, are far beyond the average citizen’s means. In addition, transportation, accessibility and safety for older persons are not always guaranteed. Cases of abuse have been reported, some including violence against older persons, both physical and in terms of social mistreatment. Legislation does not explicitly cover abuse of older persons, although the Arab Plan calls for the elaboration of legislation in order to assure the protection of older persons against abuse.

One example of constructive action that speaks to the issues faced in implementing priority direction 3 is the World Health Organization’s “age-friendly cities guideline”, which aims to provide “a framework for policies, services and structures related to the physical and social environment that will support and enable older persons to age actively and participate fully in society” (United Nations, 2006a, para. 61). Lebanon is one country in the region currently involved in fieldwork to implement this guideline.

Both the Madrid Plan and the Arab Plan emphasize Government support to families that are caring for older persons, especially where Governments cannot provide universal coverage for social assistance. Nonetheless, such policies have not yet been articulated in the region. In his report to the Commission for Social Development of the Economic and Social Council (United Nations, 2006c, para. 34), the Secretary-General observed that policy-level “support for families caring for older persons is rare...” in the ESCWA region.

Compassion or the “human factor” is greatly reinforced in cultural practice and religion as a means of ensuring a supportive environment for older persons, particularly where proper facilities are lacking. Intergenerational care and support ensure that older persons in the family are not distant or disengaged from younger members. On the psychological level, intergenerational communication helps to preserve family and societal relations for older persons, and respect for elders is generally maintained.

Yet despite the important role of families in providing older persons with an enabling and supportive environment, the State role cannot be undervalued, particularly in view of the socio-economic and attitudinal changes taking place in the region.

H. Priorities for future action

The following represent the priorities for future action on ageing issues within the ESCWA region, as elaborated in the Arab Plan.

1. Database on ageing by country

Better data on older persons in the ESCWA region are needed, encompassing a full range of age groups, socio-economic levels, rural–urban distribution and disaggregation by sex. The collection of reliable data could ensure that policies and measures are appropriately directed toward the target beneficiaries. The various countries in the region have agencies responsible for statistical surveys that can undertake this data collection. These efforts can be supported at the regional level by such organizations as ESCWA, the Arab Gulf Programme for United Nations Development Organizations (AGFUND) and various Arab League committees.

2. Coordination among agencies

Currently, there is a lack of coordination between agencies concerned with ageing, both formal and informal, creating unnecessary duplication of effort. Better coordination could be achieved through networking among all concerned parties, including Government, civil society and the private sector. However, greater effort is needed by the private sector to provide services for older age groups, especially in countries where the private sector has become an active partner in building the economy. A coordinated approach would also ensure that ageing issues are addressed from a broadened perspective – one that includes the protection of rights of older persons, their active participation and contribution to society, intergenerational issues and research on factors affecting their situation. Ageing issues should also be incorporated into a wide range of sectors and programmes, including, for example, those dealing with poverty, health and women’s issues.

3. Empowerment of older persons

The Commission for Social Development has emphasized the empowerment of older persons through a bottom-up participatory approach. Thus the first five-year review and appraisal of the Madrid Plan that started in 2007 is to be based on the opinions of older persons. “The immediate purpose...is to ensure that older persons have an opportunity to express their views on the impact of national policy actions affecting their lives. However, the overall goal is to ensure that older persons are involved in all phases of policy actions on ageing, including policy design, implementation, monitoring and evaluation” (United Nations, 2006c, para. 50).

4. Providing an enabling and supportive environment

ESCWA countries need more nursing homes for older persons, especially considering the changing social and economic conditions in the region that will leave increasing numbers of older persons with no other care available. Efforts are needed to upgrade conditions in such institutions, although in most cases, Governments have not allocated sufficient funds to achieve this objective. The private sector could also play a role, especially for vulnerable low-income groups.

To counter the persistent social stigma associated with nursing homes, Governments should begin to provide home-based support to families with older persons to help them

fulfil their caregiving responsibilities. Such support could take the form of subsidies, tax exemptions and social security. The benefits could help families provide care for older persons in their own homes, thus avoiding negative psychological repercussions of neglect, exclusion and marginalization. At the same time, older family members would remain in the company of their loved ones in the warmth of a family atmosphere, further enhancing their psychological well-being. Family support benefits would also serve to protect families from the social stigma associated with placing older family members in institutions.

The League of Arab States adopted a charter in 1970, which was amended in 2001, affirming “the need for older persons to be cared for in their natural environment, namely, the family, and for needy families to be provided with the assistance necessary for them to continue to provide such care” (United Nations, ESCWA, 2002, p.8). Similarly, the Strategy for Social Work in the Arab Countries, which was adopted in 1979 and amended in 2001, confirmed the goals of the Charter of the League of Arab States. The charter advocates the role of Governments in establishing nursing homes for those older persons whose situation requires that they be housed in such institutions.

Further efforts have been made by the Council of Arab Ministers of Social Affairs. The Council, which was established in 1980, has held conferences, seminars and workshops in order to broaden the scope of ageing issues for those working in that field. One major component of those efforts has been NGO support to caregivers of older persons at day-care centres and nursing homes, as well as the provision of home support for families with older persons.

5. Health and well-being for older persons

Although the health status of older persons has improved generally in the region, older persons still lack adequate health-care services in general and primary health care in particular, especially in rural areas. If older persons are to enjoy active ageing, they will need appropriate health care, even if their health had been neglected earlier in life.

The health status of older persons is the cumulative result of health care received throughout their lifetime. Health-care facilities should thus be available for the population at large, enhanced by centres of geriatric medicine for older persons. Moreover, older persons with disabilities need special care. Extensive awareness campaigns are also necessary to clarify cultural misconceptions about the health conditions of older persons. In general, the proper provision of care for older persons must integrate “preventive, curative and rehabilitative measures within a continuum of care, including palliative care, and enhancing support for caregivers” (United Nations, 2006c, para. 26).

6. Building national capacity

National capacity to implement the Madrid Plan is lacking in the ESCWA region, as the institutional and legal infrastructure is inadequate to the task. Where Government agencies dealing with issues of older persons exist, for example in Egypt and the Syrian Arab Republic, they are departments within the ministries of social affairs and tend to

have a relatively low profile. They need to be upgraded and expanded, with the objective of mainstreaming ageing issues into national policies and programmes, as specified in both the Madrid and Arab plans. In addition to securing better coordination among agencies, advisory bodies on ageing should be established at different levels of the Government. More ambitiously, special bodies on ageing issues could be designated to act as focal points for all relevant policymaking units.

Appropriate human resources are also needed to deal with ageing issues, and personnel should be trained in designing and managing social security programmes, budgetary plans, health-care and social services. Existing systems in the region mostly depend on NGOs with little, if any, training. Currently, health-care personnel, social workers and policymakers are not specialized in dealing with ageing issues. Training for social workers in the needs of older persons or their caregivers is “rare, or even nonexistent” in the ESCWA region (United Nations, 2006c, para. 34). Field training for health-care professionals is lacking and therefore highly recommended.

Training support from international agencies can help in developing national capacity on ageing issues. The Arab Plan highlights the importance of regional and international cooperation; although technical support for capacity-building in the region tends to focus on issues other than ageing that assume greater priority for the countries concerned.

A shortage of financial resources also constrains policies and programmes on ageing. If older persons are to be targeted in poverty reduction strategies, social security and other policy areas, additional financial resources are needed. Given the projected demographic transition, Governments should allocate an increased share of State budgets to meeting the needs of the growing numbers of older persons – particularly in the areas of health care and social security. International assistance can also help in providing funds for capacity-building in cases where national budgets fall short.

Progress in building national capacity can be boosted with greater research on ageing issues, since very little research is available outside of academic circles. Steps to expand research and enlarge the available pool of data and information could doubtless point to effective modes of action. One relevant example is the in-depth study conducted in 2003 by the WHO Regional Committee for the Eastern Mediterranean, focused on the current state of community-based care for older persons in Bahrain, Egypt and Lebanon. Such a study could serve as a good basis for devising appropriate policies for the integrated care of older persons.

VIII. The way forward

Alexander Sidorenko and Robert Venne³²

Since the Second World Assembly on Ageing in 2002 at Madrid, Governments have introduced a wide range of policies and programmes that address various challenges stemming from population ageing. During 2007, all five regional commissions of the United Nations organized special events that marked the fifth anniversary of the Madrid International Plan of Action on Ageing.³³ The focus of activities in this anniversary year was on the review and appraisal of implementation of the Madrid Plan of Action, with stocktaking of progress as well as shortcomings of the implementation process, and suggestions and ideas for charting a course for further action.

A bottom-up participatory assessment was chosen to be the principal approach for the review and appraisal exercise.³⁴ The central idea of a bottom-up approach is to allow the traditional intergovernmental deliberative process to benefit from a participatory assessment involving older persons to determine whether the Madrid Plan's objectives are being achieved at local, national, sub-regional and regional levels (United Nations, 2006b). While the principal “site of action” of the review and appraisal is the national and even local level, the regional component of the review and appraisal exercise has been quite prominent. In addition to promoting networking among the various stakeholders, the regional commissions were also expected to assist countries throughout the process of gathering and exchanging information, including its distillation and analysis, towards formulation of findings and priorities for future policy action at the regional level.

A. Regional events for the review and appraisal process

The Asian and Pacific region. The Economic Commission for Asia and the Pacific (ESCAP) held the High-level Meeting on the Regional Review of the Madrid International Plan of Action on Ageing from 9 to 11 October 2007 in Macao, China. The country assessments presented at the meeting reflect the gradual change in policies and programme approaches since the Second World Assembly on Ageing. In the face of growing needs of older persons, especially social security and long-term health-care concerns, many countries in the ESCAP region have demonstrated a growing fiscal sensitivity in allocating public resources to meet those needs and have developed long-term plans and policies to deal with ageing. National mechanisms have been installed to oversee the development and implementation of projects and programmes related to ageing. The ESCAP meeting report (United Nations, ESCAP, 2007) observes that countries in the region with higher levels of socio-economic development were ahead of other countries in taking proactive measures against ageing. Inadequate allocation of

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³³ Copies of the reports from these regional meetings are available on the website of the United Nations Programme on Ageing (http://www.un.org/esa/socdev/ageing/regional_review.html)

³⁴ See Resolution of the UN Economic and Social Council 2003/14 (http://www.un.org/esa/socdev/ageing/documents/cosd_resolutions/resolution_2003_14.doc)

funds and difficulties in acquiring expertise and information continue to hinder governmental efforts to develop effective interventions to meet the escalating demands of ageing. Currently, income security in old age, public awareness about the benefits of active ageing, and intergenerational solidarity dominate the policy agendas on ageing of most countries.

Increasing awareness of ageing issues has also prompted many Governments to involve major national stakeholders in partnerships for tackling challenges brought about by ageing. Many Asian and Pacific countries are seeking collaboration with NGOs in preparing their national review and appraisal of the Madrid Plan. Such collaboration and increased transparency helps bolster the value of bottom-up participatory approaches to the evaluation of the Madrid Plan. Nearly half of the countries surveyed by ESCAP report having used participatory tools, such as client satisfaction surveys and focus-group research, in conducting analyses of their situations.

While Governments in the region are increasingly recognizing population ageing as a development issue, their record of mainstreaming ageing concerns into development agendas at the country level is mixed. Some of the difficulty may be attributed to insufficient funds, inadequate training for programme implementation and limited interdepartmental cooperation. Since Governments have begun stepping up their policy attention to ageing over the past five years, the need to mainstream ageing into development policy areas in alignment with regional and global norms and standards has become more obvious. For example, the Government of China included modalities for mainstreaming ageing concerns in its Tenth National Five-Year Development Plan on Ageing, 2001–2005. Generally, the more affluent countries have achieved greater progress in mainstreaming ageing in development policies and creating supportive environments for active ageing.

The African region. The Economic Commission for Africa (ECA) organized an Expert Group Meeting on Ageing in Addis Ababa, Ethiopia from 19 to 20 November 2007. The countries of Cameroon, Ethiopia, Ghana, Mauritius, South Africa, Uganda and the United Republic of Tanzania were invited to present their country review and appraisal reports. The meeting focused on those reports and on the contents of the 2007 ECA report on ageing in Africa, an exploration of selected topics on ageing in Africa and future policy and programme directions.

Regarding mainstreaming of ageing considerations in national development, the United Republic of Tanzania incorporated several cross-cutting issues in its National Strategy for Growth and Reduction of Poverty (NSGRP) that extends from 2005 to 2010. Uganda set up a cross-ministerial, multisectoral working group consisting of the ministries of Gender, Labour and Social Development; Agriculture; and Finance Planning and Economic Development, and two local NGOs. The task of the group is to mainstream ageing into health and nutrition policy.

The Latin American and Caribbean region. The Economic Commission for Latin America and the Caribbean (ECLAC) adopted its regional strategy for implementing the Madrid Plan in 2003. ECLAC held the Second Regional Intergovernmental Conference

on Ageing from 4 to 6 December 2007 in Brasilia, Brazil. In preparation, ECLAC sent a questionnaire to Member States on ageing-related issues and issued a Spanish-language guide for participatory evaluation of ageing policies and programmes. The conference determined priority areas for the Regional Strategy for the Implementation in Latin America and the Caribbean of the Madrid Plan to tackle during the next five years.

Among notable successes in participatory evaluation of the Madrid Plan in the ECLAC region, Argentina performed a bottom-up evaluation of the national programme for home care. The National Council of Human Rights of Older Persons in Brazil used a participatory process in the work plan to implement the “Law of human rights of older persons” (*Estatuto Idoso*). Panama included a participatory approach to the national policy on ageing, while Bolivia, Panama, and Peru drafted their respective national reports on implementation activity with participatory methodology. Bolivia, Colombia and Peru cooperated with NGOs in their evaluations.

The European region, including North America and Central Asian republics. The Economic Commission for Europe (ECE) held the 2007 UNECE Ministerial Conference on Ageing from 6 to 8 November 2007 in León, Spain. The conference presented an overview of the ageing situation and adopted a Ministerial Declaration. An expert group provided policy advice and assistance to the Intergovernmental Preparatory Committee of the Conference. NGO representatives were active in that committee and contributed to the draft declaration. A civil society forum and a research forum were held prior to the conference in León on 5 November 2007.

In the ECE region, a report on regional activity in implementing the Madrid Plan was issued in preliminary form that summarizes ageing-related policy activities and highlights priority areas (United Nations, ECE, 2007). ECE Member States reported on a variety of policy-related actions with regard to each of the 10 commitments of the Regional Implementation Strategy (United Nations, ECE, 2006/2002). Countries in the region have been innovative in responding to demographic ageing, mostly by adopting age-specific policies in, for instance, such areas as age discrimination; age-adequate infrastructure; economic, political, social and cultural participation and integration of older persons; adjustment in social protection and health-care systems; promotion of life-long learning; and support for caregivers as well as strengthening of long-term care systems. Although most countries follow a holistic approach in their ageing policies, none mentioned specific efforts to mainstream ageing into other policy fields. Meanwhile, many countries identified mainstreaming across all policy areas at the local, national and international levels as a major priority for the coming five to ten years. Five ECE Members reported having used participatory mechanisms in the review and appraisal process. Most countries reported strong involvement of civil society organizations in policy formulation.

The Western Asian region. During the lead-up to the Madrid Assembly in 2002, the Economic and Social Commission for Western Asia (ESCWA) adopted the Arab Plan of Action on Ageing to the Year 2012. To mark five years since the adoption of the Madrid Plan, ESCWA organized a regional seminar in Amman, Jordan from 20 to 21 November 2007 that reviewed and appraised progress made at country level. Besides reviewing

country situations, the seminar took stock of regional experiences, identified good practices in implementation and priorities for the future, and adopted recommendations for action.

B. Planning for the future

The findings of the first cycle of the review and appraisal of the Madrid Plan revealed major trends in the area of ageing and policy responses to them. As discussed in detail in this publication, since the Second World Assembly on Ageing in 2002, national policy actions on ageing in various world regions have focused primarily on sustainability of social protection systems, participation of older workers in the labour market, and approaches to health care and social services for older persons. Growing attention has also been given to the empowerment of older persons, including the protection of their rights, facilitation of their participation in society, and promotion of positive and balanced images of ageing (United Nations, 2006c).

In their policy actions since the Second World Assembly on Ageing, Governments have paid particular attention to developing and/or strengthening the essential elements of their national capacity on ageing, including mobilization of financial resources, a sound policy (and political) process, institutional infrastructure, human resources, and policy-related research. The review and appraisal exercise helped to identify the major trends in international policy action on ageing and collected replicable good practice.

The review and appraisal has also revealed major shortcomings in global efforts to reach the objectives of the Madrid Plan. Notwithstanding many worthwhile initiatives on ageing during the first five years of the implementation process, it appears that progress in several crucial areas remains slow and insufficient. Among the areas of insufficient progress are mainstreaming of ageing, participatory involvement of older persons in implementation and evaluation of national activities, and evidence-based approaches to policy development, implementation and evaluation.

The Madrid Plan clearly states that mainstreaming of ageing and the concerns of older persons into national development frameworks and poverty eradication strategies is a necessary first step in the Plan's implementation. At the international level, the Madrid Plan emphasizes the important role of United Nations funds and programmes in ensuring integration of the questions of ageing in their programmes and projects, including at the country level. Meanwhile, mainstreaming efforts remain sporadic around the globe. This is particularly worrisome in developing countries whose limited resources make mainstreaming an approach of choice in addressing the needs of vulnerable societal groups, including older persons.

Resolutions of the General Assembly and the Commission for Social Development have elaborated and expanded the idea of a bottom-up participatory approach as the principal dimension of the entire implementation process: from policy design to its monitoring and evaluation. Yet the review and appraisal exercise revealed that the bottom-up participatory methodology has been used on an ad hoc basis and the involvement of older persons in policy processes has been limited.

Findings from the review and appraisal process also indicate that improvement could still be made in collecting reliable and timely data disaggregated by age, sex, socio-economic status and health status. At the same time, evidence-based policy action should also involve quantitative and qualitative analysis of collected information from different viewpoints, and formulation of relevant conclusions. In addition, research findings have to be appropriately presented and thoughtfully communicated to end-users, primarily policymakers, as well as the general public and media through interactive participation. Unfortunately, research and policy are often disconnected at different levels – global, regional and national, and communication between policymakers, practitioners and researchers is poor.

Clearly, furthering the implementation of the Madrid Plan towards the end of its first decade in 2012 would require additional efforts to bring mainstreaming, along with a participatory and an evidence-based approach, to the core of national, regional and international activities on ageing.

In accordance with the resolution of the General Assembly,³⁵ a strategic implementation framework will be prepared for the consideration of the Commission for Social Development at its forty-seventh session in 2009. Such a framework would identify policy priorities for the future as well as measures for international cooperation to support national implementation activities. All major national and international stakeholders will be invited to cooperate with the Secretariat of the UN Programme on Ageing in developing the framework.

The national, regional and global deliberations of the first cycle of the review and appraisal are envisaged to provide core analytical information for the formulation of the strategic implementation framework. Significant inputs are expected from independent review and appraisal exercises undertaken by civil society, including academia and NGOs. Thus the preparation of the strategic implementation framework is envisaged as a consultative process of receiving and analyzing contributions from various stakeholders, and development by the UN Secretariat of a draft document which would be reviewed and consolidated at a meeting of independent experts in 2008 and submitted to the Commission for Social Development in 2009.

The future strategic framework could include analysis of the major findings of the first cycle of the review and appraisal, together with the identification of principal advancements, as well as obstacles encountered during the first five years of the implementation of the Madrid Plan. Particular attention would be paid to detecting policies that work in different settings and developmental contexts, and to revealing replicable good practices. The implementation framework would also identify major prevailing trends on ageing and policy priorities to respond to the new and continuing challenges and opportunities of population and individual ageing.

³⁵ See Resolution of the UN General Assembly A/C.3/62/L.9

The future strategic framework will identify a specific focus for the next stage of the implementation of the Madrid Plan and propose viable policy measures to streamline implementation towards the end of its first decade in 2012. Thus the ultimate goal of the framework is to promote policy action on ageing within the strategic directions outlined during the Second World Assembly on Ageing.

Implementation of the Madrid Plan is and will remain an immediate responsibility of national governments. At the same time, one would argue that without well-coordinated international cooperation, implementation of international policy frameworks on ageing, including the Madrid Plan, will remain uneven and insufficient. Thus measures to improve international cooperation, including technical assistance on ageing, should be given proper attention in the future implementation framework. Effective and efficient international cooperation would help to ensure that the international policy documents on ageing are being translated into practical programmes and projects with fruitful results, particularly in developing countries and countries with economies in transition.

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