

FOR PARTICIPANTS ONLY

21 December 2006

ENGLISH ONLY

UNITED NATIONS ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE
PACIFIC

**UN REGIONAL WORKSHOP ON GENDER-RESPONSIVE HEALTH SECURITY FOR
THE ELDERLY**

18-19 SEPTEMBER 2006, SEOUL, REPUBLIC OF KOREA

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I. BACKGROUND

Many developed and developing countries in the Asian and Pacific region have populations that are rapidly ageing as a result of falling fertility rates and the increase in life expectancy. The decrease in fertility also suggests that the cohort of younger people providing care for the older population will shrink concomitantly. As such, the role of governments in providing care toward older persons becomes inevitable.

That women outlive men is a well-known fact, which has given rise to the phrase, the feminization of ageing. For these women, dignity of ageing means that they should be guaranteed access to adequate and appropriate health security as they approach old age. Research has shown that men's and women's experiences of access to healthcare and health outcomes are different. The factor of age adds complexity to these existing differences in health experiences. Given this trend, it is significant that policies are reconfigured to promote gender equality so as to ensure women's access to healthcare in old age.

In Asia and the Pacific, few countries have in place universal health coverage in the form of schemes funded by general tax revenues or social health insurance. The changing pattern of social needs as a result of existing systems marked by economic transitions and the unexpected increase in the older age cohorts especially of women has presented numerous challenges to governments.

In order to address the persistent gender inequality in health access and outcomes among women, the Emerging Social Issues Division (ESID) of the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) launched a two-year project called the Technical Cooperation Project on Gender-Responsive Health Security for the Elderly to guide policy planners and relevant partners in identifying effective initiatives on health security planning, financing and designing for the provision of gender-responsive health security schemes for older persons, both men and women. The United Nations Workshop on Gender-Responsive Health Security for the Elderly, which was held in Seoul, Republic of Korea from 18 to 19 September 2006, was the first activity organized under this project which spans over 18 months from 2006 to 2007. The workshop is a result of the tri-partite cooperative effort of three agencies: UNESCAP, Korea National Health Insurance Corporation (KNHIC), and World Health Organization (WHO). The second activity includes a national-level workshop to be conducted in

two selected countries. Under this activity, UNESCAP will also provide advisory services to a few countries.

This project builds upon past and on-going efforts of UNESCAP on social protection issues. Specifically it aimed to prepare senior policymakers in meeting the emerging demographic developments and social demands as a result of the growth in older populations in the region especially elderly women. In addition, the project sought to create innovative and gender-responsive modalities to improve the effectiveness and sustainability of health-care programmes for older persons in the UNESCAP region while promoting gender equality among both older men and women.

The Workshop held in conjunction with the project also sought to encourage governments in the UNESCAP region to adopt and integrate gender-responsive policies and schemes to meet the health security needs of older men and women, facilitated by private and public sector and community participation in providing health security for older persons. In addition, the workshop aimed to act as a forum for the exchange of ideas on existing and potential innovative gender-responsive health security schemes.

Experts consisting of academics and government officials presented papers on the following sub-topics: gender-responsive health security programmes, the planning and financing of health security programmes, and the significance of private sector and community organization partnership to generate schemes targeted at the elderly. Working groups were also organized to discuss best practices, principles and guidelines. A plenary that followed aimed at the formulation and adoption of recommendations.

II. ORGANIZATION OF THE MEETING

The Workshop was held in Seoul from 18 to 19 September 2006. Participants from 17 countries representing China, Cambodia, Fiji, Federated States of Micronesia, Iran, Indonesia, Lao PDR, Malaysia, Mongolia, Philippines, Samoa, Thailand, Vietnam, Vanuatu, Tonga, and Tanzania attended the Workshop. Experts as well representatives from various UN bodies were also present.

A. Keynote lecture

The Workshop was opened with a keynote lecture on social security systems by Kenichi Hirose, Social Protection Specialist, International Labour Organization Sub-regional Office for South-East Asia and the Pacific. ILO's four strategic objectives were described with emphasis given to gender and ageing as cross-cutting issues. Women's risks in the lifecycle were also explained as a result of structural and cultural factors. Hirose highlighted ILO's Social Protection Sector which concentrates on social security, occupational safety and health, conditions of work, international migration and HIV/AIDS in the workplace. ILO also recognizes social security to be a basic human right issue. As such, the International Labour Conference of 2001 encouraged governments to prioritize social security.

Mr. Hirose also examined the historical and socio-cultural conditions for the development of social security systems in the Asian and Pacific region, drawing attention to influences of colonialism and cultural factors. In addition to comparing the formal and informal sectors of the economies in the region, the lecture focused on the vital role of government intervention in ensuring social security schemes for reasons of market failure, adverse selection, and moral hazards. While maintaining efficiency by addressing the challenges resulting from asymmetric information and the imperfect capital market, governments should aim to create equity through the redistribution of income, policies and programmes that lead to poverty relief, and programmes to ensure social solidarity.

B. Opening ceremony

Jae-Yong Lee, President of Korea National Health Insurance Corporation (KNHIC) delivered the welcome address. In his address, he highlighted the particular relevance of the Korean experiences in improving access to the health care by introducing universal health care under the resource scarce context. He emphasized the importance of political will and efficient management as well as operation. By sharing Korea's own practices in enhancing its health care system by continued improvement of quality of services through various measures including the use of new IT technologies, he further confirmed Korea's willing to contribute to the development of health care system in the region.

The welcome address was followed by an opening statement by Thelma Kay, Chief, Emerging Social Issues Division (ESID) of UNESCAP. Highlighting the debate on how best to

manage the emerging social security needs of an ageing population, she emphasized the role of multilateral agencies in actively assisting governments to design suitable social protection policies to meet this emerging need. While it is less common for social protection policies to address gender dimensions of ageing, Ms. Kay emphasized the relevance of the Workshop to examine the gender and ageing dimensions of health security planning and design since women are more disadvantaged in many aspects of life as well as in old age.

Regional Advisor of WHO Regional Office for the Western Pacific Region (WPRO), Bayarsaikhan Dorjsuren also presented a welcome statement, highlighting the importance of health financing in contributing to the mobilization of adequate resources to deliver essential health services to people. Owing to rising costs in health-care provision, governments are struggling with how best to mobilize and allocate resources to meet the health needs of their people especially the poor and vulnerable groups. WHO has been supporting national and international efforts and consolidated actions that have led to national policy consensus and commitments for social health insurance development suited to country-specific needs. While efforts to introduce social health insurance has met with economic and social barriers in some developing countries, other countries in the Asian and Pacific region such as the People's Republic of China, the Lao People's Democratic Republic, Mongolia, the Philippines, and Viet Nam have successfully generated social health insurance schemes that others in the region may adopt. Dorjsuren also emphasized that the Workshop was an ideal forum for governments to learn from each other.

C. Opening of the workshop

Hyeo-Kyeong Lee, Social Affairs Officer, Gender and Development (GAD) Section of ESID, UNESCAP provided a brief overview of the demographic changes and the extent of the feminization of ageing in the Asian and Pacific region. She described the various gender disparities experienced by women in the contexts of poverty and gender-based violence. Since existing policies, programmes and activities of many countries tend to be gender blind, she emphasized the need for gender-sensitive measures to ensure older persons' access to healthcare. In addition, she highlighted the need for gender-sensitive policies to overcome gender biases in delivery to ensure that both men and women receive equal health benefits. Her introduction was followed by a brief overview of the Technical Cooperation Project on Gender-Responsive Health Security for the Elderly of which the expected outcome was that governments would develop

gender-responsive social protection schemes, especially health security schemes for the elderly in collaboration with private organizations and civil society participation.

D. Agenda

1. Registration

2. Orientation

3. Keynote lecture

4. Opening ceremony

5. Opening of the workshop

6. Presentation of papers

(a) Thematic Background Paper on Gender-Responsive Health Security for the Elderly

(b) Ensuring Health for the Indian Elderly: Devising Gender-Responsive Health Security

(c) Gender Justice, Women and Aged Care: Some Ethical and Policy Questions

(d) Health-care Financing: Some Considerations on Ageing and Gender Aspects

(e) Trends in National Medical Expenditure and the Medical System Reform in Japan

(f) Gender-Responsive Health Security for the Elderly under the Implementation of the 30-Baht Health-care Policy in Thailand

(g) Financing the Korean Health-care System in an Ageing Society

(h) Caregiving and Gender in the Republic of Korea

7. Discussion and adoption of policy guidelines and recommendations

8. Closing of the meeting

III. PROCEEDINGS OF THE MEETING

The first paper of the Workshop provided an overview of the significance of initiating policies and programmes to ensure gender-responsive health security for older persons. Titled “Thematic Background Paper on Gender-Responsive Health Security for the Elderly,” Susana Concorde highlighted ageing as a social construct and as such how people experience the process of ageing greatly depends on their gender, their living conditions, and the time at which they live. Echoing the Madrid International Plan of Action (MIPAA), this paper emphasized the necessity for ensuring that older persons age with security and dignity and to participate in society with

equal citizenship rights as younger members. Given that older women outnumber older men, there is urgency for governments to prioritize women's issues in the formulation and implementation of policies and legislation.

The author also highlighted that governments need to ensure that all policies and programmes on health is gender-responsive. Although women have experienced marked improvements in education, living conditions and healthcare, social inequality remains a concern in many countries in Asia and the Pacific. The vulnerability of certain groups of women such as those living in the rural areas, those living in traditional societies, and those representing ethnic minorities remains high particularly in terms of their health condition in old age. Women's health experiences in old age is connected to various factors such as poverty, gender-based violence, and women's unpaid work and caregiving role that remain unrecognized, unremunerated and unrewarded, and gender-based discrimination in their access to healthcare, fair wages, participation in political decision-making, and access to basic needs including food and shelter.

The paper also examined the significance of setting up a comprehensive health-care and social services system to address the shift in medical problems from communicable diseases to chronic and non-communicable diseases. In addition, it was mentioned that very few health-care professionals are trained in geriatrics while primary health-care clinics and centres in many countries in the Asian and Pacific region continue to be inaccessible to older people because of the lack of transportation and administrative procedures that do not facilitate the use of such services.

Although older men and women are in need of special health-care services, women are at a more disadvantaged position than men. It was found that older women tend to be poorer and, hence, are unable to pay for their health-care needs. In some countries, the caregiving responsibilities of women have placed limits on their movements to seek medical attention even for themselves. In addition, older women are more likely to hide their symptoms while they may not actively seek out regular medical tests and health monitoring. Should they visit the clinic, often they do so to accompany their sick children who need medical help. Men provide the contrast. They only seek medical help as children or when they reach old age. Health promotion and disease prevention programmes thus need to be aggressively directed at adult men before they reach the old age cohort so that they adopt healthy lifestyles and experience fewer disabilities and diseases in old age.

Concordo emphasized that ensuring a health-care system that is age-friendly should be a priority of governments in the region. The health-care system also needs to take into consideration the different groups of older people in relation to their functional status. The need for a social services structure to complement the health-care system was also discussed. It was highlighted that the health of older people may be managed more efficiently with combined medical and social services specifically to manage those with chronic health conditions and to prevent the onset of disability. In addition, such services are also useful to prolong the lives of those who are healthy. In the various countries in the Asian and Pacific region, many community-based organizations provide various services to the elderly. As such, governments should recognize the urgency in investing in community-based organizations and developing formal caregivers at this level. Attention should also be given to setting up institutional care centres such as nursing homes and old ages homes in a cost-effective manner. The drawback, however, is that these organizations tend to be based in the urban areas, thus disadvantaging older persons living in the rural areas. Nonetheless, the main concern here is capacity and coverage both in quantity (in relation to staffing and funding) and quality.

The gender dimension in caregiving by way of women being the main caregivers of the elderly was also addressed. The extent of care provided by women sometimes spans a lifetime which in turn has impacts on the caregivers themselves receiving care in their old age. While self-care in terms of one's health is vital for both men and women, the paper highlighted that women themselves are not aware of the importance of ensuring their own well-being since they may be working as well as providing care for others—a dual role which impacts on their stress levels. In old age, some women may not have any relatives to provide care for them especially if their husbands die before them and if their own children are unable to undertake this task. For these women, informal support from the community becomes important.

The poverty many women in the Asian and Pacific region experience thus has an adverse effect on their health outcomes particularly in old age. In this region, many poor women live in patriarchal societies which block them from receiving an inheritance. As a result of gender discrimination based on traditional norms about women's roles and status, many women slip deeper into poverty owing to the lack of family and community support, education and literacy. They suffer greater marginalization should they be victims of gender-based violence, which in turn has implications on their physical and mental well-being. Poverty has implications not only on access to healthcare but also health-care knowledge. Although women use greater amounts of medication compared with men, they are found to be disadvantaged in this regard. For example, it

was pointed out that health professionals across the region are not adequately trained in providing clinical counsel to the elderly who are in need of medication and, as such, women more than men are at greater risk of suffering from side-effects of some medications. In addition, many women do not receive relevant information on the kinds of medications they may be purchasing and using. Paradoxically, while women may have to rely on more medications as a result of greater morbidity in old age, generally they are more likely not to have the funds to buy them because of poverty.

The paper on “Ensuring Health for the Indian Elderly: Devising Gender-Responsive Health Security” by Ranjana Kumari followed. Demographic projections estimate that the number of people in the 60+ cohort in India will increase to 100 million in 2013 and 198 million in 2030. Nearly 60-70 percent of the elderly are economically dependent on others. Citing the National Policy on Aging (1999), the paper mentions that one-third of the older population lives below the poverty line and about one-third slightly above the poverty line, indicating that the older population belongs to the lower income group. Among those who have pensions, their economic status has been found to drop after retirement. However, among the lower income group, it is difficult to analyse the economic status of the numbers of old people since many were employed in the informal sector when they were younger and did not have fixed or regular incomes. The problems with coping with an ageing population is compounded by the fact that the majority (about 80 percent) live in rural areas which makes the delivery of services to this group a challenge.

In India, feminization of ageing is evident as 51 percent of the elderly population will be female by the year 2016. The most pressing issues among the older population are found among the old-old (70+ years) cohort of whom a sizeable number are women. In 2025, older women (57 percent) are expected to outnumber older men (51.25 percent). Following the trend of older women in other countries, older women in India are expected to experience lower health status than men. Thus, issues of age-related physical and mental disabilities and dependence are of concern. In addition, the increase in the proportion of older women means that there will be widows living without the social and economic benefits of spousal support and lacking assets to remain independent. Women from families that are already poor will be at greatest risk of falling further into poverty as a result of the lack of financial support from dependents. With the emergence of HIV/AIDS and women having to provide care to their own children who have become victims of this disease, women have had to take on the added burden of providing care to their orphaned grandchildren.

In India, the family has been the main safety net for the elderly. As of now, the country does not have a comprehensive old age income security system. However, there exist a few mandatory schemes for employees of the State and central governments, employees of public sector banks, and employees in the larger firms. In recent years, the insurance and mutual fund industry have also started offering pension plans. In 2004, an individual account pension system was established for central government employees recruited after January 2004. This will soon be open for all Indian citizens on a voluntary basis.

India has already put in place a national policy for the elderly called the National Policy for Older Persons (NPOP). In addition, the National Social Assistance Programme (NSAP) and Annapurna Scheme have provided assistance to poorer old citizens. Under the NSAP are the National Old Aged Pension Scheme (NOAPS) and the National Family Benefit Scheme (NFBS). The NOAPS is to extend financial assistance to the older destitute having little or no regular means of subsistence. The welfare of older persons comes under the arm of the Ministry of Social Justice and Empowerment. Ageing issues are mainstreamed in other ministries and government departments as well. For example, the Ministry of Finance provides income tax rebates to senior citizens above 65 years of age. However, social security systems are not fully developed in that most schemes only protect salaried staff in the private and public sectors. In addition, it was found that women's employment trends by way of their earning lower salaries than men and not working as long as men in the labour force has disadvantaged them. An added problem is the fact that close to 93 percent of India's labour force is engaged in informal wage work. For this reason, the social and health security of women who do not work in the formal sector is almost negligible.

In spite of these efforts, health expenditure on health by the Indian government is declining from 5.2 percent of its GDP in 1998 to 4.5 percent in 2004. People who are hospitalized are increasingly finding themselves having to borrow money or sell their assets to cover their medical bills. In addition, there is a lack of gender sensitivity in social security policies offered by both the private and public sectors. This problem is compounded with the fact that health security is a state concern and with many state governments experiencing a fiscal crisis, it is difficult for them to provide additional funds to the health sector. Other health security issues are that older women have been found not to be included in health insurance plans.

Susan Dodds's paper on "Gender Justice, Women and Aged Care: Ethical and Policy Questions," highlighted gender-bias in aged care in Australia in spite of various government provisions on financial security, healthcare, welfare and housing schemes targeted at the ageing population. Essentially non-gendered policies of the country in effect disadvantage women because of their role as caregivers and as a result of economic and demographic shifts. In addition, women's shorter work lives, interrupted careers, lower salaries than men, and the struggles they face in having to cover out-of-pocket health costs and to secure private health insurance premiums affect their access to care. In addition, their access to unpaid care is uncertain owing to the fact that women have fewer children besides children who themselves can afford to provide paid care. That families are breaking down also has had an effect on women's experience of ageing.

Overall carework is under-valued and under-compensated, exposing caregivers to the risk of exploitation. Dodds emphasized that the State is at fault for not ensuring resources are available to allow caregivers to exercise standards in providing care as a result of poor staffing, physical risks, and lack of access to support. That these individuals are ignored by the State stems from the lack of understanding of the notions of human vulnerability and dependency which characterize not only older persons but also caregivers themselves. Dodds concluded that the role of caregivers needs to be rethought as it is linked to ethical questions about carework, justice in society, and the moral conception of a person. Other related issues that need to be addressed are how social welfare and health policies may be able to better account for carework and how carework should be viewed as a significant contribution to society.

In "Health-care Financing: Some Considerations on Ageing and Gender," Hiroshi Yamabana described the steadily increasing life expectancy trends in several countries in Asia, which in turn called for greater attention on social security schemes to meet the health needs of a rapidly ageing population. The urgency for these schemes stems from the fact that demographic trends show that the old-age dependency ratio has been increasing. Such schemes are also needed to address the rising costs of health-care services. The discussion also covered the various health security plans, both individual as well as collective efforts. While individual efforts usually constitute out-of-pocket means of payment including co-payment, collective efforts refer to private insurance, social insurance (which is publicly-subsidized), and tax-financed schemes. Yamabana also examined the income redistribution implications on individuals and groups in relation to private insurance and social insurance.

Yamabana emphasized that health-care financing systems should take into account the specific needs of the elderly particularly since many have less financial resources than younger individuals. In this effort, substantial redistribution is indispensable by those who are more productive in the labour force and who have less health risks. Insurance schemes, therefore, should ensure compulsory coverage required to ensure optimal levels of redistribution. In addition, such schemes should also serve to cover long-term care for the elderly. The author also emphasized the need for governments to undertake financial reforms, particularly tax reforms in order to meet the needs of growing elderly populations. In this regard, there is the need for gradual reforms to maintain financial sustainability in the face of rapidly ageing populations through the rationalization of medical care and medical benefits for this group.

The paper also addressed the income/asset situation of the elderly, particularly women. While women may have some material assets, in terms of financial assets, they usually lack financial assets. As they may suffer from greater health risks characterized by chronic diseases and various disabilities, they are more likely to require living assistance. Thus, their need for healthcare is greater as a result. In addition, owing to their longer life expectancies compared with men's, women have a greater prolonged exposure to various risks as well as financial difficulties in overcoming the problems they face. The effects of their dependency on husbands and lack of work opportunities were also examined. Yamabana also points out that while women may have less number of years of work experience compared to men, they are also more likely to retire earlier than men when taking up employment in the formal economy.

The paper on "Trends in National Medical Expenditure and the Medical System Reform in Japan" followed. Takashi Nishioka elaborated on Japan's efforts on increasing its medical expenditure by twice in 20 years, which has had a positive impact on the elderly population. As a result of improved health-care facilities, male life expectancy stands at 78.5 years and female life expectancy is 85.4 years in 2005. Owing to the increase in life expectancy and falling fertility rates, the Japanese population is ageing rapidly. The percentage of the population aged 65 years and over now exceeds 20 percent and is the highest in the world. In 2050, it is estimated that the percentage of older persons in the population will increase to 36 percent and the population will be 106 million. As in other countries, women will constitute the majority in the old age cohort. In the 1990s in particular, medical expenditure exceeded economic growth amidst a long-lasting economic downturn in the country. Yet it must be noted that in terms of per capita expenditure in relation to medical costs, Japan falls in the middle range among OECD countries. Specifically medical expenditure for older persons is five times more than for non-elderly persons. Japan has

also done fairly well in terms of having an over-supply of hospital beds. According to a WHO World Health Report, Japan ranked the highest among 191 countries in terms of quality and equity in healthcare.

In Japan, medical insurance coverage is universal. Every citizen holds one medical insurance scheme: the Employees' Health Insurance for salaried workers and their dependents and the National Health Insurance for others such as self-employed individuals. Co-payment has gradually increased in recent years as a result of the rise in health-care costs. Currently, 50 percent of medical care is financed by medical insurance schemes, 35 percent from taxation, and 15 percent from co-payment. Long-term care insurance schemes have been in place for the last five years. Medical service fees paid by social insurance schemes are determined by the Ministry of Health, Labour and Welfare with recommendations made by the Central Social Insurance Medical Council (CSIMC). CSIMC examines the actual situation of the management of medical institutions, the trends in prices and wages, and related issues on medical services such as the technological advancement of medical science and medical treatment, which in turn determine medical service fees.

In comparison to other OECD countries, Japan is characterized as having a larger percentage of old-age pensions and a more comprehensive long-term care and health infrastructure, indicating that services for older persons have expanded in recent years to meet the needs of a rapidly ageing population. The success of the pension systems in Japan has led to a substantial improvement of the income situation of the elderly. Yet there are older persons who struggle since they have to make co-payments similar to that of non-elderly persons. The system has not only contributed to the improved health status of the elderly population but has also prevented many from falling into poverty through financial protection. Implicitly, the system reaches out to women who are dependents who suffer most as a result of not working and, therefore, not having access to health insurance schemes. Reforms of the medical system are underway. The new independent medical system for the elderly is to be implemented in 2008. It is expected that an outcome of these reforms is a decrease in national expenditure toward healthcare.

Orasa Kovindha's paper "Gender-Responsive and Health Security for the Elderly under the Implementation of the 30-Baht Health-care Policy in Thailand" focused on the health security of older persons as a result of a national health insurance scheme. In the country, life expectancy stands at 69 years for men and 74 years for women. In this developing country, government

expenditure on healthcare constitutes 13.6 percent of the total budget in 2003. While the percentage of older persons in the general population stands at around 10 percent in 2000, this figure is expected to reach 15 percent in 2020. With this increase in the proportion of the old age population, clearly the Thai government was aware of the urgency for a health security scheme for this group. The increasing risk to morbidity among both older men and women also justifies a health security scheme for this group. In recent years, the Thai government has been actively expanding national health-care services in urban areas, and at the regional, provincial, district, sub-district and village levels. There has also been a growth in the private health industry. The government's investment in the health security of the Thai people is evident in the 30-baht health-care scheme which ensures universal health-care coverage. The implementation of the 30-baht health-care scheme has resulted in an increase in health-care coverage from 75 percent in 1998 to about 95 percent in 2004. The benefits of such a scheme include inpatient and outpatient care, prescriptions, preventive and dental care, and ambulance fees. It was also mentioned that the 30-baht health scheme will prevent households from slipping into poverty.

Kovindha also mentioned how the Thai government has been vigilant in providing healthcare for its elderly women and disabled persons. Specifically for older women, they have benefited from the 30-baht health scheme, home care, health promotion programmes, and disease prevention programmes. The Thai government's efforts in investing in health-care services for vulnerable groups including older women are aimed at achieving the Millennium Development Goal (MDG) targets of 2015.

Hyoung-Sun Jeong authored the paper "Financing the Korean Health-care System in an Ageing Society" by highlighting key aspects in health-care financing such as health expenditure, the financing structure of different health-care services, the service structure of different financing agents in healthcare, the provider structure of different health-care services, the service structure of different health-care providers, and trends in health-care service. In spite of fluctuations in economic growth trends from 1983 to 2004, the total health-care expenditure has increased gradually over the years. In comparison to other OECD countries, the Republic of Korea's public expenditure on healthcare per capita has always been considerably less. For example, in 1994, national expenditure on healthcare per capita was 34.2 percent while OECD's expenditure was 72.3 percent. While 2004 figures show that the Republic of Korea's health-care expenditure increased to 51 percent, OECD's expenditure per capita was 72.7 percent. The country's total health expenditure as a share of GDP also fell below the OECD average.

Trends in the composition of total health-care financing by the different sources was also highlighted. While in 1992, total health-care financing was 15.6 percent by the government, 18.1 percent by businesses, and 66.2 percent by households, in 2004 the figures were 19.5 percent, 28.5 percent, and 52 percent by the government, businesses and households respectively, which indicated a drop in health-care financing by households and a rise in health-care financing by the government and businesses. Yet it was found according to 2004 estimates that social security schemes and out-of-pocket payments remain the most viable social security measures. It was also highlighted that government funds were instrumental particularly in services of long-term nursing care, ancillary services to healthcare, prevention and public health services, health administration and health insurance. Social security funds, in contrast, were most important for in-patient curative and rehabilitative care, out-patient curative and rehabilitative care, medical goods dispensed to out-patients and health administration and health insurance. Particularly private social insurance has been used toward in-patient curative and rehabilitative care. The paper also highlighted the critical role of non-profit institutions in providing out-patient curative and rehabilitative care.

The paper “Caregiving and Gender in the Republic of Korea” was presented by Kyungchee Chung. In terms of the age composition of the country, it was emphasized that recent shifts toward a growth in the ageing population has had implications on care provided toward this group. Generally there has been a weakening of the caregiving role of the family as a result of the nuclear family increasingly becoming the norm with a concomitant decrease in the extended family set-up. The weakening of the family as a site for elder caregiving has also come about because of greater numbers of women entering the labour force and, thus, having less time to meet family and household responsibilities. It was also found that many women on reaching old age are more likely to be living alone compared with men. In addition, more women were found to be in need of nursing and rehabilitative care as well. Older women more than men are more likely to have to depend on non-household members for care. If older men and women receive care, caregivers are usually women especially when the family is the main provider of care. The author highlighted that most women provide care not necessarily because of the emotional attachment between the caregiver and the person cared for but because of societal norms on women’s roles in the family. In addition, filial piety continues to be a major reason for providing care for the elderly in the family context. While women experience higher levels of care burden than men, yet Korean society does not attribute an economic value to the work caregivers provide and, thus, carework is undervalued.

In 2008, plans are underway to introduce the Long-Term Care Insurance with the aim of increasing the number of long-term care facilities. This reflects the Korean government's share in protecting and providing care for older persons by strengthening social care services targeted at this group. In-kind benefits will be made available in this insurance plan while in remote areas, cash benefits will be provided. The advantage of cash benefits is that it recognizes informal care. The downside, however, is that it encourages women to stay at home instead of taking up wage employment, which in the long run would impact on their ability to be financially independent. Nonetheless, measures will be put in place to prevent the misuse of this cash provision.

IV. RECOMMENDATIONS

Based on the papers presented and the ensuing discussions, the Workshop adopted a set of recommendations. The recommendations provide guidelines for the formulation of policies and the implementation of programmes in order to ensure adequate and appropriate health security for older women in the Asian and Pacific region. The following are the recommendations:

1. Governments should ensure that there are national policies on ageing to take care of the needs of the older population.
2. Governments should make full use of the Madrid International Plan of Action on Ageing (MIPAA) to guide their own national policies on ageing.
3. There is a need for a more coordinated approach among different ministries or government departments to implement policies on ageing since currently in most countries there is the absence of one agency to oversee the concerns of the ageing population. The rationale for setting up a central body is linked to the fact that the advancement of health and well-being in old age is a multi-factorial issue composed of three major aspects: health, financial/income security and participation, with gender and cultural factors as related issues.
4. Countries that have for many years already had a significant proportion of their populations growing old should act as role models to countries whose populations are now experiencing rapid ageing.
5. Governments in the region should collaborate at the regional level to generate benchmarks and standards for monitoring and evaluating national policies and programmes on ageing.

6. Priority should be given toward identifying the most vulnerable among older persons and putting in place policies and programmes toward protecting their welfare.
7. Older people should be given the opportunity to influence policies and programmes so that these policies and programmes meet their needs.
8. There is a need to avoid generalizing the older population as a heterogeneous group. Instead it is important to segment older people into classifications such as chronological age (which may not always be a good indicator) or functional abilities (which are relevant for some populations).
9. Governments should recognize that health is a basic fundamental human right.
10. The health status of older persons should be regularly monitored.
11. More effort is needed in capacity building in terms of gender issues. There is a need to mainstream ageing into all gender programmes so as to ensure that the needs of older women are met. Related to this, governments should be equipped to conduct gender analysis, gender planning, and gender mainstreaming so that the formulation of policies for older people and the translation of these policies into programmes and actions are gender-responsive.
12. A gender perspective should be incorporated into all development programmes, including health programmes, to improve the status of women so that this group does not suffer marginalization as they reach older age. Attention should be paid to ensure that girls and women receive education so as to improve their position in society and, hence, ensure their health security in old age.
13. There is the urgency for governments to increase gender representation across all levels of government to ensure that national policies operationalised at the community levels are gender-responsive.
14. There is a need for governments to recognize that older women are in a disadvantaged position in three areas of the economic determinants of health: income, work opportunities and pension. Since they are in a more vulnerable position, their concerns should be thoroughly considered in policy analysis and planning.

15. In addressing older women's health needs through policies and programmes, governments should not fail to consider the specific health needs of older men as well, as defined by their gender.

Healthcare infrastructure

16. There should be greater effort to establish a comprehensive health-care system ranging from that which provides acute care to one that provides preventive care especially targeted at the elderly population.

17. Governments should pay more attention in developing the capacity of health-care professionals in order that there will be sufficient health-care personnel trained in geriatrics.

18. Governments should ensure that there is an increase in health-care services and community-based organizations that provide medical and social care for the elderly in rural areas.

19. Governments should monitor the quality and coverage of health-care programmes and services since the health-care infrastructure in most countries in the region are not able to cope with the growing numbers of older people.

20. There should be increased public-private and civil society partnership in providing a range of health-care services to older persons. In this regard, governments need to strengthen their human resource capacity in order to facilitate collaboration between various stakeholders.

21. There is a need to provide affordable primary health-care services so that they are accessible to older people, both men and women.

22. There is a need to set up women's health clinics within the primary health-care system which would ensure that women's health needs are addressed.

23. Owing to the fact that women suffer from greater morbidity than men at older age, governments should play a larger role in ensuring that medicines are widely accessible and affordable to older persons, especially older women.

24. The health-care infrastructure should also include mental health services both for men and women who suffer from depression, isolation, loneliness and poverty as a result of different factors.

Healthcare policies and programmes

25. There needs to be national efforts to establish a comprehensive health security policy for older persons.

26. Priority should be placed on developing a framework for formulating and implementing national policies on ageing.

27. Health policies and programmes should be increasingly responsive to persistent and emerging health vulnerabilities of specific groups within a society so that these individuals on reaching old age are able to remain relatively healthy and may continue to be employed in the labour market.

28. In order to ensure health security for older citizens, governments should focus on health promotion programmes for this group.

29. Health programmes should take into account risk factors to detect and diagnose diseases as early as possible in order to avoid development of chronic conditions which could result in the need for long-term care as a result of disability.

30. There is a need for health promotion programmes for older persons to take into account major life-course transitions that men and women undergo. These life-course transitions should be regarded as windows of opportunity for programme planners to detect the health vulnerabilities of men and women.

31. Governments should support and provide regular platforms for the exchange of ideas among policymakers, public servants and other key stakeholders including older people especially women to enhance understanding and awareness on health security issues among the elderly.

32. Current primary care orientation characterized by 'episodic care' should change and health programmes should consider the impact of an episodic disease on individuals especially in old age.

33. Governments should enhance mental health programmes and counselling programmes.

34. There is a need for governments to recognize gender as a cross-cutting issue in policies and programmes on health and ageing.

35. Attention should be given at the policy and programmatic levels to ensure a health-care system for the elderly to be gender-sensitive. Related to this, gender-neutral policies and programmes on healthcare should also be reviewed since they may not address the specific concerns of older women. Thus, it is important that benchmarks and indicators on health-care policies and programmes should be gender-responsive.

36. There is a need to increase awareness among women on the importance of seeking regular medical check-ups so as to diagnose diseases at an earlier stage. This may be achieved through public education talks or health promotion materials. In addition, women should be educated about proper nutrition.

37. Health promotion programmes on healthy lifestyles should target particularly men since they tend to engage in unhealthy lifestyles such as smoking, drinking, consuming diets rich in salt and saturated fat more than women.

Healthcare financing

38. There is an urgent need for political commitment to mobilize public finances to meet the changing health-care demands of a population.

39. There needs to be gradual reforms to maintain financial sustainability through the rationalization of medical care and medical benefits. In addition, rationalizing the provider payment mechanism needs to be prioritized.

40. Attention should be given to resource mobilization of the various taxation schemes such as direct and indirect tax schemes so that contributions toward ensuring health security can be affordable to vulnerable groups such as the elderly.

41. There needs to be a containment of medical care utilization as more emphasis is placed on prevention through the guaranteed effective use of financial resources.

42. Governments should aim for universal health-care coverage based on pre-payment schemes with minimal co-payment. Governments should regard private health insurance as voluntary while social health insurance should be wage-based.

43. Governments should regularly review their expenditure and budgets channelled into health-care services targeted at the elderly.

44. Health policies should take into account a life course perspective on health and, as a result, investment in healthcare should be channelled into primary healthcare (preventive health) rather than tertiary care (acute/curative care).

45. Greater attention should be paid to generating a national pension scheme so as to ensure universal coverage for older persons.

46. Based on experiences of other countries, consideration should be granted to the decentralization of responsibilities in healthcare coupled with the devolution of authority and adequate human, institutional and financial resources to meet the health needs of older people since this approach has been shown to enhance client responsiveness, administrative efficiency, and service access.

47. Governments should increase their investment in funding for training and adequate staffing and improve the policies and regulations that guide care in institutional health-care settings for older persons.

48. Consideration should be given to extend coverage of health insurance to cover out-of-pocket health expenses.

49. Governments should consider taxes and social insurance schemes as they have been proven to ensure equitable outcomes in health financing for both men and women.

50. Governments should avoid direct user fees and private, for-profit health insurance schemes as a strategy for financing healthcare as these measures increase health inequity while shifting the burden of payment to economically less privileged groups such as women.

51. Governments should also avoid the privatization of care and non-medical services in health-care facilities as they tend to result in poor quality care while being more costly. In addition, these measures have the effect of lowering the wages of workers.

52. Governments should encourage or mandate all private employment-based insurance schemes including hospitalization expenses to cover spouses so as to ensure that women are able to access health-care services for themselves.

53. Among governments that are experiencing fiscal problems, partnership-based health insurance plans should be considered to serve as an important source of health security.

54. In countries with sizeable rural populations, governments should consider expanding formal social security schemes through micro-insurance plans and support them via partnership with local grassroots organizations and commercial insurance companies.

Caregivers of older persons

55. There should be greater effort to recognize and support the role of caregivers of the elderly. Measures should also be put in place to compensate for their services.

56. That caregiving has a gender dimension should be recognized by governments since the majority of caregivers are women. Owing to this fact, caregiving should also be seen to have an impact on long-term care.

57. Policies and programmes should be generated to protect the vulnerability of elder caregivers and the elderly for whom they provide care.

58. In the event of changes in the health-care system, mechanisms should be put in place to protect healthcare staff from losing their jobs and receiving lower wages since the majority of health-care workers tend to be women.

Further research

59. Further research needs to be conducted on the health outcomes of the elderly, especially women.

60. Research methods used to gather data on the health of older persons should adopt a longitudinal and life course approach.

61. Country- and regional-level research on the different determinants impacting on the health of older people should be conducted.

Annex I

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Annex II

LIST OF DOCUMENTS

Thematic Background Paper on Gender-Responsive Health Security for the Elderly by Susana Concorde

Ensuring Health for the Indian Elderly: Devising Gender-Responsive Health Security by Ranjana Kumari

Gender Justice, Women and Aged Care: Some Ethical and Policy Questions by Susan Dodds

Health-care Financing: Some Considerations on Ageing and Gender Aspects by Hiroshi Yamabana

Trends in National Medical Expenditure and the Medical System Reform in Japan by Takashi Nishioka

Gender-Responsive Health Security for the Elderly under the Implementation of the 30-Baht Health-care Policy in Thailand by Orasa Kovindha

Financing the Korean Health-care System in an Ageing Society by Hyung-Sun Jeong

Caregiving and Gender in the Republic of Korea by Kyunghee Chung