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REGIONAL STUDY ON ELDERLY CARE SERVICES IN THE ASIA-PACIFIC REGION: CHALLENGES AND GAPS, GOOD PRACTICES AND POLICY OPTIONS

Alfred C M CHAN, Phoebe TANG and David LK DAI

1 Alfred C M CHAN, Chair Professor and Director; Phoebe TANG, Senior Project Officer; and David LK DAI, Consultant Geriatrician and Adviser, Asia Pacific Institute of Ageing Studies, Lingnan University

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I. Introduction

This paper aims to provide an overall orientation to health and social services for the elderly population in the Asia Pacific region. Noting some common characteristics of the ageing trends in the region, the present paper also proposes a framework based on a harmonization of those policy priorities with an active ageing policy framework, proposing a coherent way forward for countries in the region while still allowing adequate flexibilities.

II. Ageing Trends of the Asia-Pacific region

Increasing longevity coupled with a low fertility rate lead to an ageing population worldwide. It is estimated that the proportion of persons aged 60 years and older in the world will double from 10 to 21 per cent between 2000 and 2050 (i.e. from 600 million to 2,000 million in absolute numbers). In 2025, it is projected that 15 per cent of the world population will be aged 60 and above and the number of older persons in Asia-Pacific is estimated to triple from 419 million in 2010 to more than 1.2 billion by 2050, which means 59 per cent of the world's population aged 60 years will live in Asia and the Pacific. The population will triple from 438 million in 2010 to 1.26 billion by 2050. By that time, one in every four persons in the region will be over 60 years old. In East and North-East Asia, more than one in every three persons will be older than 60 years. This will be one of the most important demographic transformations of this century. Women constitute the majority (60.7 per cent) of the population aged 60 or older in the region and that proportion is expected to increase. By 2050, women will account for almost two thirds (65 per cent) of the older population, and women will represent more than 70 per cent of the ‘oldest old’ population (80 years and older). (United Nations Population Prospects 2012 Revision)

Various forces of modernization and rapid economic development over the past few decades have served to emphasize regionalization in the global economy whilst others have tended to promote diversity. Demographic transition, urbanization and economic change, have been major factors. However, the pace of demographic change and ageing varies across the Asia-Pacific. The region includes the demographically oldest country in the world, Japan, which is facing new challenges of slow or negative population growth, as well as other countries which are rapidly becoming demographically aged, such as People's Republic of China (including Hong Kong and Taiwan), the Republic of Korea and Singapore. At the same time, the region has several countries, such as Cambodia, Indonesia and Lao People's Democratic Republic, which remain predominantly youthful and whose major population policies focus on family planning and reproductive health. Countries in the Asia-Pacific region share some general characteristics that distinguish them from the western developed economies:

The Asia-Pacific region has countries with the largest segments of older persons and the longest longevity in the world

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2 People's Republic of China, the Democratic People's Republic of Korea, Japan, Mongolia, the Republic of Korea and the Russian Federation).
Approximately 60 per cent of the world’s total older population live in the Asia-Pacific region and many will live beyond 70 years of age (the longest average life expectancies from birth are found in Japan; Hong Kong, China; and some parts of People’s Republic of China). The consequence is a high demand in health care services in general as well as services specifically related to age-related health concerns, such as dementia, osteoporosis and arthritis.

The Asia-Pacific region is ageing faster than other parts of the world

Whereas it took more than 100 years for the share of France’s population aged 65 or older to increase from 7 per cent to 14 per cent, countries such as People’s Republic of China and Thailand will experience the same demographic shift in just over 20 years. This gives them much less time to put in place the infrastructure to address the needs of this older population. For example, accumulation of assets through prefunded public pensions, “pay as you go” mechanisms, or programs that mandate or encourage private savings for retirement or elderly health care require a long time to mature. Workforce skills development through training to assist the future strain and demands of care support systems also need time to build.

Graph 1: The speed of population ageing. Time required or expected for population aged 65 or older to increase from 7% to 14%


The Asia-Pacific region is becoming old before becoming rich

Asia-Pacific is an extraordinarily vast and heterogeneous region whose countries span the spectrum of wealth, economic development, and urbanization. Unlike countries such as the United Kingdom and United States, whose industrialization and urbanization came earlier than population ageing, thus allowing time to accumulate adequate wealth to build the infrastructures, e.g. universal pension, training institutes, and hospitals needed for an ageing population, most parts of Asia have only witnessed steady economic growth over the second half of the century. While economic development in certain parts of the Asia Pacific has brought about
transformation at an unprecedented speed and scale, other parts of the continent have had no significant economic development. Most parts of Asia, particularly agrarian countries, still experience resource restraints for developing or strengthening the necessary “age friendly” institutions and financial systems such as pensions and capital markets, healthcare programs and regulatory systems, and may simply not be able to afford a large dependent elderly population.

The Asia-Pacific region has far more older women than older men

As in the rest of the world, older women outnumber older men in the Asia-Pacific, particularly in the oldest age groups. The fastest growing group among older women is the oldest-old (aged 80 or above) with women generally outliving men by 4-5 years (World Health Organization, 2011). Women constitute the majority of the older population and by 2050 women will represent 65 per cent of the population above the age of 60 in the Region.

Table 1: Numbers of years lived beyond life expectancy at 60 years of for male and female by WHO Region

<table>
<thead>
<tr>
<th>WHO Region</th>
<th>Male 2009 (years)</th>
<th>Female 2009 (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>Africa</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Americas</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>16</td>
<td>18</td>
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<tr>
<td>Europe</td>
<td>19</td>
<td>23</td>
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<tr>
<td>South-East Asia</td>
<td>15</td>
<td>18</td>
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<tr>
<td>Western Pacific</td>
<td>19</td>
<td>22</td>
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</tbody>
</table>

Poverty affects the lives of the majority of people across the world, in particular women and children. Traditional Asian values of patriarchal hierarchy serve to perpetuate the negative implication of being female in Asian families. As in most parts of the world, older women in Asia experience more types of vulnerability than older men. A higher proportion of older women are single or widowed, illiteracy levels are higher among older women and a lower proportion of them are remuneratively employed as they often take up traditional roles as housewives and/or are involved in informal low-wage occupations. Women’s dependency on men for land and income often puts them at great financial risk when their husbands pass away. Hence, most may have no or little national retirement protection as they age. The change in contemporary family structures brought about by a drastic drop in birthrates with many Asian families now having two or fewer children, will also threaten the viability of the traditional family support system for older women. Education also plays a major role in determining a person’s utilization of available services. Especially in rural areas, the isolation and lack of formal support places widows at greater risk for health and cognitive deterioration.
Cultures in the Asia-Pacific region value family and community welfare

The region’s cultural heritage and contemporary cultural mosaic has been shaped under several different civilizations, belief systems and religions, including Buddhism, Christianity, Confucianism, Hinduism and Islam. A common socio-cultural characteristic in these regions is the high value placed on family integration and consensus in social relations to maintain harmony among members of groups, with an expectation of community welfare often rising above individual interests.

III. Analytical framework: An overall orientation to the provision of elderly care services

The diversities in the region call for a flexible policy directive enabling governments to address diverse needs as appropriate for each country context. However, members of ESCAP may also wish to adopt some common policy frameworks for moving forward and for inter-governmental reviews and collaborations. In the global framework the Madrid International Plan of Action on Ageing (MIPAA), there are three key priority areas: (1) Older persons and development, (2) Advancing health and well-being into old age, and; (3) Ensuring enabling supportive environment, along with 18 corresponding issues as shown in Table 2.

<table>
<thead>
<tr>
<th>Older Persons and Development</th>
<th>Advancing Health and Well-being Into Old Age</th>
<th>Ensuring Enabling and Supportive Environments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Active participation in society and development</td>
<td>9. Health promotion and well-being throughout life</td>
<td>15. Housing and the living environment</td>
</tr>
<tr>
<td>2. Work and the ageing labor force</td>
<td>10. Universal and equal access to healthcare services</td>
<td>16. Care and support for caregivers</td>
</tr>
<tr>
<td>5. Intergenerational solidarity</td>
<td>13. Mental health needs of older persons</td>
<td></td>
</tr>
<tr>
<td>7. Income security, social protection/ social security and poverty prevention</td>
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<td></td>
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<tr>
<td>8. Emergency situation</td>
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Table 2: Three key priority areas with 18 corresponding issues of the Madrid International Plan of Action on Ageing

Modified Policy Framework for Active Ageing incorporating priority areas of the Madrid International Plan of Action on Ageing

To accommodate the various contexts in Asia-Pacific a proposed Framework for Active Ageing is outlined below, drawing upon the World Health Organization (WHO) 2002 Policy Framework for Active Ageing (World Health Organization (WHO) 2002) and the Madrid International Plan of Action on Ageing.

To promote social development, improve the quality of life of older persons and sustain support systems for older persons and for services to be delivered under an articulated policy structure in a society for all ages, adjustments in policies and services will be required at all levels, including individual, organizational and societal. As a contribution to the Second United Nations World Assembly on Ageing held in 2002, in Madrid, Spain, the WHO proposed a Policy Framework for Active Ageing, developed through a broad consultation process. The Active Ageing policy framework also fits well with the three key priority areas contained in MIPAA.

The concept of active ageing was proposed by WHO as a framework to further assess what makes a good model for elderly care services. The Active Ageing policy framework focuses on areas such as preventing and reducing the burden of disabilities, chronic diseases and premature mortality; reducing the risk factors associated with non-communicable diseases and functional decline as individuals age, while increasing factors that protect health; enacting policies and strategies that provide a continuum of care for people with chronic illness or disabilities; providing training and education to formal and informal carers; ensuring the protection, safety and dignity of ageing individuals; and enabling people as they age to maintain their contribution to economic development, to activity in the formal and informal sectors, and to their communities and families.

There are three pillars under WHO's Active Ageing concept, with each pillar bearing a key message on for the relationship between the individual's and the state's responsibilities, acknowledging that governments play a key role in providing a conducive environment for individuals' greatest achievements. Taking into consideration the specificities of the Asia-Pacific region, a modified Policy Framework of Active Ageing is proposed that specifies the role of governments, civil society and individuals as shown in Figure 3.

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3 The preliminary version of the Policy Framework for Active Ageing, published in 2001 entitled "Health and Ageing: A Discussion Paper, was translated into French and Spanish and widely circulated for feedback throughout 2001 (including at special workshops held in Brazil, Canada, the Netherlands, Spain and the United Kingdom). In January 2002, an expert group meeting was convened at the WHO Centre for Health Development in Kobe, Japan, with 29 participants from 21 countries. Detailed comments and recommendations from this meeting, as well as those received through the previous consultation process, were compiled to complete this final version as a contribution to Second United Nations World Assembly on Ageing.
The analysis below will follow the three pillars under the Policy Framework for Active Ageing, which depend on a variety of influences or determinants related to health and social services systems, behavioral factors, personal factors, physical environment, social environment and economic situation. These are all inter-related and would require inter-sectoral actions for their implementation, thus forming a coherent framework for a life-course towards a graceful old age for all.

IV. Redefining Elderly Care towards Active Ageing for Asia Pacific Region and its Challenges

Elderly Care, in general, refers to health and social care services provided to older persons in maintaining their daily living in a place they are accustomed to. Services are provided to meet the person’s needs at different levels of frailty. For instance, when the older persons are mobile and able, enabling a basic level of subsistence is the primary concern, activities such as social and recreational ones are necessary for improving their life quality. When a person becomes semi-ambulant or less mobile, making a barrier-free environment with assisted living facilities or services is crucial for staying in the community. Towards the end of life residential or hospital care may be required for the comfort of both the older person and his or her loved ones, whilst it may be desirable to keep these periods to a minimum.

The below recommendations are structured according to the three pillars of active ageing - health, security and participation.
The Health Pillar: Recommendations for governments, civil society and individuals

Promoting and protecting health is central to elderly care and contributes to a better quality of life at old age. The promotion and sustaining of good health is not confined to the health sector. The circumstances in which people grow up, education, housing, food, their lifestyles, working life conditions, and age strongly influence how people live and die (World Health Organization, 2008). Elderly Health and Social Service can be understood by four limbs: Health promotion and disease prevention; Curative services; Long-term care; and Mental Health Services.

Prevention of Non-Communicable Diseases

Health promotion is the process of enabling people to improve and be in control of their health. Disease prevention includes the prevention and management of the conditions that are particularly common as individuals age. By early establishing healthy eating habits (i.e. low salt, low fat and low sugar diets), frequent exercises, non-excessive alcohol consumption and avoiding smoking, individuals could avoid many chronic or non-communicable diseases (NCDs). Such diseases will continue to be the top killers regardless of the level of economic development of a country or area. Among these are ischemic heart disease, cerebro-vascular disease and chronic obstructive pulmonary disease. Graph 3 allows us to compare the relative impact of each of these conditions in different settings. The burden of pre-mature mortality from non-communicable diseases in older people is higher in low- and middle-income countries than high-income countries. Prevention refers both to ‘primary’ prevention (e.g. avoidance of alcohol consumption and tobacco use) as well as ‘secondary’ prevention (e.g. screening for the early detection of non-communicable diseases), or ‘tertiary’ prevention (e.g. appropriate clinical management of diseases), which all contribute to reducing the risk of disabilities.

Graph 3: Years of life lost due to death per 100 000 adults aged 60 years and older by country income group

Practices or services for health promotion to avoid or delay the onset of NCDs should be combined with early detection and intervention. Early diagnosis improves proper disease management, including for common diseases such as diabetes, hypertension and dementia. Among these, dementia is the most complicated and would require care at all levels.

Textbox: Examples of health promotion initiatives for the elderly in Asia-Pacific

Russian Federation has invested in the promotion of healthy ageing by various means. The Ministry of Healthy Lifestyle launched an advertising campaign to promote healthy lifestyles. Studies show that Russians have responded positively to the campaign and the average amount of alcohol consumption dropped, for the first time since 2000, from 18 to 15 liters per capita and the number of drug addicts and people who suffer from obesity have declined as well. A nation-wide health promotion project ‘Healthy Russia’ was launched in 2010, aiming to instill health values and a responsible attitude to citizens’ own health and the health of their family members, through healthy eating, exercising, quitting smoking and drinking and encouraging citizens to take preventive measures for maintaining good health, such as regular health check-ups and visits to public health centers around the country for free consultations and services. The project has set up a hotline to offer free consultation services on nutrition and tips on how to quit smoking.

Samoa has a Health Promotion Policy and Mental Health Promotion Policy in place. Guided by that policy, the Ministry of Women Community and Social Development, in partnership with the Ministry of Health, launched a Gardening Project to promote healthy living by encouraging people to grow and consume vegetables in daily meals. Funds are provided to community-based organizations to carry out projects in different neighborhoods. Also under the Ministry of Women Community and Social Development is the project ‘Healthy Home, Healthy Villages’ which emphasizes the eight components: (1) Healthy homes; (2) Satisfactory kitchens; (3) Sanitized toilet facilities; (4) Smoke-free homes; (5) Vegetable gardens; (6) Clean environment surrounding the house; (7) Access to safe drinking water; and (8) Pig pens for pigs.

Australia appointed an Ambassador for Ageing in 2008. The Ambassador promotes healthy, positive and active ageing including lifelong learning and continuing participation in the workforce and volunteering. The Ambassador also encourages community attitudes that value and respect older people, and explains Government programs and initiatives to the public including raising awareness among older people of programs and how to access them. In the past three years the Ambassador has attended over 138 events across Australia. This includes television appearances, health promotion activities such as flu vaccinations for the elderly and falls prevention, and speaking at different events.
Thailand supports the establishment of Elderly Clubs in sub-districts in all provinces of the country. Health promotion activities for the elderly are organized by the clubs to encourage self-care and social participation of older persons. The Ministry of Public Health organizes an annual elderly health promotion conference to support and strengthen the capacity for those elderly clubs and elderly networks. Outstanding elderly clubs are granted awards as incentives to boost their morale. Documents, manuals, CDs, leaflets, and posters are also produced to promote knowledge on elderly care are distributed at the conference.

Source: Regional Survey on Ageing 2012, UNESCAP

Prevention of Disability

The prevalence of disabilities increases with age, while poor prevention measures accelerate the rate at which people experience disabilities. More than 46 per cent of persons aged 64 years and over live with disabilities (World Health Organization, 2004). Disability prevalence among older people in low-income countries is higher than in high-income countries, and higher among women than men (World Health Organization, 2004). Often, some of the disabilities could be traced to life styles and an unhygienic environment, thus health education and healthy life styles promotion should be included in school curricula and taught through community education.

Dementia Care

Dementia should be given a higher priority considering its high global prevalence, the economic impact of dementia on families, caregivers and communities, and the associated stigma and social exclusion. Forty per cent of the world’s 25.5 million patients suffering from dementia aged 65+ live in Asia. Dementia is a condition that often requires institutionalization (Magaziner et al., 2000; Woo, Ho, Yu & Lau, 2000) and over 60 per cent of residents in long-term care institutions suffer from dementia (Matthews & Dening, 2002). However, institutionalization is not the only nor necessarily the best option as early institutionalization is associated with increased mortality. Care in the community is demanding, often round-the-clock, while family care and living at home remains what most old people in the region desire.

The prevalence of dementia in socio-economically advanced societies is around 10 per cent for persons aged 75 years and above and 30 per cent for the above 85 years group. Alzheimer’s disease comprises the greatest proportion of cases of dementia in old age, amounting to 60-70 per cent of cases. A life course approach should be taken as in other chronic non-communicable diseases to maximize the brain and cognitive reserves to delay the onset of the disease.

Along with strategies of prevention, primary prevention can take the form of a life-course approach to promote good socioeconomic conditions in childhood, continuous education, cognitively stimulation and occupational opportunities in youth, risk modification for cardiovascular burden such as hypertension and diabetes mellitus through life style changes and medical treatment at middle age, attention to emotional health around retirement and continuous social engagement and learning in “third age”. A useful framework indigenous to the Asian cultures is the employment of the principles of the Six Confucian Arts of Human Mental Functions: (1) Social etiquettes and self awareness (禮 Li); (2) Music (樂 Yue); (3)
Archery (射 She) which is training of attention; (4) Horseback riding (御 Yu) which is exercise; (5) Learning (書 Zhu); and (6) Mathematics (數 Shu) which is problem solving. Programmes can thus be creative and diversified to include all the above elements such as playing mahjong which includes social engagement, attention, and problem solving; ballroom dancing which includes social engagement, music and exercise, etc. These activities can be developed for retirees and persons with mild cognitive impairment, which in some persons may progress to dementia in 5-6 years time.

Secondary prevention is early detection, diagnosis and treatment. The high prevalence of dementia in old age calls for early detection by family members and diagnosis to be made by the family physician. As the disease impacts the patient and the whole family, the family physician in liaison with local community service providers assumes a role in the care for the person with dementia and the family. Diagnosis at the early stage of the disease remains low. Hence, family physicians should be trained in the diagnosis and treatment of early dementia through opportunistic screening for cognitive decline in their patients aged 75 and above. Likewise, family members should be educated on early symptoms detection of dementia in persons aged 75 and above.

Tertiary prevention aims at minimizing the complications from a chronic disease. In dementia this involves maintaining the social, cognitive and physical functioning of the person especially in the early and moderate stages of dementia. In the advanced stage, ambulation and feeding problems arise and nursing and palliative care are required. All these care strategies require collaborative efforts from the family and service providers in a process of advance care planning. Day care is an important supportive facility for the patient and family members and should best be integrated into a residential facility in the local community of the family. A concept of “boutique daycare” may be appropriate for densely populated countries or areas like Hong Kong and Singapore.

Curative Health Services and Long-Term Care Development

Despite efforts in health promotion and disease prevention, curative services are indispensable due to the vast increase of aged population. Most curative services must be offered by the primary health care sector, which is best equipped to make referrals to the secondary and tertiary levels of care. Acute and emergency care should be sufficiently provided to cure communicable diseases to which older persons are particularly vulnerable, such as infectionspneumonia, and bronchitis.

The shift in the global burden of disease towards non-communicable diseases requires a shift from an acute care model to a coordinated and comprehensive continuum of care. This will require a reorientation of the present health system and service delivery in order to address the health needs of rapidly ageing populations. The shift also means that there is less need for heavily geared, professionals-led, hospital based treatments, so governments can spend less in building the expensive infrastructures for an acute healthcare system, i.e. hospitals with a germs-free environment, staffed with highly trained medical and para-medical professionals and very expensive medical facilities. However, with more and older patients in households assistance for daily living and management of sickesses, medications for delaying and treating non-communicable diseases, alleviating pain and
improving the quality of life will be in great demand. This calls for renewed, innovative, flexible partnerships among governments, health professionals, the pharmaceutical industry, traditional healers, employers and organizations representing older persons to increase affordable and easy access to essential safe medication and to better ensure appropriate and cost-effective use of current and new drugs.

Under initiatives for ‘ageing in place’ and ‘community care’, whereby older persons are encouraged to stay active and live at home for as long as possible, assisted by community support services when needs arise, long-term care is becoming increasingly important. Long-term care refers to the system of activities undertaken by informal caregivers (i.e. family, friends and/or professionals (i.e. health and social services) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfillment and human dignity (WHO, 2000).

When the promotion and maintenance of health is provided at home or at the community level, it implies a more socially oriented type of care network with the technical levels of care remaining basic. This is sometimes referred to as social care services, ranging from simple non-invasive home-making and cleaning services, to body-touching personal care, e.g. assisted toileting and bathing, and home nursing services.

Mental health services are central to ageing in place, although the promotion of mental health and well-being later in life continues to receive little attention. More focus is required on the early diagnosis of mental illnesses, such as depression and conditions, which may be associated with increased risk of depression and suicide rates among older persons.

Risk factor management and healthy ageing

Physical activity and good nutrition are important components of ageing well, since it delays functional declines and it can reduce the onset of chronic diseases in both healthy and chronically ill older persons. Active living improves mental health and often promotes social contacts. Being active can help older people remain as independent as possible for the longest period of time. Nutritional habits should be modified after the age of 50, as caloric needs decrease with ageing (depending on activity levels), while nutritional needs increase. For example, osteoporosis is much more pronounced in older women than in men but evidence suggests that the onset of osteoporosis can be stalled or even deterred for women if they engage in a number of preventative actions across their life course, including engaging in a sufficient level of physical activity, consuming a balanced diet and not smoking.

According to the advice from WHO, adults need at least 30 minutes of regular, moderate-intensity physical activity on most days, while more activity may be required for weight control. Physical activity benefits both physical and mental well-being, and reduces by about 50 per cent the risk of many disorders related to inactivity, such as heart disease and type 2 diabetes. It also reduces the risk of hypertension and some forms of cancer and it decreases stress, anxiety, depression and loneliness. There are important economic benefits when older people are
physically active, as medical costs are substantially lower for older people who are active (WHO, 1998). It is however observed that a high proportion of older person in many countries and areas in Asia-Pacific region lead sedentary lives. Populations with low incomes, disabilities and ethnic minorities are most prone to be inactive.

The adoption of healthy lifestyles and to actively participate in the care of oneself are important at all stages of the life cycle. Engaging people of all ages in appropriate physical activity, healthy eating, not smoking and using alcohol and medications wisely, even in older age, can prevent disease and functional decline, extend longevity and enhance one's quality of life.

The Security Pillar: Recommendations for governments, civil society and individuals

Security means both financial and environmental securities, which are important components that allow individuals to feel secure while staying active and productive in ageing. In providing the general population a secure financial base to live into old age, policy makers in the region are in general agreement that a minimum pension, however small in accordance with different levels of development, should be provided to the older persons. In addition, employers and individuals should be encouraged to contribute to a provident fund (i.e. occupation-related saving schemes, if available). Family contributions or personal savings provide good supplements for a better retirement.

Financial Security

The Asia-Pacific region is in the midst of tremendous change. Economies are modernizing rapidly; with life expectancy improving while birth rate continuing to decline, causing the family size to shrink and leading to a dramatic increase in the aged population. Ageing policies in the region relating to retirement protection contain a basket of diverse arrangements taking into account country diversities in geography, politics and socio-economic conditions. Policies for the ageing population include the most comprehensive type covering all aspects of daily living, as seen in Australia, Japan and New Zealand, and the bare subsistence level of provision or even none in less wealthy countries. It has been widely agreed by governments in the Asia-Pacific region that there are no universal solutions to the complex array of retirement issue or a simple reform model that can be applied in all settings. Australia, Japan and New Zealand are more advanced, parallel to the United States and other European countries, while most retirement institutions in the region are still taking shape and formal retirement systems in Asia-Pacific are maturing, generally with limited scope and generosity. To minimize the administration's role and implied burden, governments in many countries look to the families to provide for their own elderly members despite the weakening role of family.

The World Bank proposed the refined pension conceptual model in 2008 by adding two more pillars to the preceding three-pillar model, redefining the range of design elements to determine the pension system modalities and reform options that should be considered. The multi-pillar design proposed by the Bank which includes - (1) the non-contributory 'zero pillar'; (2) the mandatory 'first pillar'; (3) the mandatory 'second pillar'; (4) the voluntary 'third pillar' and; (5) the non-financial 'fourth pillar' - provides flexibility and can address country-/ area-specific conditions and
needs of the older population. It provides security against economic, demographic, and political risks faced by pension systems. Although family care is declining it is still strongly present under the fourth pillar and governments in the region are trying to strengthen this pillar in order to significantly reduce care services spending.

Pensions are an important source of income in old age. The pension systems in developed economies tend to be more diversified and have sought to incorporate multiple elements of the five-pillar model to deliver a retirement income effectively and efficiently. China is developing in this direction, while it tackles issues of scope and generosity. Universal coverage retirement protection for older persons, meaning a flat-rate benefit of subsistence level to all older persons, with conditions on age and length of required residency etc., has been developed in some countries. Great efforts have been made, especially among developing countries, to ensure a basic income support to the population considering that the social protection and social security systems in many countries and areas in the Asia-Pacific region have been developed recently.

However, means-tested income support schemes leave a majority of workers to either enter old age without a pension or work outside the formal economy. The approach also provides a foundation to cover gaps in coverage and benefit adequacy in societies with mandatory first and second pillar schemes that may not be reaching workers through their full working lives due to their movement in and out of formal employment, as commonly seen with women. In addition women are often expected to be carers for both low paid and unpaid care giving tasks, leaving them inadequately covered. Albeit being comprehensively developed, the pension systems in developed economies such as Australia, Japan and New Zealand, have been recently reformed to keep up with the growth in ageing population so as to stay strong against the criteria of adequacy, affordability, sustainability, equitability, predictability and robustness.

Environmental Security

Environmental safety is a pivotal part of security, complementary to financial support in old age. It refers to the physical environment of housing as well as emotional and psychological security at home and in the community, enabling older persons to live independently with community-based and home-based care and support. In enabling a safe and healthy environment for the elderly people to live in, WHO has encouraged a series of initiatives for environment-friendly accreditations: namely “Healthy Cities”, the barrier-free and universal designs for buildings, and the “Age-friendly Cities”. These are set protocols that governments can subscribe to for the benefit of their elderly people. Technical standards and codes of practice are clearly laid down for easy adoption. Many cities in the Asia-Pacific have been designated as an Age-friendly or Healthy Cities, though these tend to be more economically developed cities such as Seoul, Shanghai and Sydney.

To meet the demand for home care from a large proportion of elderly people, the informal care system, which includes voluntary care provided by family, friends or neighbors, should work closely with the formal system (i.e. trained and recognized health and social service providers). This will require a major shift as elderly care in the region has been developed based on western models. Elderly care will only be
sustainable under a coordinated policy framework that will require joint efforts from all stakeholders including the elderly themselves, family, community and government. The informal care system, including family and neighbours, will assist to initiate voluntary help to the elders living in the neighborhood under WHO’s active ageing policy framework, while individuals will be encouraged to exercise their self-responsibilities for maintaining their good health (e.g. regular exercise, healthy diets) while governments need to invest in providing a conducive environment to safeguard elders’ basic health (e.g. provision of health services), sustain a descent standard of living (e.g. social security or pension for those who need it) and security (e.g. a safe shelter including nursing homes when necessary). Mobilizing and empowering informal caregivers of all ages, including through training, is therefore considered crucial for sustainability of any future model.

Considering shrinking revenues and rising expenditures, governments in the region may want to allocate their limited resources to elders most in need while leveraging social capital to ensure a better living for everyone in the society, including the older persons.

A note of concern is that, despite the filial respect said to be still evident in the region, recorded cases of elder abuse have risen. Physical, psychological and financial abuse often comes from close relatives, spouses and children or children-in-law. While there are many reasons behind the increase, to address the shortcomings some governments have enacted legislation obliging children to pay maintenance to their parents (e.g. India, Singapore). Other recent initiatives include a mediation model where family disputes are dealt with through a compulsory process of negotiations under the supervision of experienced mediators/counselors, with the advantage that the process focuses on reconciliation rather than ‘separation’.

The Participation Pillar: Recommendations for governments, civil society and individuals

Participation or engagement in community activities is an important part of active ageing. Activities primarily involve paid or unpaid work, participation in the policy-making process and life-long learning activities. Some argue that work, leisure and retirement are recent man-made concepts introduced as a result of waged labour in industrialized economies, while they were never a practice in agrarian societies. Whether one has paid work now tend to determine one’s social status and, in many countries, entitlement to a retirement pension. This has put older persons, in particular older women, in a disadvantageous position.

Given the rapid demographic changes a stronger focus is needed on labour policies, especially for countries with large populations nearing retirement age. This would ease the pressure on public budgets and contribute to a society where everyone is empowered to participate at all ages. Work can be demanding and can compete with family time and leisure activities, but employment also makes people feel valued and connected to society. Data from the Survey of Health and Ageing in Europe indicated that poor health was strongly associated with non-participation in the labor focus in most European countries (Alavinia SM, Burdorf A (2008). Some governments in the Asia-Pacific are developing policies in this direction, with the

4 Downloaded from http://www.share-project.org/.
extension of the statutory retirement age and the introduction of special programmes and incentives to encourage older persons to remain in the workforce, share their experiences, keep playing an active role in society and live as healthy and fulfilling lives as possible.

Volunteering

Socially embedded older persons who are in frequent contact with family, close friends and neighbours tend to have better physical health than those who are less involved. Involvement in neighborhood and community activities is also associated with better social support, greater physical activity and lower levels of stress. Volunteering or other forms of professional activity can be an antidote to social exclusion and loneliness, helping to keep people active and involved and providing a sense of meaning and purpose.

Volunteers can become an important supply of labour for home-based and community care in countries or areas in Asia-Pacific region. Countries with existing volunteering systems could initiate training programmes leading to formally recognized qualifications. In developing countries, especially those with vast rural areas, training of trainers for the dissemination of volunteer knowledge and skills could be especially fruitful. The establishment of an accreditation system for care training is becoming increasingly important, while being available in only a few countries and areas in the region, with accreditation systems that allow portability of qualified local trainees to work in other Asia-Pacific countries and areas. Commonly referred to as a Qualification Framework (QF), it is a model capable of assessing work life experience for different skill and knowledge levels comparable to academic training. The Qualification Framework is in operation in a few countries in the region and it provides a model of training and recognition that enables informal caregivers to become formal ones. These ‘registered’ caregivers, can be either paid or volunteers who attend to mostly lower level care needs, and will be trained in large number – materializing the vision of having an elderly caregiver around the corner twenty-four seven.

Employment

Among developed economies in the region, older workers have been leaving the workforce earlier in the last two decades than they did in the 60s and the 70s. Using Hong Kong as an example, the labor force participation rate of individuals aged 65 to 74 declined steadily from 18.7 per cent in 1991 to 10.4 per cent in 2001 and the situation is similar in for other developed economies in the region, such as Australia, Japan, Korea, New Zealand and Singapore. These statistics contradict the popular belief that people with higher education attainment tend to continue working in later years. If the trend continues there will be twice the number of retirees per worker in the region by 2050. This would pose a significant threat to living standards and public and private sectors in the region should therefore work together to encourage older workers to remain in employment. Countries and areas in the region may in this regard want to consider eliminating early retirement schemes and increase the official pensionable age, to correct distorted financial incentives to retire early. A
A 2008 study by the Hong Kong-Shanghai Banking Corporation, indicated that there is a supply-demand gap as more than 70 per cent of the retired population indicated that they wished to be able to continue with some kind of work after retirement. The figure is even higher for older women in the region - 40 per cent of women in Taiwan and Hong Kong and 70 per cent in Singapore - expressed a strong desire to provide for their own independent living. To tackle the demand/employer constraints to the hiring of older workers, countries and areas could consider balancing labor costs with productivity by offering tax incentives to employers and providing wage subsidies for businesses hiring older workers to help those workers get a foothold in the job market.

Lifelong learning and targeted training in connection to the concept of Qualification Framework in mid-career, could improve employability in later life and discourage early withdrawal from the labor market. With the removal of a mandatory retirement age and the implementation of optional retirement, employers would be provided a better incentive to invest in older workers through training. Governments should encourage companies to set up progressive retirement plans that allow older employees to reduce working hours gradually over a number of years. Older workers are perfectly seasoned and positioned to help maximize the use of skills and expertise, to develop relevant skills in younger workers and supply their skills and experience to the labor market. Companies must make career planning an integral part of their human resources policy to gradually orient older employees into the new work mode and to ensure that knowledge and skills are passed on to the younger employees.

Life-Long Learning

The promotion of life-long learning is also important to stimulate social inclusion and active ageing. It is the responsibility of communities, through local and national policies, to create institutional frameworks, condition and learning environments in which individuals feel welcome and motivated to develop their own knowledge and skills in order to stay active. Increasingly, life long learning for older persons has three key meanings: (1) learning for interest; (2) learning for a career; and (3) learning for making a contribution to the community.

For Asian elders, the purpose of learning is often for the benefit of their next generations - a wish to hand down their legacy for the good of their offspring, contributing to the promotion of intergenerational relationships. As fertility drops and longevity increases, efforts are needed to bring the generations closer together for harmonious relationships.

Among the effective approaches for learning in later life include drawing upon the knowledge of older persons and learning in groups or networks. One such example is the Elder Academy in Hong Kong, which was launched in 2007 to promote continuous learning for elders. Elder Academies are established jointly by school sponsoring bodies and welfare organizations in the physicality of primary and secondary schools. As some elders aspire for university education, the Elder Academy Scheme has been expanded to cover tertiary institutions so that elders can pursue higher-level academic studies. As at June 2011, there were 109 elder
academies in primary and secondary schools, and a total of eight tertiary institutions offered Elder Academy courses.

Learning can also be through electronic platforms. In Hong Kong the Women’s Commission launched the Capacity Building Mileage Programme for Women, whereas the Radio 5 Elder Learning Programme was run by the government-owned radio station. Macao has developed a web-learning program to enhance the caring ability of family caregivers and professionals on diagnosis, disease symptoms, patient behaviour and psychological reactions to specific diseases.

Projects and programmes show the best results when older persons are involved in the project design and implementation, through peer to peer learning, when older persons contribute to the project as networkers and trainers and when the action responds to older persons’ feedback, such as the ‘Age-friendly City Campaign’ organized by the Hong Kong Council of Social Service. It is however worth noting that organizations focusing on learning should also provide initiatives to increase participation of excluded older people, particularly from disadvantaged backgrounds as most learning activities or programmes in the region are centered on informed and savvy older persons. Social groups and community led networks can be effective at reaching these reach groups.

Life-long learning to promote health and social care should begin in childhood, to i.e. primary and secondary school students, who will be provided with trainings by trainers (i.e. trained older persons or women leaders who are well-equipped with necessary skills and knowledge) on the concept of health practices (i.e. basic, non-invasive caring skills for elders such as lifting and personal care).

The relationship of giving can take root from caring for older persons in the younger persons’ families and by extension to other older persons in their neighborhood. For example, Hong Kong launched the Neighborhood Active Ageing Project in 2008. Through cross-sectoral collaboration, the Project mobilizes community organizations and volunteers, including older persons, to promote neighborhood support, inter-generational harmony as well as care and respect for elders. Cases of hidden older persons identified through these projects are referred to service units for follow-up as appropriate. As at 2011, a total of 75 projects had been carried out under the Project, reaching out to 200,000 older persons and their families. Such approaches will form a self-reinforcing giving-and-receiving cycle and enhance intergenerational harmony among different generations. Young people are encouraged to take responsibility for being good citizens in building a caring society, and formulating a caring and support system that fits the local situation and assists in better managing the transitions in society. Moreover, to overcome geographical constraints, there should also be an increasing focus on utilizing “e-inclusion” methods, through information and communications technologies and online tools, in order to reach vulnerable groups, especially those who reside in rural areas.

Lifelong learning is a two-way interactive process empowering older persons to engage in activities meaningful to them both as a way to learn to serve as well as a way to serve to learn – further enhancing them as role models for the younger generation in service-learning. Some practitioners have proposed that lifelong learning should form the ‘fourth pillar’ of active ageing.
Political Participation

The participation of older persons in decision-making or in shaping policy development and its implementation appears to be the weakest link for the Asia-Pacific. Older persons’ participation in decision-making ensures that age-specific policies are designed and implemented responding to the needs of older persons. Several countries and areas in the region have taken measures to ensure that the voices of older persons are heard and also to actively involve them in policy-making and/or decision-making at different levels. Commonly seen approaches to give a voice to older persons include appointing older persons representatives as members of high-level consultative bodies to community-level committees (e.g. village communes, bottom-up appraisal groups etc) that advise on policy-making and its implementation and evaluate the provision of services. In Thailand and Malaysia a number of seats in the consultative body on ageing and/or for older persons are reserved for older persons. While is a little knowledge about the political impact of older persons as voters in democratic systems in the region, the ever-growing group of older voters will increasingly influence policies, such as those concerning health services, social welfare, income security, and housing.

V. Issues of cross-cutting concerns to Asia Pacific Region

Elderly care service financing

Introducing sustainable policies for the financing of different kinds of elderly services is of paramount importance. As demonstrated in Europe and other advanced economies, a financing system purely based on public taxation will not be sustainable when the economy has to cope with a high dependency ratio. Governments in the region are moving carefully, while struggling to keep up with the increasing ageing population and associated expenses. The general principle for financing elderly care services is a co-payment system, whether in kind or in cash, between government, individuals and family, generally combined with means-tests identifying those most in need, rather than elderly care provided universally and fully paid by governments and tax revenues. In making the financing system more sustainable, this paper suggests that the following principles are considered pivotal:

- Individual and family responsibility are at the core, with neighbourhood or community support as supplement and government or institutional care as the last resort: As evidenced from western societies, models of financial dependence on only one single source, whether through taxation alone (as in many welfare States in Europe) or all-private insurance schemes (as in the of the United States and Japan), are not sustainable when confronted with high old age dependency (i.e. low fertility and large number of older persons with longer life spans). The only way to sustain the expenses for old age is to have multiple sources for the high expenses in old age care.

- Needs-driven approach instead of universal coverage of services: As resources are limited, services need to be allocated to those most in need, so that people with sufficient means pay for their own care.
- Co-payments whenever possible: In encouraging individual and family responsibilities, as well as to avoid moral hazards co-payments are encouraged to the extent that cost recovery should be aimed for.

- Public-private partnerships: In encouraging quality, choice and constructive competition in the provision of services, both public and private service providers are encouraged to offer their services; partnerships can develop good platforms for innovative practices e.g. social enterprises.

- The "3 As" criteria for service provision: Taken the above as core, the service provided must fulfill the "3 As": affordability, availability and accessibility. Services provided must be at a cost affordable to the consumers or the funders, users must have a range of products or providers to choose from and services should be appropriate to the person’s health needs, and they should be easily accessed (e.g. a provider near to place of residency).

- Intergeneration-solidarity: As high old age dependency means a financial burden on the younger generation, both in terms of family and neighborhood care, and financial contribution, mostly through taxation, it is recommended that governments enact policies to promote harmonious relations between different generations or/ and filial responsibilities.

Women and gender

Women and men over the age of 60, suffer from the same leading causes of death and disability as a result of behaviors established in their youth and adulthood, including smoking, sedentary lifestyles, and diets heavy in cholesterol, saturated fat and salt; but low in fresh fruits and vegetables. While health systems and care services remain largely geared to the health needs of younger persons, and to the management of communicable diseases in developing countries in the region, low levels of fertility and a growing proportion of older persons in population are beginning to emerge (World Health Organization, 2009). Examples of life course events that often increase women’s vulnerability to poor health in older age include discrimination against girls leading to inequitable access to food and care during childhood; restrictions on access to education at all levels; childbirth without adequate health care and support; low incomes and inequitable access to decent work due to gender-discrimination in the labour force; care-giving responsibilities associated with mothering and looking after one’s spouse and older parents that prevent or restrict working for an income and access to an employee-based pension; domestic violence, which is also a common form of elder abuse; widowhood, which commonly leads to a loss of income and may lead to social isolation; and cultural traditions and attitudes that limit access to health care in older age (World Health Organization, 2007).

Gender is a powerful determinant of mental health that interacts with such other factors such as age, culture, social support, biology, and violence. While women do not experience more mental illness than men, they are more prone to certain types of disorders, including depression and anxiety. In older age groups, more men than
women commit suicide. The male:female ratio for completed suicides among people over age 75 is 3:1 to 4:1.5

Older women play key roles in their families and communities, acting as caregivers. There is a cultural preference for women as caregivers in both the formal (paid and trained) and informal sectors where women’s contribution should be recognized. The recent introduction of experience-based qualification accreditation system (e.g. qualification framework in Australia, New Zealand and Singapore) should be taken forward to attract, encourage, recognize and protect women and the informal caregivers.

Keeping older women healthy, fit and active benefits both the individual and also makes sound economic and social sense as preventive interventions can help reduce the costs of long-term care for chronic conditions. Older women face double jeopardy — exclusion related to both sexism and ageism. In the traditional Asian society, where the extended family predominates, older women often acquire enhanced social status when their children marry and have their own children. However, increasing urbanization and more nuclear family structures often lead to isolation of the older persons of both sexes. Because women tend to marry older men, and as women usually live longer, many older women become widows. In most cases, they adjust both emotionally and financially to their changed situation. However, in some settings traditional practices relating to widowhood may result in violence and the abuse of older women, posing a serious threat to their health and well-being (Chen, 2000). It is therefore essential to build “age-friendly environments” specifically focusing on older women. Longer and healthier life is a social goal that will give women opportunities that they and their communities will value, and at the same time will lead to major social changes in the organization of work, family and social support.

VI. Conclusion

The Asia-Pacific region is ageing at a much faster rate than most other regions and it is experiencing the impacts of a larger and longer living older population, while fertility is on the decline. Modernization with industrialization and urbanization in the main has brought about better living standards to our region but also posed threats to our family cohesion and the traditional family-provided and family-centered care. It is clear that the Western model of universally covered elderly care service is not sustainable nor viable, while sole reliance on the family is not possible either as extended families are shrinking and the tradition of caring for older relatives gradually being lost.

To materialize the blueprint laid out in this paper, a change of mindset at the service delivery front is required, with an acceptance that ordinary people in the community, including relatives and neighbours could provide a certain level of care complementing the highly skilled, expensive and limited numbers of professional care givers. The first step is to provide a platform for the community to engage

people in a culture of “giving”. Many of these platforms are being built in communities of high deprivation, ethnic minorities, abused wives and elderly. The next step is to identify people and resources offering help. This is where elderly people, students, housewives, and corporate volunteers become obvious human resources, and where community organizations such as schools, churches, elderly centers and clan associations become the platforms for interaction and for forming a “relationship” network. The final step in building this “help” structure is to provide training for these people, such as essentials of care giving, equipping them with skills and competence to provide self-care and basic personal care to others under a regulated system that recognizes, protects and reward their level of competency and professionalism.
References


