



CommonAge

# Ageing in The Commonwealth



CommonAge Research Report



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The Gambia is not included in this report because at the time the research was undertaken, The Gambia was not a Commonwealth member country.

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## Acknowledgement

This research was commissioned by the Commonwealth Association for the Ageing – CommonAge and was undertaken by the Oxford Institute of Population Ageing at the University of Oxford.



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The commissioning of the research and the production of this report has been made possible by the generous support of: St Monica Trust, The Abbeyfield Society, The Anchor Trust and Age International. This support is gratefully acknowledged.



## Foreword

Welcome to this first research report commissioned by the Commonwealth Association for the Ageing – CommonAge, and undertaken by the Oxford Institute for Population Ageing at the University of Oxford.

CommonAge is one of the newest accredited organisations of the Commonwealth. It is a voluntary organisation established in Australia in 2013, with the purpose of working for the interests of elders across the Commonwealth, and to promote the concept of an Age Friendly Commonwealth in which all generations are valued, supported and encouraged to contribute to its continued successful development.



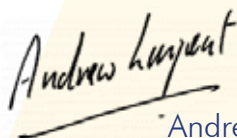
Population ageing is affecting all Commonwealth countries. This fact is well known to those who work in the field of ageing and who advocate for the rights, needs and contributions of older people to be recognised and appreciated by governments and institutions. From the time it was first conceived by a group of professional colleagues working on service provision for elders, CommonAge has experienced how the interests and potential of older people are too frequently overlooked. In the early days of its journey the response too often heard in Commonwealth circles was: “Our focus and priority in the Commonwealth is on young people, as we need to help them to understand the Commonwealth. Why should the Commonwealth be interested in older people?”

In response to this question, CommonAge realised that there is important work to be done to help the Commonwealth to understand the support needs, the demographic trends in member state populations, and the potential of older people to contribute to civil society and to policy development in all 53 member countries. To achieve this a strong evidence base was needed so, as its first major contribution, CommonAge decided to commission this research project. Who better to undertake the work than the widely respected research organisation The Oxford Institute for Population Ageing?

This report is the result of that research project and CommonAge would like to acknowledge the excellent work that has gone into assembling the evidence on which this report is based. This report presents a baseline overview of “Ageing in the Commonwealth” and has been timed to be presented at the 2018 Commonwealth Summit. It is intended that the evidence will be regularly updated and shared at subsequent Commonwealth Summits in order that population changes and governmental and social responses to those changes can be regularly updated.

As readers of the report will see, population ageing affects all countries across the Commonwealth. Even in countries with predominantly young populations, people are living longer and they are developing more complex health and social needs as they age. However, for as long as they remain healthy and well, they also have the capacity, long into their retirement years, to contribute their wisdom, skills and experience to their communities. They should be encouraged to do so in a Commonwealth that rejects ageism in all its forms and in a Commonwealth that respects them and affords them the dignity of a safe and secure environment in which they can live and age well.

The commissioning of the research and the production of this report has been made possible by the generous support of four of the founding members of CommonAge: St Monica Trust, The Abbeyfield Society, The Anchor Trust and Age International. This support is gratefully acknowledged.



Andrew Larpent OBE  
Chairman  
March 2018

# Commonwealth Countries

## Population on total and GDP



The Commonwealth is a voluntary association of independent countries spread over every continent and ocean. Its 2.4 billion people account for more than 30 per cent of the world's population. They are of many faiths, races and cultures.

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AFRICA	Population*	GDP (billions of US dollars)**
Botswana	2,319,000	17.54
Cameroon	24,474,000	33.06
Gambia, The	2,143,000	1.09
Ghana	29,258,000	49.23
Kenya	50,541,000	85.98
Lesotho	2,253,000	2.88
Malawi	18,987,000	6.74
Mauritius	1,267,000	12.87
Mozambique	30,247,000	14.76
Namibia	2,570,000	13.28
Nigeria	194,241,000	460.66
Rwanda	12,405,000	9.41
Seychelles	95,000	1.56
Sierra Leone	7,667,000	4.12
South Africa	57,176,000	361.16
Swaziland	1,384,000	4.02
Uganda	43,809,000	28.36
United Republic of Tanzania	58,507,000	56.58
Zambia	16,788,000	27.33

ASIA	Population*	GDP (billions of US dollars)**
Bangladesh	165,815,000	273.62
Brunei Darussalam	432,321	11.99
India	1,349,204,000	2.65 thousand
Malaysia	31,906,000	340.92
Pakistan	199,572,000	278.91***
Singapore	5,765,000	316.87
Sri Lanka	20,926,000	87.33

EUROPE	Population*	GDP (billions of US dollars)**
Cyprus	1,186,000	22.96
Malta	432,000	13.33
United Kingdom	66,446,000	2.66 thousand

CARIBBEAN AND AMERICAS	Population*	GDP (billions of US dollars)**
Antigua and Barbuda	103,000	1.6
Bahamas, The	398,000	9.52
Barbados	286,000	5.13
Belize	380,000	1.19
Canada	36,846,000	1.76 thousand
Dominica	74,000	0.63
Grenada	108,000	1.16
Guyana	781,000	3.72
Jamaica	2,896,000	14.96
Saint Lucia	179,000	1.78
St Kitts and Nevis	56,000	0.99
St Vincent and The Grenadines	110,000	0.85
Trinidad and Tobago	1,371,000	20.8

PACIFIC	Population*	GDP (billions of US dollars)**
Australia	24,667,000	1.48 thousand
Fiji	910,000	5.39
Kiribati	118,000	0.2
Nauru	11,000	0.12
New Zealand	4,735,000	215.17
Papua New Guinea	8,364,000	23.14
Samoa	197,000	0.87
Solomon Islands	619,000	1.37
Tonga	109,000	0.44
Tuvalu	11,000	0.04
Vanuatu	280,000	0.89

\*Source: www.worldometers.info, March 2018 to nearest 1000

\*\*Source: www.imf.org, International Monetary Fund World Economic Outlook, October 2017

\*\*\* Source: World Bank 2016

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# Ageing in the Commonwealth

## Executive Summary

### Population ageing and its challenges

- Despite the enormous diversity in population dynamics across the countries of the Commonwealth, they all share one important common trend: the older population is set to grow more quickly than the total population. The only exceptions to this are Lesotho and Mozambique, two of the countries in Sub-Saharan Africa that have been most severely affected by HIV/AIDS.
- In the majority of Commonwealth countries, the absolute size of the older population will increase by at least 100% over the next 25 years. These are mostly low- and middle- income countries.
- In the slowest ageing countries in the Commonwealth - those with the smallest projected change in population share of older people – where continuing high fertility acts as a brake on population ageing, the number of older people is still set to grow very rapidly. Most of these slow ageing countries are in Sub-Saharan Africa and the Pacific Islands. Pakistan is the only country outside these two regions where children are expected to outnumber older people until at least 2095.
- The very high mortality from HIV/AIDS among younger adults in recent years also acts as a brake on population ageing. This is evident in several Sub-Saharan African countries.
- Although high-income countries, which already have a high population share of older people, will still have the oldest populations in the Commonwealth in 2040, many of the fastest ageing countries are less developed and fall into the middle-income category.
- The slowest ageing countries in the Commonwealth are all low- and lower-middle income countries where the resources available to governments and households for responding to the contingencies and risks associated with later life challenge are relatively limited. These are mostly countries where rapid population growth remains a major challenge for the development of services and public goods.
- The fastest ageing countries in the Commonwealth are mostly in the Caribbean and Asia, where fertility rates have been falling quite sharply and substantial gains have been made in life expectancy at birth. Some of these countries have to consider the prospect of ‘growing old before they grow rich’.
- In those Commonwealth countries that combine a high national income with an already large and growing population share of older people, the sustainability and adequacy of social protection arrangements and publicly subsidised health care has become the subject of continuing, close and anxious scrutiny.
- To help households and families adjust to the pressures and challenges associated with demographic change, governments everywhere have to rethink the nature and range of public goods they provide. This applies to the slowest ageing countries in the Commonwealth as well as the fastest.



## Families and households

- The typical living arrangements of older people vary greatly across the Commonwealth countries. In less developed countries co-residence in extended or multi-generational households is the most common living arrangement for older people. In more developed countries, a minority of older people rather than a large majority live in multi-generational households. The majority of older people either live alone or with a spouse only.
- The family continues to function as an essential pillar of income security in old age as well as an indispensable provider of care in case of disability and ill-health in the majority of Commonwealth countries.
- Even in those countries where co-residence with adult children is still the most common living arrangement for older people, the assumption of the availability of this kind of support as a basis for policy is increasingly out of touch with the realities of demographic and social change.

## Income security in old age

- In most high-income countries, it is generally accepted that government has a responsibility to guarantee, or underpin, a combination of contributory pension schemes and non-contributory cash transfers that together provide for income security in old age without assigning any kind of role to family intergenerational transfers. That older people should be financially independent from their families is a generally accepted objective of public policy.
- Outside this rather small group of countries, policy commitment to the idea that older people should not have to rely at all on family transfers as a source of income security in old age is less widely shared than the desire to support the continuing development of savings mechanisms that will enable as many people as possible to be financially independent in retirement.
- Over the last decade or so, programmes to provide social pensions for older people have been implemented in a steadily increasing number of countries where extreme poverty remains a problem and the population coverage of contributory pension schemes remains low. In Sub-Saharan Africa, countries that have been hard hit by the HIV/AIDS epidemic have led the way in this. Most countries in the Commonwealth now have some form of social pension.
- There are, however, several Commonwealth countries in which continuing labour force participation or reliance on their family are the only sources of income security for a majority of older people. This is because (i) the coverage of contributory pension schemes is still very limited, (ii) there are no special non-contributory cash transfers for older people, and (iii) a non-negligible proportion of households live in extreme poverty.
- Social pensions tend to have different functions in different social and economic conditions. In high-income countries they typically serve to supplement or underpin a mature contributory scheme with high population coverage. Elsewhere they are often the main source of income security for a substantial proportion of the older population (i.e. if they supplement anything it will be earnings from employment or transfers from children), and may have a positive impact on household poverty as well as old age poverty.

- All kinds of contributory pension schemes are vulnerable to problems, and these vulnerabilities are generally compounded by population ageing.
- Most high-income countries in the Commonwealth have enacted reforms that try to deal simultaneously with threats to the sustainability of their pension systems as well as the adequacy of the retirement income they provide.
- Less developed countries have different priorities as they are faced with the task of expanding contributory pension schemes so that they cover most of the working age population. Coverage ranges from under 10% in much of Sub-Saharan Africa and South Asia to more than 50% in Malaysia.
- Although coverage tends to increase with the growth in waged employment, there are a number of middle income countries that are exploring ways of extending coverage to the informal employment sector, including Kenya and Sri Lanka.

### Long-Term Care (LTC)

- A great deal of LTC is provided by family caregivers and is unpaid. This is true in high-income countries as well as in low and middle income countries. The balance between informal family care and formal care services varies enormously between different countries, and the variation is broadly associated with levels of national income.
- Future increases in the absolute size of the older population are almost certain to lead to an increase in the numbers of older people who need LTC. This means that nearly all Commonwealth countries face a common challenge: how to meet this increase in demand for LTC.
- Doubts about the capacity of families to increase the supply of informal care in response to need mean that governments have to ask themselves what they should do either to support the continuing provision of informal care or to expand access to formal LTC services.
- Although there are many commentators and international organisations that endorse a strong normative commitment to universalism in the provision of formal LTC services, very few Commonwealth countries match up to this commitment, even in the high-income group.
- It seems highly likely that nearly all Commonwealth countries outside the high-income group (as well as some within it) would question the applicability or relevance of such a universalist ideal to their own societies. In many countries the idea that it is undesirable to substitute formal care services for family care if family care is available is widely endorsed, and in some cases forms the basis for government policy.
- The ideal of 'ageing-in-place' has been explicitly embraced as a guide to the provision of formal LTC care in Commonwealth countries with a substantial LTC sector. In countries with very limited formal services, the same ideal is often associated with a strong affirmation of the value and desirability of family care.
- In most low- and middle-income countries in the Commonwealth, the overwhelming majority of older people have no option but to rely on their families in case of need and the overwhelming majority of families lack the resources to buy services in the private sector<sup>1</sup>. What makes this situation increasingly unsustainable is the way in which demographic and social changes are combining to reduce the availability of family caregivers.

<sup>1</sup> There are of course differences to be discerned even here. Countries such as India, with a sizeable and rapidly growing urban middle class, offer more scope to the private sector than other less developed economies.

- If households and governments have only the very limited resources for the purchase of formal services, the immediate challenge for policy is not so much to find ways of substituting formal care for family care, but to find ways of supporting family care and to ensure that an adequate safety net is in place when it is not available. This can include the provision of caregiver allowances; and the introduction of social pensions in countries that do not yet have them could perform a similar function.
- In those high-income or developed countries that already have a large and diverse formal LTC sector financed in part by public subsidies, the challenge of expanding provision to cope with an expected surge in demand raises workforce issues as well as funding issues.
- Net inward migration is an important source of labour in many high-income countries, and the role of international migration in ensuring a continuing supply of care workers is explicitly acknowledged by the policies that some of these countries have adopted to facilitate migration for the care sector.

## Health and health care

- All the Commonwealth countries have to contend with emergent patterns of non-communicable diseases (NCDs) in populations with rapidly increasing numbers of older people: either a shift towards a growing burden of death and disease from NCDs or a shift in the burden of death and disease within the broad category of NCDs.
- Even in the poorest and slowest ageing countries, where a majority of deaths are still caused by communicable diseases, poor nutrition, and childbirth, a large and growing proportion of the population is surviving to ages where they are more likely to die from NCDs than anything else.
- Although there is a lack of consensus about universalist approaches towards financial protection against the costs of LTC, Universal Health Coverage (UHC) is a policy objective that all Commonwealth countries affirm. There are, however, many low- and middle-income countries in the Commonwealth where the affordability of health care is a general problem in the sense that it affects all age groups in the population; they have some way to go before they achieve UHC. There are also some middle-income countries - such as Ghana and Jamaica - that not only enjoy UHC, but combine this with special cost exemptions for older people.
- The Commonwealth includes countries that have only a very limited primary care infrastructure for the prevention and management of the most common NCDs as well as countries with well-developed services that are increasingly effective in preventing and managing the most common NCDs. Everywhere in the Commonwealth, however, there are emergent patterns of chronic disease that are either generating new challenges for health care systems or intensifying the pressures they have to face.

All the Commonwealth countries have to contend with emergent patterns of non-communicable diseases (NCDs) in populations with rapidly increasing numbers of older people

## Ageing in the Commonwealth - Executive Summary

- In most countries that are having to contend with a double burden of disease, the primary care infrastructure for the prevention and management of the most common NCDs is limited and fragmented. The immediate challenge is to develop nationwide and universally accessible services without taking energy and limited resources away from the demands associated with widespread communicable disease and high infant and child mortality. The immediate challenge in high-income countries, that already have high quality health services and UHC, is to improve the effectiveness and develop more effective models of care for responding to the demands placed on services by large and growing numbers of frail older people with multiple chronic diseases. The balance between prevention and treatment in the provision of care for such people is still tilted too much towards reactive interventions.
- Although there is general consensus about the best models of service delivery for the prevention and management of chronic disease, the achievement of change – especially with regard to appropriate level of integration between health and social care - requires a major reorientation in organisations that are now very large and very complex.

### Community infrastructure and empowerment for active ageing

- A social world that is adapted to longer lifespans is one that provides opportunities for older people to remain active and social engaged.
- Older people are a potential resource, and in ageing societies they are an increasing one. Community-based programmes that enable or empower older people to become a resource for themselves as well for each other and for the wider community are an important part of the infrastructure that is needed in ageing societies.
- Although it is possible for civil society organisations to develop and sustain these programmes entirely from the resources available to older people within the community where they operate, there are many low resource settings in which this expectation is unrealistic. Communities that have fewer resources to mobilise have a greater need for support from an external agency. This applies just as much to disadvantaged communities in high-income countries as to low- and middle-income countries.
- National strategies for healthy and active ageing enable governments to identify existing assets and deficits in community infrastructure. They are an invaluable planning tool for inclusive nationwide programmes.



Women in the Maldives after the Tsunami  
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*Table 1.1 Approximate date at which 65+ population first exceeds <15 population*

2010	Malta
2015	United Kingdom; Canada
2020	Australia; Singapore
2025	New Zealand; Barbados; Cyprus
2030	Mauritius
2035	Bahamas; Saint Lucia
2040	Brunei Darussalam; Sri Lanka; Seychelles
2045	Jamaica; Trinidad and Tobago; St Vincent and The Grenadines
2050	
2055	Malaysia; Bangladesh; Grenada
2060	
2065	India
2070	
2075	Guyana; Belize; Fiji; Botswana
2080	South Africa
2085	Samoa
2090	Namibia; Rwanda; Swaziland; Vanuatu
2095	Kenya; Lesotho; Pakistan; Tonga; Solomon Islands
2100	
Post 2100	Cameroon; Ghana; Malawi; Mozambique; Nigeria; Sierra Leone; Uganda; Tanzania; Zambia; Papua New Guinea; Kiribati

## Differences in the demography of the Commonwealth countries

The Commonwealth countries are extremely diverse. As well as being scattered over most of the globe in very different climatic zones, they include the second most populous country in the world as well as small island states with very small populations. In more than half of them the majority of the population live in rural areas and gain a livelihood from agriculture. There are others that are extremely urbanised, including a couple of city states. On top of all this there are enormous differences in per capita income: GDP per capita in Malawi is a small fraction (1.4%) of what it is in Brunei Darussalam.

They also differ in the two main determinants of population age structure, their fertility rates and life expectancy (see table 1.2). The range that we see in these variables is in fact only slightly smaller than the range found globally, i.e. in all the member states of the United Nations. Uganda, for example, has a fertility rate of 5.9 children per woman, and in only a handful of UN member states (all in Sub-Saharan Africa) is fertility higher than this. At the other extreme of the fertility spectrum is Singapore (1.23 children per woman), which is close to the global minimum. Only Hong Kong and Macao have lower fertility. The difference in life expectancy at birth between Singapore (which has the highest life expectancy in the Commonwealth<sup>1</sup>) and Swaziland (which has the lowest life expectancy in the world as well as in the Commonwealth) is 33.4 years. This is only slightly smaller than the gap between Swaziland and Japan, which has the highest life expectancy in the world. It is not surprising therefore that there are enormous differences in the current age structure of the populations within the Commonwealth and in the rate at which they are ageing. Some are ageing fast and others not so fast; some still have relatively young populations and others have populations that may best be described as 'mature'.

In the last 50 years the demography of *all* the countries that belong to Commonwealth has changed massively, and these changes reflect global trends. Fertility rates have fallen, life expectancy has improved, and populations have grown considerably in size. There are now 14 Commonwealth countries with fertility rates below replacement level, whereas in 1965 there were none; and there are no countries with fertility rates above 6 children per woman, whereas in 1965 there were 28, including nearly all of Sub-Saharan Africa (SSA), all the Pacific Islands, most of South Asia, and some of the countries around the Caribbean. The pace and extent of fertility decline has, however, varied greatly, and this variation is one of the major determinants of differences in population ageing between the Commonwealth countries. So, for example, fertility rates in the Caribbean island states have fallen by about 50% since the 1960s and are now below replacement level. In South Asia reductions of a similar magnitude have pushed fertility down close to replacement level (with the exception of Pakistan). At the other extreme is most of Sub-Saharan Africa, where the pace of fertility decline has been quite a bit slower. Continuing high fertility acts here as a brake on population ageing.

<sup>1</sup> Exceeded only by Japan and Italy.

<b>Table 1.2</b>	<b>TFR<sup>(i)</sup></b>	<b>Life expectancy at birth</b>	<b>%65+ 2015</b>	<b>%65+ 2040</b>	<b>Median age 2015</b>	<b>Mortality &lt;60 1985-90</b>	<b>Mortality &lt;60 2010-15</b>	<b>WB income group</b>
<b>Sub-Saharan Africa</b>								
Uganda	5.9	57.3	2.5	2.8	15.9	570	424	Low
Nigeria	5.7	52.3	2.7	3.3	17.9	541	469	Lower middle
Mozambique	5.5	54.6	3.3	3.6	17.1	600	478	Low
Zambia	5.5	58.8	2.9	3.2	17.2	579	398	Lower middle
Malawi	5.3	61	3.4	3.5	16.9	569	372	Low
Tanzania	5.2	64	3.2	4	17.3	491	327	Low
Cameroon	4.8	54.9	3.2	4	18.5	448	458	Lower middle
Sierra Leone	4.8	50.2	2.7	3.5	18.5	655	513	Low
Kenya	4.4	60.6	2.8	4.4	18.9	358	363	Lower middle
Ghana	4.3	61	3.4	5	20.6	408	328	Lower middle
Rwanda	4.1	63.1	2.8	5.2	19.2	545	318	Low
Namibia	3.6	64.3	3.5	5.8	21.2	342	323	Upper middle
Swaziland	3.4	49.2	3.6	3.6	20.5	373	618	Lower middle
Lesotho	3.3	49.5	4.1	3.7	21.0	390	630	Lower middle
Botswana	2.9	64.1	3.6	6.9	24.2	306	336	Upper middle
South Africa	2.4	57.1	5	8.4	25.7	357	479	Upper middle
Seychelles	2.3	72.9	6.9	18	34.3	206	185	High
Mauritius	1.5	74.2	9.6	20.7	35.2	224	162	Upper middle
<b>S &amp; SE Asia</b>								
Pakistan	3.7	65.9	4.5	6.7	22.5	340	244	Lower middle
India	2.5	67.5	5.6	10.7	26.6	386	238	Lower middle
Bangladesh	2.2	71	5	11	25.6	343	177	Lower middle
Sri Lanka	2.1	74.6	9.3	18.9	32.3	233	152	Lower middle
Malaysia	2	74.5	5.9	12.4	28.5	192	137	Upper middle
Brunei Darussalam	1.9	78.4	4.4	17.8	30.6	167	80	High
Singapore	1.2	82.6	11.7	29.8	40	130	61	High
<b>Americas and Caribbean</b>								
Belize	2.6	69.8	3.8	7.6	23.5	203	165	Upper middle
Guyana	2.6	66.3	5	11.8	24.7	254	213	Lower middle
Grenada	2.2	73.2	7.2	12.6	27.2	302	254	Upper middle
Antigua and Barbuda	2.1	75.8	7.2	18.4	30.9	209	145	High
Jamaica	2.1	75.5	9.1	17.6	29.1	181	154	Upper middle
St Vincent and the Grenadines	2	72.7	7.3	16.2	29.8	211	180	Upper middle
The Bahamas	1.9	75.2	8.3	18.4	32.4	232	176	High
Saint Lucia	1.9	74.8	9	17.6	31.2	208	158	Upper middle
Trinidad and Tobago	1.8	70.2	9.4	16.7	33.8	241	203	High
Barbados	1.8	75.4	14.2	24.5	38.5	184	114	High
Canada	1.6	81.8	16.1	25.3	40.6	116	72	High
<b>Europe &amp; W Asia</b>								
United Kingdom	1.9	80.5	17.8	23.8	40	122	79	High
Cyprus	1.5	79.9	12.8	21.4	35.9	100	61	High
Malta	1.4	80.3	19.2	26.4	41.5	104	64	High
<b>Pacific</b>								
Samoa	4.2	73	5.2	10.4	21.2	309	156	Lower middle
Solomon Islands	4.1	67.5	3.4	6	19.9	413	228	Lower middle
Kiribati	3.8	65.8	3.7	7	22.4	363	258	Lower middle
Papua New Guinea	3.8	62.3	3	5.4	21.2	470	333	Lower middle
Tonga	3.8	72.6	5.9	9.1	21.3	209	161	Lower middle
Vanuatu	3.4	71.5	4.2	7.7	22.2	318	165	Lower middle
Fiji	2.6	69.7	5.8	11.8	27.6	272	213	Upper middle
New Zealand	2.1	81.6	14.9	23.9	38	139	72	High
Australia	1.9	82.1	15	21.3	37.5	117	68	High



Woman in Kenya  
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Photographer: Rebecca Nduku

Life expectancy at birth has improved across the entire Commonwealth. One way of thinking about these changes is in terms of the *life expectancy gap* between countries with the highest life expectancy and the rest. In the 1960s, life expectancy at birth in Canada was 71.3 years, the highest in the Commonwealth, and the life expectancy gap between Canada and Kenya was 23.6 years. Both countries have seen life expectancy improve considerably, but the gains in Kenya have been slightly larger with the result that the life expectancy gap is now 21 years. Several countries have seen even larger reductions in the life expectancy gap, though as a rule they had much lower life expectancy than Kenya in the 1960s. In Papua New Guinea, for example, the life expectancy gap with Canada has fallen from 30 years to 18. In Jamaica, on the other hand, there has been virtually no change: the years added to life expectancy in Jamaica have been matched by the gains in Canada. Lastly there is a small handful of countries, all in Sub-Saharan Africa, in which the life expectancy gap with Canada has actually increased since the 1960s. South Africa, Lesotho and Swaziland, all with very high HIV prevalence, are in this position. The overall picture is more encouraging than this, however. More often than

not, the life expectancy gap (with Canada) has narrowed. The assumptions that underpin the UN projections mean that over the next 25 years they will narrow still further, but convergence is a long way off. In 2040 the life expectancy gap between Kenya and Canada will still be 15 years.

When life expectancy is improving, the ages at which mortality rates are falling fastest matters a great deal for population ageing. If big improvements in infant and child survival are accompanied by only small reductions in adult mortality, a population with high fertility rates will grow fast and age very slowly. High adult mortality limits the number of people that live into their 60s and 70s and beyond at the same time as high fertility and improved early life survival is increasing the numbers of young people reaching reproductive age. As the scope for mortality improvements in childhood becomes limited (child mortality is unusual in low mortality countries), gains in life expectancy require continuing reductions in adult mortality. The difference between the 10 or so years added on to life expectancy at birth in both Canada and Kenya since the 1960s is just this. In Kenya, they come mostly from big improvements in infant and child survival; in Canada almost entirely from continuing reductions in adult mortality. What is remarkable about the evolution of life expectancy over the last 50 years is that reductions in adult mortality are being made at ever older ages.

The relative size of the older population is increasing not just because more people survive to see their 65th birthday, but also because life expectancy at older ages continues to improve.

In the last third of the 20<sup>th</sup> century the combination of high fertility (i.e. well above replacement level) and falling child mortality produced extraordinary population growth rates in many parts of the world. In the 1970s and 80s concern about population growth was focused largely on Asia and Latin America. Now that fertility has fallen in these regions, attention has switched to Sub-Saharan



Africa where it remains high. Over the next few decades<sup>2</sup> the region's populations will continue to grow rapidly even if fertility rates decline in line with UN assumptions. In four of the Commonwealth countries in Sub-Saharan Africa, the population will more than double over the next 25 years; and there are another six where it will increase by more 50%. Outside SSA only the Pacific Islands (Papua New Guinea and the Solomon Islands) will see this level of population growth.

High rates of population growth require large increases in economic productivity to meet expectations for improving living standards, and this requirement is one of the main factors shaping the challenge of social and economic development in countries with low levels of GDP per capita and high rates of extreme poverty. It is not surprising, therefore, that in many of the Commonwealth's higher fertility countries, rapid population growth has tended to dominate any overview of the importance of demography in shaping their future and defining major policy challenges.

On the other hand, in those Commonwealth countries, where fertility rates are either approaching or have already dropped below replacement level, the rate of population growth is slowing down, so much so it is expected to bottom out in the not too distant future, i.e. sometime this century. There is, however, only one Commonwealth country expected to see its population decline by 2040, and this is Trinidad and Tobago. It is interesting in this respect to compare Trinidad and Tobago with Singapore, which has lower fertility. The difference is net migration. Singapore is a small island state with one of the highest immigration rates in world. In Trinidad and Tobago, like much of the Caribbean, outward migration exceeds inward migration.

It is, however, a decline in the absolute size of the working age population (rather than the total population) that most exercises policy makers who are concerned about the implications of sustained low fertility. Ten Commonwealth countries are expected to see a decline in their working age population between now and 2040: Mauritius, Seychelles, Sri Lanka, Singapore, Malta, Barbados, Jamaica, St Vincent and The Grenadines, and Trinidad and Tobago. Note that Canada, New Zealand, Australia and the United Kingdom are not included in the group.

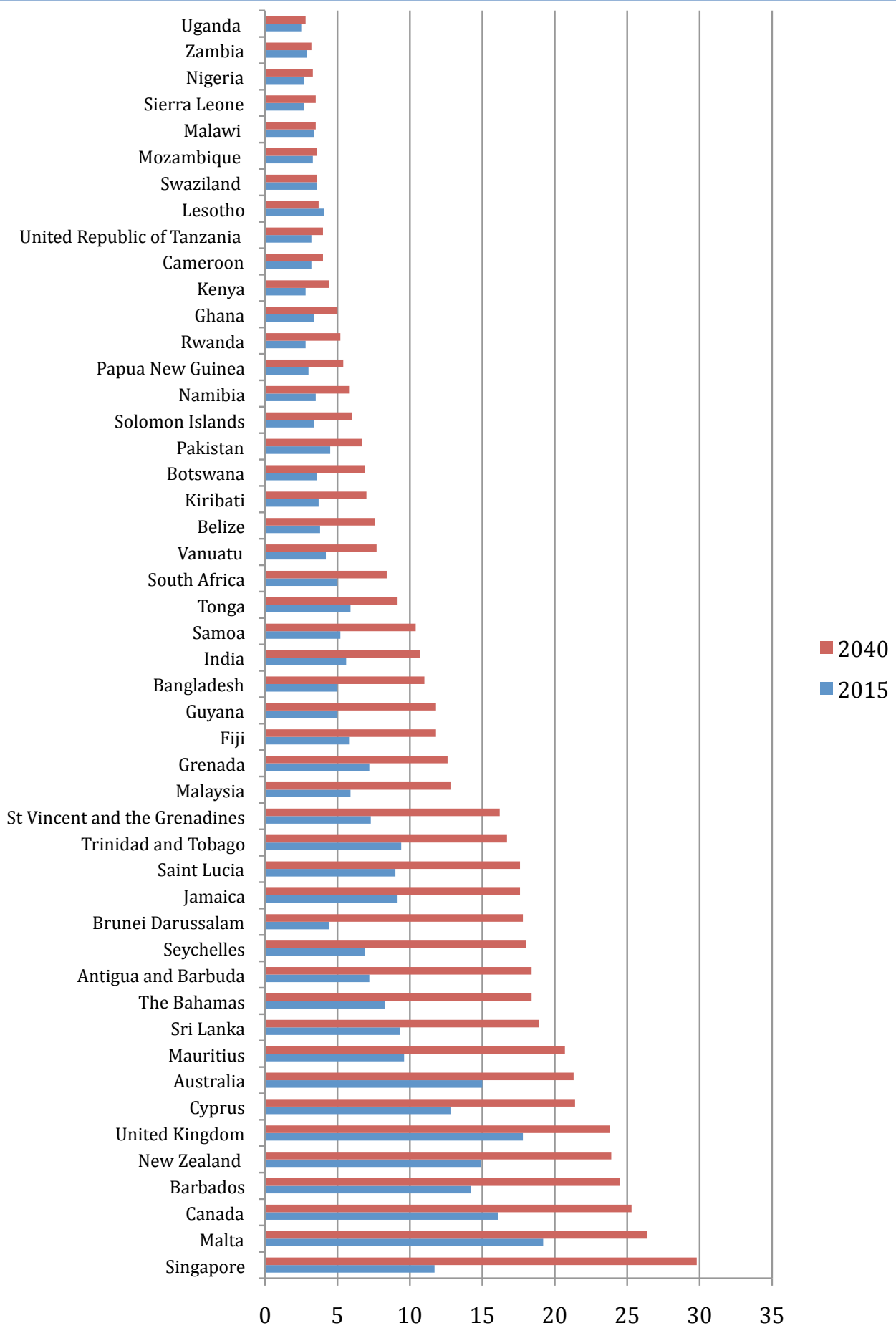
## Which are the 'oldest' countries in the Commonwealth?

The demographic metric that is most widely used to distinguish old and not so old populations is the population share of people aged 65 years or more. This gives us a measure of the extent to which the age structure of the population is tilted towards older people. *Fig. 1.1* captures the difference in age structure between the various countries in the Commonwealth by comparing the population share of people aged 65+ years at two dates, in this case 2015 and 2040. In 2015 the oldest country in the Commonwealth (by this measure) was Malta. In 2040, it will be Singapore. With one exception (Trinidad and Tobago is displaced by Mauritius) the 10 countries with the largest proportion of older people in 2015 will still be the 10 countries with the largest proportion of older people in 2040. The membership of this group is to this extent fairly stable. In these 10 countries the population share of people aged 65+ will increase by an average 10 of percentage points over the next 25 years. These are currently the oldest countries in the Commonwealth and they will still be the oldest countries in the Commonwealth in 25 years' time.

At the other extreme the picture is somewhat more complicated; there is perhaps a little less stability in the rankings. What really stands out in *Fig. 1.1*, however, is the fact that there is a group of countries in Sub-Saharan Africa which not only has a very small proportion of people aged 65+ (<5%) now, but will see hardly any change in this figure over the next 25 years (< 1 percentage point). By this measure, therefore, there are several countries for which population ageing might seem to be too distant a prospect to be a cause of serious policy concern. Uganda, for example, has a young population (48% under 14 years), and although it is ageing, it is doing so at a snail's pace – from 2.5% aged 65+ in 2015 to 2.8% in 2040. In Malawi, the increase in population share is even smaller at 0.1%. These are currently the youngest countries in the Commonwealth and they will still be the youngest countries in the Commonwealth in 25 years' time.

<sup>2</sup> The population of Sub-Saharan Africa is projected to grow fourfold over the course of this century. Demographic trends in the region are so different from the rest of the world that most of the increase in the global population over the course of this century will come from continuing population growth in Sub-Saharan Africa (~75%).

Fig. 1.1 Population share of people aged 65+, 2015 and 2040



<sup>(a)</sup> Population share of 65+ is percentage of total population aged 65+

## Which are the fastest ageing countries in the Commonwealth?

Another way of presenting essentially the same data is to rank countries according to the change in the relative size of the older population over the same period. By how many percentage points did the population share of people aged 65+ increase? This gives us a crude measure of the rate of population ageing, a way of distinguishing between fast ageing countries and slow ageing countries. *Fig. 1.2* ranks the Commonwealth countries according to their rate of ageing, and it provides a useful shift in perspective by bringing into prominence a different set of countries. The ten fastest ageing countries in the Commonwealth include Brunei Darussalam, Antigua, Mauritius and Sri Lanka as well as Singapore. Fiji, Sri Lanka, and all the Caribbean island states will age faster than the United Kingdom.

The slowest ageing countries in the Commonwealth are in Sub-Saharan Africa. In Lesotho the population share of people aged 65+ actually shrinks over the next 25 years, while in Swaziland it is projected to remain unchanged. What this figure also highlights is how little the population share of people aged 65+ has changed over the last 25 years in several of these countries. There are in fact 10 countries in the region where the population share of people aged 65+ increased by less than one percentage point in the last 25 years and will increase by less than one percentage point in the next 25 years (*see table 1.1*). In this respect at least, these populations are fairly stable. They may be growing fast and urbanising fast, but they are ageing very slowly.

What is also apparent in this chart is that in virtually all the Commonwealth countries, the pace of population ageing quickens over the 25 years. Malta is one of the most striking exceptions to this generalisation.

## A benchmark for population ageing

One way of combining information on current age structure with information on the pace of ageing is to use a benchmark to identify countries that

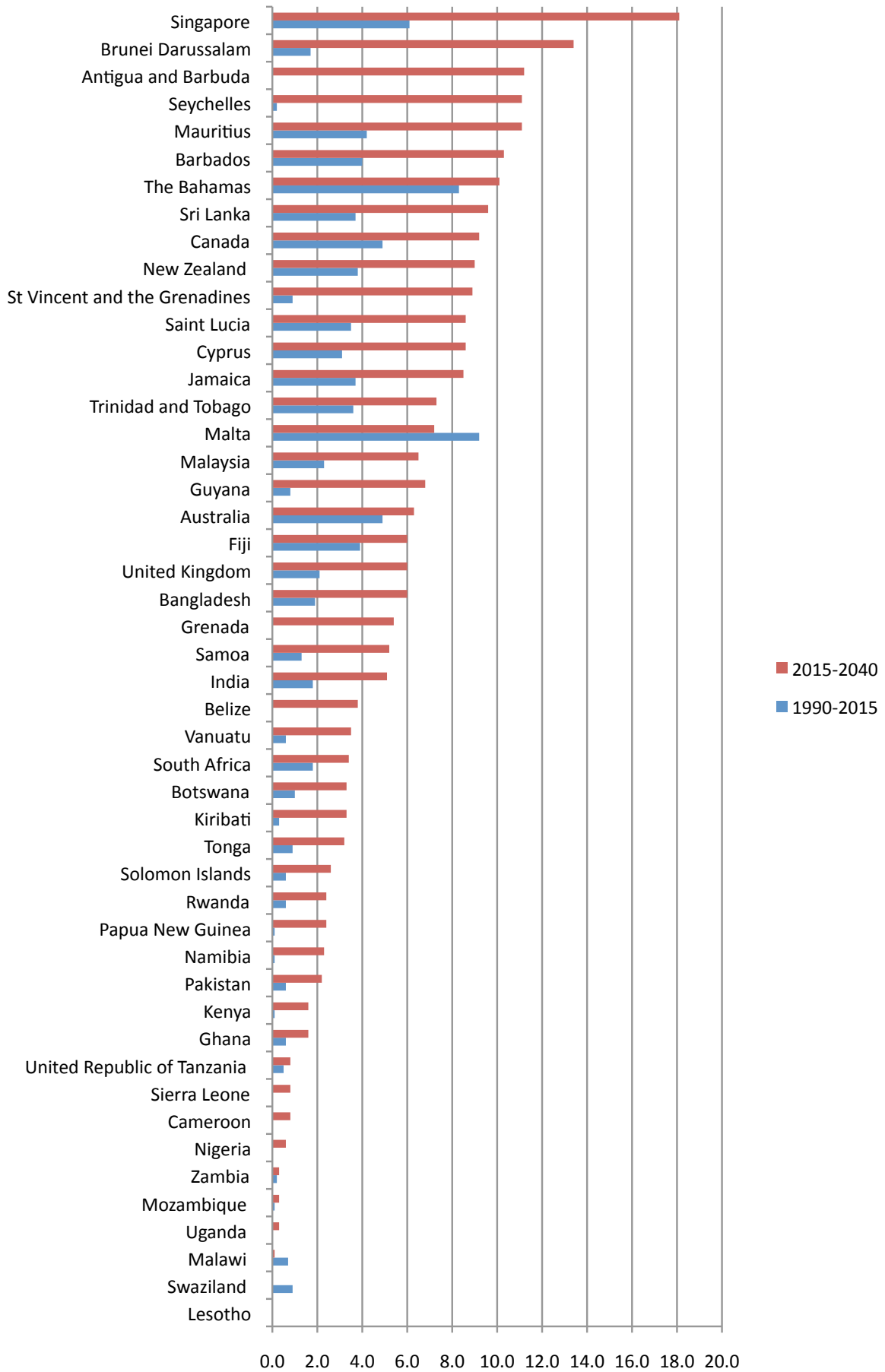
have become or are soon to become 'mature'. When, for example, will the process of population ageing have progressed to the point at which older people outnumber children in the population? The benchmark is of course in one sense quite arbitrary, but in historical terms it marks a remarkable change in the age structure of a typical human population. For most of human history children and young people have easily outnumbered older people. This is now changing, and by the end of this century population ageing in most Commonwealth countries will have passed this point. *Table 1.1* gives the approximate date at which people aged 65+ in the population will outnumber children (<15 years). About a third of the countries for which we have data will have passed the benchmark by 2045. They include the countries where the population share of older people is already relatively high, such as Malta and the United Kingdom, as well as the fastest ageing countries in the Commonwealth. All the Caribbean islands states are in this group also.

At the other end of the table are a group of countries that are now relatively young and are also ageing slowly enough to postpone the crossing of this benchmark till the next century. Although most of them are in Sub-Saharan Africa, the group also includes Papua New Guinea and Kiribati.

The table also allows us to pick out countries which are clearly different from others in the same region. Population ageing is moving relatively slowly in Guyana and Belize compared with the other Caribbean nations. In Sub-Saharan Africa, Botswana and South Africa stand out as the fastest ageing countries.

Despite these differences, however, and they are evidently very large, if we take a long-term view then all the countries in the Commonwealth have ageing populations. This is true even if we restrict our time horizons to the next 25 years. In those countries where the general population is growing rapidly, the older population is growing even faster; and in those countries where overall population growth is sluggish or negative, the gap between the growth rates of the older population is even larger. The only exceptions are two countries with very high mortality from HIV/AIDS, Lesotho and Mozambique.

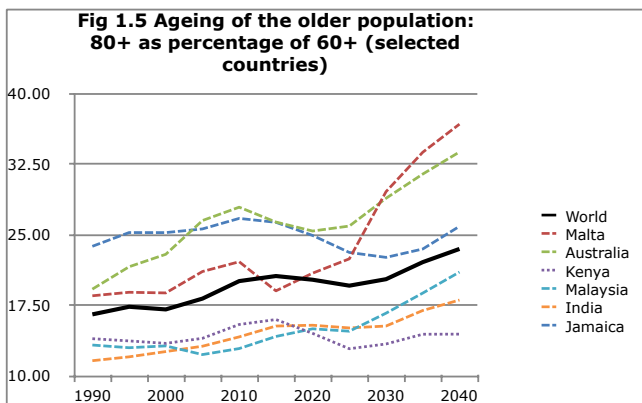
Fig. 1.2 Change in population share of people aged 65+ (percentage points)





## Changes in the age composition of the older population

Why choose 60 or 65 years as the age at which people become part of the older population? The UN's World Population Ageing report on global ageing takes 60 years as the lower limit for demarcating the older population from the rest of the population, and in doing so it follows common practice among many less developed countries. This report has taken 65 years as the threshold used in most of the tables and figures. In either case - 60 years or 65 years - the older population will contain a very diverse group of people, some healthy and active and still working, others with health problems that seriously limit their functional abilities. Since the risk of ill-health and disability increases quite steeply with age, the age composition of the older population is sometimes taken as a useful, albeit rather crude, indicator of the likely levels of need for care and support within the overall older population. The average 80 year old is much less likely to be healthy and active than the average 65 year old.



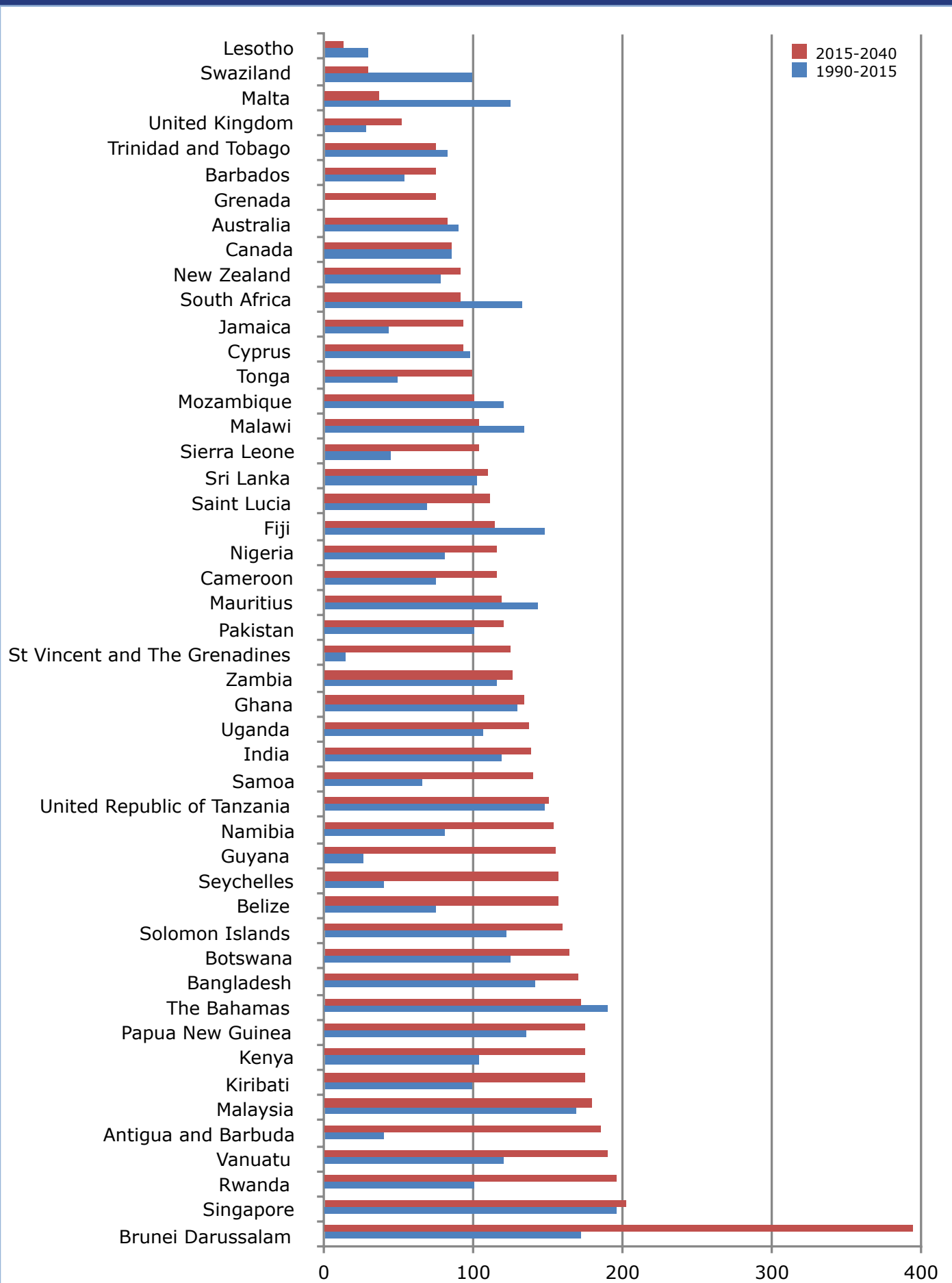
As Fig. 1.5 shows, the older population is itself ageing, and as the percentage of people aged 80+ within the older population increases, the balance changes between that part of the older population which is active and independent and that part which is at high risk of needing care. There are, however, as Fig. 1.5 also shows, very large international differences in the growth of the relative size of the 'older-old' population. In Malta and Australia, the relative size of the older-old population will increase very steeply over the next 25 years. By 2040 about one third of the older population will be aged 80 years or more. This reflects the ageing of earlier baby boom cohorts as well as big improvements

in life expectancy at older ages. In Kenya, on the other, the proportion of people aged 80+ in the older population will be lower in 2040 than it is now. The cohorts of younger people reaching 65 years are increasing in size, but the improvements in survival at older ages are expected to be relatively small.

## Changes in the absolute size of the older population

Whichever measure we use to identify the youngest and slowest ageing populations, we should be careful about the inferences we draw on the basis of information about the *relative* size of different population groups. It would no doubt be considered rather strange if the implications of population ageing had the same prominence or urgency in the concerns of policy makers in Uganda and Singapore, but this does not mean that policy makers in Uganda would be justified in ignoring the impact of demographic change on the position of older people in their country. To see why demographic change in the older population matters in countries where the prospect of the older population outnumbering the young is very distant or where they will make a small proportion of the total population even in 2040, we need to consider the *absolute* size of the older population. Fig. 1.3 ranks countries according to the percentage change in the numbers of older people in the population. In the majority of Commonwealth countries, the older population will increase by at least 100%. This is true even in the slowest ageing countries in SSA and the Pacific Islands. By this measure, the United Kingdom, Canada, New Zealand, Australia, Malta, and Cyprus will all of them see a relatively modest amount of change. And in Brunei Darussalam, the projected increase in numbers is extraordinarily large, almost twice as large as in Singapore. Note that several of the Sub-Saharan countries, especially Rwanda and Kenya, now feature towards the higher end of the rankings. If we combine this information with what the other figures and tables tell us about the pace of population ageing, it should be clear that in a substantial minority of the Commonwealth countries, it is the increase in numbers rather than a big change in age structure that is driving the demographic challenge of ageing. The increase in absolute size may be higher

Fig. 1.3 % increase in total numbers of people 65+



in some of the faster ageing countries, but it is large enough to have major policy significance in the countries with younger, slow-ageing populations.

## Demographic dividends and demographic deficits

In the last third of the 20<sup>th</sup> century, the so-called ‘East Asian tigers’ benefited from a demographic dividend<sup>3</sup>. Rapidly declining fertility was reducing the number of dependent children in the population (and in households) at the same time as the prime working age population (e.g. 20-60 years) continued to grow. The decline in the proportion of dependent children was large enough, moreover, to offset any increase in the numbers of non-working older people. This combination of demographic conditions provides countries with a window of opportunity to give an extra boost to GDP *per capita* that is eventually closed by population ageing, i.e. when the growth in the working age population levels off and the decline in the numbers of dependent children no longer offsets any increases in the numbers of non-working older people. There is, however, nothing automatic in this process. What drives the growth in GDP *per capita* is the productivity of the working age population. In other words, for the dividend to be realised, improvements in labour productivity are needed as well as high levels of labour force participation.

The idea of the demographic dividend depends on a distinction between two very broad classes of individuals in society. For individuals who are in their ‘prime working years’, the value of what they produce is much greater than the value of what they consume. For everyone else, and that means people, both old and young, on either side of this rather elastic age category, the value of what they consume is much greater than the value of what they produce. Children who have not started work and older people who no longer work share this much in common. The position of school age children is of course very different from that of people who no longer work. As rule they are economically dependent on their parents. In high-income countries, older people are likely to be economically independent, since many of them will derive their income entirely from their personal

assets and lifetime savings. The key point, however, is that their retirement from work represents a loss to the productive capacity of society: they have ceased to make a contribution to the output of goods and services that are bought and sold in their society.

It is conventional to take age as a proxy for membership of these two population groups, i.e. working age and non-working age. Figure (1.5) defines the working age population as everyone from 15 to 64. The rest of the population falls either side of this group (1-14 years; 65 years +). We have to recognise of course that the average age at which young people start work varies a great deal between developed and less developed countries, and the same goes for labour force participation at different ages, including older ages. Even so, the ratio between the working age population and the non-working age population is a useful statistic provided we bear in mind what it does and does not tell us. It is a demographic ratio rather than a ratio between the ‘productive’ and ‘non-productive’ parts of the population, and as such is widely used as an indicator of the challenges and opportunities associated with population ageing. For high fertility countries, the opportunities emerge when fertility decline increases the size of the working age population relative to the non-working age population; for low fertility countries the challenges arise when continuing fertility decline increases the size of the non-working age population relative to the working age population. The conditions for a demographic dividend have as their obverse the conditions for a demographic deficit.

What we can see from the charts in [Fig. 1.4](#) is that population ageing drives two kinds of change: the composition of the non-working age population changes (more older people and fewer children) as well as its size relative to the working age population. These compositional changes are important at least partly because some of the spending on young people is regarded as a form of investment in human capital. This means, for example, that a policy of extending the amount of time children or young people spend in education beyond the minimum required for functional literacy and numeracy can be easily justified even though it has the effect of increasing the relative

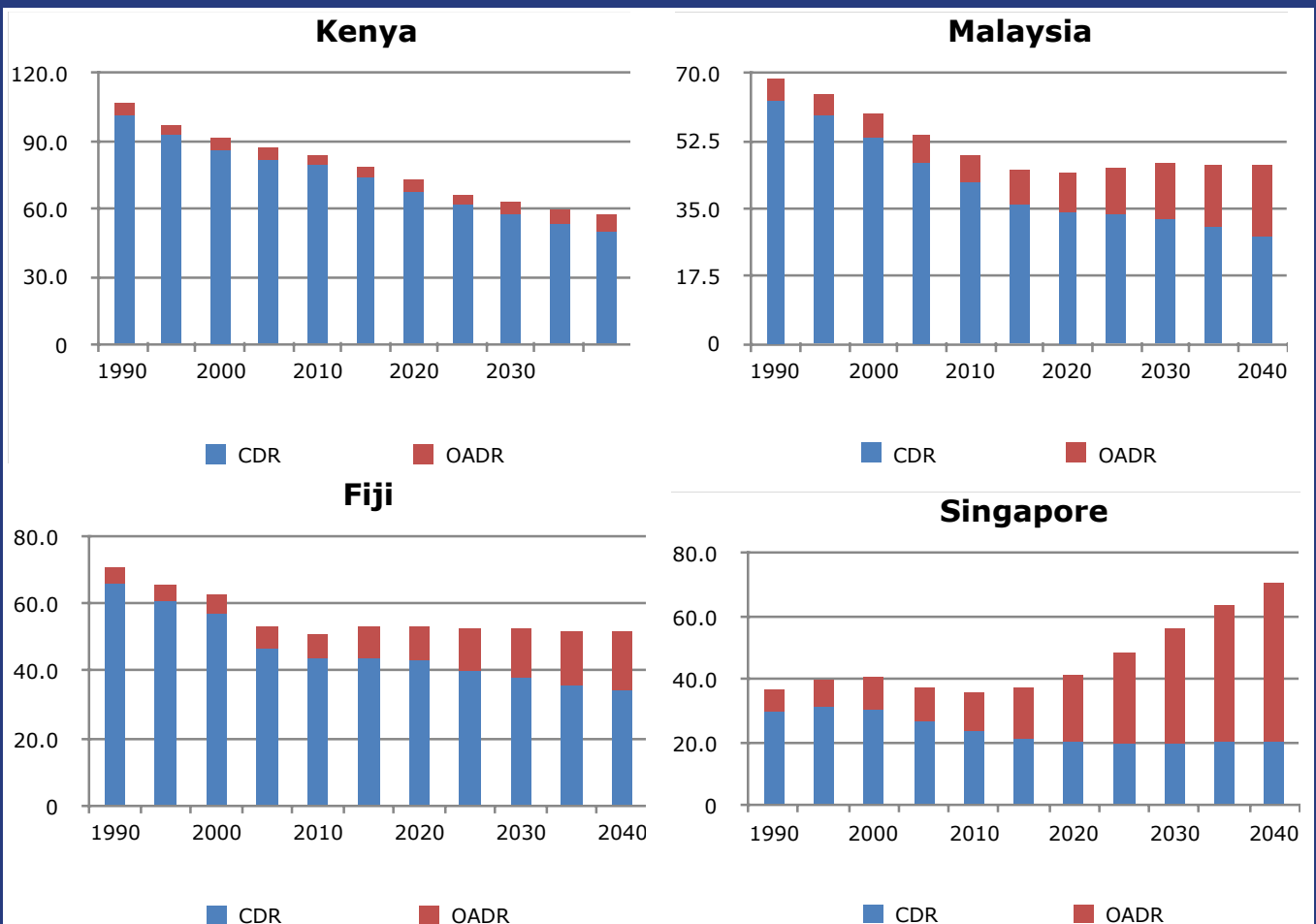
<sup>3</sup> *The demographic dividend: a new perspective on the economic consequences of population change.* David Bloom et al. RAND 2003

size of the non-working population. It is justified because of the expected gains from improved labour productivity. A policy which has the effect of extending the amount of time people spend in retirement would not be regarded in the same way.

The examples in *Fig. 1.4* illustrate the diversity that can be seen in the Commonwealth countries stages with respect to changing ratios between the working age and non-working age populations. In the late 1980s, as a result of very high fertility rates and large numbers of children, the non-working age population in Kenya was actually smaller than the working age population. The fact that fertility has been steadily (but slowly) declining since the 1980s at the same time as the absolute size of the working age population has been growing points to the potential for a demographic dividend. With one very important qualification (the relatively slow pace of fertility decline), these demographic conditions resemble those that underpinned the remarkable improvement in living standards of living in East Asia in the last quarter of the 20<sup>th</sup> century. In Fiji

and Malaysia, although the falls in the ratio of the non-working age to working age population have bottomed out, they remain fairly stable over the next 25 years. In both countries, however, the change in the composition of the non-working age population is relatively large (i.e. compared to Kenya). We could say that demographic ‘window of opportunity’ stays open for as long as the working age population continues to grow. The situation in Jamaica is different again, and potentially less favourable. The ‘window of opportunity’ will start to close quite soon, and by 2040 the ratio of the non-working age to working age population will be significantly higher than they are now. In Singapore, the increase in this ratio is much larger. The situation is further complicated by the decline in the absolute size of the working age population. This combination of circumstances makes for strong ‘demographic headwinds’. There is a deficit in the supply of young people to replenish a labour force depleted by an increasing retirement rate.

*Fig. 1.4 Changes in total dependency ratios 1990-2040 for selected countries*



<sup>(ii)</sup> The ratio is defined as follows: no. of children (0-14 yrs) + older population (65+) for every 100 people aged 15-65 yrs.

<sup>(iii)</sup> CDR is Child Dependency Ratio; OADR is Old Age Dependency Ratio.



## Regional groupings, demographic clusters and the importance of the non-demographic context for ageing

There are many ways of grouping Commonwealth countries to highlight differences and similarities. Probably the most obvious grouping is that which is suggested by geography, and up to a point it is true that different regions of the world tend to share broad patterns and trends in demography. But only up to a point. Consider, for example, SSA which has many of the slowest ageing countries in the Commonwealth. Although the UN regional groupings place Mauritius and the Seychelles in SSA, fertility and mortality in the two island states are much lower than in the rest of the region, and Mauritius is in fact the only country in the region where fertility has fallen below replacement level. This gives us a good reason to distinguish Mauritius and the Seychelles from what we might call 'continental' Sub-Saharan Africa. Even within continental Sub-Saharan Africa, however, the five countries in southern Africa stand part as a distinct demographic cluster because of their lower fertility. The *really* high fertility countries lie further to the north.

There is, on the other hand, one very important feature of the demographic landscape which can be seen in all of continental Sub-Saharan Africa and justifies us in treating these countries as a single demographic cluster: the high prevalence of HIV/AIDS has led to high mortality rates among 'prime working age adults'. Over the last 25 years mortality for people aged under 60 years has actually *increased* in six of the SSA countries (and by more than 60% in Lesotho and Swaziland). Nor can there be any doubt that this has had (and will continue to have in the medium term future) a considerable impact on the pace of population ageing. In the two countries with the highest prevalence of HIV/AIDS and the highest levels of mortality in people aged under 60 - Lesotho and Swaziland - there will be *no* increase in relative size of the older population over the next 25 years. And in South Africa, which has the lowest fertility in the region (excluding the islands of Mauritius and the Seychelles), it is clear that HIV/AIDS has been a very significant brake on population ageing.

The acceleration in population ageing that would otherwise have resulted from its relatively low fertility – compared to other countries in the region - has been offset by high mortality levels from HIV/AIDS. We can see this if we compare the case of South Africa with India, which has a comparable fertility rate (2.5 children per woman rather than 2.4 as in South Africa). Life expectancy at birth is now a full 10 years lower in India, where death rates in people aged <60 have been reduced by about one-third over the last 25 years, and as a result India's population will age faster than that of South Africa. The demographic landscape in South Africa has been blighted by HIV/AIDS, whereas in India the chances of surviving into a seventh decade of life have been dramatically improved. South Africa presents an extreme case of a set of circumstances that can be seen elsewhere in the region.

Outside SSA too, it is apparent that regional groupings often bring together countries that display very substantial differences in the demographic metrics that are relevant to population ageing. In Latin America and the Caribbean, for example, the three mainland countries (Guyana, Belize and Grenada) have higher fertility and higher mortality than the island states. And should we think of Barbados as something of an outlier for the Caribbean? The population share of older people in 1990 was only slightly lower than in Canada at the same time (10.1% and 11.2%). In the Pacific the island states are obviously quite different from Australia or New Zealand, but then they also have a fair amount of diversity among themselves. The fertility difference between Fiji and Samoa is the same (1.6 children) as that between Pakistan and Sri Lanka, and that is large enough to put 6 decades between the approximate dates at which they cross the benchmark for 'maturity'. Australia and New Zealand, moreover, are much closer demographically to Canada or the United Kingdom than to their regional neighbours.

Regional groupings then have their limitations. We quickly run into difficulties if we specify a set of regions that includes all the Commonwealth countries with a view to outlining a typical or representative pattern for age structural change in each region. If we are looking for way of reducing the demographic diversity of the Commonwealth countries to manageable proportions, it is

possible to look for clusters of countries that share demographic characteristics and enable us to pick out different patterns or stages of population ageing. To a certain extent this has been done already. We can pick out the ten fastest ageing countries in the Commonwealth or those where older people will outnumber children by 2045 or the countries where the population share of older people will still be less than 5% by 2040. The trouble is that any clusters defined in terms of demography alone are likely to seem rather arbitrary and of questionable usefulness. In the end they are only really useful for presentational purposes if they are also useful for analytical purposes.

We can use metrics for population ageing to rank countries in different ways and this will give us a sense of the demographic pressures on existing institutions and arrangements. It would be a mistake, however, to suppose that these metrics enable us to take the measure of the challenges faced by different countries. Nor is the situation substantially altered if we take account of increases in the absolute size of the older population as well as its relative size. The demography matters of course, but the challenges associated with population ageing only come properly into focus when we know about the social and economic context in which demographic change occurs.

We need to know, for example, about existing arrangements for income security in later life. What institutions are there apart from the family to support older people when they are no longer able to work? What proportion of the older population benefit from them? What is the reach of government and the level or quality of government-provided services? Is there a well-developed private sector for the provision of care, or for the investment of savings? Does the health service infrastructure have the capacity to provide high quality care for older people with age-related problems?

The answers to most of these questions depend very heavily on economic development. In poorer countries, households have fewer and more limited resources to deal with the contingencies of old age, and so also do governments. The constraints on households and governments are different in both degree and kind in richer countries. Local views on the appropriate division of responsibilities between households and government may further complicate the picture. Since the particularities of the context shape the options and opportunities for action, it is against this background that we have to consider the ways in which households and governments (and other non-state actors) respond to demographic pressures. Our aim on this report is to highlight differences and commonalities not only in the challenges associated with population ageing but also in the responses to these challenges.



Man in Papua New Guinea  
© Commonwealth Secretariat

# Chapter 2

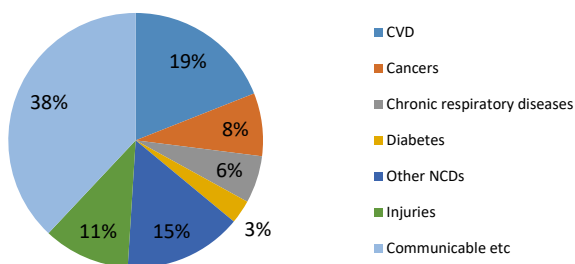
## Health and health care The epidemiological transition

In countries with high fertility and mortality most deaths are caused by communicable diseases, poor nutrition, and childbirth. Infant mortality and maternal mortality are generally high. In Kenya, for example, WHO estimates that 64% of all deaths are accounted for by (i) communicable diseases, (ii) maternal and perinatal conditions, or (iii) poor nutrition.

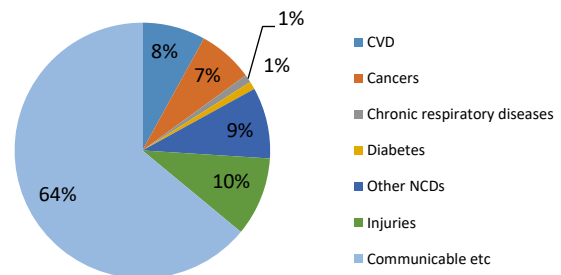
In Papua New Guinea this figure drops to 48%, and in Pakistan it is lower still at 38%. What distinguishes Pakistan from, say, Kenya is that more people survive to ages where they are more likely to die from non-communicable diseases (NCDs) than anything else. Success in improving survival for children and younger adults shifts the burden of mortality and morbidity onto other diseases. Deaths from cardiovascular disease are more than twice as high in Pakistan (19%) as in Kenya. The same goes for

The same goes for the other Commonwealth countries where deaths from communicable diseases have fallen from the relatively high levels found in Kenya (and several other Sub-Saharan countries), but still account for between a half and a quarter of all deaths. Kenya is at the beginning of a major epidemiological transition that is well under way in Pakistan or India or the Solomon Islands. It is a transition, moreover, whose effects are often exacerbated by the increasing prevalence of lifestyle behaviours that increase the risk of NCDs.

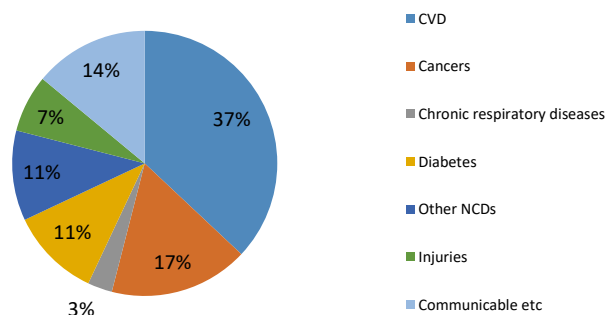
**Pakistan: % of total deaths by cause**



**Kenya: % of total deaths by cause**



**Jamaica: % of total deaths by cause**



## Implications of HIV/AIDS for older population in Sub-Saharan Africa

- The problems associated with the double burden of disease are compounded in countries with high HIV prevalence, as this one disease is likely to absorb a correspondingly large proportion of health resources. A recent USAID report for Mozambique estimates that HIV expenditure accounts for one-third of the country's current health expenditure (with most of this coming from overseas donors).
- Rapidly increasing coverage of anti-retroviral treatment (ART) is leading to improving survival rates for people with HIV. This means firstly that increasing numbers of people are ageing with HIV/AIDS, and secondly that these numbers will increase over the next couple of decades as treatment coverage improves - a considerable challenge in countries where prevalence rates have been high and health infrastructure is weak. It has been estimated that if treatment coverage continues to increase at present rates then the total number of HIV-infected patients aged 50+ will nearly triple over the coming years: from 3.1 million in 2011 to 9.1 million in 2040, dramatically changing the age composition of the HIV epidemic in SSA. In 2011, about 1 in 7 HIV-infected people was aged 50 years or older; in 2040, this ratio will be larger than 1 in 4. (Hontelez 2012).
- The ageing of the epidemic has "important consequences for both the organisation of healthcare services and the general organisation of societies in the sub-continent, as older HIV-infected patients require specialised treatment and care, as well as social and financial support. In addition, expanded treatment coverage is likely to increase the burdens of other diseases in SSA, in particular NCDs. Health policymakers need to anticipate the impact of the ageing HIV epidemic in their planning for the future capacity of health systems to prevent and treat diseases of old age in HIV-infected individuals". (Hontelez 2012).

*The impact of antiretroviral treatment on the age composition of the HIV epidemic in sub-Saharan Africa. JAC Hontelez et al. AIDS 2012. doi: 10.1097/QAD.0b013e3283558526*

The main dimensions of the health challenge for countries moving through the epidemiological transition Commonwealth are marked by continuing high levels of mortality and morbidity from communicable diseases and a growing burden of mortality and morbidity from NCDs. They have a double burden of disease<sup>4</sup>. With rapidly growing populations and relatively low rates of investment in health, these countries find it very hard to switch extremely scarce resources from providing services for communicable diseases and childbirth to the prevention and management of NCDs. The provision of health care services for children, pregnant women and mothers puts very large demands on formal services in countries with lots of births and lots of children. The reduction of maternal and childhood mortality are rightly seen as development priorities.

The epidemiological transition has proceeded even further in countries such as Jamaica or Fiji or

Sri Lanka, which have broadly similar death rates from communicable diseases (between 10% and 20%)<sup>5</sup>. Cardiovascular disease in these countries accounts for at least one-third of all deaths. Death rates from cancers and diabetes are also relatively high. In other words, health services are required to ratchet up provision up for NCDs as the balance in the kinds of demand made by ill-health makes on health services continues to shift. In Jamaica, for example, cancers now account for 17% of all deaths, and although this is lower than in any of the high-income countries, cancers are generally expensive to treat and clearly require major developments in hospital-based services and palliative care (including adequate supplies of medication for pain control) if they are to meet local needs. In Singapore, the only high-income country where communicable diseases account for more than 10% of deaths, death rates from cancer are even higher (30%).

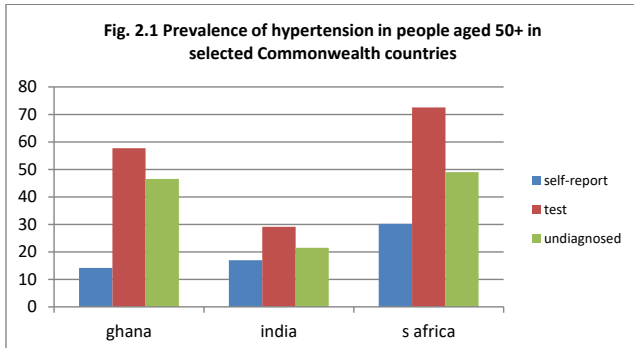
<sup>4</sup> In a Lancet paper from 2009, South Africa was described as having a *quadruple* burden of disease: (i) high levels of maternal and child mortality; (ii) a growing burden of NCDs; (iii) the HIV/AIDS epidemic combined with a high burden of TB; (iv) high levels of violence and injuries (Mayosi, Lancet 12 Sept 2009). The pattern is of course not unique to South Africa.

<sup>5</sup> Very low compared to Kenya, but still relatively high compared to Australia, where only 3% of deaths are due to communicable diseases, the lowest in the Commonwealth.

## Hypertension and diabetes

Hypertension is one of the main risk factors for stroke and heart disease, and it increases in prevalence with age. The Health Survey for England (2011), for example, found that the majority of older people (65+) in England are hypertensive – 57% of men and 60% of women aged 65-74, with even higher prevalence in the 75+ age group. In this particular study about one third of all cases in the older age groups were undetected.

The WHO SAGE survey provides data for people aged 50+ in six developing countries including Ghana, India, and South Africa, and although these data are not strictly comparable, two points stand out<sup>6</sup>. First, in both Ghana and South Africa, as in the United Kingdom, the majority of older people are hypertensive. Second, detection rates are much lower in all three SAGE countries than in the United Kingdom, i.e. the proportion of older people who had survey-defined hypertension and had not been diagnosed by health services is much higher (see Fig. 2.1)<sup>7</sup>.



The prevalence of type 2 diabetes, like hypertension, increases with age. We would expect therefore to find a higher prevalence of diabetes in countries with older populations, e.g. a large population share of people aged 65+. There are however, other factors at work in driving up the

prevalence of diabetes, most notably the increasing prevalence of obesity. Obesity, as recent studies have made clear, is not an exclusively rich world problem. Just as the prevalence of diabetes varies, so too do death rates from the disease. Data on deaths are informative for the purposes of comparison, as they reflect the effectiveness of the health care system in detection and management as well as the underlying population prevalence. In the United Kingdom, for example, where type 2 diabetes is widespread in the older population, deaths from diabetes are relatively uncommon. In Mauritius and Fiji, the proportion of deaths caused by diabetes is higher than in any other of the Commonwealth countries (26% and 16% respectively). These two countries, moreover, have the highest death rates from diabetes *in the world*. In this case the measure is deaths per 100,000 population - adjusted for the age composition of the population<sup>8</sup>. In other words, the fact that one country has an 'older' population than another is taken into account. As table 2.1 shows, diabetes is a major health problem in most regions of the world. The burden of disease varies however in different countries. In Mauritius and Fiji, there is a very high mortality burden as well as a high morbidity burden. In the United Kingdom and Australia, the mortality burden is relatively low even though the morbidity burden is high.

## Change at the limits of the epidemiological transition

In countries like Australia or Malta or the United Kingdom, the chances of dying from communicable diseases or in childbirth or as a result of perinatal health problems are already extremely low, and although they could be further reduced, the effect of such reductions on the distribution of deaths between broad categories of cause is going to be very small. This is not to say, however, that

Table 2.1 Diabetes in selected countries

	Mauritius	Fiji	South Africa	Jamaica	Sri Lanka	Australia	United Kingdom
Deaths/100000 pop. (WHO ranking)	174 (1)	147 (2)	92 (8)	77 (11)	48 (31)	11 (131)	5 (164)
% of all deaths	26	16	6	11	7	3	1

<sup>6</sup> Cardiovascular disease accounts for 18% of all deaths in Ghana and in South Africa, more than twice as many as in Zambia (8%). The figure for India is even higher, at 24%.

<sup>7</sup> Estimates are taken from: *Chronic non-communicable diseases in 6 low- and middle-income countries*. P Arokiasamy et al, *Amer J Epidemiology*, 2017; 185: 414-428.

<sup>8</sup> <http://www.worldlifeexpectancy.com/cause-of-death/diabetes-mellitus/by-country/>



continuing social and demographic change in these countries is not associated with further, large-scale epidemiological change. What is changing in this case, however, is not the distribution of the burden of morbidity and mortality between NCDs, on the one hand, and communicable diseases and maternal mortality, on the other. What is happening is the emergence of different patterns of chronic disease is shifting some of the burden of morbidity and mortality within the broad category of NCDs<sup>9</sup>. A great deal of this change is due to continuing improvements in life expectancy at older ages. Increasing numbers of older people are surviving to ages where the chances of having multiple chronic conditions are very high, and this is going hand in hand with large increases in the prevalence of dementia, a disease for which advanced old age is the main risk factor. Dementia, which is the paradigm example of a health problem for which advanced old age is the main risk factor, is rapidly becoming one of the leading causes of death in low-mortality countries. As a result of these changes, the management of very large numbers of frail older people with complex care needs as a result of multi-morbidity – often including dementia – is increasingly dominating the demands made on health services.

A second major social trend leading to change in prevalence of different kinds of chronic disease is the change in prevalence of different risk factors for chronic disease. Obesity and physical inactivity are overtaking tobacco smoking as the lifestyle risks that preoccupy public health agencies and epidemiologists in most low mortality countries. Obesity in particular is seen as a major emergent public health concern, not least because of its connection with type 2 diabetes. Although some of the increase in population prevalence of diabetes that has been seen in most high-income countries can be attributed to population ageing, there is a growing convergence on the expectation that the *age-adjusted* incidence of diabetes will increase over the next few decades.

Finally, and this is one of the reasons why survival in later life is improving so much, an increasing proportion of older people are living with potentially fatal chronic diseases. In the United Kingdom, for example, it seems clear that CHD mortality is falling

faster than disease incidence, which points to an increase in the numbers of the older population receiving continuing treatment for a heart condition<sup>10</sup>. Falling death rates from cancer suggest a parallel phenomenon. When cure is not possible, significant improvements in treatment mean many cancers can be controlled and managed for longer and longer periods of time. As survivorship for people *with* the disease improves, it is increasingly being transformed into a chronic illness<sup>11</sup>.

## Disability

Many NCDs are both chronic and disabling. Since the prevalence of disabling disease increases with age, so too does disability. The same pattern is observed everywhere no matter what measures of disability are used. Although comparisons of disability rates between high resource settings and low resource settings are very few and far between, there are now plenty of studies in low and middle income countries which provide estimates of the prevalence of severe functional limitations or disabilities in the older population, and they show prevalence increasing with age within the older population. It is important in these cases of course, to have some idea of the level or severity of the functional limitation as well as the functional domains that are affected. Among the different indicators of the presence of severe functional problems that have been used in various prevalence studies are: inability to leave the house because of severe mobility problems; Activities of Daily Living (ADL) dependency; and frailty.

- About one in ten older Indians in the 70-74 age group were confined to their homes in a 2004 NSSO survey<sup>12</sup>. The prevalence of this degree of functional limitation in respect of mobility more than doubles in the 80+ population. So one third women and 3 in 10 men aged 80 or more are either confined to bed or confined to their homes.
- A similar measure, with similar results, was used in a 2012 study in Bangladesh<sup>13</sup>. Twenty percent of men and 30% of women aged 85+ were confined to their homes.
- A measure based on dependence in Activities of Daily Living (ADLs) was used in a 2011 study in Nigeria<sup>14</sup>. The prevalence

<sup>9</sup> *Healthy ageing: the role of health services*. K Howse. *Perspectives in Public Health*, 2012: 132(4)

<sup>10</sup> *Contribution of the changes in incidence and mortality to trends in the prevalence of coronary heart disease in the UK 1995-2005*. AR Davies et al. *European Heart Journal*, 2007; 28, 2142.

<sup>11</sup> *Delivering affordable cancer care in high-income countries*. R Sullivan et al. *Lancet Oncology Commission*. *Lancet Oncology*, 2012. 12 (10): 933-980.

<sup>12</sup> *Survey on disability*. National Survey Sample Office, 2004.

<sup>13</sup> *Disability among elderly rural villagers: report of a survey from Gonoshasthaya Kendra, Bangladesh*. N Cherry et al. *BMC Public Health* 2012. doi: 10.1186/1471-2458-12-379

of ADL dependency on a five-item scale (feeding, bathing, dressing, toileting, transferring) increased from 9% in the 60-64 age group to 30% in the 75+ age group.

- The WHO SAGE study uses a frailty index which classifies people as frail or non-frail. The age-adjusted prevalence of frailty in the 50+ age group was 59% in India, and 38% in Ghana and South Africa<sup>15</sup>. If the estimates seem very high, it is partly because the study uses a cut-off point on a continuous scale to classify as people as frail<sup>16</sup>. Frailty, like disability, not only increases with age, but is a matter of degree.
- The English Longitudinal Study of Ageing uses a different measure of frailty (the Fried criteria). The overall weighted prevalence of frailty in the 60+ population was 14%. Prevalence rose steeply with increasing age, from 6.5% in those aged 60-69 years to 65% in those aged 90 or over<sup>17</sup>.

## The affordability of health care for older people

When health care is expensive, as it very often is, the fact that the costs are high may lead some individuals or households to decide they cannot afford it, and others may end up spending more than they can really afford (they go into debt to pay for health care). To aim for Universal Health Coverage (UHC) is to aim for a system in which affordable health care is accessible to everyone. UHC means that no-one is deterred from seeking health care because it is too expensive and no-one is impoverished as a result of using it. There are, however, many Commonwealth countries that have yet to achieve a goal that they all affirm as a priority policy objective. What is required to achieve UHC is a system of collective risk-pooling that offers everyone access to some level of *prepaid* health care. In other words, a condition of affordable health care is that out-of-pocket (OOP) costs are low enough not to deter anyone, including the poorest members of society, seeking health care because of its costs.

There can be no doubt there are many countries in the Commonwealth where the affordability of health care is a general problem in the sense that it affects all age groups in the population; they have some way to go before they achieve UHC. Although it may not be possible to say for every country in the Commonwealth whether or not this is the case, the position is reasonably clear in many cases. Low-income, or lower-middle income, countries with high levels of out-of-pocket spending on health care are almost certain to be in this position. Nigeria and Cameroon in Africa, and Bangladesh, Pakistan, and India in South Asia, with OOP spending estimated by WHO to be above or around 60% of total health spending, are perhaps the most egregious examples of a problem which is certainly more widespread across the Commonwealth (*see table 2.2*).

Consider, for example, the situation in Pakistan or India or Bangladesh. These three South Asian countries are very similar in that the public health care system (public facilities with professional staff paid out of public funds) has received inadequate funding over several decades. The result is publicly-provided care covers a limited range of needs in understaffed facilities with inadequate access to essential supplies. The inability of the public sector to provide treatment that is timely and effective has created the space for the growth of a very large private sector which is not only expensive to use, but now dominates the health care system. Even if the private sector is not used by most people most of the time, it is certainly where the majority of professionals work and where medicines are most readily available. As well as being expensive to use, private providers tend also to be concentrated in urban areas, which means that people in rural areas and the urban poor mostly rely on public facilities (and traditional practitioners). High levels of poverty and informal sector employment mean that only a minority of households are able to protect themselves against the costs of health care by taking out insurance (i.e. private) for prepaid care<sup>18</sup>. The system has developed in a way that is *clearly* ineffective at providing adequate cover

<sup>14</sup> Prevalence and correlates of physical disability and functional limitation among elderly rural population in Nigeria. IS Abdurraheem. J Ageing Res 2011. doi: 10.4061/2011/369894.

<sup>15</sup> In China the prevalence was much lower at 13.5%. There were strong associations with education and income.

<sup>16</sup> Prevalence of and factors associated with frailty and disability in China, Ghana, India, Mexico, Russian Federation and South Africa. R Biritwum et al Maturitas 2016, 91: 8-18.

<sup>17</sup> Prevalence of frailty and disability: findings from the English Longitudinal Study of Ageing. C Gale et al. Age and Ageing 2015, 41:162-165.

<sup>18</sup> In the WHO SAGE sample for India (50+) only 6% of individuals had some form of health insurance. See *Disability and chronic disease among older adults in India: detecting vulnerable populations through the WHO SAGE Study*. S Basu et al 2013. Amer J Epidemiology (178) pp.1620-1628.

<b>Table 2.2</b>	<b>GDP per cap. \$ppp</b>	<b>Poverty head-count @\$1.90 per day</b>	<b>Pension coverage % for pensionable pop</b>	<b>Per cap. health exp (\$us)</b>	<b>OOP as % of total health exp (2014)</b>	<b>WHO HW threshold (2013) <sup>(v)</sup></b>
Brunei Darussalam	77440	-	81.7	958	6	✓
Singapore	87855	-	?	2752	55	✓
Australia	46790	-	83	6031	19	✓
Canada	44025	-	97.7	5292	14	✓
New Zealand	39059	-	99.8	4896	11	✓
United Kingdom	42609	-	99.5	3953	10	✓
Cyprus	32580	-	85.2	1819	49	✓
Malta	37899	-	60.5	2471	29	✓
Trinidad & Tobago	31908	-	98.7	1136	38	✓
Seychelles	28391	-	100	494	2	✓
Antigua & Barbuda	22413	-	69.7	774	24	✓
The Bahamas	23173	-	84.2	1720	29	✓
Barbados	16816	-	68.3	1146	30	✓
Malaysia	27281	-	19.8	456	35	✓
Mauritius	21087	-	100	482	46	x
Botswana	16735	18.2	100	385	5	✓
South Africa	13225	16.6	92.6	570	6	✓
Namibia	10585	22.6	98.4	499	7	✓
Grenada	13927	?	34	506	51	✓
St Vincent and the Grenadines	11605	?	76.6	575	49	✓
Saint Lucia	11545	?	26.5	500	46	✓
Fiji	9560	4.1	10.6	204	23	✓
Jamaica	8835	19.9	55.5	266	28	x
Belize	8448	?	64.6	279	23	✓
Swaziland	8342	42	86	248	10	x
Guyana	7819	?	100	222	37	x
Nigeria	5867	53.5	?	118	72	x
Ghana	4294	25.2	7.6	58	67	x
Zambia	3922	64.4	7.7	86	30	x
Lesotho	3029	59.7	100	105	16	x
Kenya	3156	?	7.6	78	67	x
Cameroon	3286	29.3	12.5	59	66	x
Sri Lanka	12316	1.9	17.3	127	42	✓
India	6572	21.2	24.1	75	62	x
Pakistan	5249	6.1	2.1	36	56	x
Bangladesh	3580	18.5	39.9	31	67	x
Samoa	6345	8.4	49.5	301	6	✓
Tonga	5752	1.1	1	213	12	✓
Kiribati	2047	14.1	?	154	0	✓
Vanuatu	3018	15.4	3.5	158	6	x
Papua New Guinea	?	39.3	<1	92	10	x
Solomon Islands	2236	45.6	13.1	102	5	x
Tanzania	2787	46.1	3.2	52	23	x
Uganda	1849	34.6	6.6	86	41	x
Rwanda	1913	60.4	4.7	52	28	x
Sierra Leone	1473	52.3	0.9	86	61	x
Mozambique	1217	68.7	17.3	42	9	x
Malawi	1169	70.9	4.1	29	11	x

to everyone in the population. What does mean for older people? Since detailed data on health care utilisation are hard to obtain, all we can do is surmise that they are unlikely to be in a better position - as regards the accessibility and affordability of reasonable quality health care - than anyone else, and there is good reason to think that they might be worse off. This certainly is true if we suppose either that older people tend to need more health care or that what they need tends to be more expensive.

On some key outcome measures, furthermore, Samoa's health care system performs well, especially maternal and child health. If there is a problem, it is not so much affordability as the very low level of provision for NCDs.

In many low resource settings countries the main public mechanism for collective risk-pooling is some form of social insurance which provides access to health care with some degree of prepayment (i.e. not tax-financed or only partially tax-financed). It

### Text box 2.2

## Rwanda – Mutuelles de Santé

Rwanda has a nationwide Community Based Health Insurance scheme (CBHI) - the Mutuelles de Santé – which stands apart from nearly all the other CBHIs in the region as a clear and unambiguous success story. It has achieved something approaching Universal Health Coverage. A thematic report based on the 2012 Population and Housing Census estimates that 87% of older Rwandans (60+) have health insurance, which is the same as the percentage for the population as a whole. There is hardly any difference, moreover, between men and women, and urban or rural populations. Rwanda in fact has the highest health insurance coverage of any country in Africa. Co-payments are still quite high, however: OOP on health in Rwanda is 28%.

As with most CBHIs elsewhere, the scheme provides household coverage for a yearly premium. This allows individuals from the household (up to 7) to access healthcare at 10% of the billable cost of services. Enrolled households are then affiliated to designated health centres. With referrals from the health centre, members may obtain the hospital services that are covered by Mutuelles. In other words, there is basic health care package defined by the scheme. Two features of the approach used in Rwanda that are thought to have contributed to its success in extending coverage in the informal sector are (i) the use of community-led assessments of the financial circumstances of different households within the community to determine contribution subsidies and exemptions (ii) the granting of microcredit to facilitate the payment of premiums in a single instalment. For individuals in waged employment/ formal sector employment payroll contributions are mandatory.

*Socio-economic status of the elderly: a thematic report.* National Institute of Statistics of Rwanda, 2014.

*Strategies towards universal health coverage in Rwanda: lessons learned from extending coverage through mutual health organisations.* WHO African Health Observatory, 2013.

There are, however, examples of low-income or LMI countries with relatively low levels of OOP spending. Both Samoa and Mozambique have publicly supported health care systems that receive enough funding to keep OOP spending at about 6% (of total health spending). These figures compare very favourably with average for LMICs (Samoa) or LICs (Mozambique). A 2013 World Bank assessment of the health care system in Samoa concluded, on the basis of the low OOP spending, that “financial protection for health expenditure is generally satisfactory”.

is not uncommon, however, for national health insurance schemes in these situations to be very limited in their population coverage, mainly because of their high levels of informal sector employment. One approach to this problem that has been widely adopted in Sub-Saharan Africa involves local Community-Based Health Insurance schemes. These are not-for-profit social insurance schemes that are specific to a particular geographical area within a country, and are often best understood as complementary to the national health insurance schemes that collect

premiums through a mandatory payroll tax. They are intended, in other words, to provide affordable health insurance cover to households in rural areas and workers in the large informal sectors. Premiums are usually collected directly from households as cash payments (i.e. not payroll deductions). Many evaluations have been conducted over the last 15 years or so, and it is probably fair to say that - with Rwanda as a notable exception - enrolment rates have generally been disappointing. It is hard in particular to attract the poorest households.

Community Based Health Insurance schemes (CBHIs) have an obvious advantage over employment-based insurance schemes when it comes to coverage for older people who are not in employment<sup>19</sup>. Household coverage will include any older people in the household. It matters in these circumstances to try and determine whether or not the age of the household head or the presence of an elderly person in the household affects enrolment. A 2014 study of four districts in Tanzania confirmed the importance of income. Poor households did enrol, but not the poorest (bottom quintile). What is interesting in this case is the households with an elderly person or a member with chronic disease were more likely to enrol than those without such members. These results run counter to a recent review of factors influencing voluntary uptake of CBHIs in low and middle income countries. Separate analysis for SSA countries (treated as a group) concluded the presence of elderly people in the household *negatively* influenced enrolment.

In Sub-Saharan Africa, Ghana is one of the few countries that has attempted to implement a truly *national* social insurance scheme for health care<sup>20</sup>. For older people not in employment, they provide exemptions (*see text box 2.3*). Nigeria and Tanzania, by contrast, are examples of countries with national health insurance schemes that are very limited in their population coverage; and in both countries the national scheme is supplemented by community-based health insurance schemes. What is interesting about Ghana is its national health insurance scheme includes exemptions from user fees for elderly health care users. As the evidence for Ghana suggests, however, even nominal user fees can deter poor people for making use of public health care services. Tanzania provides a slightly different illustration

of how implementations problems can stymie a policy which formally exempts older people from user fees at public health facilities. To promote access to care for older people, the government declared everyone aged 60+ was to be exempt from user fees. The country's 2003 National Ageing Policy (NAP), however, acknowledges many older people are denied access to free health care simply because they cannot prove their age (lack of proper ID card). The NAP is clear, therefore, the administration of the system has to be improved. The problem has been exacerbated by the limited availability of health services, equipment and expertise. A commentary from the World Bank in 2012 found little improvement: data from the Tanzanian 2010-11 National Panel Survey suggested that almost 90% of older Tanzanians had been refused exemptions in 2010<sup>21</sup>.

## Responding to the challenge of NCDs in less developed countries

The organisational challenge for health care services is to provide the right kind of health care for populations with rapidly increasing numbers of older people, and to provide enough of it in the right settings. In most countries with a double burden of disease, this challenge has to be seen in the context of total *per capita* spending on health care that is a small fraction of what is spent in most high-income countries. Access to health care is likely to be massively constrained by inadequacies and shortages in the supply of facilities and professionally trained personnel. These problems can be found, moreover, not only in the provision of care for people with NCDs but also in the acknowledged priority areas of maternal and child health. The challenge therefore is to develop the appropriate health infrastructure for the prevention and management of NCDs without taking energy and limited resources away from the demands associated with widespread communicable disease and high infant and child mortality.

The existing primary care infrastructure in many of these countries, besides being thinly spread and over-stretched, will most probably concentrate its resources on (i) the prevention of problems in childbirth and child health, and (ii) a limited

<sup>19</sup> In Nigeria, for example, where most people working in the formal sector have health insurance, retirement means loss of health insurance coverage.

<sup>20</sup> The South African government published a White Paper with detailed proposals

for such a scheme (NHI) in 2017.

<sup>21</sup> <http://blogs.worldbank.org/africacan/old-and-vulnerable-the-status-of-tanzania-s-elders>



## Exemptions and subsidies for elderly health care users: Ghana and Jamaica

**Ghana** introduced a National Health Insurance Scheme (NHIS) in 2003, and it remains “one of the very few attempts by a sub-Saharan African country to implement a national-level, universal health insurance program”. There is a legal requirement for all Ghanaians either to enrol in the Government scheme or to find an equivalent scheme that provides them with cover against healthcare costs. It is recognised, however, that this is largely unenforceable, partly because of the size of the informal sector among the paid labour force, and partly because there are no penalties for non-enrolment. Several categories of individual are exempt from premium payments, and for our purposes, the two significant exemptions are all persons aged 70 years or more, and all pensioners who receive a SSNIT pension, i.e. a national insurance fund pension (60+ years). Exempt does not mean completely free, however, since individuals in the exempt categories have to pay a small registration fee (about 1\$), which is repeated every year.

What has this done for health care utilization by older people in Ghana? Less than might have been expected, according to a study published only this year (2017) which uses data from the World Health Organization’s SAGE survey. Despite exemption from NHIS premiums, only half of the sample (all 70+ years) were insured, and poorer people were less likely to be insured. Why should this be? The paper offers two possible explanations. First, although the registration fee seems negligible, it may be enough to deter poorer households. Second, in many places, especially rural areas, the costs of registration are likely to be only a fraction of the total real costs, which will include transportation to registration centres etc. *Socio-economic status of the elderly: a thematic report. National Institute of Statistics of Rwanda, 2014.*

*Is the pro-poor premium exemption policy of Ghana’s NHIS reducing disparities among the elderly? VZ Kuire et al, Population Research and Policy (36)2, 2017.*

In **Jamaica** the public health care system is funded mainly out of general taxation, and since user fees were abolished in 2008, the cost of medicines accounts for most OOP spending in the public sector. There are two main programmes that help older people with the costs of medicines. The Jamaica Drugs for the Elderly Programme (JADEP) targets people aged 60+ with 10 specified chronic diseases; and they pay only nominal prices for prescribed medicines at both public and private pharmacies. The National Health Fund targets anyone with 15 specified chronic diseases (with the intention of providing universal coverage). In 2010, 70% of older people were benefiting from JADEP and 45% from the NHF.

*Empowering older citizens monitoring project, Jamaica. End-of-project evaluation report. HelpAge International 2010*

response to common communicable diseases. The inexorable rise in the prevalence of NCDs means that primary care also has to be able to (a) implement extensive screening for risk factors and early symptoms, and (b) provide the level of *continuity of care* that is needed for effective management of chronic disease. To put it another way, primary care has to change. It has to become more pro-active. The situation with respect to secondary care is usually characterised by a very small number of specialist physicians and few facilities accessible to a fraction of the population who need them.

Although it is very unlikely that there are any

countries in the Commonwealth that have no services for the prevention and management of NCDs, there will be many in which a large proportion of people with NCDs receive either no medical care or inadequate medical care. What is lacking is a care infrastructure that is proactive (and effective) in identifying people with needs in the community and also provides treatment either in the community or in the home.

A clear and urgent priority therefore is an expansion of existing primary care services so they can be effective in preventing and managing NCDs in the community; and some sense of the scale of the challenge this involves can be given by WHO data

## WHO SAGE study – Assessment of universal health coverage for adults aged 50+ with chronic illness in South Africa, India and Ghana

The study found that access to basic chronic care for adults aged 50+ with chronic illness was 47.6% in South Africa, 32.9% in India and 36.9% in Ghana. Individuals were counted as having access to basic care (i) if treatment, such as medications or advice on physical activity or diet, was being provided for each of their conditions; (ii) if they had visited outpatient services for the chronic condition or conditions one or more times in the last reported year; and (iii) if the treatment had maintained a stable health state after the last outpatient visit. In both India and Ghana, access varied with health insurance coverage, i.e. uninsured individuals were less likely to have access.

The study also estimated the risk of catastrophic health spending (defined as 30% of annual household income) in the same three countries. The poorest households everywhere were most likely to be at risk. In Ghana, more than 60% of individuals in the bottom three income quintiles reported catastrophic health spending (just under 80% for the lowest quintile) in the previous year. Even in the highest quintile more than 20% of individuals reported that level of spending. South Africa had the lowest risk – with less than 40% of individuals in the lowest income quintile reported catastrophic health spending, and an overall rate of 23.5%.

on so-called ‘critical shortage’ countries: those with a low density of health professionals and low coverage of skilled birth attendants<sup>22</sup>. Of the 57 countries identified by WHO in 2006 as having a critical shortage in the health workforce, almost two-thirds were in Africa, and these included 12 of the SSA Commonwealth countries. Outside Africa, Pakistan, India, Bangladesh and PNG were also had critical shortages. In 2013 WHO revised the data and dropped the binary classification of critical shortage/no critical shortage used in the earlier report. They did, however, identify countries that fell below the 2006 threshold of 22.8 nurses, doctors and midwives per 10,000 population. Of the 183 countries covered by the data, 87 fell below the threshold. These included 22 Commonwealth countries: all the low-income countries in the Commonwealth, most of the lower-middle income countries (13/18), and two upper middle countries (Jamaica and Mauritius)<sup>23</sup>.

One widely used and much researched solution to the problem of chronic shortages of qualified health professionals has been to train volunteer health workers to work in their local communities. Community Health Workers (CHWs) or Village Health Workers (VHWs) have been used with notable success in a variety of settings and roles, often to provide first stage contact for reproductive and child health services or to provide nutritional advice. Typically they form part of an outreach

service with carefully delineated functions, and have been shown to be effective in various ways, for example, by increasing uptake of contraception and immunisation services, and access to antenatal and post-partum care. They have also played an important contact and support role for people with communicable diseases, especially HIV and TB. In rural areas, they can extend the reach of primary care services to communities which have no clinics within easy travelling distance. In urban areas, they can help to expand the capacity of services that struggle to respond to very high levels of demand. In many countries the use of CHWs for these various kinds of health problem has now achieved a scale which requires their work to be into national health planning.

An application of the CHW model to the provision of care for health needs that are closer to those of older adults and has been quite widely adopted is palliative care. As the name suggests, the service is not designed to provide care specifically for older people or indeed for NCDs. Palliative care is concerned with the relief of suffering rather than the prevention or treatment of disease. It is in the very nature of the epidemiological transition, however, that death is pushed to increasingly older ages, which means the demand for palliative care comes increasingly from older adults. One of the most cited examples of this care model is the Neighbourhood Network in Palliative Care (NNPC)

<sup>22</sup> *A universal truth: no health without a workforce*. WHO 2014.

<sup>23</sup> Antigua and Barbuda also fall below the threshold, but the data in this case were pre-2000.

in Kerala in South India. In 2010 it was estimated the NNPC in Kerala was seeing 2500 patients per week. Over 400 professional staff working across 230 clinics were supported by approx. 10,000 trained volunteers.

After completing [their] training, volunteers in the NNPC assume central roles and bring with them important skills from their previous professions. In addition to carrying out in-depth needs assessments with the community, providing comprehensive social, psychological and spiritual care, they improve symptom control by ensuring compliance, providing free medications and determining side effects early. These factors can seriously undermine excellent prescribing from physicians. The volunteers in NNPC never give medical advice or perform medical procedures. This is always left to trained health care staff<sup>24</sup>.

The HIV/AIDS epidemic has led to similar initiatives in SSA. As in Kerala, trained volunteers working in the community - visiting people's homes – are a core part of the services. Without the volunteers, many fewer individuals would have the benefit of palliative care. The Home-Based Care Charitable Trust programme in Malawi (i.e. an NGO programme), for example, relies on volunteers who not only identify people who might need the service but continue to support them throughout the duration of their illness<sup>25</sup>. What enables this particular scheme to work, apart from the volunteers themselves, is the fact that they have a reliable connection with professionally managed palliative care services, including specially trained home care assistants as well as qualified palliative care nurses. There are many similar initiatives across SSA.

While CHWs are increasingly recognised as a critical link in improving access to services and achieving the health-related goals, there is solid evidence to suggest that their contribution can be handicapped by various problems arising with implementation. Different schemes for the same kinds of health need often work in isolation from each other in the same country, often run by NGOs with varying sources of funding. There are sometimes serious issues around sustainability and incentives for volunteers. Organisational support

from mainstream services can be weak. Broadly speaking, their contribution towards the extension of health care coverage depends on the ability of governments to integrate the work of CHWs with the mainstream services and scale up from small local projects<sup>26</sup>.

As for the contribution of services that rely on CHWs to the prevention and management of NCDs, we are dealing more with potentiality than actuality. There are plenty of small -scale local projects that have been established with a view to testing the feasibility of a new model for care. The challenge is integration and scaling up from feasibility projects to full-blown operational services. As an example of how this might be done, health reforms are being introduced in South Africa to prepare the system for the implementation of the new National Health Insurance (NHI); and they include a restructuring of primary care that incorporates CHWs in a way that addresses some of the problems that are known to undermine their effectiveness. The new primary health care system relies on the nationwide introduction of ward-based outreach teams (WBORTs) that are intended to act as the frontline in a pro-active approach to prevention and management of NCDs.

There are many other examples of service developments that target older people in the community besides those make use of CHWs. They can take many forms, and often they are the focus of feasibility studies that serve mainly to highlight systemic problems that would stand in the way of scaling up. In Nigeria, for example, a cardiovascular disease prevention scheme was embedded within a community-based health insurance scheme (CBHI) serving a rural area<sup>27</sup>. The CBHI gave its members access to prepaid care at a particular private clinic (physician-led), and although the scheme did well at retaining patients, travel costs compromised adherence to the care regime (monthly check-ups), and the unaffordability of multidrug prescriptions was a barrier to following optimum treatment guidelines. The authors' conclusions point to challenges that are probably widespread in such settings. Although the study "demonstrated that high-quality CVD prevention care can be successfully implemented in a primary

<sup>24</sup> Home-based palliative care in Kerala, India: the Neighbourhood Network in Palliative Care. L Sallnow et al. *Progress in Palliative Care*, 2010 18(1): 1-4

<sup>25</sup> Palliative care making a difference in rural Uganda, Kenya and Malawi: three rapid evaluation field studies. L Grant et al *BMC Palliative Care*, 2011. doi: org/10.1186/1472-684X-10-8

<sup>26</sup> Community health workers for Universal Health Coverage: from fragmentation to synergy. Kate Tulenko et al. *Bull. World Health Organization*, 2013; 91:847-852.

<sup>27</sup> Feasibility and quality of a CVD prevention within a community-based health insurance program in Nigeria. ME Hendriks et al. *J Hypertension*, 2015; 33:366-375.

## Health care reform and home-based care delivery in South Africa

Ward-based PHC outreach teams are the corner stone of the reformed health system. Although aimed at improving equity in access to primary health at all ages, they are understood to be particularly relevant for older people living in the community who may have co-morbidities and may be responsible for the healthcare needs of other (e.g. children). The WBORTs will consist of a professional (registered) nurse with 4 years of training (including midwives), an enrolled nurse with 2 years of training and six or more community health workers per municipal ward. The team will also be supported by a medical officer, an environmental health practitioner and a health promotion practitioner. Each outreach team is expected to serve a population of about 7 660 persons with each community health worker serving an average of 270 households. WBORTs will identify vulnerable households (e.g. those without identity documents, eligible for grants, etc.), provide information and education on a range of health matters, offer psychosocial support in collaboration with community caregivers supported by the DoSD, carry out basic screening for early detection and intervention of health complications and illnesses, provide support with treatment adherence and assist with referrals to appropriate levels of healthcare. Older persons, who may be less able to travel to clinics and less inclined seek regular check-ups and screening services, are especially likely to benefit from this new home-based care delivery.

care setting in rural SSA within the context of a CBHI program, ....provision of guideline-based care was resource-intensive and the identified health system-related barriers to care may threaten the rapid scale-up of services. Therefore, more simple models of CVD prevention care delivery are needed to expand coverage of CVD prevention services in SSA”.

The initiative for the introduction of WBORTs in South Africa comes from the national government, and for many CHW schemes it comes from NGOs. There are, however, some less developed countries in which the initiative for developing appropriate infrastructure for the management of health problems arising from chronic disease comes from the private sector. Given the relative dominance of private sector healthcare in India, it should not be surprising that the country has a rapidly developing market for home healthcare services. The private sector, in other words, is responding to demand from a growing urban middle-class. It may take a while for hard evidence about these developments to appear in medical journals, but there is still plenty of information available about the individuals and firms that are beginning to invest in what is seen as a major business opportunity<sup>28</sup>. Unsurprisingly these businesses are targeting major cities with large middle classes who can afford to buy this kind of care (which is not covered in most insurance policies). The focus of the services they provide will *not* be regular (and

long-term) assistance with activities of daily living, but rather the medical and nursing inputs required for the management of late-life chronic disease in patients with severe health problems, e.g. post-operative care, palliative care and the treatment for acute crises that would otherwise require hospital admission. They know that in order to be profitable they have to operate on a large scale and they know that they have to make good use of modern technologies that allow them to bring certain aspects of hospital care into the home. The aim is to develop a technology-intensive service that will rely on large numbers of highly trained personnel. Although it has yet to be seen whether or not this model of ‘standalone’ providers (i.e. independent of the hospital system) can actually work, there is no question but that the experiment is well under way<sup>29</sup>.

## Meeting the health needs of ageing populations in developed countries

Although the organisational challenge for health care services in countries which already have large older populations is formally the same - to provide the right kind of health care for populations with rapidly increasing numbers of older people, and to provide enough of it in the right settings - the context is of course very different. These are all high-income countries with well-funded health services and they share a common concern with

<sup>28</sup> <http://knowledge.wharton.upenn.edu/article/home-health-care-india-search-right-business-model/>

<sup>29</sup> A somewhat different scheme is operating in Malaysia, where ‘mobile health

clinics’ were introduced a few ago to provide mainly nursing support to people who are living at home and cannot easily make their way to a hospital-based clinic. In this case, unlike in India, the costs are covered by health insurance.

the implications for healthcare spending of rapid growth in that segment of the population which is most susceptible to life-threatening or disabling chronic disease. Will it lead to a surge in demand that is large enough to undermine attempts to achieve what has become a paramount goal for health policy in rich countries, namely, to improve the quality of care while avoiding unsustainable increases in spending? In recent years, as projections for a demographically-driven surge in demand have been dampened by a considerable body of economic and epidemiological research and analysis, these concerns have been much qualified. Results from many different attempts to model increases in aggregate health spending over the last few decades (nationally and internationally) support the conclusion that growing affluence and technological innovation are much more important as drivers of expenditure trends than ageing. Analyses of the concentration of lifetime health spending for individuals in the last months of life have shown that the impact of population ageing is greatly exaggerated if it is based on projections which work directly from current age profiles of expenditure and ignore the tendency of improvements in remaining life expectancy to *reduce* per capita health spending among older age groups. Even with these qualifications, however, it is still deemed sensible by many analysts to assume that an acceleration in the rate of population ageing will make it more difficult for modern healthcare systems to provide satisfactory care at a reasonable cost<sup>30</sup>.

What these countries also have in common are health services that have been developing and refining their responses to the challenge of chronic disease over several decades<sup>31</sup>. This is most evident perhaps in the way that services have responded to the epidemic of CVD in the last third of the last century. As well as investing heavily in the development of secondary prevention, most of these countries will have implemented a risk reduction strategy for the general population. They have also invested considerable effort and resources in the early identification and treatment of cancer. In other words, their health services do more than pay lip service to the idea that the prevention and management of chronic disease

demands a pro-active approach to the provision of services for people in the community. They have tried – no doubt with varying degrees of success – to adopt the idea in practice. They have had time to accumulate considerable experience in handling the complex connections between different ‘levels’ of care in the treatment of chronic disease, and it seems unlikely that they are not well aware of the importance of coordination between different care settings and types of care. None of this implies, however, that they are properly geared up to meet the challenge of complex chronic disorders as the work of health services becomes increasingly dominated by the provision of care to older people with multiple health problems.

The view that most high-income countries still have a lot to do if they are to provide effective and patient-centred care for growing numbers of people with chronic disease is widely shared<sup>32</sup>. Healthcare services in these countries have been built around a hospital-based model of care which is no longer suited to prevailing epidemiological conditions. Although there is a general consensus about the need to adapt services to changing circumstances, what has to be changed is invariably a large and complex network of organisations, facilities and working practices. The achievement of change constitutes a major organisational challenge that requires clear strategic guidance as well as resources. Services have to learn to provide person-centred rather than disease-centred care, something which is especially important when dealing older people with multiple health problems. They have to get better at developing care pathways that take these multiple problems into account and at recognising the risk of acute crises when planning community-based services, and this means getting better at using alternative care settings to hospitals and planning for home-based care. It also means that the provision of medical and nursing care should be properly integrated with social care in those cases where both are needed. Overall the criticism would be that the balance between prevention and treatment is still tilted too much towards reactive interventions. This does not mean simply that more should be done to prevent the onset of chronic disease in people who do not have it. The point is rather that the management of

<sup>30</sup> Ageing, health, and health care. F Breyer et al. *Oxford review of economic policy*, 2010 26(4):674-690.

<sup>31</sup> The exceptions probably are Singapore and Brunei Darussalam.

<sup>32</sup> *Caring for people with chronic conditions: a health system perspective*. European Observatory on Health Systems and Policies. Maidenhead: Open University Press, 2008



## Text box 2.6

## New Zealand Healthy Ageing Strategy

The Healthy Ageing Strategy sets the strategic direction for the health and wellbeing of older people in New Zealand for the next ten years. Its vision is that “older people live well, age well and have a respectful end of life in age-friendly communities”. Of particular interest is the way that the strategy is broken down into 5 outcome areas relating to different aspects of the life course.

- Ageing well – prioritise healthy ageing into and throughout people’s older years
- Acute and restorative care – facilitate and enable provision high quality care for effective rehabilitation, recovery and restoration after acute events
- Living well with long-term conditions
- Supporting people with high and complex needs - better support for people with high and complex needs to ensure they are able to receive the care that most appropriately meets their needs
- Respectful end of life - provide respectful end-of-life care that caters to physical, cultural and spiritual needs.

To illustrate what this means in practice, the implementation strategy for Supporting people with high and complex needs has three main objectives for the first 2 years of the plan:

- Work with the sector to identify and test frailty identification tools for primary care settings
- Agree standard referral and discharge protocols for people moving into and out of residential care facilities
- Facilitate access to medicines management for people living at home and in residential facilities

The strategy has identified gaps and weaknesses in current provision, and proceeds by introducing procedures and practices that should help deal with them. As ever, planning is one thing and implementation another. It is important, however, to be clear about where and how improvements can be made.

<http://www.health.govt.nz/system/files/documents/pages/has-snapshot-03-first-two-years-july17.pdf>

people with chronic disease should itself involve a proactive and preventive approach to the provision of care<sup>33 34</sup>.

As far as primary prevention is concerned, there is considerable consensus around the view that the development and implementation of a more effective strategy for age-related disease and disability is one of the main policy challenges associated with population ageing<sup>35</sup>. The problem here has been summarised by OECD as one of ‘engineering behaviour change’. Individuals can improve their chances of healthy ageing (i.e. delaying the onset of chronic disease and disability) by adopting behaviours that are known to promote

this outcome. Lack of regular physical activity, poor diet and excessive alcohol consumption are widespread in many high-income countries. They are widespread in young people and in adults in mid-life. There is a great deal to be gained by effecting behaviour change in these domains and primary prevention strategies now focus as a matter of course on ways on *encouraging* and *enabling* individuals to make better lifestyle choices. It is recognised, in other words, that the problem is not lack of knowledge, but a host of factors, often inter-related, that are understood as barriers to the adoption of a healthy lifestyle.

<sup>33</sup> *Making our health and care systems fit for an ageing population*. Kings Fund, London 2014

<sup>34</sup> *The ten characteristics of the high-performing chronic care system*. Chris Ham.

Health, economics, policy, and law, 2010; 5(1):71-90.

<sup>35</sup> *Policies for healthy ageing*. OECD 2009

The reference to end-of-life care in the New Zealand strategy on healthy ageing is important. It owes its place not just to the requirements of logical completeness in a strategy that is based on different phases of the life course, but also to an awareness of the effect that continuing population ageing in countries that already have relatively large older populations will have on the demand for end-of-life care. As well as leading to an increase in the demand for end-of-life care<sup>36</sup>, the kind of end-of-life care that will be required is also changing. A model of end-of-life care that has been developed around the need for effective pain control in terminal cancer is not always appropriate for people with other conditions who may nonetheless benefit from planned end-of-life care. As the modal

age of death continues to increase, the underlying causes of death are changing, and there is a role for end-of-life care in deaths from chronic diseases other than cancer. Closely associated with this trend is the increasing disquiet about the proportion of deaths that occur in acute hospitals rather than at home and the suboptimal end-of-life care that is provided in such settings<sup>37</sup>. An acute hospital bed is not an ideal place in which to die, and although it is often unavoidable, there is a general consensus that it can and should be avoided more often than it is. This is especially so when the people who are dying are in their nineties and may have multiple severe health problems that are likely to include cognitive impairment or persistent confusion.

Text box 2.7

## NHS England: a national choice offer in end-of-life care

“End of life care has made great strides forward in recent years, in particular following the publication of the End of Life Care Strategy in 2008. However, we know that too many people still do not receive good quality care which meets their individual needs and wishes. For example, only just over half of respondents to the National Survey of Bereaved People (VOICESSEF) felt that their relative had died in a place of their choice. At the same time the challenge of delivering consistently good experiences and outcomes for people at the end of their lives is growing. Each year, around 480,000 people die in England. This is predicted to increase to 550,000 by 2035”<sup>\*</sup>.

This particular report argues not only that choice is an essential element in good end-of-life care, but that the National Health Service should set a specific date for the delivery of ‘a national choice offer’ in end-of-life care and specific timescales for key service improvements, so that all people in all areas are able to benefit from it. The implementation of a strategy that gives a central place to choice, and in particular the choice to die at home and not in hospital, requires large-scale change.

“This is, however, only achievable if the people and organisations who deliver this care, in particular the NHS, change the way they work. It requires more care in community settings, with investment in these services coming from the savings flowing from reduced hospital-based care; it requires providers of hospital services to plan care proactively, beyond hospital, to avoid unnecessary admissions; it requires a change in attitudes and behaviour from all involved in the commissioning and delivery of care to make care truly person-centred; and it requires a skilled, capable and flexible workforce”.

And change in this instance is expensive. The report estimates that £800m would be required to implement a national choice offer by 2020. It also acknowledges that this is much more than is likely to be forthcoming in a time of financial stringency.

<sup>\*</sup>*What’s important to me: a review of choice in end-of-life care, NHS 2015*

<sup>36</sup> See text box for estimates of the increase in the annual number of deaths in England between 2015 and 2035 (approx 15%).

<sup>37</sup> *Supporting Australians to live well at the end of life*. National Palliative Care Strategy, Commonwealth of Australia, 2010.

<sup>38</sup> See, e.g. *The Oldest Old in the Last Year of Life: Population-Based Findings from Cambridge City over-75s Cohort Study Participants Aged 85 and Older at Death*. J Zhao et al. *J Amer Ger Soc*, 2010, 58(1):1-11

# Families and the living arrangements of older people

There is a close and readily intelligible relationship between the living arrangements of older people and the extent to which they are dependent on their family (usually children) for care and support *in case of need*. If older people are financially independent from their children and their children can afford to set up their own household when they marry, the older and younger generations have less reason to maintain co-residence than they do in a social environment that provides very little protection against the risks of older age outside the family. Co-residence ‘makes sense’ when neither generation has sufficient financial independence to maintain a separate household. This kind of extended household provides the setting for an exchange of family resources for care and support that typically involves three generations: an elderly couple living with a married child and their grandchildren.

Just as family ties underpin the exchange of care and support available within the household, so does the fact of sharing a household facilitate the exchange of care and support between family members. Households are usually understood as social units for pooling resources and sharing costs between individuals who are united by the bonds of family. Sharing the same household with adult children may be no guarantee of support in old age, but it makes it more likely that it is on hand should it be needed. There is a difference between buying and preparing food for a family that includes an older parent in the same household and giving money for the same purpose to an older parent who lives in a separate household. Although cash transfers between adult children in one household and older parents in another household are without question very common in poorer countries, it seems clear that this kind of separation increases the risk of some older people being left without support from their family. Separate households are not just

separate; they tend to function as independent units with regards to certain kinds of costs.

## Patterns in living arrangements

It is evident that the typical living arrangements of older people vary a great across the Commonwealth countries. The countries vary in the proportion of older people that live alone or in ‘elderly couple’ households and in the proportion of older people that co-reside with adult children or grandchildren<sup>39</sup>. The broad outlines of the picture that emerges from various data sources are familiar<sup>40</sup>. In less developed countries, the most common living arrangement for older people is co-residence with adult children who are usually non-dependent adults with children of their own: they live in extended or multi-generational HHs. So, for example, in India, 77% of older people live in some kind of an extended household arrangement, either with a spouse and ‘other members’ of the family (45%), or with children but no spouse (32%)<sup>41</sup>. In Ghana, the pattern is very similar. 75% of older men and 80% of older women live in some form of extended or multi-generational household – which is to say that they live with one of their children and at least one grandchild<sup>42</sup>. In Fiji, about two-thirds of older people co-reside with adult children<sup>43</sup>, and in South Africa, although the proportion of older people living in extended households is quite a bit less (50%) than in Ghana, it remains the most common form of living arrangement in this age group<sup>44</sup>. Similar estimates for some of the low and middle income Commonwealth are available in the ASPIRE data compiled by the World Bank.

In high resource settings, on the other hand, this kind of living arrangement is relatively uncommon. A minority of older people rather than a large majority live in multi-generational households. Although in some high-income countries such as

<sup>39</sup> See note on data at end of chapter.

<sup>40</sup> For a global summary, see *Current status of the social situation, wellbeing, participation in development and rights of older people worldwide*. United Nations Department of Economic and Social Affairs, 2011.

<sup>41</sup> *Elderly in India 2016*. Central Statistical Office.

<sup>42</sup> *The elderly in Ghana, 2013*. Ghana Statistical Service.

<sup>43</sup> *Living arrangements of the elderly in Fiji*. Seniloli & Tawake, J Pacific Studies, 2014, 35:168-187

<sup>44</sup> *Profile of older persons in South Africa*. 2011 Census report

Table 3.1<sup>(vi)</sup> World Bank Aspire data (recent) on elderly/non-elderly co-residence for selected Commonwealth countries<sup>45</sup>.

Table 3.1	Male %	Female %		Male %	Female %
Botswana	72	81	Bangladesh	92	85
Cameroon	87	81	India	85	80
Ghana	76	76	Pakistan	96	94
Kenya	87	82	Sri Lanka	85	82
Lesotho	87	85			
Malawi	80	77	Guyana	74	78
Mauritius	74	65	Jamaica	64	74
Mozambique	85	73			
Nigeria	91	78	Fiji	85	86
Rwanda	92	87	Papua New Guinea	87	89
Sierra Leone	97	98	Vanuatu	78	77
Swaziland	90	92			
Tanzania	90	87			
Uganda	88	86			
Zambia	91	87			

Singapore, the minority is still quite large – almost a quarter of the 65+ population live in ‘3-G’ households, in the Anglophone high-income countries like Australia or the United Kingdom, the minority is considerably smaller. In Australia, for example, in 2011 about three-quarters of people aged 65+ lived alone or with a spouse only (i.e. a nuclear-type household with no dependent children), with another 6% living in communal or ‘non-private’ dwellings. It is uncommon for older people to live with non-dependent children: 7 % of older people live with a child but not a partner – i.e. they are widowed or divorced; and about 1 in 9 of all older couples have a non-dependent child in the household<sup>46</sup>.

It is more common for older people to live alone in high resource settings than in low resource settings.

Text box 3.4

### Living alone: data on selected Commonwealth countries

Of the Commonwealth countries included in the Demographic and Health Survey coverage of SSA, Ghana has easily the highest proportion of older people (60+) living alone (14.4%), and Sierra Leone has the lowest (1.4%). In most of the other countries, the figure is between 7% and 11%. All these estimates are taken from surveys conducted between 2004 and 2010. South Africa stands apart from this group with a much higher proportion of older people living alone: in the 2011 Census 20% of older people aged 60+ were in single-person households. There is, however, a big difference in this respect between individuals in the white population (33%) and those in coloured (13.9%), black African (17.7%) or Indian/Asian (15.9%) populations.

The estimates for India and Bangladesh in South Asia are, if anything, slightly lower than they are in most of SSA. The 2011 Census in India puts the proportion of older people living alone at 5.2%, lower than all the Sub-Saharan African countries except Sierra Leone. And in Bangladesh a 2015 survey (not a census) found that 6.2% of older Bangladeshis were living alone.

In SE Asia, both Malaysia and Singapore have 2014 data on the proportion of older people that live alone: 9% in Malaysia (60+) and 11.9% in Singapore (65+).

The UK seems to have the highest proportion of older people who live alone in the Commonwealth (31% of people aged 65+ in 2011). This compares with 27% in Malta\*, 25% in Australia, 24.6% in Canada\*\*, and 18% in Cyprus\*. In New Zealand 36% of people in the 64-84 age group live alone, though this drops very steeply for the 85+ age group (8%)\*\*\*.

In all settings, older women are more likely to be widowed than older men, which means that they are more likely to live alone, and less likely to live in ‘elderly couple’ households. The likelihood of losing a spouse, increases, moreover with age: the older-old are much more likely to have be widowed than the younger-old. In most of the countries for which data are readily available the proportion of older women who live alone is about twice that of older men.

\* <http://ec.europa.eu/eurostat/cache/infographs/elderly/index.html>

\*\* 2011 Census \*\*\* Statistics New Zealand, 2014 data

<sup>45</sup> An examination of elderly co-residence in the developing world. Social Protection and Labour Policy Note, World Bank 2015.

<sup>46</sup> <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2071.0main+features602012-2013>

<sup>(vi)</sup> percentage 60+ co-residing with at least one non-elderly adult

It is more common for older people to live alone in high resource settings than in low resource settings. Data on the proportions (and numbers) of older people who live alone are considered important because they are often taken as an indicator of at least *potential* vulnerability, which here refers to the risk of having unmet needs for care (i.e. help with tasks of everyday living) or support (i.e. income to buy basic necessities). The extent to which living alone really is an indicator of risk will vary, however, across different settings and between different groups within these settings. In low resource settings, for example, it is more likely to be an indicator of risk than in high resource settings where the evidence suggests there are increasing numbers of older people for whom living alone is a positive choice and financial independence (i.e. independence from younger members of the family) is largely taken for granted.

## Changes in household composition as a source of policy concern

Policy concern over changes in household composition is most evident in Commonwealth countries where multi-generational households are still regarded as the norm and the social environment is such that older people are heavily dependent on adult children for care and support *in case of need*. It is found in countries that still have relatively high fertility rates (and hence a plentiful supply of children), like Ghana, as well as in those where fertility is approaching replacement level, like India, and those which have made a rapid transition to below replacement fertility, like Jamaica. It reflects an awareness of trends that are likely to diminish the capacity of the family and the household to provide care and support in a context where such care and support is regarded as essential for well-being in later life.

Families and households are changing partly because of the same factors that are driving population ageing. Couples are having fewer children and older people are living for longer. The well-being of older people may be compromised if there are fewer children to provide care and support within the household; and at the same time

improvements in life expectancy are increasing the probability that adults in mid-life will have a surviving parent who may at some point be dependent on them for care and support. There are, however, two factors besides population ageing that are affecting the availability of family support in case of need. Firstly, there are several countries, mostly in SSA, in which the availability of family-based care and support for older people has been radically depleted by the HIV/AIDS epidemic. A large proportion of the working age adults who might otherwise have provided this care and support to their parents have died as a result of AIDS.

Secondly, there is a much larger set of countries in which a combination of economic and cultural trends are driving change in patterns of household formation that affect the likelihood that older people will be able to rely on care and support from adult children within the household in case of need. Increasing numbers of older people are either living on their own or with a spouse only in circumstances where it is very unlikely to not reflect any underlying improvement in financial independence or the capacity for self-care. What makes these changes in living arrangements problematic is the fact that they are not being driven by older people's desire for independence and their improved capacity to achieve. Older people are losing out as a result of social changes that are straining the bonds that held multi-generational households together.

The ways in which changes in household composition are relevant to the welfare of older people are shaped then by the social and policy context. What institutional structures other than the family have been developed to provide care and support to older people in case of need, and how accessible are they? What is generally expected of the family in this regard? How does the idea that older people *should* be able to rely on their family in case of need affect policy-making on the development of extra-familial structures of support and care? If the context is such that large numbers of older people are dependent on family support for their means of subsistence - for meeting the everyday costs of living (i.e. relatively undeveloped pension systems) - as well as for their care in case of disability or ill-health, then social trends that

## The impact of HIV/AIDS on HH composition

Two studies from 2009 and 2010 give us some idea of the impact of HIV/AIDS on household composition in Sub-Saharan Africa, where mortality from AIDS has been highest. The earlier study (Zimmer 2009) asks whether or not it is possible to confirm a cause-effect relation between the epidemic and occurrence of skipped generation households. The second study (Kautz 2010) tries to estimate the size of the effect.

The 2009 study found that about 1 in 4 older people in Sub-Saharan Africa lived with grandchildren whose parents were absent, i.e. in skipped generation households. As the author says, this is a notable finding with or without an AIDS epidemic, and he thinks that “under ideal circumstances” the arrangement benefits both grandchildren and grandparents. The ideal circumstances include the provision of regular remittances from parents who are away working. If HIV/AIDS intervenes, the arrangement changes its character. It ceases to be a way of adapting to changing economic conditions, which are increasing the pressure to travel or migrate to find work. A planned fostering arrangement with cash support from the parents is replaced by unplanned fostering without cash support. Although the study is cautious about the ability of the analysis to demonstrate a direct causal link between HIV/AIDS and changing household composition (since there are other factors at work which would lead to household change), there is a clear correlation between high mortality from HIV/AIDS and the prevalence of older people living in skipped generation households and households with a double-orphaned grandchild. In this particular study, the highest death rates were found in Kenya, Malawi, Zambia and Tanzania. The southern African countries - which also have had very high AIDS mortality - were not included in the study.

The same dataset (the Demographic and Health Surveys) was used by Kautz et al to estimate the magnitude of the impact of mortality from HIV/AIDS on household composition in the same region. The key point is that HIV/AIDS has been and still is reducing the number of ‘prime age’ adults (18-59) in the populations of many countries in Sub-Saharan Africa. The impact in countries with high prevalence rates - such as those in southern Africa - is very large, large enough to be apparent at a population level. By pooling data from the whole region, the authors estimated that a one point increase in the AIDS mortality rate was associated with a 1.5% increase in the proportion of older people living alone and a 0.4% increase in the proportion of elderly individuals living with children under the age of 10 and without prime age adults in the household. As a result of the epidemic therefore, many countries in SSA have a significant and sizeable new population of elderly individuals who lack support from adults and who may need to provide for their grandchildren.

*Household composition among elders in Sub-Saharan Africa in the context of HIV/AIDS. Z Zimmer. J Family & Marriage, 2009 (71):1086-1099.*  
*AIDS and declining support for dependent elderly people in Africa: a retrospective analysis using demographic and health surveys. T Kautz et al. BMJ 2010. <https://dx.doi.org/10.1136%2Fbmj.c2841>*

make it more difficult for older people to access this support will be a matter of policy concern. If it is widely thought that older people can, as a rule, rely on family in case of need, trends that undermine this assessment of the availability of care and support in the family will worry the public as well as policymakers. And if the context in which policy is made is shaped by strong normative views on the social desirability of maintaining a generational contract within the family<sup>47</sup>, we should expect policy responses to reflect this.

In countries where co-residence with adult children is the most common living arrangement for older people the expectation that older people can rely on family transfers may seem to have a solid basis in the facts of family life; it simply takes for granted what is an established pattern of living

arrangements. If older people who are no longer able to work do not have their own independent household, the everyday costs of living are merged with those of the rest of the household. If they are ill and need care, they are looked after by someone who shares the same household. In most low resource settings over the last couple of decades, however, the consequences of demographic and social change have made themselves felt in such a way that it can no longer be taken for granted that this kind of support will be available. A good example of how this change is registered in policy-making can be seen in the Ghanaian National Ageing Policy (see text box 3.2). What the policy has to say about the social trends that are combining with demography to generate a major policy challenge for government is not untypical for Sub-Saharan Africa.

<sup>47</sup> Parents look after their children while they are dependent; and when these children become adults they look after their parents in case of need (e.g. no longer able to work).



## National policies on ageing: Ghana and Tanzania

National policies on ageing or older persons can have different functions in different countries. In many low resource settings, their primary function has been to affirm the rights of older people and commit the government to protecting them. Such policies are often conceived as declarations of intent and statements of principle rather than as firm commitments to a programme of action with targets for implementation and earmarked resources. In Ghana, for example, this was done in 2010\*. The global framework is set by the United Nations resolution of 1991 which encourages Governments to incorporate a set of basic principles (18 in all) “into their national programmes whenever possible”, and the adoption the Madrid International Plan of Action on Ageing by the 2nd World Assembly on Ageing (2002). In Africa the statement of principle was repeated by the African Union in its Policy Framework and Plan of Action on Ageing (2002), and national policies, as in Ghana, explicitly place themselves in this regional framework as a global one. Also, as in Ghana, they typically appeal to wider development goals. They acknowledge that there is a risk of older people being ‘left behind’ in the ‘national development process’, and declare their resolve to work against such an outcome.

“The overarching goal of the national ageing policy is to achieve the overall social, economic and cultural re-integration of older persons into mainstream society, to enable them as far as practicable to participate fully in the national development process. In the pursuit of this goal full recognition will be given to their fundamental human rights including the right to independence, active participation in society, benefit from community support and care, self-fulfilment in pursuit of educational and other opportunities and dignity, security and freedom from exploitation”.

The challenges for policy are set by economic and social change as well as demography.

“Unfortunately due to social transformation, economic constraints and high level of unemployment and under employment, the traditional expectation that the younger generation will take care of the old in time of need is no longer tenable. Older persons therefore can no longer rely on the traditional family support for survival”.

Although governments are aware that traditional forms of support are subject to macro-trends that are effecting profound structural change, they continue to affirm the importance of the family and are concerned to maintain its viability as a source of support for older people.

“Effort will be made to uphold the traditional family structures and norms such that it will be able to provide the needed support to older relatives. The family will be encouraged to develop plans and incorporate in these plans strategies to support older people in the family. The family will be assisted to identify, support and strengthen traditional support systems to enhance the ability of families and communities to care for older family members”.

The National Ageing Policy in Tanzania is similar in the way it highlights the erosion of traditional forms of support as a result of the migration of younger people to cities, and adds to this the impact of the enormously disruptive HIV/AIDS epidemic. Along with traditional ways of life go traditional roles and the status assigned to older people in their communities. The care and support provided by younger people who leave in the household is replaced at best by remittances, and at worst by nothing.

For the 1991 UN resolution, see <http://www.un.org/documents/ga/res/46/a46r091.htm>

\* In 2012 the Ghanaian Government asked the World Health Organization for assistance in implementation.

Another related issue that emerges quite explicitly in a small handful of these SSA policy documents concerns not just the failure of family networks to provide support when it is needed, but also their occasional active rejection of an elderly member. The Malawi Elderly Policy, for example, draws attention to the position of dependent older people, especially widows, who are actually made destitute by their families, usually against a background of disputes over the ownership of land.

*The majority of [older people in rural areas] live on land whose ownership is governed by customary law. Property disputes affect older persons as family and community members strive to take control following the death of a spouse. In some instances, social exclusion, marginalisation, family disputes and violence against older persons render them destitute.... Older persons who are destitute will be provided with shelter and deliberate efforts will be made to prevent communities from evicting older persons from their homes and villages.*

At the core of many such property disputes is the position of older widows in respect to the laws of inheritance (i.e. their inability to inherit land). This understanding of the position of older women in customary law is not confined to Malawi, of course, and the Census Report on Older Persons in South Africa draws attention to the problems it causes across much of the SSA as a region. Widowhood is often the trigger for an older women to have to find alternative accommodation, and her ability to do this will depend on the availability of other children who can take her in. The combination of cultural attitudes embedded in customary law with increasing life expectancy at older ages and economic strain on households may very easily produce a situation in which an elderly relative who makes no contribution to the income of the household is regarded principally as a burden. It seems quite plausible to suppose that increasing dependency ratios within households is one of the factors contributing to make this a publicly visible problem. However this may be, the policy statements acknowledge that a response is required at a national level.

If data on patterns of living arrangements among older people in the Commonwealth are patchy, good data on *changes* in living arrangements are even sparser for middle or low-income countries. In

such cases, we have to rely on other more indirect forms of evidence. Policy-makers are well aware of rural-urban migration as a force for social change, and one of its consequences is the fracturing of extended households. It is very hard to get good data on internal migration flows, and even in high-income countries we may have to rely on information from successive decennial censuses to get some idea of how migration is affecting urban and rural areas.

What is clear is that younger people are more likely to move to cities than their parents.

Fast rates of urbanisation therefore are almost everywhere associated with big changes in household composition – more rural households without younger adults (or with fewer younger adults) and more urban households without older adults as head of the household and where the parents of the head of the household live elsewhere. Policymakers in many low and middle income countries see migration as a major causal factor in what seems to be a growing trend towards the abandonment or neglect of older people. Hard data, i.e. numbers, for this phenomenon are very difficult to obtain, especially if we are looking for trend data. There is, however, a local consensus in many countries that increasing numbers of older people (i.e. the older-old) are being ‘left’ by their families at public or charitable institutions with the expectation that the institution will or should take over the costs of supporting them. To put the matter another way, policy-makers and public are aware both of *pressures* that weaken established family structures of care and support, and of *symptoms* of failure in these structures. They are also aware the pressures are increasing and the symptoms are forcing themselves on public attention in a way that demands some kind of policy response.

The best we can do in these circumstances of data scarcity is to highlight a few cases where national data on trends are available and are seen as a cause for concern. In South Africa, for example, the report on older persons which is based on the 2011 Census describes extended households as indicative of ‘traditional living arrangements’. Just

over 50% of older people in South Africa live in extended households and this figure is more or less the same as what it was in 1996. In between these two dates, however, the proportion shot up to 58% before returning to 50%, most likely in response to the HIV/AIDS epidemic. The trend for living alone is clearer. The percentage of older people living alone increased steadily between 1996 and 2011, from 14.6% to 20.2%. Nearly all this increase comes, moreover, from the non-white population groups; and amongst Black Africans the proportional increase was largest, from 9.6% to 17.7%. In other words, the proportion of older Black Africans living alone almost doubled in this 15-year period. Although these findings may “seem to follow a pattern of developed countries where wealthier elderly persons prefer intimacy at a distance and are therefore more likely to live alone”<sup>48</sup>, the census report reads them another way. The breakdown by

population groups in particular suggests that living alone is becoming much more common among South Africans who lack the economic means available to more wealthy individuals as well as the kind of family support that is summarised in the idea of ‘intimacy at a distance’.

The data for Singapore are somewhat different. As fig 3.1 shows, 3-generation households are less common than in South Africa, and so is living alone. There are, however, fairly clear trends apparent in the data. Between 2000 and 2014 the proportion of older people living in 3-generation households declined steadily from about one-third to less than a quarter. At the same time, the proportion who were living alone or with a spouse only increased from 16.7% to 28.6%. And this is happening in spite of public housing schemes to incentivise children to live with or near their parents.

Fig. 3.1 Household structure for Households with older residents (65+) - Singapore



<sup>48</sup> Profile of older persons in South Africa. 2011 Census report. P98.

## Policy pushback and the role of the family

The Ghanaian policy statement is similar to others in the region in the way that the government holds on - by implication if not explicitly - to the idea that older people *should* be able to rely on family transfers in case of need. Even if it is no longer realistic to take this kind of family support for granted, there is an evident reluctance to base policy on the principle that older people should be financially independent from their families. There are two problems that countries like Ghana face as a result of their position. First, can they devise a system of cash transfers that gives effect to the recognition that not all older people can rely on family support (or that it might be necessary to supplement family support for a substantial proportion of the older population) without undermining the normative principle that older people should be able to rely on their family support? Second, should they do anything to enforce this principle?

The least equivocal examples of government action to enforce the principle that older people *should* be able to rely on family support can be found in legislation that places a legal obligation on children to provide financial support for parents in case of need (*see text box*). The rationale behind this legislation in the three countries from South Asia lies partly in the decline of elderly/non-elderly co-residence. All three countries are urbanising very quickly, which means that many elderly people are left behind when their children move to the cities for employment. As long as elderly parents live with their children, the role of family transfers in providing for their maintenance can be taken for granted. When they live apart, this may no longer be the case. The law makes it clear that the responsibilities of adult children are not dissolved by separate residence. In the case of Singapore, it seems reasonable to suppose that we should also understand the legislation as a way of defining the respective responsibilities of adult children and the state in the provision of support in case of need. The primary responsibility falls on the children, which is to say that the state will provide this support only if the children are unable to do so.

### Text box 3.3

#### The law and parental maintenance in South and South East Asia

Examples of legislation on parental maintenance can be found in India, Bangladesh, and Pakistan. India, for example, enacted a Maintenance and Welfare of Parents and Senior Citizens Act in 2007. Senior citizens who can show that they are unable to maintain themselves from their own earnings or property can claim maintenance from their adult children (or grandchildren) and the courts will enforce the claim. All adult children and adult grandchildren, both male and female, are deemed to be responsible for paying maintenance to parents and grandparents. Bangladesh has similar legislation, a Parent's Care Act, enacted more recently in 2013 to ensure social security for senior citizens. The law requires children to look after their parents and provide them with food and shelter, and it specifies what proportion of their income the individual children (where there is more than one) have to pay to their parents if they do not live with them. As this provision makes clear, we should understand the law, at least in part, as an attempt to ensure that the responsibility for maintaining elderly parent is fairly shared between all the adult children in a family. In Pakistan, some of the provinces are considering (or have enacted) legislation that is similar in effect. In Punjab the Senior Citizens Welfare and Rehabilitation Bill includes provisions for the imposition of penalties on offspring who neglect or refuse to maintain an elderly parent (i.e. a parent who qualifies as a senior citizen), and gives the parents a right to claim a monthly maintenance allowance when they are living separately from their children.

The likely model for the legislation in India and Bangladesh is the Maintenance of Parents Act which passed into law in Singapore in 1995. The act entitles any Singapore resident aged 60 years or more to claim maintenance from their children if they are unable to maintain themselves adequately. Maintenance is defined in the legislation to cover only 'basic amenities and physical needs', i.e. food, clothing and shelter. The act constituted a special tribunal to deal with family disputes about parental maintenance in cases where mediation does not work. In 2015 36 applications for maintenance were made to the tribunal.

## Singles living and an emergent problem of loneliness?

It would be a mistake to suppose that changing patterns of household formation are seen as problematic only in countries where multi-generational households are regarded as the norm. In the United Kingdom, for example, in spite of the fact that increasing life expectancy amongst men is pushing down the proportion of older people who live alone (e.g. from 34% in 2001 to 31% in 2011), there is some concern in policy and research circles over the implications of household change and family formation for potential vulnerabilities in later life. This concern centres on the increasingly high rates of single living and 'union disruption'<sup>49</sup>, a phenomenon that tends to be seen as part of the so-called Second Demographic Transition<sup>50</sup> for which there is evidence in many high-income countries. Although it is commonly discussed in the light of choices for independence and autonomy that made in mid-life, it has obvious implications for potential vulnerabilities in later life. If we think

of the formation of a stable union with children as an asset for later life, a form of social capital, then it seems that an increasing proportion of people in mid-life are approaching 'old age' without this kind of asset. Vulnerability to social isolation and loneliness is not at all peculiar to old age, but the risk of disability and the depletion of friendship networks tend to be much higher in old age, and these are factors which increase vulnerability to social isolation. Even though living alone is a positive choice for many older people (i.e. it is better than any of the available alternatives), there seems little doubt that social isolation and loneliness in the older population, especially the older wide, is widely seen as a major social problem, and indeed as a major contributor to health problems<sup>51</sup>. The main concern, in other words, is a potential lack of social resources or companionship rather than a potential lack either of care services or financial resources. The difference is important since it suggests that effective responses to the challenge are more likely to depend on civil society associations rather than government.

### Note on data

*Standardised and up-to-date data that would allow us to compare the living arrangements of older people in all the Commonwealth countries are unfortunately not available. There is a World Bank dataset (ASPIRE) that includes 29 Commonwealth countries, though even this has limited usefulness, not least because some of the data are very old (e.g. > 10 years). The dataset does not include any high-income countries. There is also good coverage of less developed countries in the Demographic Health Surveys conducted at regular intervals by USAID. The Integrated Public Use Microdata Series (IPUMS) holds samples of census data for 22 of the Commonwealth countries, with a combination of both high-income and low-income countries. And last of all individual reports based on census data and focused on the living conditions of older people have been published by several national statistical offices. Among the non-high-income countries that have published a thematic report on this topic since 2010 are India, Ghana, Rwanda, South Africa, Belize, Jamaica, and Malaysia.*

<sup>49</sup> *Single person households and social policy: looking forwards*. Joseph Rowntree Foundation, 2006.

<sup>50</sup> *Second demographic transition: a concise overview of its development*. Ron

Lesthaeghe, PNAS 2014, vol. 111, 51.

<sup>51</sup> *Age and social isolation*. The Scottish Parliament. Equal Opportunities Commission, 2016.



# Structures for care and support in old age: poverty and income security

### The role of the family as a pillar of income security in later life

One of the most fundamental dimensions of difference between Commonwealth countries when it comes to supporting people in later life is the extent to which the family functions as an essential pillar of income security in old age *as well as* an indispensable provider of care in case of physical or mental frailty. Older people who are no longer able to earn income from employment are financially dependent on their families for the everyday costs of living (food, clothing, housing etc.) if they have no assets or savings and if there is very little by way of social assistance from the government i.e. income transfers.

In most of the high-income countries in the Commonwealth countries, it is generally accepted that government has a responsibility to guarantee or underpin a combination of contributory pension schemes *and* non-contributory cash transfers that together provide for income security in old age without assigning any kind of role to family intergenerational transfers. Indeed one of the main criteria of the effectiveness of these arrangements is that they should eliminate (and not just reduce) dependence on family transfers as a source of income security in old age. Whatever role is to be assigned to family care and support in old age, this is emphatically not part of it. That older people should be financially independent from their families is, therefore, a generally accepted objective of public policy.

Outside this rather small group of countries, the proper division of responsibility between governments and families is not invariably seen in the same way. Financial independence from the family for ordinary living expenses requires a combination of effective contributory pension schemes and generous non-contributory cash transfers to make up for gaps and shortfalls in

contributory pension coverage. If only a minority of people have access to contributory pension schemes and the public resources that can be devoted to non-contributory transfers is constrained by the low productivity of the economy, the idea that older people *should* be financially independent from their families is at best a policy objective for the future rather than a principle by which to assess the performance of government in the present. It is one thing to try to *reduce* dependence on family intergenerational transfers by developing or sustaining institutions (i.e. savings mechanisms) that enable as many people as possible to be financially independent in old age. It is quite another to seek to eliminate this dependence altogether by a system of income transfers that is designed to make up for any shortfalls or weaknesses in *existing* arrangements for pension savings. Individuals living in poor households in poor countries are unlikely to have enough resources to cover present needs, let alone future needs (i.e. saving for old age), and governments in poor countries have limited resources to spend on their populations.

It is not merely the limitations imposed by lack of resources and relatively undeveloped institutions that constrain governments in this matter, however. As we have seen, there are countries in which legislation has affirmed the principle that in case of need older people *should* be able to rely on family intergenerational transfers - to some extent at least. The same principle can be discerned in the conditions that are used in some countries to restrict eligibility for non-contributory cash benefits. The government in Malaysia, for example, distributes cash transfers to older people under its Assistance to the Elderly scheme. The objective of the scheme is "to enable an elderly person to live in the community and enjoy a normal life with respect and dignity, receiving family and community acceptance". The benefit is paid under the following conditions: the recipient should be

(i) aged 60 years and above; (ii) with no means of income for daily living; and (iii) no family or with family incapable of providing financial support<sup>52</sup>. With this last condition, the Government acknowledges the community as a whole (i.e. government) should provide maintenance support for older people when the family cannot do so, but it also rejects the principle that older people should not have to rely *at all* on their family.

## Continuing labour force participation as a pillar of income security in later life

Individuals living in poor households in poor countries have very limited opportunities as well as limited capacity to save for old age, that is to say, for a time when they are no longer able to contribute to the income of the household. The

institutions that enable people to save typically cover only a small minority of the population, i.e. those who have secure employment in the formal sector, and poor households can be so pressed for basic necessities that little or nothing can be spared from earnings for saving. Older people in such circumstances have little choice but to work for as long as possible. If and when work becomes too difficult, they have to rely on support from their family, that is to say, the younger family members who are still working.

It is not easy to say exactly how many Commonwealth countries have significant numbers of older people in this position, i.e. faced with a choice between continuing labour force participation and reliance on their family. What is clear, however, is that there are several Commonwealth countries in which

### Text box 4.1

#### Extreme poverty

The World Bank does not provide data on the prevalence of extreme poverty for all the countries in the Commonwealth. For the high income countries and some of the upper-middle income countries, it is reasonable to assume that extreme poverty, if it exists at all, is a strange anomaly. People at the very bottom of the income distribution in these countries are generally entitled to public welfare transfers that provide them with a level of income much higher than that which the World Bank takes as a threshold for extreme poverty. This is not to say of course that there is no poverty in high income countries. The point is rather that the appropriate measure for household or individual poverty is different in poor countries and rich countries. There are countries for which the most appropriate measures of poverty are based on comparisons with the income of other people in the same society; and countries where under-nutrition is common and it is still important to determine what proportion of the population struggle to get enough food to eat.

Statistics on the prevalence of extreme poverty - with the threshold of \$1.90 per day - are available for 25 of the countries in the Commonwealth, which is another way of saying that 'absolute' poverty remains a significant problem in these countries. The range of prevalence estimates is, however, very large, with more than 70% of the population living in extreme poverty in Malawi, compared with only 1.1% in Tonga. In continental Sub-Saharan Africa there are six countries where more than half of the total population are living on less than \$1.90 per day - and only two where the prevalence rate has fallen below 20% (South Africa and Botswana) \*. Apart from Papua New Guinea and the Solomon Islands in the Pacific, the prevalence of extreme poverty elsewhere in the world tends to be considerably lower than it is in much of Sub-Saharan Africa. Even so, it remains a major social problem in much of South Asia (not least because of the sheer numbers involved) and some of the Caribbean countries.

\*Reasonable goals for reducing poverty in Africa, Institute for Security Studies/South African Futures paper no 13, 2015

<sup>52</sup> Malaysia-updating the social protection index. Asian Development Bank 2012

- the coverage of contributory pension schemes is still very limited,
- there are no special non-contributory cash transfers for older people,
- a non-negligible proportion of households live in extreme poverty, and
- a large proportion of the population derive their livelihood from small-scale agriculture.

Cameroon, Nigeria and Ghana in SSA and Pakistan in South Asia are four examples of countries to which these conditions apply. In other words, we can be confident that in these countries a majority of older people are faced with a choice between continuing labour force participation and reliance on their family. Retirement with a pension is not an option. They work for as long as they can.

In most countries where there is still a lot of extreme poverty, the majority of older people, especially in rural areas, live in multi-generational households: they co-reside with younger family members. The prevalence of poverty among co-residing older people will therefore be more or less the same as the overall prevalence of household poverty. What tends to put older people more at risk of poverty than younger adults, especially in places where much of the paid work depends on the ability to engage in hard or taxing physical labour, is of course the effect of age on their ability to continue in paid work. If they live in a poor household, their inability to work will make the household even poorer as they will have to rely on family support. If the family is poor, so are they. And if they have no family, they face destitution.

#### Text box 4.2

### Labour force participation at older ages in low and LMI countries

In Tanzania, Ghana, Malawi, and Rwanda, the latest ILO estimates (2014-15) report pension coverage of between 3% and 8%\*. None of these countries has non-contributory pensions. Pension coverage, in other words, is very low. In 2010 the majority of the 65+ population (59%) in Ghana was engaged in some kind of paid work. The rate for mainland Tanzania in 2014 was very similar, at 56% and in Malawi it is 58%. Data collected in Rwanda in 2012 are not presented in quite the same way but they do say that more than half of the males in the 70-74 age group were still economically active. In Ghana, it is remarkable to see that 48% of 75-79 year olds are still in work, and 38.5% of people aged 80+. The Ghana data also illustrates the difference between urban and rural areas in this respect. Two-thirds of older people in rural areas are still working compared to 49% in urban areas, and the most common type of occupation for older people in Ghana is in agriculture or fisheries. Although the data does not say this explicitly, we might guess that where households have access to land, older people will continue to work as part of the household labour force. Because LFP rates are so high in among older people, the older population in countries like Ghana comprises a much larger proportion of the total labour force (8.8 %) than in high-income countries like the UK (4% in 2016), even though the relative size of the older population is much smaller in Ghana. In all three countries male-female differences in LFP are relatively small.

In South Asia, the prevalence of extreme poverty is lower than in most of SSA, and pension coverage - with the exception of Pakistan - is higher. India and Bangladesh have substantially higher poverty rates than either Pakistan (6.1%) or Sri Lanka (2%). In all of these 4 countries the majority of older people are no longer economically active, but labour force participation rates are still high. In Bangladesh it stood at 34% in 2013. The most recent estimates for both India and Pakistan are slightly lower: 27% of the 65+ population (male and female combined) are still working in both countries. Unlike in SSA, the differences between men and women are very marked across the region. So, for example in Pakistan the LFP rate for men aged 65+ is 42%, whereas for women it is only 7%. In Bangladesh the male-female gap is even larger - 55% vs 13%. Sri Lanka has a higher GDP per capita than either India or Pakistan, though it is still classified as lower-middle income. Extreme poverty is now comparatively rare - certainly compared to India and Bangladesh, let alone Sub-Saharan Africa. The LFP rate for both sexes combined (65+) is 21%, the lowest in the region. Even so 38% of men aged 65 years or over are still working - as against 10% of older women.

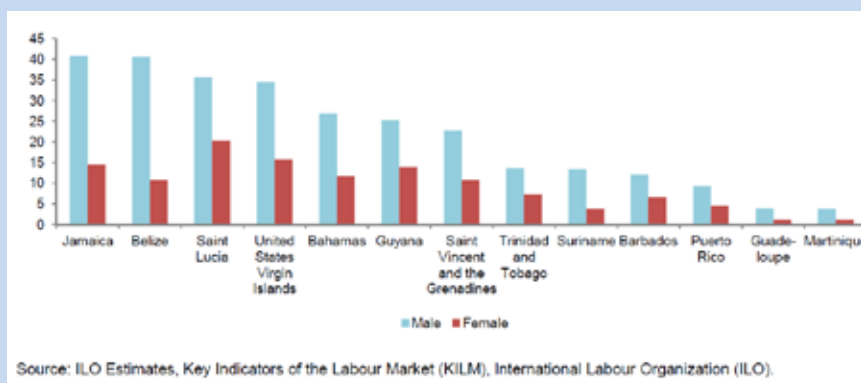
\* *proportion of older population receiving a pension*

It is not surprising, therefore, to find that continuing participation in the workforce is very high among older people in countries where pension coverage is very low and extreme poverty is still endemic. Readily accessible data on labour force participation at older ages – with a detailed age breakdown (i.e. not just 60+<sup>53</sup>) – are hard to come by in these countries. What data there are, however, do confirm the view countries with low pension coverage have high rates of labour force participation at older ages.

It would be a mistake, however, to think that high levels of labour force participation are found only in low-income or lower-middle income countries. Fig. 4.1 is reproduced from a 2015 UN report

on ageing in the Caribbean<sup>54</sup>, and it shows very marked differences in labour force participation among people aged 65 years and over. In both Jamaica and Belize about 40% of men over 65 are still working. Both countries, even though they are classified as upper middle income, have significant levels of extreme poverty<sup>55</sup>. They do differ, however, in pension coverage, which is more than 3 times higher in Belize than in Jamaica. The Jamaican Ministry of Labour and Social Security estimated that in 2010 52% of the older population (60+) were receiving *neither* a National Insurance Scheme pension (public contributory scheme) nor a social pension under the means-tested PATH programme<sup>56</sup>. This was the size of the ‘social protection gap’.

Fig. 4.1 Labour Force Participation of Persons Aged 65 and over by Sex, 2013 (Percentages)



## Pensions as a pillar of income security in later life

### Non-contributory cash transfers and social pensions

Over the last ten years or so programmes to provide non-contributory (NC) cash transfers for older people have been implemented in a steadily increasing number of countries where extreme poverty remains a problem and the population coverage of contributory pension schemes remains low. They are in effect a response to the recognition by governments that the availability of family transfers as a source of maintenance in old age can no longer be taken for granted. An increasing number of older people have no family who can take on the role of provider and there are many others who live in poor households that

are at risk of being further impoverished by their dependency (i.e. their inability to contribute to household income). In this context, non-contributory cash transfers targeted at older people (i.e. they incorporate an age threshold as a condition of eligibility) are generally seen as part of a wider poverty alleviation strategy. The rationale for the transfers is not just that older people are more than usually vulnerable to the risk of poverty. More often than not, they are members of multi-generational households that rely on pooled resources to support everyone in the household.

In Southern Africa, the HIV/AIDS epidemic has been an important factor behind policy change in this matter. In all five of the Southern African countries,

<sup>53</sup> The profile of older persons in South Africa has data for the 60+ age group. 26% of older person - thus defined - were in employment at the time of the 2011 Census. Statistics South Africa, 2014.

<sup>54</sup> Ageing in the Caribbean and the human rights of older persons. United Nations ECLAC, 2015.

<sup>55</sup> Just below 20% according to WB estimates for Jamaica. A Caribbean

Development Bank estimate made for Belize in 2010 used a slightly different poverty line (the cost of a minimum food basket) than the WB, and concluded that at least 10% of all households were ‘indigent’, i.e. had insufficient income to provide all their members with a minimally adequate diet. Once non-food costs are included, this figures more than doubles.

<sup>56</sup> See: [www.slideshare.net/FAOoftheUN/faith-innerarity-jamaica](http://www.slideshare.net/FAOoftheUN/faith-innerarity-jamaica)

the epidemic has had an enormous impact on the situation of older people because of the high mortality among 'prime age' adults (18-59) in the population, i.e. adults who would otherwise be supporting elderly parents. In 2010 it was estimated that a one point increase in the AIDS mortality rate was associated with a 1.5% increase in the proportion of older people living alone and a 0.4% increase in the proportion of elderly individuals living with children under the age of 10 and without prime age adults in the household<sup>57</sup>. As a result

of the epidemic therefore, many countries in SSA have a significant and sizeable new population of elderly individuals who lack support from younger adults and who may need to provide for their grandchildren many of whom will have been orphaned. Non-contributory cash transfers targeted at this population provide assistance in a situation where it is all too plain that the availability of family transfers as a source of maintenance in old age can no longer be taken for granted.

#### Text box 4.3

### Evaluating social pensions in Sub-Saharan Africa

#### Uganda Social Assistance Grants for Empowerment (SAGE).

A pilot scheme for universal social pensions - with support from donor funding - has been running in 15 out of the 112 administrative districts in Uganda since.....An evaluation of the Senior Citizens' Grant (SCGs) conducted 2 years after their introduction makes it clear that a relatively small cash payment can have a significant impact on food consumption for an entire household, and for the poorest households this represents the difference between hunger and its absence\*.

- "The increases in food expenditure for the group receiving SCGs were matched by a reduction in the proportion of households suffering hunger..."
- The grants also had a positive impact of the proportion of households owning livestock.
- "At the household level, the cash transfer has helped to reduce the dependence of the elderly, and in some cases promoted a new dependence on the elderly as a source of support. This latter development is welcomed by the elderly themselves, as it increases their status and dignity".

*\*Final report of the Uganda SAGE programme evaluation. Oxford Policy Management 2016. Quotations are from the report.*

#### Old age grants in South Africa

There have been several evaluations of the impact of social pensions on poor households in South Africa, and they all point to a positive impact beyond their effect of old age poverty. "In South Africa, the social pension has had a positive effect on the health and nutritional status of other members of the recipient's household. Girls in these households have significantly better weight-for-height indicators than do girls in non-transfer households. There is also evidence that, when an older South African begins receiving a social pension, the likelihood of the working age adults living in the same household being employed increases. This is because social pensions provide resources that enable these adults to migrate in search of work and to pay for care for the children who remain in the household. South Africa's social pension has reduced the poverty gap by 54 percent among households that include older people, while the poverty gap has almost disappeared among older people living alone. At the same time, the country's comprehensive system of cash transfers has doubled the share of national income that the poorest 20 percent of the population receives". Quoted from a 2012 *World Bank Policy Brief on pensions in Africa*.

<sup>57</sup> AIDS and declining support for dependent elderly people in Africa: retrospective analysis using demographic and health surveys. T Kautz et al. *BMJ* 2010;340:c2841



Non-contributory pension schemes can be classified according to the conditions for eligibility. They all have age thresholds, which is why they are considered to be a form of pension. Universal NC pensions pay a pension to everyone above a given age who meets some form of residence or citizenship requirement. It is possible to achieve the same result - everyone gets a pension – by making the absence of any other kind of pension an additional condition of eligibility for an NC pension ('universal minimum' schemes). Last of all there are means-tested NC pensions, which take into account income or assets or both.

As table 4.1 shows, most countries in the Commonwealth have some form of NC pension. But there are several that do not. A few of the

countries not listed in the table have pilot schemes or programmes that have been implemented in only part of the country, as in Uganda where the government has committed itself to a rolling introduction of a national scheme that has been piloted in 15 districts, although the process of scaling-up is proving quite slow. Zambia and Nigeria also have regionally limited schemes, and outside Sub-Saharan Africa, Papua New Guinea is preparing to introduce a universal social pension in one region/province. In Tanzania, one of the poorest countries in the Commonwealth, the semi-autonomous region of Zanzibar introduced a universal pension in 2016 for everyone over the age of 70 years. The pension, moreover, is entirely tax-financed from the budget of the Zanzibar Government, i.e. there is no direct donor-funding.

Table 4.1	Universal NC pensions	'Universal minimum' NC pensions	Means-tested NC pensions	No NC pension
Low-income	-	-	Mozambique	Uganda*, Malawi, Rwanda, Tanzania*, Sierra Leone
LMIC	Kiribati, Samoa	Lesotho, Swaziland	Bangladesh, India, Kenya	Pakistan, Sri Lanka, Cameroon, Ghana, Nigeria, Zambia, PNG*, Solomon Islands, Tonga, Vanuatu
UMIC	Botswana, Namibia, Mauritius, Guyana	St Vincent and the Grenadines, St Lucia, Fiji, Tuvalu?	Belize, Jamaica, South Africa, Malaysia	Grenada, Dominica
High-income	Brunei Darussalam, Seychelles, New Zealand, Canada	Bahamas, Barbados, Cyprus	United Kingdom, Malta, Australia, Nauru, Trinidad and Tobago, Antigua & Barbuda, St Kitts and Nevis	Singapore

\*These countries have social pension schemes operating in some regions, but not the whole country.

For the group of countries that do not have a social pension in any shape or form, it is of course important to bear in mind that social pensions are not the only kind of social safety net or publicly funded cash transfer from which older people may benefit. Benefits that are targeted at poor households or poor individuals form part of a social safety net which has been designed without giving special consideration to age, and in some countries without social pensions, such as Sri Lanka, the majority of the people who benefit from a particular 'general population' poverty alleviation scheme may in fact be older people<sup>58</sup>. From the point of view of older people who are no longer able to work, there may, however, be problems with such

benefits. This would be the case, for example, if they are designed primarily as a short-term safety net for people who are temporarily unable to find employment, or if they target households with young children.

Two very contrasting countries without any kind of NC pension (see table 4.1) are Pakistan and Singapore. Pakistan is a lower-middle income country with a prevalence rate for extreme poverty that is impressively low for its income level. In other words, efforts at poverty reduction have been reasonably effective over the last 10 or 15 years, and moreover, the social protection system does reasonably well in distributing the benefits of

<sup>58</sup> This happens with the Public Welfare Assistance Scheme. See *Income security for older persons in Sri Lanka*. ESCAP working paper, 2015.

economic growth among the poorest of its citizens. In this respect at least, Pakistan ‘performs better’ than its neighbours India and Bangladesh<sup>59</sup>. As for older people, the ILO estimates that only 3% of the older population receive some kind of contributory pension, which is extremely low for the region. Apart from the contributory pensions, there are three main safety net programmes in the country, the Benazir Income Support Program (BISP), which was introduced in 2008, the much older *Pakistan Bait-ul-Mal* (PBM), and the *Zakat*. The PBM targets various groups considered to be specially in need, such as the disabled and widows, and older people may receive them if they are eligible (i.e. on grounds other than age per se). The *Zakat* programme institutionalises the religious duty to

provide alms to ‘needy and deserving Muslims’, which will include, for example, older people who are destitute. Both the PBM and the *Zakat* have, however, been criticised for poor targeting, i.e. a large proportion of funds going to non-poor households<sup>60</sup>. The BISP, on the other hand, is widely considered to be a success as a poverty alleviation programme. It effectively targets the poorest households by using a ‘Proxy Means Test’, and the transfer is given to female heads of households, i.e. the oldest female in the household. Benefit levels are high enough to have a measurable impact on living standards, and the aim is to reach up to 7% of the total population (*Zakat* has been estimated to reach about half this number with a large leakage to non-poor households).

#### Text box 4.4

### Economic dependence on the family in India

In rural areas 68% of older people are either totally or partially dependent on other individuals for financial support. In urban areas the figure is only slightly lower at 63%. Economic dependence was much more common amongst women. In rural areas 72% of older women were totally economically dependent on others. In the majority of cases, for both men and women, children are the primary source of support. Although a higher proportion of women than men are dependent on spouses (16% of economically dependent women in rural areas and 19% in urban areas), more than 70% are dependent on children. For men, their position reflects the lower levels of dependency on a spouse. If they are dependent, they are more likely to be dependent on their children than are women. Of the older men who were economically dependent on someone else, 85% are dependent on their children. Only a small minority of older people are dependent on people outside the family – between 6 and 7%.

*Elderly in India: profile and programmes.* Central Statistics Office, Government of India 2016. The data are mostly from 2004.

Singapore is the richest country in the Commonwealth after Brunei Darussalam, and the only high-income country without some form of NC pension. The government, moreover, has a very clear and explicitly articulated ‘philosophy’ when it comes to social assistance. Social assistance should be organised so as to promote self-reliance, and government assistance should always be seen as a last resort, in other words, if the support provided by the family and the ‘many helping hands’ to be found in the community should prove inadequate<sup>61</sup>. The country has one national contributory scheme for the management of retirement savings, the Central Provident Fund, and contributing membership is mandatory for all employees.

Despite high levels of membership, however, there are problems. Or rather there is one main problem. Because there is very limited redistribution within the scheme, individuals with low lifetime earnings are at risk of having pension savings that are too small to meet basic needs. Reforms announced in 2014 have gone some way towards mitigating this problem, but the increasing numbers of retirees applying for social assistance suggests that in many cases Provident Fund benefits are not enough to meet basic needs<sup>62</sup>. Social assistance in Singapore is distributed from the ComCare Fund, and although most of the payments are made on a short to medium term basis, there are long-term payments and most of them go to older people

<sup>59</sup> The figures behind this assessment are, however, highly contested. See *Progress under scrutiny: poverty reduction in Pakistan.* Amina Khan et al, ODI, 2015.

<sup>60</sup> *Targeting efficiency of poverty reduction programs in Pakistan.* G Arif. Asian Development Bank, 2006.

<sup>61</sup> *Social policy in Singapore: a crucible of individual responsibility.* U Sahn. Ethos, issue 9, 2011

<sup>62</sup> <http://www.straitstimes.com/singapore/more-retirees-seeking-financial-assistance>

aged over 65+ who live alone<sup>63</sup>. The payments, moreover, are not strictly speaking entitlements for which there are clear eligibility criteria. Rather they are discretionary payments made in case of need, and need in the case of older people will be interpreted in a way that takes account of the responsibilities of the family, and its capacity to fulfil them. Singapore, like India and Bangladesh, has national law on the maintenance of parents by their families. Essentially the law recognises and will enforce the right of parents to claim support from their adult children. Government assistance is provided as a last resort.

If we turn from countries without social pensions to those that have them, there are very considerable differences not only in the generosity or scale of national schemes (i.e. the level of the benefits and the inclusiveness of the eligibility conditions), but also in the ability of different countries to afford large-scale transfer programmes for older people. A poor country will be able to afford a large-scale programme only if benefit levels are low, even in local terms. Mozambique, for example, is the only low-income Commonwealth country with a fully implemented national scheme for a social pension, where it was introduced as long ago as 1992 (at the end of the country's prolonged civil war). The scheme is means-tested and reaches about one quarter of the 60+ population. Benefit levels, however, are considerably lower than the World Bank's threshold for extreme poverty and represent about one-sixth of the country's average wage<sup>64</sup>. In Botswana, on the other hand, a much wealthier upper middle-income country with a universal scheme for everyone who 65 or over, the benefit levels are higher than the World Bank's threshold for extreme poverty – but in this case are equivalent to only 5% of the average wage. If we take national GDP into account in making the comparison, both countries spend about the same proportion of GDP on their transfer scheme (just over 0.25%). There are, however, examples of countries from all the income groups (apart from low-income) that spend a larger proportion of GDP on social transfers than Botswana or Mozambique. Guyana and Kiribati, for example, both LMICs, spend between 1.2% and 1.3% of GDP on their universal social pension schemes. In the UMIC group South Africa and Mauritius are probably the outstanding examples of

countries that spend a relatively large percentage of GDP on social pensions, 1.3% and 2.9% respectively. In both countries the benefits levels represent about one-fifth of the average wage – which is relatively generous. As for the high-income countries, the levels of GDP spending range from Malta, where public spending on NC pensions is about the same as in Botswana or Mozambique, to New Zealand, which spends more than 4% of GDP on the universal NC pension.

The inclusiveness of the eligibility conditions will of course be one of the major determinants of the levels of public spending on social pensions. The age at which people become eligible for a pension is in this respect no less important than the distinction between a universal scheme and a means-tested scheme. The age of eligibility in South Africa (60 yrs), for example, ensures the safety net is available for a much larger proportion of the older population than in Lesotho (70 yrs). Antigua and Barbuda stands at the other extreme: the eligibility age (85yrs) is set at a level which is designed to help only the most elderly and frail. South Africa is in fact a good example of a country that has a very high coverage rate for its social pension despite the use of means-testing. The combination of a low age threshold and a high-income threshold ensures that a high large proportion of the older population receive the pension – well over 70% according to ILO estimates – and the relatively generosity of the benefits means that the pensions are a major factor in old age income security.

Although in one sense, NC pensions all perform the same function wherever they are – to mitigate the risk of old age poverty – it seems evident their role differs in different conditions. This is not only because of the widespread prevalence of extreme or absolute poverty in some countries but not others, but also because in some cases social pensions are supplementing (or perhaps underpinning) a mature contributory scheme with high population coverage. In others they are not only the main source of income security for a substantial proportion of the older population (i.e. if they supplement anything it will be earnings from employment or transfers from children), but also play an important role in alleviating household poverty<sup>65</sup>.

<sup>63</sup> According to a 2011 estimate of poverty in Singapore, which used a government-devised measure of the income required to meet basic needs for food, shelter, clothing and other essential expenses, between 111,000 and 1400,000 households had insufficient income to meet basic needs, and approx. 20,000-30,000 of these were retiree households. ComCare payments are made with this measure in mind.

See *Measuring poverty in Singapore: frameworks for consideration*. Singapore Management University 2013.

<sup>64</sup> <http://www.pension-watch.net/country-fact-file/mozambique/> accessed 09/09/17

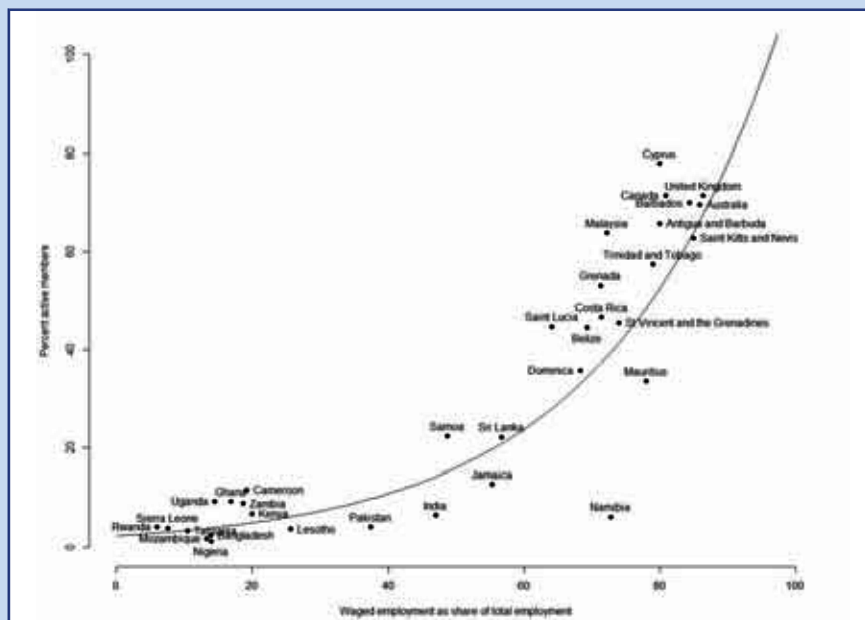
<sup>65</sup> In many less developed countries the poorest households are those with children as well as older people.

## Contributory pensions

Saving for retirement by means of employment-based contributory pensions is the backbone of any workable system for providing a retirement income to a large segment of the population for an extended period of time. Population ageing exerts pressures on all kinds of contributory pension schemes: the falling ratio of contributors to pensioners threatens to make unfunded or Pay As You Go (PAYG) schemes unsustainable; and

the increasing length of time that individuals can expect to spend in retirement makes it harder to accumulate enough pension savings in funded schemes to cover all the years of retirement. Population ageing makes it harder to devise effective ways of providing an adequate retirement income<sup>66</sup> by means of savings made over the course of a working life. As the amount of time that a working adult can reasonably expect to spend in retirement (i.e. drawing a pension) and the proportion of the total population that relies

Fig 4.2 Participation in contributory pension schemes and size of formal sector: selected Commonwealth countries (ILO data).



on a pension for their income increase, so do the demands and pressures on systems for managing retirement savings and turning them into retirement income.

When considered at a national level contributory pension schemes are susceptible to three kinds of weakness or failing. First, there is a question of participation or population coverage. Quite apart from the fact that non-working people are usually excluded from participation in the scheme, participation may be limited in other ways, as for example, when schemes are voluntary for some portion of the labour force and uptake is low in these groups, or indeed when they simply unavailable to workers in some kinds

of employment. In poorer countries, levels of participation are as a rule so low that this problem will tend to dominate the agenda for reform. Schemes cannot be considered 'fit-for-purpose' if they provide coverage only for a fortunate few. Second, there is always a potential problem in respect of the adequacy of the retirement income that schemes provide for low earners, that is to say, people whose incomes are so low that they cannot really be expected to save enough over the course of their working lives to finance a lengthy period of retirement. In countries with high rates of scheme participation and heavy reliance on funded pensions, it is this second problem often dominates the agenda for reform. Together these

<sup>66</sup> And where adequacy implies financial independence, i.e. no need for family support.

two sources of weakness in contributory pension schemes - limited participation and inadequate savings among earners at the lower end of the wage distribution - inevitably create demand or pressure for income transfers to older people. The third weakness to which some forms of contributory scheme are prone is a problem that stores up trouble for the future: the changing ratio of pay-outs to contributions may threaten its long-term sustainability. In countries where a very large proportion of retirement income is financed through PAYG or defined benefit schemes, this third problem will tend to dominate the agenda for reform. It is not only contributory pension schemes, however, that are vulnerable to sustainability problems as a result of population ageing. If a large and growing proportion of the population is heavily dependent on non-contributory cash transfers for income security in old age, this is very likely to place a lot of pressure on the public finances. Under conditions of population ageing therefore, the requirement of sustainability imposes a constraint on what can be done to remedy or address systemic problems with adequacy of the retirement income.

In many of the Commonwealth countries one of the main barriers to widespread participation in contributory pension schemes is the relatively large size of the informal sector as a proportion of total employment, i.e. the working population who are not in waged or salaried employment. According to ILO estimates, the formal or waged sector in Kenya stands at about 20% of total employment, a little higher than the rest of the LMIC group in the region. In South Asia, Bangladesh stands out for very low levels of formal sector employment (<15%), which is less than a third of the level in Sri Lanka (57%). As we would expect in most of the UMIC group, the size of the formal sector is even larger. The big exception here is Jamaica, where about 55% of the workforce are in waged employment, which is considerably lower than in the other Caribbean countries. And in the high-income countries for which data are available, people in waged employment account for more than 80% of the workforce.

These differences in the size of the informal sector are quite closely correlated with active (i.e.

contributing) membership of a contributory old age pension scheme, though there are some outliers. In Namibia, for example, the proportion of the working age population that is effectively covered by a contributory scheme is not very different from the average for the region (6.1%) whereas over 70% of the labour force is in waged employment. Namibia, in other words, does not do very well in extending participation of contributory schemes to people working in the formal sector, let alone the rest of the labour force. Namibia does, however, have a universal NC pension.

All the LI and LMI countries in the Commonwealth have very limited population coverage for their contributory pension schemes – mostly less than 10% of the working age population. Coverage is sometimes effectively limited to civil servants and the higher earners in the formal sector<sup>67</sup>. Two examples of lower-middle income countries that do relatively well in this respect are Sri Lanka and Samoa. Sri Lanka, according to a recent ILO assessment has had some success in extending scheme participation to the large informal workforce engaged in rural employment. It has a special contributory old age pension for farmers and fishermen, and this has achieved relatively high coverage rates (57 per cent of the farmers and 42 per cent of the fishermen). This goes some way towards explaining why, in Sri Lanka, 22% of the working age population are active members of a contributory scheme, much higher than in the other Commonwealth countries in South Asia. Samoa has an even larger informal sector than Sri Lanka and comparable levels of scheme coverage for the working age population; and this is in spite of a universal NC pension. The UMIC group includes countries with relatively high coverage (i.e. considerably higher than the average for the group) such as Malaysia and a couple with relatively low coverage – Jamaica, for example, as well as Namibia.

There are of course many varieties of contributory pension scheme across the Commonwealth. Rather offering an exhaustive overview, the rest of this chapter provides some illustrations of different kinds of scheme and how they respond to pressures for change.

<sup>67</sup> There are, however, countries which have generous non-contributory pensions for some public sector employees. These are generally regarded as unsustainable. Uganda, for example, has a non-contributory defined benefit pension scheme

for civil servants. So also does Malaysia. In Nigeria, on the other hand, non-contributory pensions for civil servants were abolished in 2004.



## Extending pension and savings scheme coverage to the informal sector

Kenya's Mbao Pension Plan has attracted a lot of attention since it was started in 2011, partly because of the explicit targeting of informal sector workers with the aim of encouraging saving, and partly because of its use of mobile phone technology to make contributions, collect benefits and check balances. The scheme was launched by the Kenyan Pensions regulator (Retirement Benefits Association) working together with an umbrella association for informal sector workers.

Mbao is slang for 20 shillings which is the minimum contribution (approx. \$0.25). Because contributions can be set very low, the Mbao Pension Plan counts as a micro-pension scheme, and payouts also are low.

By the end of the first year of operation (2012), the scheme had 38,000 contributors. This had increased to 67,000 by the end of 2014. For the time being, benefits are payable only as a lump sum, though there is nothing in principle to prevent the introduction of annuities, which have the obvious advantage that they can provide a lifetime income.

What many commentators like about the Mbao Pension Plan is the way that it "seeks to tailor a savings product particularly to marginal population groups and contribute to their improved social and economic security while also supporting the further development of the financial services and communication sectors".\*

\* *Extending pension and savings scheme coverage to the informal sector: Kenya's Mbao Pension Plan.* RM Kwena & JA Turner, International Social Security Review, 2013

## National Provident Funds: Fiji

In several Commonwealth countries, the main vehicle for the management of contributory pension savings is a National Provident Fund (NPF)<sup>68</sup>. Typically these schemes are mandatory for a large subset of employees in the formal sector (e.g. in Kenya all companies with at least five employees are required to enrol their employees in the fund), and employers are required to contribute. The Fund is managed (or guaranteed) by the government, and it provides savers with individual retirement accounts, which is to say that there is no redistribution from high earners to low earners within the scheme. As a general rule, accumulated savings can be taken as a lump sum, and schemes often have some kind of early (i.e. pre-retirement) withdrawal provision for individuals who want to use some portion of their savings for specified non-retirement purposes – such as health expenses or contributions towards the education of children.

Fiji's National Provident Fund (FNPF) has all the features typically found in NPFs. It is the only superannuation fund mandated by law to collect contributions from all formal sector workers in the country. Although informal sector workers can apply

to be members of the fund and make contributions, the UN estimates that only 1% of Fund members have informal sector employment<sup>69</sup>. This would matter less if the informal sector were relatively small, but in Fiji the majority of the workforce are employed in the informal sector<sup>70</sup>. There is, moreover, quite a large-female difference in this respect. Although women make up just over half the total labour force, they are much less likely than men to have formal sector jobs. It is not surprising then that a World Bank estimate from 2011 puts the proportion of the older (60+) population in receipt of FNPF benefits at about 12.5%. Fiji does, however, have a social pension for everyone aged 66 or over<sup>71</sup> who is not receiving FNPF benefits, and a social assistance programme that targets vulnerable older people as well as those who have a chronic illness or disability. FNPF offers a lump sum withdrawal option and two pension products, a fixed term annuity as well as a lifetime annuity.

If the FNPF has problems with low coverage, it also has problems with income adequacy. The adequacy of the pensions provided by provident fund depends not only the earnings and contribution levels of scheme members, but also on the provisions for

<sup>68</sup> These include Singapore, New Zealand, and all the Pacific Island states. In Sub-Saharan Africa, Kenya and Tanzania have NPFs. Malaysia has a single Employees Provident Fund intended to cover the whole of the private sector.

<sup>69</sup> *Income security for older persons in Fiji.* UN ESCAP, Bangkok, 2016.

<sup>70</sup> *Fiji creating quality jobs: employment diagnostic study.* Asian Development Bank and International Labour Organization, 2015.

<sup>71</sup> The eligibility age has been lowered twice since the pension was introduced in 2013 – from 70 to 68 in 2015, and from 68 to 66 in 2016.

pre-retirement withdrawals and how savers make use of them. It has been estimated over 80 per cent of members who are close to retirement (i.e. within four years) had an individual balance well below the threshold required to sustain them during old age. Although current average pension payment is FJD 350 per month, equal to 1.7 times the basic poverty line, the number of actual pensioners who receive such a payment remains low, i.e. the distribution is highly skewed with a majority receiving much less than this. Moreover, despite the range of pension options offered by FNPF, most members choose a lump sum payment rather than a life or fixed term annuity.

The recent history of the FNFP also demonstrates Provident Funds are not immune to sustainability problems. Here the problems arose because the so-called pension conversion rates<sup>72</sup> were so high that the fund was using current contributions to pay current pensioners, i.e. fund capital was being run down to pay for current pensions. Essentially, there had been a long-term failure on the part of the fund administrators to take proper account of the increases in pensioner life expectancy when fixing the conversion rates. In 2012, when pension conversion rates were eventually reduced to restore fund sustainability, the reductions had such a major impact on pension benefits that there appears to be some loss of trust in the governance of the fund on the part of pensioners<sup>73</sup>.

## Pension reform and the introduction of a nationwide contributory pension scheme: Nigeria

Nigeria in 2004 enacted a root-and-branch reform to its pension system, and it is important to emphasise quite how radical the reform actually was: all pensions were to be put on a defined contribution basis within a unified nationwide scheme. Up until to 2004 Nigeria had very limited pension coverage in a system that was widely regarded as lacking in transparency, poorly managed and not 'fit-for-purpose'. Coverage in the private sector was extremely low, not least because of the absence of an effective regulatory and supervisory mechanism to secure public trust,

and the public sector pensions that dominated coverage were non-contributory and paid on the basis of defined benefits out of general taxation. The aim therefore was to create a well-regulated pension scheme that would work for private sector employees as well as public servants, and would work in the same way for both.

To achieve this end the government opted not for a National Provident Fund, but for a system that depended on schemes run by the private sector under the aegis of a central government regulator. Public sector pensions would no longer be non-contributory, nor would they come with defined benefits. In the private sector, employers with more than 5 employees were required not only to facilitate access to Retirement Savings Accounts with an authorised Pension Fund Administrator, but also to make contributions to the accounts. In other words, the scheme would operate in a very similar way to a provident fund, and as with many provident funds, it was hoped that the reforms would encourage long-term savings that could be channelled into investment and harnessed for economic development.

The reforms have achieved a modest extension of coverage – from just over 1% of the working population in 2004 to 8% in 2016 (less than the 10% expansion of coverage achieved by the Ghanaian system in 8 years). One major problem faced by the expansion of the scheme is the sheer size of the informal sector. In 2016 the scheme covered 6.9 million workers; to achieve the Pension Commission objective of 20 million enrolees by 2018, it will probably be necessary to find some way of extending coverage to the informal sector (estimated at 70% of the workforce)<sup>74</sup>. The most likely approach will involve so-called micro-pension schemes. Secondly, there is the challenge of achieving benefit adequacy for workers on low-incomes (which could include as much as 90% of the workforce): pension savings, even when made over a full working life, may not be enough to live on. The challenge is one that is common to many middle income countries. If the government were to introduce a universal NC pension, this would go some way towards resolving the problem. Whether this is on the cards is another matter. Thirdly, there are the problems and challenges that arise in

<sup>69</sup> A fixed percentage of savings that varies with age at retirement and determines how much is paid out as an annual pension.

<sup>73</sup> *Income security for older persons in Fiji*. UN ESCAP, Bangkok, 2016. p25

<sup>74</sup> The details of this assessment come from *The Nigerian Pension Industry: Overcoming Post Reform Challenges*. PWC Nigeria, 2016.

making the transition from a defined benefit scheme (in which large numbers of workers have accrued liabilities) to a defined contribution scheme. The transition imposes heavy costs on employers (especially the Federal and State governments) that have to pay contributions under the current DC scheme as well as the pensions of retirees under the older DB scheme. State governments in particular have struggled to honour their obligations under the DB scheme. It is hoped that the 2014 reforms will address some of these problems.

## Public Pay-as-you-go (PAYG) schemes: Malta

Although several countries in the Commonwealth besides Malta have public pension schemes that are either completely or partially run on a PAYG basis<sup>75</sup>, the Maltese system offers a particularly clear example of how demographic ageing can undermine the adequacy and sustainability of such schemes. The two main components of the pension system in Malta are a mandatory public PAYG scheme that pays earnings-related benefits (i.e. benefits as defined in law and government regulation) and a non-contributory minimum pension guarantee. Provision for voluntary occupational pensions (with employer and employee contributions) that are designed to pre-fund pension income is limited and 'at an early stage of development'. For several years now both the adequacy and sustainability of the public pension system have been a focus of serious political concern. There are several reasons for this. Firstly, the lack of voluntary occupational schemes puts all the pressure for achieving income adequacy onto the public system, which is generally acknowledged to be threatened with serious sustainability problems. Secondly, although the formal employment sector in Malta is large, as one would expect from an OECD country, and pension coverage in the labour force is very high, female participation in the workforce has traditionally been low and remains low (lower, for example, than the European average). This means the typical pensioner household in Malta has only one pension. Thirdly, the Government has been reluctant to raise retirement age thresholds in a way

that would offset some of the increase (actual and projected) in the ratio of pensioners to contributors. These retirement age provisions are out of line with policy objectives implicit in recent reforms in many other high life expectancy countries in the Commonwealth – which is to look for ways of increasing rates of labour force participation not only in the 55-65 age group but also in the 65-70 age group.

## Occupational contributory schemes: United Kingdom

In the United Kingdom, the basic state pension is a PAYG scheme with mandatory contributions and flat rate benefits. The benefit levels are such that participation in 'second' pillar *occupational* pension schemes – with joint employee and employer contributions - is regarded as essential in order to secure income adequacy in retirement. When individuals join an employer with an occupational pension scheme, they are automatically enrolled, i.e. payroll contributions are deducted from wages unless new employees explicitly request to 'opt out' of the scheme. The challenge of maintaining sustainability has led to major changes in both the first and second pillar schemes.

Reforms to the basic state pension have focused on the age at which the pension benefits are accessible. This has been increased to reflect improvements in pensioner life expectancy, and further increases are planned over the next few decades. The policy benefits from such a move are moreover wider than the improvement of scheme sustainability, important though this is. By shifting the balance of incentives around retirement in a way that encourages individuals to delay labour market exit, government (i) helps relieve the pressures on labour supply that arise from continuing below replacement fertility (ii) helps to maintain or even enlarge the tax base for central government at a time when spending pressures on age-related services are increasing (iii) nudges individuals towards choices that improve their chances of income adequacy in retirement. These policy goals are generally shared by governments in high-income countries with ageing populations<sup>76</sup>.

<sup>75</sup> All the Caribbean countries have PAYG/DB schemes, though some combine PAYG financing with a funded element. Canada also.

<sup>76</sup> In low resource settings, governments are not as a rule looking for ways of trying to ensure that most of the working population people continue to work for as long as it is feasible to do so. For the majority of people who lack contributory pensions, the incentives are harsh enough as it is.

One of the main responses to sustainability problems in second pillar pensions has been to make the move from defined benefit schemes to defined contribution schemes<sup>77</sup>. As pensioner life expectancy has increased, so have the liabilities of defined benefit schemes. Occupational pension schemes, especially in the private sector, have taken some the pressure off by closing 'old-style' defined benefit schemes to new members and replacing them with defined contribution schemes. In other words, benefits are designed to be in actuarial balance with contributions. Broadly speaking this means that if individuals want to maintain the same level of income adequacy they could expect under a defined benefit scheme, they must either work for longer or increase their savings rate (i.e. start voluntary savings in a third pillar scheme). As things stand in the United Kingdom, it looks as though a substantial proportion of individuals – even though they are contributing to second pillar schemes – are under-saving. The improvement in scheme sustainability poses a threat to pension adequacy,

and the responsibility for countering the threat lies with the individual.

If under-saving by individuals who belong to defined contribution schemes points to future problems with income adequacy in retirement, so too does non-participation in second pillar schemes. For a long time in the United Kingdom, second pillar schemes have been voluntary for employers, i.e. they have not been obliged to provide them. The extent to which this is seen as a problem depends heavily therefore on employment practices and the nature of the labour market. In the United Kingdom the growth in self-employment and more precarious forms of employment in the service sector has been one of the main factors which generated pressure for reform to mandate the provision of workplace pensions by all employers<sup>78</sup>. Although participation rates in the private sector have undoubtedly improved since the introduction of automatic enrolment into S2P in 2012, a large minority of workers with low-incomes are still not participating (approx. 35% in 2016)<sup>79</sup>.



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<sup>77</sup> The alternative – to maintain defined benefits and change the basis on they are calculated – has been confined mainly to the public sector.

<sup>78</sup> In other words, it is mandatory for employers (i) to provide their employees with the opportunity to join a workplace pension scheme, and (ii) to pay into the scheme

that their employee joins.

<sup>79</sup> *Workplace pension participation and savings trends: official statistics 2016*. DWP, 2017.



# Structures for care and support in old age – long term care

The close association between increasing age and increasing risk of chronic disease and disability underpins the close association between increasing age and the risk of dependency. It is the inability to perform tasks that are understood as essential for self-care (e.g. washing and getting in or out of bed) without help from someone else that defines the need for long-term care (LTC). As the OECD notes in a lengthy report on long-term care from 2005, this help is 'often provided by family or friends or formal caregivers with lower skills than nurses'<sup>80</sup>. Although individuals with LTC needs typically have medical nursing care needs associated with the chronic health problem that is affecting their ability to look after themselves, for our purposes, LTC is to be distinguished from medical or nursing care. We are interested in the provision of help with a range of tasks and activities essential for daily living, and most centrally with what is now usually called *personal care*. Many people who need help with some of the tasks involved in daily living have no need for personal care. This would apply, for example to older people with mobility problems that prevent them from leaving their home to shop for food. The reason for highlighting personal care needs is straightforward: the provision of personal care is often very demanding. Personal care needs do of course vary, but they may require a caregiver to be more or less permanently 'on hand' to provide help that can be physically exhausting and psychologically stressful. If the person who needs care also has dementia, the demands made on the caregiver are typically intensified.

A great deal of LTC is provided by family caregivers and is unpaid. This is true in high-income countries<sup>81</sup> as well as in low and lower-middle income countries. Formal LTC services, on the other hand, are generally provided by paid caregivers who are being employed either by an agency or more directly by the person who needs care (or their family). They may be brought

into the home or provided in various kinds of institutional setting. Home-based formal services often supplement family care just as day care centres may also supplement family care. The balance between informal family care and formal care varies enormously between different countries, and the variation is broadly associated with levels of national income. In low resource settings, very few households will be able to afford formal LTC and governments are heavily constrained in their capacity to help households with an older member who needs LTC. In richer countries, households are more able to afford some degree of formal LTC and governments can do more on behalf of those who would struggle to pay for it themselves.

This does not mean, however, that the costs of formal LTC are not a problem in high-income countries. Quite the contrary. Costs *per capita* can turn out to be very high if care is required for long time – as it often is; and as life expectancy at older ages improves, so does the risk of dependency. Moreover, public expectations of the quality standards that it is reasonable and proper to require in formal LTC services for older people are now much higher than they used to be. It is generally recognised that formal LTC services for vulnerable older people have too often failed, even in the recent past, to treat their clients decently and respectfully. Institutional care in particular has been open to this kind of criticism, with the result that both the public and the regulatory authorities are alert to the risks. There is, however, a cost attached to the provision of good quality formal care that treats older people respectfully and with dignity. This applies to home-based care as well as to institutional care. Policies for LTC services in most high-income countries have been developed with a view to enabling older people to stay in their own homes for as long as possible, and this too comes at a cost. Intensive home-based personal care services for people who need a lot of help are not

<sup>80</sup> *Long-term Care for Older People*. OECD 2005

<sup>81</sup> Various attempts have been made to put a monetary value on informal care in high income countries and the estimates are generally higher than spending on

formal services. In the UK, for example, the Government Statistical Office put a figure of £61 billion on the value of informal care provided to adults (mostly older people). This is considerably higher than the estimates for combined public and private spending on formal LTC.

cheap in economies that find it increasingly difficult to meet various kinds of labour shortage.

Our interest in this chapter is primarily with formal LTC rather than family care. More precisely, it is with the nature of the care available for older people other than what is provided within the family. What services are available for people who need them and how do households pay for them? Are these services available only for households who can pay for them out of their own resources or are there public subsidies or subsidised services that protect households against such costs? What makes these questions so pressing is the combined effect of demographic and social trends on the need for LTC, on the one hand, and the availability of family carers, on the other. The challenge this represents affects high-income countries as well as low-income and slow ageing countries as well as fast ageing countries. It is no less of a mistake to suppose that high-income countries can easily and painlessly absorb the costs of a surge in demand for formal LTC than it is to suppose that families and extended households in slow ageing countries will have no difficulty in continuing to provide unpaid care in the way they do now. In Sub-Saharan Africa, for example, the feasibility of relying on family caregivers in case of need is widely seen as questionable in the light of a perceived weakening of extended family support systems<sup>82</sup>. And in between these extremes, there are plenty of Commonwealth countries that are neither rich nor ageing slowly.

## Frameworks for comparison

When the OECD published a report comparing 'LTC systems' in its member countries<sup>83</sup>, it was mindful of the importance of a multi-dimensional approach to the analysis. What is the level of public spending on LTC (as opposed to health care)? What are the conditions of eligibility for publicly subsidised LTC? How is the formal LTC sector organised and regulated? Is it possible to estimate the shortfall between need for LTC in the population and the provision of publicly subsidised services? Their efforts, understandably enough,

are concentrated on comparing LTC systems where there is something to compare. In countries where there is very little formal LTC other than what may be offered by charitable institutions and NGOs, there is not much purchase for some of the OECD's more refined analytical categories. They were designed, after all, to make distinctions within a set of high-income countries with eligibility conditions and cost-sharing regimes that reflect the administrative complexities of mature welfare states.

A more explicitly global approach to the comparison of publicly supported arrangements to make formal LTC services available to those in need can be found in a 2015 review published by the International Labour Organization (ILO) of long-term care protection for older persons<sup>84</sup>. The review is a kind of snapshot of the situation in 46 selected countries, and it is deliberately framed to include less developed as well as developed countries. The core idea is to treat LTC by analogy with health care. Universal Healthcare Coverage is accepted as a policy goal, and the same should apply to financial protection against the costs of formal LTC services. This view is similar to that of WHO<sup>85</sup>, which argues that formal LTC should be regarded as a public good. What the ILO aims to do in its 2015 report is identify (and estimate) a 'social protection deficit'. What kind and level of financial protection is provided to households (or individuals) against the costs of formal LTC services in the case study countries? And how far does this fall short of a universalist standard? And how many trained workers in LTC would be required to fill the gap<sup>86</sup>?

## Countries can be placed in one of three broad categories of financial protection:

- (i) *no coverage for the costs of LTC out of public funds (either taxation or social insurance);*
- (ii) *limited and means-tested coverage for the costs of LTC out of public funds;*
- (iii) *universal coverage for the costs of LTC out of public funds.*

What distinguishes these groups of countries is (a) the presence or absence of an entitlement to

<sup>82</sup> *Towards long-care systems in Sub-Saharan Africa*. World Health Organization, 2017. Key factors thought to be driving this shift include increased rural to urban migration and labour force participation, especially among young women; increasingly monetised economies; the impact of the HIV/ AIDS epidemic; and loosening norms and structures for extended family solidarity.

<sup>83</sup> *Help wanted? Providing and paying for long-term care*. Colombo F et al. OECD Health Policy Studies, 2011.

<sup>84</sup> *Long-term care protection for older persons: a review of coverage deficits in 46 countries*. Scheil-Adlung, X. International Labour Organization, 2015

<sup>85</sup> See, for example, *Towards long-care systems in Sub-Saharan Africa*. The fact that there is a difference between health care and LTC in the level of expert knowledge or skill that is required from the provider is irrelevant to this assessment. What matters is that providing for personal care needs very often makes excessive demands of family caregivers.

<sup>86</sup> The estimate is made for a selection of case study countries only, and is based on simple rule of thumb: 4.2 formal LTC workers are required for every 100 persons age 65 or over.



protection against the costs of formal LTC services, and (b) the conditions that determine entitlement.

In first group, no-one is entitled to publicly funded services or public subsidies for private services on the basis of an assessment of care needs. This is not to say that there are no publicly funded services or no kind of social safety net in case of extreme need. The point rather is there is no public guarantee of access to formal LTC services for people in need, irrespective of their ability to pay. According to ILO, most countries round the world fall into this category. We should expect all LICs and LMICs - countries in which the achievement of Universal Health Care remains a major challenge - to provide no financial protection in the relevant sense. The social protection deficit in these countries is assessed as 100%. The size of the formal care sector depends entirely on the size of the population that can afford to pay the full cost of LTC services whether they provided in the home or in institutional settings. It is extremely limited in terms of breadth as well as depth.

In the second group, some individuals with LTC needs are entitled to subsidised care (i.e. protection against the costs of formal care), but the entitlement depends on their income as well as their care needs. There is a guarantee of financial protection, but it does not extend to everyone. Entitlements are conditional upon income or wealth; in other words, on an assessment of the ability of the household to cover the cost of formal LTC out of its own resources. Most high-income countries are classified by ILO in this group, and although there is enormous heterogeneity in the details of the entitlements and in the level of coverage, the general conclusion of the ILO assessment is that the social protection deficit in these countries is 'very high'. The size of the formal LTC sector in many of these countries is however extremely large. Where this is case, the core problem (from the point of view of the ILO) is not so much the lack of formal LTC infrastructure as the extent to which access depends on the ability to pay.

In the third group, everyone who is in need of LTC is entitled to support which relieves them of all or some of the costs of formal services. Globally only a very small number of countries provide what the ILO would regard as universal coverage, and none of the Commonwealth case study countries

fits their criteria. The fact that coverage (i.e. some level of financial protection) is available for everyone through a single comprehensive system of collective-risk-pooling does not mean that personal care is free. Co-payments, user charges or up-front deductibles are generally required even in universal systems. They are, however, typically subject to income thresholds, with full or partial exemptions available for poorer household. There is means-testing, but no-one is excluded from coverage on the basis of the means-test.

To apply the ILO framework to all Commonwealth countries would be a major undertaking requiring consultation with local ministries and intensive data collection exercises. What we propose therefore is something much simpler, a presentation of case studies for selected Commonwealth countries which makes use of the ILO's tripartite categories. Some of these countries are included in the ILO report as case studies<sup>87</sup>. Our aim here is not so much to determine the social protection deficit in selected Commonwealth countries as to give an overview of the major dimensions of difference in the services and support from outside the family that are available for people with LTC needs. Although we are not able to quantify the size and diversity of the care infrastructure in different countries, we do have enough information to make very broad comparative assessments.

## LTC in lower-middle income in the Commonwealth: case studies

The ILO review includes three examples of Commonwealth countries that fall into their first category. Ghana, Nigeria and India all have 100% deficit in social protection against the costs of using formal LTC services. Levels of public spending on LTC are effectively indistinguishable from 0%, and the leading role of the family in provision of LTC is taken for granted by policymakers. This means families have one of two options in case personal or 'hands-on' care is needed: the work is taken on by one or more family members (typically female); or the family pays for some kind of formal LTC out of its own resources. We can surmise that in all three countries, the overwhelming majority of households fall into the first group. None of the three countries provides any form of social pension,

<sup>87</sup> Ghana, India, South Africa, New Zealand, Australia, UK, Canada.

and only Ghana has a nationwide health insurance scheme, though it cannot yet claim to have achieved Universal Health Coverage.

In the case of Ghana, the ILO analysis uses an estimate of the proportion of older people living alone as one of the symptoms of social and cultural change that “indicate an urgent need for LTC services”. What little formal care is available depends on a very small nascent private sector that caters for the needs of an urban middle class by providing home-based and occasionally residential care<sup>88</sup>, as well as the efforts of the voluntary or charitable sector. There is a very small number of

‘aged care homes’ run by the charitable sector that are essentially refuges for older people who have no family or have been rejected by their family. Although only two such homes are mentioned in a Government report based on the 2010 Population and Housing Census<sup>89</sup>, we should assume there are probably more faith-based organisations that are working in this space. Attempts have been made for some countries in Sub-Saharan Africa to document the relatively small number of such institutions that provide residential care for the elderly, and they confirm the importance of faith-based organisations<sup>90</sup>.

Text box 5.1

### Two contrasting types of home care initiative in Sub-Saharan Africa

The Care for Aged Foundation in Ghana was formed in 2006 to address the needs of frail older people who do not have traditional family support. Ga East, the municipality where it operates, is known to have a high number of neglected older people. The organization provides care to people in their own homes by recruiting young volunteers living in the same community. They assist with tasks such as bathing, personal grooming, dressing wounds, cooking, light housework, shopping, accompanying older people to hospital appointments and providing companionship. Although they are not paid, they do get free health care at specific partner facilities. Although many families were initially resistant to enrolling their older relatives and some were suspicious of the idea of strangers coming into their homes, uptake increased as families saw how the service could ease the burden of caregiving. Currently, the organization provides regular home visits to approximately 160 older people and access to medical care – if required – to 400 older people. The organization’s operations are reliant on a number of partners. Services are resourced through cash and in-kind donations such as geriatric training, medical supplies and supervisory support. Well-established donors provide the bulk of direct monetary support. Expansion of services beyond the immediate geographic area and existing clientele would require an infusion of additional resources. At the moment there are about 3000 older people on a waiting list. The organization is, however, facing a problem that affects many arrangements reliant on volunteers. Their inability to offer any financial compensation to volunteers makes it difficult to attract and retain enough younger people to cope with the demand. Sustainability and scaling-up are a major challenge.

The Nursing Angels agency in Kenya is an example of how private companies are being formed to provide organized long-term care services to those who can afford to pay for them or who have medical insurance that covers home-based care. The agency was formed in 2012 and is geared to provide professional services in clients’ homes. It offers personal care, specialized home health care, nutritional advice, psychosocial support and disease management services. Its diverse staff consists of approximately 140 people. Almost half are health professionals (nurses; physical, occupational and speech therapists; counsellors; and an agency physician); the others are patient attendants who assist clients with activities of daily living. All employees are screened and subject to background checks prior to employment. Services can be of short or long duration and on a part-time, full-time or live-in basis. Care managers conduct initial assessments and develop individualized care plans according to clients’ and families’ needs, preferences and available resources. Care plans are highly personalized and adapted over time, according to changing needs. Clients and their families participate in the selection of specific caregivers and provide structured feedback to the agency on caregivers’ performance. Other quality assurance practices include clearly articulated standards of care, supervision and regular personalized contacts with the client and family by a site supervisor. This agency is illustrative of the type of good-quality, multidisciplinary, integrated and personalized long-term care that can be provided to those who have the resources to pay for it. Some medical insurance companies are realizing the advantages of including home-based services in their policies. However, because most older people do not have medical insurance, they or their families generally pay out-of-pocket for care. This substantially limits the number of people who benefit from the services offered by this agency.

Both examples are taken from: *Towards long-care systems in Sub-Saharan Africa*. World Health Organization 2017

<sup>88</sup> Social support for the aged: the role of private care homes in Accra. Frimpong J. 2015 (PhD thesis for U Accra)

<sup>89</sup> And one of these is a refuge for women accused of witchcraft. See *The elderly in Ghana*, Ghana Statistical Service, 2013

<sup>90</sup> EG A 2015 study identified a total 9 care homes in Zambia. Two of

these were run by government; the other were faith-based. *Challenges faced by the aged in old people’s homes in Zambia*. M Changala et al. Int J Multidisciplinary Research and Development, 2015, 2(7).

<sup>91</sup> Long term care of older persons in India. UN ESCAP 2016

<sup>92</sup> Unlike home-visiting by health care services which requires a different kind of

Although India is placed in the same category as Ghana by the ILO, and like Ghana it is a lower-middle income country, it has a much larger (and faster growing) urban middle class. This makes a difference to the space for private provision. So, for example, it has become quite common for better-off families in urban centres to employ a paid caregiver to help with personal care, especially if regular help is needed<sup>91</sup>. Although we can guess that a very large proportion of households in urban areas could not afford this option, it has to be born in mind that the costs of employing a paid caregiver may still be very relatively low<sup>92</sup>. In recent years, the demand for this kind of care has increased to a level which has transformed the supply of trained caregivers into a large-scale commercial venture. Not only are there institutions that train caregivers and organise their employment, but the government, through the Ministry of Social Justice and Empowerment has provided financial support for their development. For the time being then, the ‘solution’ is a private sector solution, and it is available only to those who can afford it.

## LTC in Upper Middle Income Countries in the Commonwealth: case studies

The only case study of a UMIC from the Commonwealth included in the ILO report is South Africa. There is, however, enough information available for some of the others to be reasonably confident about where they would fit in the ILO framework. Jamaica is an example of a country that would fall into the ILO’s first category: no financial protection for households to help with the costs of formal LTC services. There is, however, a limited social safety net in case of extreme need, namely a number of ‘public infirmaries’ for that accept indigent older people (see text box 5.2). It also has a small private sector for residential care (as well as agencies that provide home-based personal care), though the absence of public subsidies means that access depends entirely on personal or household resources. What is striking about the situation in Jamaica<sup>93</sup> is that it presents, in an extreme form, a problem that has caught the attention of analysts and commentators in many SSA countries: the

impact of migration on the capacity of the family to provide care for older members has been depleted by large-scale emigration of younger adults. The scale of the outward migration and the proportion of older people that are affected by it in Jamaica are large enough to undermine any claims for the robustness of family care in the country. In a 2012 study of older people in Jamaica, half of those interviewed had no relatives in the country<sup>94</sup>. Although older people with relatives outside the country are quite likely to have regular contact with them and may also receive remittances, there will be no family available for caregiving. It is becoming increasingly common for such remittances to be used to pay for a live-in caregiver (an increasingly common arrangement). In the absence of publicly funded community home-based services or the ability to afford a paid caregiver, this leaves older people with care needs dependent on the charitable sector, run mostly by the churches<sup>95</sup>, or exposed to the risk of abandonment<sup>96</sup>. The only publicly funded service dedicated to older people in the community with LTC care needs is a very small-scale Home Help service run by the National Council for Senior Citizens. Although it includes the provision of personal care for older people who are housebound, in a 2012 assessment the programme was described as ‘operating on a very limited basis’ in four areas only<sup>97</sup>.

The South African constitution states “everyone has the right to have access to social security including, if they are unable to support themselves and their dependents, appropriate social assistance”. The cornerstone of this commitment to the provision of social assistance is case of need is the Older Persons Grant. So-called *Grant in Aid* payments were introduced in the 2004 Social Assistance Act from 2004 as a monthly cash benefit for dependent persons. Eligible persons must (i) already receive the Older Persons Grant (i.e. qualify as poor); (ii) be unable to look after themselves owing to their physical or mental disability, and therefore be in need of full-time care from someone else; (iii) not be cared for in an institution that receives a subsidy from the government for their care or housing. The Grant in Aid payments are intended therefore for people with LTC needs living in the community who could not afford to purchase formal services without

‘business model’. They are in the business of providing prolonged post-acute care rather than long-term care.

<sup>93</sup> As this was presented to us by Prof Eldemire-Shearer.

<sup>94</sup> *Older persons in Jamaica*. Denise Eldemire-Shearer et al. Mona Ageing and Well-Being Centre. These facilities provide care - usually residential - and ask

people to pay what they can afford.

<sup>96</sup> As in some other Commonwealth countries (e.g. Fiji), there is strong anecdotal evidence that increasing numbers of older people are taken by their families to hospitals or infirmaries and then left there with no contact address.

<sup>97</sup> Report prepared for ECLAC on efforts to improve quality of life for older persons.

a subsidy. Since the payments are cash benefits, recipients are at liberty to use them to recompense a family caregiver<sup>98</sup>. The value of the grant-in-aid is just under a quarter of the social pension, and according to 2017 data about 1 in 20 of those older people who receive a social pension also receive the grant-in-aid<sup>99</sup>. There is, however, no entitlement to publicly subsidised institutional care (see text box 5.2). As we might expect in a country with a moderately large middle class, there is a flourishing private sector in home-based services and residential services for households that can afford it.

Malaysia is a country where policies for the development and provision of formal LTC services are clearly framed so as not to undermine what is regarded as the 'proper' division of responsibilities

Text box 5.2

### Some examples of institutional care in Middle Income Countries

Jamaica resembles Ghana and India in having no public subsidies or benefits that would help cover the costs of formal long-term care services for older people who need them. For older people who qualify as poor and indigent there is a network of publicly funded 'infirmaries', but no long-term care facilities 'as such'. Kingston, for example, has a large and well-known infirmary with about 400 residents. These facilities are regarded as refuges of last resort for older people who have nowhere else to go and no-one to look after them. Some of the residents will have no family in the country and others will have family who have decided that they cannot cope with an older person with care needs. Publicly funded care is judged to be necessary as a kind of safety net when family 'fails' – i.e. when the family is unwilling or unable to provide care – but the supply of places is extremely limited when compared with likely demand. The primary problem to which this kind of residential facility is a response is often framed in terms of destitution or abandonment or neglect, even though the care they provide will often include help with personal care needs (and this may be the underlying reason for abandonment).

South Africa, like Jamaica, has publicly subsidised residential facilities (operated by NGOs and faith-based organisations) for people who qualify as poor. It is also one of the ILO case study countries. Admission to a publicly subsidised residential facility depends on the availability of beds, and according to the ILO there is a massive shortage of beds. Unlike Jamaica, however, eligibility for admission explicitly includes the presence of LTC needs. One of the criteria for admission that an individual has to in need of 'full-time attendance'; and a formal assessment is made by a social worker to verify that this is the case.

In India, although 'old age homes' are traditionally seen as shelters for indigent older people in exceptional circumstances, they are becoming more accepted and increasing in number, or at least this is how the matter is seen in a recent UN report on the topic. It seems quite plausible to suppose that this is associated with their adoption of a more specific LTC role. India has a large (and fast growing) urban middle class, and although as yet, there are no public financial mechanisms to help households with the costs of formal LTC services, it seems clear that there is an emergent (and growing) private sector. In the absence of any licencing requirements, however, it is not possible to estimate its size with any accuracy\*.

Malaysia has two kinds of residential facility for the elderly in need of care and support: a small number of government-run residential facilities for the indigent elderly; and a growing private sector for residential care, which is optimistic about the chances of attracting residents from elsewhere in the region, e.g. Singapore. The sector sees itself as innovative and is promoting various kinds of special housing development, including extra-care housing.

\* Long term care of older persons in India. UN ESCAP 2016

between families and government. On this view, the family has primary responsibility for meeting the personal care needs of older family members, and this includes the costs of purchasing personal care in case they are unable to provide enough unpaid care themselves. Although there are no subsidies that help households with the purchase of formal LTC services, the government does provide means-tested financial assistance to some family caregivers. To be eligible for this assistance, the caregiver household has to be classified as poor and the caregiver should be providing full-time care to an older family member who is bedridden. Whether this should be classified as financial protection against the costs of LTC is open to question. From the point of view of ILO, the answer is almost certainly not. From the point of view of OECD, the answer would probably be that this is a financial benefit that helps poor

<sup>98</sup> Although the arrangement bears a superficial similarity to the mean-tested payments for family caregivers in Malaysia, it is in fact quite different. In Malaysia the payment is only made to recompense a family caregiver.

<sup>99</sup> <https://africacheck.org/factsheets/separating-myth-from-reality-a-guide-to-social-grants-in-south-africa/>



households with the costs of LTC (i.e. loss of income as a result of provision of informal care).

What distinguishes the situation in Malaysia from that found in Jamaica or South Africa is publicly supported formal care infrastructure is *much* more developed and diverse in Malaysia. Day care and respite care facilities to lighten the load on families are available in urban centres, though whether there are enough of them is another matter, and general media coverage suggests that provision is too thinly spread. Government also encourages volunteerism through a network of volunteer-based home help services, mainly for older people who live alone (though personal care services are as a rule not included in the service). There are mobile health clinics that provide home-based nursing care with costs covered by medical insurance (i.e. again not personal care).

Mauritius was the first country in SSA to adopt a national policy on the elderly (in 2001). It also has a Protection of Elderly Persons Act 2005, which is aimed at protecting older people from all forms of neglect and abuse. All older people in Mauritius receive a basic pension and have access to free public transport and free health care. There are day care centres that offer recreational and educational programmes throughout the country. As in many other middle income countries, long-term care is typically viewed as a family responsibility, although this is being challenged as society undergoes change. And as in Malaysia support for family caregivers is provided by a monthly allowance allocated in case 'constant care and attention' are being provided to an older person in need. Unlike in Malaysia, however, the benefit is effectively universal. All carers of people in receipt of the basic old age pension are eligible.

Access to publicly supported residential care operates rather differently. There are currently approx. 20-30 care homes run by the charitable sector and funded by government. Access to these homes is first-come, first-served and based on means testing, and the demand for places far outweighs their bed capacity. In recent years the number of private retirement home has increased, and in 2003 this led to the enactment of legislation to establish standards and codes of practice and to monitor the quality of care delivered in private homes.



Woman in Papua New Guinea  
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## LTC in High-income Countries in the Commonwealth: case studies

We have already noted the ILO's claim that most high-income countries round the world fall into its second category, which is to say that they have limited and generally means-tested support for publicly subsidised LTC services. The Commonwealth's high-income countries are a very diverse group. They include Brunei Darussalam and Singapore in SE Asia, the four old Anglophone countries – New Zealand, Canada, Australia and the United Kingdom –, two islands in the Mediterranean, Malta and Cyprus, and a small collection of island states in the Caribbean and the Indian Ocean. Differences in GDP *per capita* are quite large despite their status as high-income countries in the World Bank classification. None of the high-income Commonwealth included as case studies in the ILO review is categorised as having universal coverage<sup>100</sup>.

What the ILO understands by universal coverage, like the OECD<sup>101</sup>, is essentially comprehensive coverage for everyone *within a single programme*. "Systems with single universal LTC coverage provide nursing and personal care to everyone assessed

<sup>100</sup> These include Australia, Canada, New Zealand, and the UK.

<sup>101</sup> *Help wanted? Providing and paying for long-term care*. Colombo F et al. OECD Health Policy Studies, 2011.

as eligible due to their care dependency status” (OECD p215). Examples include tax-funded systems in Scandinavia, social insurance schemes in Japan and Germany, and systems which fully incorporate LTC into the health care system as in Belgium. This is not to say, however, that none of the high-income countries in the Commonwealth incorporate some form of universalism in their arrangements for protecting households against the costs of LTC. Differing approaches to universalism can be seen in Australia, New Zealand, Scotland,

and some provinces in Canada.

In Australia, for example, the costs of formal care are subsidised for everyone assessed as eligible on the basis of a care-need assessment. It is one of a cluster of countries that display what the OECD calls ‘progressive universalism’. Essentially the government provides an income-related universal benefit. Personal care is not free, but everyone who is assessed as eligible is entitled to a publicly-funded subsidy. The means-test is not used to

### Text box 5.3

## Support for carers

Mauritius is not the only Commonwealth country to provide financial assistance – without a means-test - to family members who are providing personal care. The Seychelles also pays family caregivers an allowance without using a means-test to determine eligibility, just a care dependency assessment. Elsewhere among the high-income countries, means-tested payments are more common. In Australia, New Zealand, and the UK they are typically limited to those most in need, with heavy and regular caring duties that result in forgone earnings, and the eligibility conditions are such that reciprocity rates among carers are low. In 2009 the OECD cited estimates of 10% for the UK (i.e. one in ten carers), 20% for Australia, and a mere handful in New Zealand. It is important here to emphasize the fact that benefits are intended as a form of compensation to carers who are effectively excluded from the labour market as a result of their caring responsibilities. This means, for instance, that pensioners, as a rule, will not be eligible even if they are providing full-time care.

The other main ways of supporting family carers are (i) training; and (ii) the provision of respite care. What the WHO has to say about SSA\* applies to many other parts of the world where the tasks of personal care fall mostly to family caregivers, i.e. middle and lower-income countries. The immediate policy objective is not to replace family care with formal LTC services, but to support family carers, and training is an essential part of this. “As long-term care systems develop, special efforts will be needed to ensure that family caregivers have access to the resources, information and training they need in order to perform their roles. This will ensure that older people receive the best possible care and that family caregivers are relieved of unnecessary stress that arises from being insufficiently informed and skilled in how to deal with challenging situations”. It is questionable, thinks WHO, whether “family-based care, in its present configuration, is able to deliver good-quality and integrated long-term care for the many older people who need it”. The problems are most severe when the care needs are most severe, as for example, in dementia. Mauritius is perhaps unusual among middle-income countries in having a Carer’s Strategy (since 2010). Its objectives include: (i) create a pool of formally trained caregivers to respond to the demand of paid carers by families needing support at home; (ii) provide basic training to informal caregivers to enable them to provide better quality care to older members of their families.

Day centres that provide respite care also have an important role to play in helping to ease the burden on family caregivers. This is acknowledged by provision in many countries besides Malaysia and Mauritius. In 2014 the Singaporean government announced plans to expand LTC provision. “In line with our vision to support seniors to age within the community, we are doubling the capacity of our centre-based care services from 2,800 places today to about 6,200 places by 2020 to meet demand. Recognising the need for greater integration so that seniors with multiple care needs can be cared for in a single setting, we are rolling out senior care centres which are integrated eldercare facilities that provide a range of aged social and health care services such as dementia, rehabilitation and nursing care”.



determine which people are entitled to a subsidy, but rather the level of personal contribution to costs. The majority of LTC costs are paid for by the government through consolidated, tax-based revenues. Recipients of residential and community-based aged-care services usually make a financial contribution to the cost of their personal care, and it is this that is adjusted to the user's income. Residents in institutions contribute to the costs of their accommodation and their personal care via basic daily fees, income-tested fees and fees for additional services.

New Zealand differs from Australia by combining a universalist approach to eligibility for publicly subsidised home-based care with restrictions on eligibility for publicly subsidised residential care. Everyone assessed as needing home-based personal care is entitled to publicly subsidised services, although co-payments are required from everyone with income above a specified threshold. Eligibility for the Residential Care Subsidy (RCS) is determined differently, and is based on the ability to pay as well as an assessment of need. In other words, some residents in care homes do not get the RCS (about 30% in 2008). The means-test for the RCS is primarily an asset test, and it includes the value of a home (but with a significantly higher threshold)<sup>102</sup>. For the majority who do get the RCS, it pays for the costs of contracted care (including 'board and lodging') above a maximum income-related co-payment. It is important here also to bear in mind the role of the care needs assessment for the RCS: the level of dependency has to be high in order to be eligible for the RCS. Some provinces in Canada operate a similar kind of system, i.e. home-based personal care is treated differently from institutional care when it comes to public financial support.

Scotland differs importantly from the rest of the United Kingdom where eligibility to publicly subsidised home care and residential care depends on a means test. Scotland operates what the OECD calls a 'parallel universal system.'<sup>103</sup> Universal nursing care is financed through the health system and universal personal care is financed through a different scheme. Personal care (i.e. ADL support) for older people is free both at home and in institutions. Care is funded by local authorities and eligibility depends only on an assessment of care

needs; the users' financial means are irrelevant to the assessment. Help with accommodation costs in care homes is subject to similar means-testing as in the rest of the United Kingdom.

In the United Kingdom, the financing of LTC has been a bone of contention for more than 25 years, and remains so still. Although the current funding system is unpopular and has very few supporters, it has proved very difficult to secure agreement for reforms that would enable a larger proportion of people in need more people to have access to subsidised care, mainly because of central government concern over the affordability of a significant expansion of the role for public subsidies. There is, moreover, a general consensus, at least as matter of principle, that weaknesses in the LTC system (i.e. not enough publicly subsidised care) have serious knock-on effects for the National Health Service. The means-test in the United Kingdom is based on savings and capital as well as income, and it applies to both home-based and residential care. Individuals with capital above a specified threshold have to pay the full cost of their care. Individuals whose assets fall below the threshold will have some or all of their care costs covered by government depending on the level of their 'assessable income'. Because housing assets, including a personal home, are included in the capital test and the capital threshold is quite low, the means-test effectively guarantees all homeowners have to run their housing wealth to pay for the costs of their LTC. The idea, broadly speaking, is not just that wealthy individuals should use some of their wealth to pay for formal LTC services if they need them, but rather only people with very limited savings and capital are entitled to public support with the costs of care, i.e. the system lacks that those elements of universalism seen in Australia or New Zealand.

What the United Kingdom does share with Australia and New Zealand is the assumption that older people are financially independent of any adult children. The means-test does not take the income or assets of adult children into account. In this respect, Australia, New Zealand, and the United Kingdom all differ from Singapore. Here, as in Malaysia, the expectation that the costs of purchasing formal LTC services will be born by the

<sup>102</sup> Although New Zealand resembles the UK in using an asset-based means-test to determine eligibility for institutional care (see below), the system in New Zealand has designed so as to provide a much larger proportion of people in need with access to subsidised personal care services. As result, private expenditure on LTC

services in New Zealand is relatively low. In fact, OECD estimates put out-of-pocket / private expenditure on LTC in New Zealand on a level with the Scandinavian countries, which is about 10% of total expenditure.

<sup>103</sup> *Help wanted? Providing and paying for long-term care.* Colombo F et al. OECD Health Policy Studies, 2011

family of the person who needs care still holds as a principle underlying government policy. Unlike in Malaysia, however, there are means-tested benefits for poorer households where formal services are needed and the family cannot afford it. The means-test in Singapore operates, however, in the context of legislation which makes adult children financially responsible for their parents' care and support (Maintenance of Parents Act). In other words, it will take into account the income of adult children whether or not they co-reside with their parents, and their obligation to contribute to the costs of their parents' care is legally enforceable. For the majority of Singaporean households, those in other words who are not eligible for this kind of the means-tested subsidy, it has become very common to purchase the services of live-in caregivers and/daily helps (and these are usually migrant workers). For the time being therefore, the 'system' relies heavily on the import of cheap labour to provide personal care services in the home. Although there are residential care facilities (payable and means-tested), the government "places a strong emphasis on an ageing-in-place philosophy which underlines the desire to continue to keep older persons in their communities for as long as possible. Ageing in place further stresses the role of families in ensuring that older persons remain at home for care and utilise non-residential services which ease the burden on institutional healthcare facilities"<sup>104</sup>. In line with its general encouragement of personal and family responsibility, the government facilitates saving for LTC through *Eldershield* (essentially a personal account scheme without risk pooling). And finally, as in Malaysia, it encourages volunteerism and provides community-based facilities (day centres) that are intended to help lighten the load on families.

Where New Zealand and the United Kingdom do resemble Singapore is in their commitment to frame LTC policies in a way that helps older people maintain 'independence in the community' for as long as possible. The common policy challenge is to find ways of subsidising formal care services in the home that are affordable and sustainable. Malta stands apart from most high-income countries in this respect<sup>105</sup>. Residential institutions are still seen as the cornerstone of provision for people

who need long-term help with personal care, and assessments for publicly subsidised LTC operate in a way that sustains the central role of residential care infrastructure. If individuals are assessed as needing LTC services, they join a queue to wait for a place in a subsidised (state-owned) care home. The costs of these formal LTC services are then shared by the state and the individual; a means-test is used to determine the level of the contributions that individuals should make to their care. The inability of government to keep up with the increasing demand for places has led to an expansion of the private sector.

## Long-term care workforce

Formal LTC services require a workforce, and as a general rule, an expansion of formal LTC requires an increase in the numbers of people working as paid carers. Those countries which have seen the LTC workforce increase considerably in recent years and can expect a further surge in demand tend also to be countries in which the prospects for overall labour force growth are conditioned by (i) continuing below replacement fertility and (ii) the limited scope for increasing labour force participation. In several high-income countries<sup>106</sup> the issue is salient enough to have prompted the production of reports, from think-tanks as well as government, on the LTC workforce and the policies that might be required to ensure an adequate supply of appropriately trained care workers. Where these reports include estimates of the additional care workers that would be required to meet expected increases in demand *if there is no change in the way that services are delivered*, the numbers are large.

In England, for example, there were 1.55 million 'adult social care' jobs in 2015, with 1.43 million people working in the sector. The number of social care jobs grew by 18% between 2009 and 2015. If the number of jobs grows proportionally to the projected number of older people in the population (i.e. it is assumed that the percentage of older people who need LTC stays the same), then an additional 275,000 jobs will be required by 2025<sup>107</sup>. The workforce will have to grow by another 18%. The sector, furthermore, is already large, and accounts for 5-6% of all employment.

<sup>104</sup> *Long term care of older persons in Singapore*. UN ESCAP 2015

<sup>105</sup> *Long term care of older adults in Malta: factors influencing factors and their social impacts*. Pace C et al. *J Social Service Research* 2016, 42(2):263-279.

<sup>106</sup> Canada, Australia, New Zealand, UK

<sup>107</sup> *The size and structure of the adult social care sector and workforce in England*, 2016. Skills For Care.

The growth in the workforce has to come from somewhere, and so far much of it has been sustained by attracting women and migrants into the care sector. The situation in Australia, Canada and New Zealand is more or less the same. Something all these countries have in common are positive migration flows, and there is little doubt international migration in these countries plays an important role in ensuring a continuing supply of care workers. In Australia, for example, a recent census of the 'aged care' workforce found almost a quarter (23%) of direct care workers in residential care and 16% of direct care workers in the community speak a language other than English<sup>108</sup>. As well as supplying staff to agencies and residential institutions that provide publicly

subsidised care, these transnational flows also enable households to purchase care directly and without the benefit of a public subsidy (e.g. live-in caregivers). This essentially provides the mainstay of the workforce providing home-based care in Malta and Singapore.

Not all high-income countries can rely on positive migration flows to help ease their LTC workforce problems, however. The Seychelles, for example, has a net outflow of migrants. It also has a means-tested Home Care Program, which was set up in 1987 to provide home-based help to people dependent in ADLs. Between 2009 and 2015, the number of home care providers increased by more than 30% and now make up 6% of the

Text box 5.4

### The role of migrants in the LTC workforce

This role is explicitly acknowledged by the policies that some of these countries have adopted to facilitate migration for the care sector. In Canada, for example, the Live-in Caregiver Programme (LCP) provided potential immigrants with a fast-track to permanent residence, which could be obtained after two years of full-time work as "live-in carers".

The programme was employer-driven, meaning that the employer must first offer a job for a work permit to be granted. The arrangement required the carer to stay with the same employer for two years, as well as living –in with the family receiving care. There were no caps on the number of LCP permits other than the processing capacity of visa offices. In 2008 approximately 13,000 foreign nationals entered Canada under the scheme, mostly women from developing countries such as the Philippines (83%). In 2017 the LCP was discontinued, partly because of the problems generated by the live-in requirement, and replaced by an alternative arrangement, this time with caps.

entire Seychelles workforce, more than the United Kingdom with its net inflow of migrants<sup>109</sup>. Trinidad and Tobago is in a similar position with regard to immigrants. And if we go down the income ladder to less developed countries with fast ageing populations, the situation can look even worse. With high rates of net emigration both Jamaica and St Vincent and the Grenadines would struggle to recruit sufficient numbers of care workers outside the relatively small private sector that caters for the more affluent members of society.

For most Commonwealth countries of course, the real challenge is not so much the supply of potential care workers as the lack of resources, whether public or private, to attract people into the formal care sector. The formal care sector is small because so few households can afford to purchase out of their own resources and governments provide very little financial support for households where an older person is in need of care.

<sup>108</sup> Submission of ACSA to the Senate Inquiry on the future of Australia's aged care sector workforce. Aged and Community Services Australia, 2016.

<sup>109</sup> Strengthening the policy framework in the Seychelles for the delivery of long-term care. World Bank 2016

# Community infrastructure and empowerment for active ageing

This report has so far focused on the respective roles of the government and the family in developing and sustaining infrastructure for the care and support of older people *in case of need*. The perspective is informed by the idea of age-related needs and how they should be met. The analysis turns on issues in the development and funding and organisation of arrangements that do things for people when these age-related needs emerge or make themselves felt. Important as this is, there is another and complementary perspective on the challenges associated with population ageing, one which highlights what older people can do for themselves as well for each and for the wider community. Older people are a potential resource, and in ageing societies they are an increasingly important resource.

It is useful here to distinguish between two quite different ways in which older people can remain active as participants in their social world and contribute to the welfare of others besides themselves. Many older people in the Commonwealth, certainly in the poorer countries, live in conditions and circumstances which impose requirements or expectations on them to remain active. They may have to continue in paid employment either because they have no other source of income to maintain themselves, or because they are expected to contribute to the income of their household for as long as they can; if they do not continue in paid employment they may be expected to provide caring or housework services within the family as part of a tacit intergenerational compact. In other words, they continue to remain active either in paid work or within the household because of financial constraints or normative expectations within the family. It would be very misleading to think of these circumstances as providing older people with the

*opportunity* to remain active or to contribute to the welfare of others. There is, however, a kind of community-based infrastructure that does exactly that: it *enables* or *empowers* older people to remain active and participate in their social world - the world outside the household and the family - by providing with them opportunities to do so. They are being empowered rather than constrained. A social world that is adapted to longer lifespans is one that provides opportunities for older people to remain active and participate in society.

In this chapter we provide examples from different parts of the Commonwealth of community-based infrastructure (facilities and/or programmes) that is intended to empower older people to become a resource for themselves and others. The common aim in all these cases is to promote and support participation in various kinds of activity. As the examples show, we can distinguish different organisational models behind the pursuit of this goal just as we can distinguish different kinds of activity. These activities include:

- supporting older people to become more active in maintaining their own health and well-being;
- increasing social participation and engagement;
- participating in educational activities and lifelong learning;
- advocacy and raising awareness;
- mutual support and volunteering.

## Not-for-profit membership organisations - staying active in retirement

There are several membership organisations among the Caribbean islands states that are modelled more or less closely on the American Association of Retired Persons<sup>110</sup>. They rely on subscriptions for income and typically provide a mix of services and recreational or educational activities. The oldest of these membership groups is the Barbados Association of Retired Persons, which was funded in the 1990s and now has 40,000 members. Jamaica, a less affluent country, started a similar membership organisation in 2009 - the Caribbean Association of Retired Persons (CARP). The size of the membership, much smaller than in Barbados, reflects income levels as well as the time that it takes to grow organisations like this. Members have to be at least 50 years old to join, and the membership is concentrated mostly in metropolitan Kingston, mostly among professionals and the middle classes. One of the main attractions of membership, and this partly defines the model, is that it buys individuals access to discounted services of various kinds as well as private health insurance (to circumvent the delays and problems in the public sector). The CARP also offers frequent seminars and workshops at its local 'chapters' (which harness the expertise and knowledge of the membership) on wellness, energy conservation, gardening, and home security. The emphasis in the selection of workshops and seminars is on health and making limited income go as far as possible. Although members are not expected to volunteer or give their time to helping run workshops or organise meetings, they are encouraged and given the opportunity to do so. What these associations do is bring age peers together to create a new social network which can call on the skills and energies of its members to provide opportunities for collective participation in social, educational and political activities. The mission statement of the Barbados Association is representative of how these organisations see themselves and their role:

To lead the fight against discrimination and stereotyping of the elderly, through vigorous advocacy, lobbying and education of Barbadians, to market the skills and expertise of retired members so as to provide extra income for them, by creating a knowledge pool which may be drawn on by the wider community.

In South Asia, HelpAge India runs what is called the AdvantAge programme that aims "to empower senior citizens in living active and healthy lives". The programme is put together and marketed in a way that makes it quite similar to what the ARPs are trying to do in the Caribbean. India, of course, is a very different place, not just in average incomes, but also in its social and cultural traditions. Despite these differences, the AdvantAge programme shares two important features with the ARPs: it is clearly intended to appeal to people who identify themselves as *retired*; and it relies heavily on membership subscriptions and fees for the revenue that funds its activities (and aims to be financially self-sustaining). As in Barbados and Jamaica, the offer a retail discount card<sup>111</sup> is seen as a way of promoting membership and contributing to the development of local Active Ageing groups, which engage in a wide range of activities intended to help both the members themselves and the wider community, including:

- the management of physiotherapy clinics and homeopathic services,
- the provision of counselling services for people with financial, legal or medical problems,
- career counselling for young people,
- educational sessions for destitute and disadvantaged children and the under-privileged in the community,
- yoga classes and sporting activities of various kinds.

<sup>110</sup> National Seniors in Australia and Age UK are comparable examples in the Commonwealth, though the names chosen by the Caribbean organisations suggest that they had the US model in mind.

<sup>111</sup> The cost of a card is set low - 50 rupees (approx 0.6 pounds sterling) - to make it widely affordable.



## Older People's Associations and organisation for advocacy

A rather different emphasis, tailored perhaps to somewhat different circumstances, can be seen in programmes to develop the capacity of small groups of older people to engage in advocacy on behalf of older people. The focus here is not really retirement, but pressure for change, and the model depends on pre-existing community-based organisations of older people. The organisations provide a forum where they can come together to identify and articulate issues and problems specific to them as *older people*. They are being supported in their participation in the political process, not just as individual householders, but as members of a group defined in age terms. This is community development; groups of individuals are encouraged to come together around a set of common challenges and supported in developing a collective voice.

HelpAge Pakistan works with over 200 Older People's Associations (OPAs) in the country, and one of its main aims is to build the capacity of these village-based organisations for local advocacy and positive engagement with local policy makers and service delivery organisations. These groups have also been instrumental role in running campaigns for senior citizen focused legislation at provincial level. In India also, HelpAge works with local Senior Citizens Associations in different parts of the country to encourage them "to become a unified voice raising elder concerns".

## Local and time-limited feasibility projects

(i) AgeWell is a community-based peer-to-peer support programme in South Africa for home dwelling elders over the age of 60. Funding was raised from donors and operates under the auspices of Mothers2mothers, a not-for-profit organisation whose mission it is to reduce mother to child transmission of HIV using a peer support model. Peer-to-peer support, in other words, is the heart of the model. In this case, the idea is to employ relatively healthy and independent older people to visit and provide companionship to

other older people, usually older and always much less independent. Older people can be the most important resource in an ageing community. Older adults are, after all, familiar with challenges faced by the older persons and so they are well-suited to identify and respond to issues met by other, more vulnerable, older people. The AgeWell initiative assists marginalized older adults to support one another to participate actively in improving their own health and well-being.

The programme works by giving some older people the skills and encouragement needed to provide support to other older people, helping to reduce isolation and build communities around older persons with and without means, contributing to improved wellbeing through better emotional, social and physical health. The peer service providers (known as AgeWells) are trained to use smartphones programmed with research-driven screening instruments and referral algorithms designed specifically for use by lay persons. The phone apps help the AgeWells to identify evolving health problems and make referrals to primary care providers and social workers. The AgeWells, all over 60 years old and living in the project catchment area, were identified through community based partner organisations identified older persons (over 60 yrs old) to be trained as visitors and companions. They then received an intensive 3-week training course on a number of aspects of health and wellbeing as well as being trained to use the phone apps in order to collect data about the clients that they would be visiting. The AgeWells are all paid a stipend for the services that they render.

The value of this project lies in its double effect, bringing benefits not only to the people who received the visits, but also to the older people acting as AgeWells. In the focus groups held as part of the project evaluation, the AgeWells reported that since commencing the programme they felt more connected to each other and their community. They were forging stronger bonds with their neighbours,. They demonstrated improved self-esteem, and a renewed sense of purpose. They felt empowered and were excited to be able to learn about new technology and to make use of it. They had once again become economically active and described



it as life changing. Receiving a salary not only gave monetary value to their work but the income had a considerable effect on family welfare, self-esteem and alleviated some of the disempowerment of poverty<sup>112</sup>.

(ii) The Nuwara Eliya project in Sri Lanka aimed to improve the health and well-being of elders in the tea estate sector by increasing social participation. Funded by AusAID, it is a collaboration between the PALM Foundation, a local community development non-government organisation in the area, and the Burnet Institute, an international health research institute in Australia. It began in 2004. It covers a population of about 50,000 tea estate workers and adjacent villagers, which includes 4,000 elders over 60 years and their family members. The focus of the project is the retired tea estate workers, who had little or no income, lived in poor and crowded conditions, and had only limited access to services. Since social disengagement seemed to be one of the most visible consequences of stopping work in this particular setting, one of the main project strategies was to establish Elders' Clubs. PALM community mobilisers first made a register of older people in their estate communities and consulted them about forming Elders' Clubs. At the first meetings the elders mapped households where elders lived, including those bedridden or disabled. The Elders' Clubs chose two leaders, a woman and a man, and a name for their Club. They arrange monthly meetings and a variety of activities. In 2011, 7 years after the project started, there were 55 Clubs with just over 3,900 members. Participatory project evaluations found that the strategy was successful at promoting social participation and has had wider benefits than anticipated<sup>113</sup>.

## Online resources for active ageing

The Volunteering and Healthy Ageing Project run by Volunteer Canada has developed a number of tools and resources that explore the opportunities and barriers to promoting civic engagement amongst 'boomers and older adults'. As these are all online resources, they presuppose a reasonably

high level of digital literacy as well as an extensive network of voluntary organisations that offer a wide range of opportunities for volunteering. The project aims to encourage more people to see the benefits (to themselves as well as others) of volunteering and it facilitates the uptake of already existing opportunities for civic engagement. So, for example, it provides a retirement planning module on volunteering which shows the benefits of volunteering as part of a structured retirement plan and helps retirees find opportunities that suit their motivations and life circumstances.

National Seniors in Australia is a membership organisations like the ARPs in Jamaica and Barbados. It sees itself as providing a strong national voice for older Australians (as well as various consumer benefits). The *National Seniors Healthy Ageing Hub* is an example of a kind of online platform that is becoming increasingly common in middle income as well as high-income countries; these are platforms that empower older people to maintain their own health and functional ability by providing them with information and knowledge. In other words, the hub presupposes motivation as well as digital literacy. The hub is for people who are willing to spend time and effort in staying healthy, but are not quite sure about the ways and means.

SeniorsAloud in Malaysia is an online community for people aged 50 years or more. Although this is a rather different kind of social network from what the ARPs help to create in the Caribbean, the organisational aims are very similar and it shares a focus on the transition from work to retirement. In this case, however, it is combined with the use of an online platform that performs the same functions as Volunteering and Healthy Ageing Project in Canada or the National Seniors Healthy Ageing Hub in Australia. It provides information, promotes active ageing, and connects seniors with each other. By joining the online community (at no cost), members are also given the information to participate in offline activities and events held regularly 'to promote successful ageing through lifelong learning, social networking and community service'.

<sup>112</sup> First expert consultation on community-based social innovations that support older people in low- and middle-income countries. World Health Organization, 2015.

<sup>113</sup> Social participation and healthy ageing: a neglected, significant protective factor for chronic non communicable conditions. WR Holmes, J Joseph. Global Health 2011. doi: 10.1186/1744-8603-7-43

## Government-sponsored programmes to promote healthy and active ageing

Singapore's Council for Third Age (C3A) is an agency which promotes active ageing in Singapore through public education, outreach and partnerships. It was established in 2007 by the Singaporean Government as an umbrella body in the 'active ageing landscape', with a focus on lifelong learning, senior volunteerism, and positive ageing. The aim is to 'create a vibrant pro-age Singapore where seniors can participate as integral members of society'. One of its initiatives is an Intergenerational Learning Programme (ILP), which is part of the Ad Hoc Learning Opportunities offered under the newly established National Silver Academy. The ILP aims to encourage intergenerational bonding by matching youths and seniors in a group learning environment. Through practical lessons such as Skype, Facebook, managing health and laughter yoga, seniors acquire new knowledge while youths share theirs and learn character building. The



Man fetching water in Guyana  
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main objectives of the programme are to (i) forge intergenerational bonding between the youths and the seniors, (ii) promote active living by enhancing mental and social wellbeing among seniors, (iii) improve public perceptions and attitudes towards ageing. For the programme to work and reach as many older people as possible, it requires the cooperation of various partners, each with their community-based networks, including schools, grassroots organisations, and Voluntary Welfare Organisations.

Like C3A in Singapore, Jamaica's National Council for Senior Citizens is a publicly funded agency, but it has a much wider remit. It was set up in 1976 and sits within the Ministry of Labour and Social Security "to advise the Government on all matters concerning the welfare of Senior Citizens; to implement the National Policy on Senior Citizens; and to develop plans of action to promote active ageing and encourage the participation of seniors in nation building". It also delivers services and runs programmes that overlap with those of the Caribbean Association of Retired Persons. It runs Senior Citizens' Clubs and Seniors' Day Activity Centres across the island. With an office in each of Jamaica's 14 parishes, they have a more extensive network of local clubs than CARP. As with CARP each local club is a self-organizing membership group.

Different again is Vaka Tautua, a programme that runs and supports older people's groups across five Pacific Islands (Samoa, Tonga, Niue, Tuvalu, and the Cook Islands). Although the governments of the respective islands pay for Vaka Tautua's activities in the community, the organisation is itself a charitable body. The community groups it runs offer ethnic specific weekly older peoples programmes, 'providing a variety of activities, education, health promotion and safety programmes in an environment where older people are respected and valued. Participants frequently come to programmes with family members and/or carers, where they socialise, exercise, participate in arts and crafts and learn to cook healthy meals, assisting them to live healthily and independently'. What makes Vaka Tautua different from C3A or the NCSC in Jamaica is the way it operates as a service to which older people are referred. Nevertheless its aims are

defined in terms of empowerment and engagement: empowering individuals to ‘take ownership of their own decision making, health and well-being, and to maximise their own independence’; and ‘engaging older people within their own social networks and communities’.

Although strategies are not the same as agencies, they may be useful and important vehicles in complex policy environments where effective action depends quite heavily on coordinating and redirecting the efforts of already existing agencies and organisations. Malta’s Strategic Policy for Active Ageing was launched in 2014. The Strategy has three major themes:

- Active participation in the labour market – improving job opportunities and promoting employability of ageing workers;
- Participation in society – addressing social exclusion by promoting engagement in society;
- Independent Living – encouraging healthy ageing and independent living through preventative measures and by creating a more age friendly environment.

Labour participation among older people in Malta is considerably lower than the EU-27 average, and in line with the introductory remarks at the beginning of this chapter. The strategy aims to promote *opportunities* for continuing in employment. The perceived problem here is not that older people are constrained to work by inadequacies in the pension system, but rather they have limited opportunities for continuing in work at older ages if they wish to do so. There are different kinds of barrier that make it more difficult to stay in employment, including the presence of discriminatory attitudes and practices in the workplace, the lack of opportunities for re-training or ‘upskilling’ at older ages, and a lack of flexibility in arrangements over working hours. There are also barriers that stand in the way of ‘continuous and active participation of older persons in social, economic, cultural and civic affairs’. Poverty or lack of digital competence or the demands of informal caring or the depletion of particular kinds of social network can all add to the problems of social exclusion.

In 2016 the New Zealand Government updated its 2002 Healthy Ageing Strategy. The renewed strategy has a number of ‘ageing well’ goals. The central goal is older people should be ‘physically, mentally and socially active; have healthy lifestyles and display greater resilience throughout their lives’; and spend more of their lives in good health and living independently’. To this end, it is essential older people are empowered - partly by knowledge and partly by the structuring of their social world and physical environment - to participate in maintaining their own health and functional ability. The central goal requires a number of subsidiary objectives:

- Older people are health smart, able to make informed decisions about their health and know when and how to get help early.
- Everyone in the health system and in the wider social sector understands what contributes to healthy ageing and actively works to achieve it.
- All older populations in New Zealand are supported to age well in ways appropriate to their needs and cultures.
- Communities are age-friendly, with initiatives to keep people healthy, well-connected, independent, respected and able to participate fully in their communities and with family and *whānau*.

As the strategy goes on to make clear, and this is common ground in most high-income countries, efforts to promote the achievement of its goals within *all* communities are to be incorporated quite explicitly in the plans for achieving the strategy’s objectives. It recognises, in other words, that different communities within the same society are more or less disadvantaged when it comes to the ability of their members to participate actively in maintaining their health and functional ability. . Lack of knowledge (being ‘health smart’) is only part of the problem: putting knowledge into effect requires the presence of opportunities (or resources) for participation and the absence of barriers, and these are not distributed equally through society. It is apparent, furthermore, from the last of these objectives that the strategy has to extend beyond the health service to be multi-sectoral.

## and questions for further research

- To help households and families adjust to the pressures and challenges associated with demographic change, governments everywhere have to rethink the nature and range of public goods they provide. This applies to the slowest ageing countries in the Commonwealth as well as the fastest. Large increases in the absolute and/or relative size of the older population will create new challenges for government policy and exacerbate the pressures on existing programmes and services.
- One of the main conclusions of this study is that the challenges posed by large increases in the absolute and/or relative size of the older population vary enormously across the different countries of the Commonwealth. What matters here are not just the manifest differences in the pace and extent of population ageing, but the no less manifest differences in social and economic circumstances that condition the capacity of households and governments to adjust to changing patterns of fertility and mortality.
- In those Commonwealth countries that combine a high national income with an already large and growing population share of older people, the sustainability and adequacy of social protection arrangements and publicly subsidised health care has become the object of continuing, close and anxious scrutiny.
- Continuing improvements in life expectancy in countries with a large and growing population share of older people pose major challenges for health and long-term care systems. It is questionable whether health systems even in high-income countries are 'fit for purpose' in their capacity to respond to the demands placed on services by a high and increasing prevalence of frailty and co-morbidity in the older population. Although most high-income countries already have a large and diverse formal long-term sector financed in part by public subsidies, the challenge of expanding provision to cope with an expected surge in demand raises workforce issues as well as funding issues.
- The growing contribution of non-communicable diseases to the burden of mortality and morbidity is a major challenge for all LMICs. In 2012 a report from UNFPA and HelpAge International, speaking principally of LMICs, argued that "there is low priority within health policy to the challenge of the demographic transition, including age-sensitive policy to tackle the rise of non-communicable diseases (NCDs) in populations as they age"<sup>114</sup>. It would be good to be able to affirm that the situation has now changed, and much of the evidence in this present report suggests that many LMICs are fully aware of the challenge and are beginning to develop the kind of health infrastructure that is needed to prevent and manage the most common NCDs. Whether these efforts match up to the challenge is another matter. It is hard to avoid the conclusion that the response in many countries is limited, patchy and fragmented.
- In most low- and middle-income countries in the Commonwealth, formal long-term care services are relatively undeveloped: governments do not subsidise them and households cannot afford to buy them. What makes this heavy dependency on unpaid family care unsustainable is the way in which demographic and social changes are combining to reduce the availability of family caregivers. In such countries, the immediate challenge for policy is not so much to find ways of substituting formal care for family care, but to find ways of supporting family care and to ensure that an adequate safety net is in place when it is not available.



- Lack of hard evidence and data has been a recurrent problem in compiling this report. In many Commonwealth countries, especially LMICs, there is very little publicly available data on service provision for older people and too many countries fail to provide statistics on the older population that are relevant to assessing their social and economic circumstances, e.g. age-specific labour force participation rates and poverty rates. This view has been confirmed in the reviews of the Madrid International Plan of Action on Ageing (MIPAA), including e.g. the 2017 review for the African region, which complained of the “paucity of appropriate age-sex disaggregated data on socio-demographic and health indicators”<sup>115</sup>. In the absence of such data, regularly and systematically collected, it is very hard to make firm judgements about the social conditions and welfare of the older population; and this means that it is very hard to be sure whether or not these conditions are improving. Without some kind of age-disaggregated data, we cannot be sure, for example, whether or not older people are sharing in the benefits of economic growth that show up in aggregate measures such as *GDP per capita*.
- Although these data problems cut across different domains, they are especially marked when it comes to monitoring the accessibility and affordability of health and long-term care services specifically for older people. This limits the ability of the international community to assess the extent to which older people are fully included in national improvements and achievements identified as progress towards Universal Health Care and the Sustainable Development Goals.
- The 2012 review of the implementation of the MIPAA made the point that “gaps between policy and practice, and the mobilisation of sufficient human and financial resources have remained a major constraint”<sup>116</sup>. Although not all of the regional reports for the 2017 quinquennial review of the MIPAA have as yet been made available, the persistence of a major gap between policy formulation and implementation has been highlighted for some countries, e.g. Sub-Saharan Africa<sup>2</sup>. The upcoming publication of the final report of the 2017 review constitutes an important opportunity to take a Commonwealth-wide view on these issues by collating information on
  - (i) progress towards the development of comprehensive strategic policy frameworks for ageing in every Commonwealth country
  - (ii) gaps between policy formulation and implementation in every Commonwealth country.
- Another important issue for further research is suggested by clear evidence of the absence or weakness of regulatory frameworks for formal long-term care services in some countries. More systematic research into the regulation of services for older people would be a valuable resource to help guide the development of services that are certain to proliferate in the future. There is case also for extending this research to consider the legal frameworks that guarantee the rights of older people against various forms of abuse.

<sup>112</sup> *Overview of Available Policies and Legislation, Data and Research, and Institutional Arrangements Relating To Older Persons - Progress Since Madrid.*

<sup>115</sup> *Third review and appraisal cycle of the Madrid International Plan of Action on Ageing in Africa for the period 2012-2017.* UN Economic Commission for Africa, 2017.

<sup>116</sup> *Second review and appraisal of the Madrid International Plan of Action on Ageing.* UN Economic and Social Council, 2013.



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