ILC Singapore

International Longevity Centre

A Tsao Foundation Initiative

THE FUTURE OF AGEING

The ILC Global Alliance Symposium 2013

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International Longevity Centre Singapore

The International Longevity Centre Singapore (ILC Singapore) aims to promote the well-being of older people and contribute to national development through supporting policy, practice and capacity building by enabling a "connecting of the dots" between community, practitioners, academia, policy makers and the private sector through the creation of relevant stakeholder platforms as well as high impact research that strives to inform policy, facilitate cogen policy-action translation, and promote quality, effective practice in Singapore and internationally.

ILC Singapore is a member of the ILC Global Alliance, a multinational research and education consortium which aims to address longevity and population ageing in positive and productive ways, typically using a life course approach, highlighting older people's productivity and contributions to family and society as a whole.

As an initative of the Tsao Foundation, ILC Singapore's mission is to drive for constructive change in how society approaches and responds to ageing.

Tsao-NUS Ageing Research Initiative

In collaboration with the Faculty of Arts and Social Sciences, National University of Singapore, the Tsao-NUS Ageing Research Initiative was established in 2009 to spearhead ILC Singapore's research on ageing. Under the direction of Associate Profesor Angelique Chan, a leading researcher in the field of ageing in Singapore and internationally, numerous studies are already underway, and new, strategic partnerships - such as with the Duke-NUS Program in Health Services and Systems Research in community long term care service programme evaluation - are continually being forged.

Tsao Foundation

Established in 1993, the Tsao Foundation is a not-for-profit organisation dedicated to promoting successful ageing. Through its three major initatives - the Hua Mei Centre for Successful Ageing, Hua Mei Training Academy and International Longevity Centre Singapore - the Foundation pioneers and provides community-based, primary healthcare and social services, promotes capacity-building in eldercare skills, and brings together practitioners, researchers and policy-makers to generate ideas and systems which enable the actualization of the physical, social and mental wellbeing of people as they age.

The Foundation promotes access to affordable healthcare, economic security and the social participation of adults in line with the World Health Organization's concept of active ageing, and frames its activities within an interdisciplinary, intergenerational and life course perspective.

With innovation, excellence and constructive change as its core values, the Foundation's goal is to enable people to age well, regardless of life stage, health status or physical ability.

Acknowledgement

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Foreword

Tsao Foundation celebrated its 20th year in 2013. As we embark on our next decade as an organization, we are committing to a new and transformative future of ageing by embracing a new way of looking at it- not just from the lens of a sick, disabled and poor elderly, but from the lens of an ageing population and a longevity that will allow all kinds of elders to continue to grow and develop their potentials.

As the world's population grows and ages, we will be faced with complex challenges that will require innovative and inclusive responses. As part of our 20th year anniversary, the International Longevity Centre Singapore hosted and co-organised with the Tsao-NUS Ageing Research Initiative, the ILC Global Alliance Symposium 2013 focused on "The Future of Ageing" and brought together researchers, scientists and advocates from the ILC Global Alliance network to highlight these challenges and expand the dialogue on how best to address and prepare for what lies ahead.

This publication is a compilation of speeches and reports presented at the symposium, beginning with the Dr Robert Butler Memorial Lecture. The topics within this publication reflect the breadth of the field of ageing and as such cover a range of issues and topics from different regions.

Yet, within these diverse papers are common themes central to the future of ageing. A major theme spanning these works is the need for a social approach to ageing that recognizes and respects the social capital of the elderly. This approach also promotes empowerment, engagement, self-efficacy and lifelong learning – all topics explored from different perspectives within this compilation. An important facet of the social approach to ageing is intergenerational interactions and exchanges. As discussed in the following papers, to wholly realize the social capital of the elderly, there must be platforms for communication and interaction between generations. Underpinning the social approach is the need for sustainable elderly care frameworks. This theme includes the need for innovative solutions to providing old-age income security, the importance of sustainable long-term care systems, as well as the need to strengthen elderly health care while supporting the creation of age-friendly environments.

In order to meet the needs of the elderly in an inclusive and empowering way, the future of ageing requires transdisciplinary, collaborative and innovative solutions that promote the rights and needs of the elderly. The papers within this compilation strive to shed light on these needs and offer ways forward that address the complexities and challenges of the future of ageing.

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Dr Robert Butler Memorial Lecture: The Future of Income Security

I. Introduction

Good Morning distinguished ladies and gentlemen. It is an honor to be invited to deliver the International Longevity Centre (ILC) Singapore's Robert Butler memorial lecture on the future of old age income security. This is an issue of increasing importance economically, socially, and politically.

I am grateful to Dr. Mary Ann Tsao, president for the ILC Singapore, for this honor. The presence of key officials of ILCs Global Alliance is a testimony to Dr. Mary Ann Tsao's leadership and to the quality of professional staff of the ILC Singapore.

It is entirely appropriate that this lecture is in the memory of Robert Butler, who was among the pioneers in recognizing the need for a rigorous multi-disciplinary approach to longevity studies. The influence of his scholarly and popular publications (Butler 1975, 1985, 2011) among scientists and researchers from many disciplines has been immense.

His life-long pursuit in understanding the ageing process from a scientific and policy perspective, and his role as an idea-entrepreneur, not just in the United States, but also internationally, has now been institutionalized, helping to develop future generation of multi-disciplinary scholars focusing on ageing. Very few scholars are able to leave such a rich and enduring legacy behind. He founded an ILC at the Mount Sinai Medical Centre in 1990, and this gathering demonstrates the spread of ILCs internationally.

His concept of 'productive ageing', focusing on public policies and private behavior to enable individuals to have good quality life has now become part of the conventional wisdom.

He emphasized that research and policies on ageing issues concern individuals of all ages, and not just the old. This point has also been recently emphasized by Börsch-Supan (2013), labeling the proposition that the economics of ageing is only about the old as one of the myths.

The rest of the lecture is organized as follows. An overview of global ageing trends is presented in Section II. These trends arise from a combination of decline in fertility rates and increase in life expectancy. The importance of each of the two factors may vary across countries and even for the same country at different periods of time. This is followed by a discussion of how ageing impacts on the resource requirements in Section III. Section IV discusses avenues for funding and financing-mix, and is followed by concluding remarks in Section V.

II. Global Ageing: An Overview

The most recent data on population projections is from the revised 2012 population projections of the United Nations (UN). The UN projections, which focus on chronological age of the population, are conventionally used for analyzing ageing trends. Sanderson and Scherbov (2007), however, argue that as individuals live longer, both the traditional chronological concept of ageing, which they term 'retrospective age' and forward looking concept termed 'prospective age', should be used for policy formulation and analysis. While the traditional concept measures how many years a person has lived, the 'prospective age' measures the number of expected years left to live by the individuals. With increasing longevity, a fifty year old person, who currently has a much longer life expectancy than a same age person in 1990, may well make different saving, investment, labor force participation and other relevant economic and personal decisions. The differing behavioral decisions in turn have different implications for public policies and social attitudes towards ageing.

The data on 'prospective age' are however not published by UN and other international agencies. The focus in this section therefore is on 'retrospective age'. Nevertheless, policy implications of the 'prospective age' concept, which is consistent with Robert Butler's concept of 'productive ageing', will be incorporated in the analysis in this lecture.

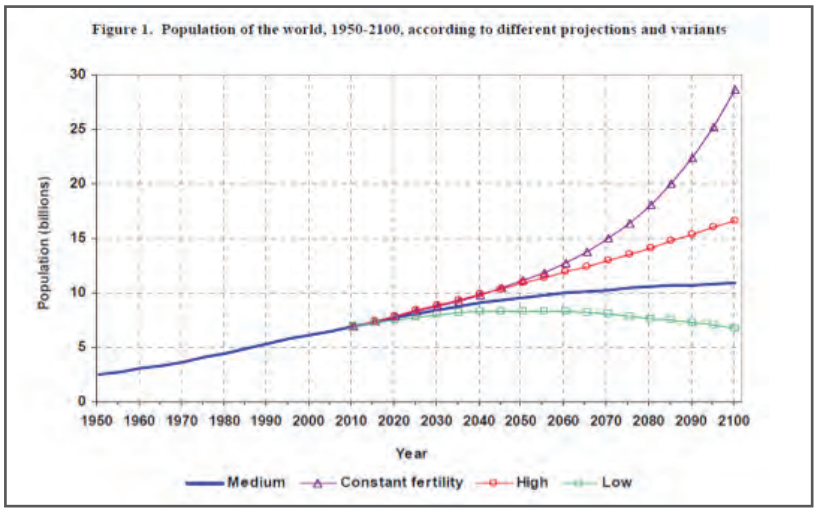
According to the medium-variant projections of the United Nations, the global population will increase from 7.2 billion in mid-2013 to 8.1 billion in 2025, and to 9.6 billion in 2050, increasing by one-third in just thirty-seven years (Figure 1).

There is, however, considerable variation in the projected global population size by the variant chosen[1], especially after the year 2050. Thus, the projections suggest that the difference in population between the low and high variant will be 10 billion people in the year 2100. Under the constant fertility assumption (2.50 during 2010-15 period), the corresponding differential in population projection will be around 20 billion people. These projections bring out the grave implications for the carrying capacity of the earth unless the fertility rates are significantly moderated.

The above suggests that even at an aggregative level, there is considerable uncertainty in population projections, with serious implications for public policy options, and behavioral responses of various stakeholders in the society. They also strongly suggest the need to strengthen population projections and research capabilities in individual countries. Flexibility and reversibility of public policies, including those

[1] The high variant assumes half a child more per woman than the medium variant while low fertility assumes half a child less than the medium variant.

Figure 1: Population of the world, 1950-2100, according to different projections and variants



Source: United Nations Department of Economic and Social Affairs/ Population Divison, World Population Prospects: The 2012 Revision, Key Findings and Advance Tables

involving old age income security, should therefore be given due weightage. As an example, keeping institutional retirement age and pension benefit schedules relatively constant, and lack of flexibility in labor markets facilitating employment of older workers even as longevity increases would imply diversion of greater of society's income and production to meet the needs of the elderly.

Uncertainty in population projections, lack of reliability and timeliness of underlying morbidity and mortality data, particularly at a disaggregated levels, and possible impact of health technologies on life expectancy, which the United Nations projections do not take into account, will make greater competence in the price discovery process for various financial products or instruments deployed by public and private sectors, including those related to pensions and health care, increasingly essential.

Number of Elderly and Pace of Ageing:

Select indicators of the number of elderly by regions are presented in Tables 1A and 1B, on the basis of which the following observations may be made.

i. The projections indicate that the ageing phenomenon is global and its extent is accelerating. Globally, the number of individuals above 60 (henceforth the elderly) is projected to increase from about 765 million in 2010 to 2021 million in 2050; an increase of two and a half times in just forty years, while the proportion of elderly will nearly double from 11 per cent of the total population in 2010 to 21 per cent in 2050. This implies rapid pace of ageing leaving less scope for gradual adjustments to the ageing society.

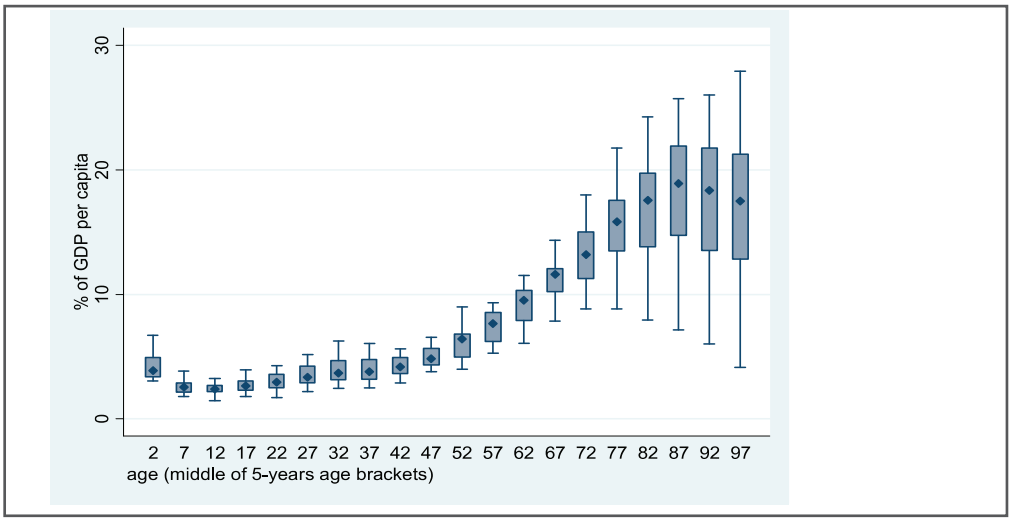
ii. Most of the increase in the number of elderly will be in less and in least developed regions, which have lower incomes and institutional capacities to address the challenges of the ageing society. Thus, the share of elderly in more developed regions will decline from thirty-five percent of the global elderly in 2010 to only twenty-one percent in 2050.

By 2050, the so-called 'old-old' (i.e. those above 80 years) will constitute about a fifth of the elderly as compared to fourteen percent in 2010. In more developed regions, however, the old-old will comprise thirty percent of the total elderly by 2050. This trend is significant as this group of elderly will require disproportionate share of the resources going to the elderly. As Figure 2 suggests, public health expenditure as share of GDP per capita increases with age in OECD countries (Maisonneuve and Martins Oliveira, 2013). The diamonds represent the median. The boxes are the 2nd and 3rd quartiles of the distribution of expenditure across countries. The whiskers are the 1st and 4th quartiles. The reasons for such dispersion and how to minimize the dispersion need to be better understood, particularly in low and middle-income countries. This is essential for pricing health insurance products, and for developing strategies for risk sharing among different stakeholders. More robust databases and research capabilities will however be needed to pursue this task.

Recent developments in Japan help illustrate the challenges awaiting other rapidly ageing countries. Japan celebrated 50 years of universal health coverage in 2011. In 2013, to address rising costs of medicines, the Central Social Insurance Health Care Committee (CSIHCC) proposed using "… economic valuation in granting the health insurance coverage and setting the prices" (Okamoto 2014). Under the proposal, economic evaluations will be undertaken to ascertain the cost of prolonging quality adjusted life by one-year for chronic diseases when certain medicines are to be covered by insurance. This is a major departure from universal access.

iii. The feminization of the elderly is evident from the data on sex ratio (number of men per hundred women) of 83.3 for those above 60 and only 59.8 for those

Figure 2: Public health expenditures by age groups as share of GDP per capita



Source: Maisonneuve, C. & Martins Oliveira, J., 2013

above 80. This is the outcome of higher life expectancy for women than for men. Globally, in 2010-15, life expectancy of women at age 60 was four years higher than for men. This suggests that old-age retirement income security arrangements must have provisions for survivors' benefits as while women live longer than men, their labor force participation rate as a group is usually lower than that for men. Thus, globally, while more than two-fifths of men over sixty were still participating in the labor force, the corresponding proportion of women was only one-fifth. The labor force participation rates tend to vary inversely with income. As per capita incomes in less and in least developed countries grow, they will begin to exhibit trends similar to those found in more developed regions.

iv. The data suggests that the tendency of the elderly to live independently tends to increase significantly with per capita income. Thus, circa 2010, while nearly three-fourths of men and women in more developed regions were living independently, the corresponding global average was about two-fifths. Thus relying primarily on family and community in formal arrangements for providing old age income security becomes less feasible as rapid ageing occurs and per capita incomes rise. Independent living widens choice, the primary benefit of higher income, but it increases the need for formalization of retirement arrangement, and raises costs of their provision.

v. The global ageing trends will have significant labor market implications. The old age support ratio (number of persons aged 15 to 64 years per person aged 65 years or over) for the world will fall from 8.6 in 2010 to 4 in 2050, implying that there will be less number of workers to support the aged. Greater labor market flexibility and other institutional arrangements will be needed to reduce the proportion of average lifespan spent without participating in the labor market. Such extended labor market engagement is consistent with Butler's concept of productive ageing, and with research that suggests that labor market participation performs an anchoring function, helping to keep the mind active and providing social interaction opportunities (Börsch-Supan, 2013).

Ageing trends in five most populous countries:

The ageing trends in the five most populous countries of the world suggests that the world will face challenges in financing old age and facilitating productive ageing in these countries on an unprecedented scale. The number of elderly in China is projected to increase from about 193 million in 2013 to over 450 million by 2050, while in India it is projected to increase from 103 million in 2013 to almost 300 million by 2050. The United States, Indonesia, and Brazil will have about 109, 68, and 67 million elderly persons by 2050 respectively (Table 2).

Population projections for Africa:

The population projections for Africa also suggest unprecedented challenges in financing old age income security. The population of Africa is projected to increase about five-fold over this century, and that of Sub-Saharan Africa about six-fold. The old age population in Africa isprojected to increase by nineteen times, to 795 million, over this century, and that of Sub-Saharan Africa by over twenty-two times. Nigeria will witness an eight-fold increase in population, and a twenty-five-fold increase in old-age population over this century. It is expected to surpass Brazil to be counted among the five most populous countries in 2100. (United Nations, 2013).

III. Ageing and Resource Requirements

An overview of the global and regional trends in ageing strongly suggests that societies will need to allocate additional resources for the aged. Productive ageing policies will also require high level of organizational and coordination capabilities by all stakeholders in the society.

This section briefly reviews the projections of additional expenditure (as a share of GDP) needed to address the

ageing trends. Even as the need for broader productive ageing policies and programs is recognized, the projections primarily focus on costs of pensions, healthcare, and long term care. Even for these areas, the main focus is on financial costs, and not broader economic costs. Thus, the opportunity costs of "unpaid" or "voluntary" care, so prevalent in the not-for- profit sector, and in civil-society organizations, are usually not estimated[2].

The focus of public policies for provisioning of old age income security is usually on pensions, healthcare, and long-term care arrangements. For the European Union (EU 27), age related expenditure on these three areas is projected to rise from 20.3 percent of GDP in 2010 to 24.5 in 2060, requiring additional 4.2 percent of GDP (Roy, Puhani, and Hsieh, 2013).

As may be expected, the average hides wide variations in resources needed for individual countries. Such projections for non-OECD Asian countries are not available. The age related expenditures are however expected to rise as coverage and benefit levels increase, and as state intermediation acquires greater prominence.

For analyzing resource needs for ageing, 'life expectancy at 60' is a relevant indicator. For 2010- 15, it is projected globally to be 18 years for men, and 22 years for women (Table 1B). The differences in life expectancy are positively correlated with income levels. As the current low and middle- income countries progress towards higher income levels, the differential may however narrow among regions, but widen among men and women.

The tendency for the elderly to live independently is also positively correlated with income. Globally, about two fifths of elderly men and women exhibit this tendency (Table 1B). The East Asian welfare model which emphasizes family as the main provider of retirement income security appears oversimplified as empirical evidence in East Asia also suggests that in some economies such as Taiwan, significant proportion of the elderly are living alone, and much of the economic support from non-government sources has been replaced by the support from the state (Li, 2013). A higher proportion of elderly living independently imposes not just financial challenges, but challenges related to delivering public services to them as well.

Many Asian countries hope to rely on increasing labor force participation of the elderly to finance old age. Globally, only about two-fifths of elderly men, and one-fifth of elderly women are participating in the labor force (Table 1B). This ratio, however, declines with rising incomes, a trend which low and middle income Asian countries are likely to exhibit as their per-capita income increases. Nevertheless, obtaining at least a portion of income in retirement from labor market activities will be essential, requiring changes not only in the functioning of the labor markets, and tax provisions for the elderly, but also attitudinal changes by the stakeholders.

Two broad avenues for funding requisite resources are through reducing expenditure needs, and through raising additional resources. It may be useful to distinguish between funding and financing for the old age.

Funding involves allocating society's total economic resources to meet the needs of the ageing population. To the extent cost compression and expenditure-needs reducing measures are effective, the requirements for additional funding will be lower. Each society however will need to find additional resources to meet ageing challenges, but their size will vary among different societies.

Financing refers to different methods or instruments, such as social or private insurance, mandatory savings, government budgetary financing, employer provision[3], etc. Financing mix is important as it impacts on where the ultimate economic burden lies and how the risks of funding the aged are distributed among different stakeholders.

Avenues for Funding Resources and Financing – Mix :

Two broad avenues for funding concern reducing expenditure needs, or more accurately reducing the growth rate of increases in funding needed to meet the ageing challenges; and to raise conventional and non-conventional government revenues, including taxes.

It should be recognized that the primary source of economic security for both the young and the old is dependent on the current level of GDP and its trend rate of growth (Barr and Diamond, 2008). Merely putting aside money for retirement is thus not adequate; the pension savings must also be utilized productively through financial intermediation.

Levy and Schady (2013) have emphasized the importance of sustainable economic funding in a recent survey of social policies in Latin America; "Social policy, in our view, should also contribute to productivity growth, or at least not hinder it. In the end, one cannot sustain a welfare state on stagnant productivity, particularly since the costs of that welfare state will increase rapidly as the region's population ages and its epidemiological profile evolves towards more cost pathologies" . . . "Higher average per capita incomes are needed if only to provide the revenue base from which social programs can be financed - a key point in a region that in the past suffered much from unsustainable fiscal deficits."

The above message is particularly instructive in the current global economic environment that has led to diminished

[2] This is an area meriting greater research efforts.

[3] The economic burden however may be partly or wholly shifted to employees and others as employers alter other elements of the overall staff costs of the company.

[4] Towers Watson's Global Pensions Assets Study (GPAS) 2014, covering 13 countries/economies indicates that pension assets as at end of 2013 were nearly USD 32 trillion, equivalent to slightly more than four-fifths of the GDP of the sample countries. Investing these assets in a manner which enhances long term growth rate of these countries could help generate real resources to fund ageing needs. It is in this context that the issue of allocation of savings by global financial and capital markets assumes significance.

growth prospects, increased importance of fiscal and debt sustainability, increasing difficulties in generating high returns from the pension assets[4], search for more reliable macroeconomic theory and policy guidelines, and rising global inequalities. (IMF, 2013).

Reducing Expenditure Needs:

Policies conducive to productive ageing facilitate at least three avenues for reducing the expenditure needs. First, they could lead to better understanding the underlying reasons for certain diseases being more prevalent in the elderly, reducing their incidence and treatment costs.

Second, they could assist in keeping individuals economically (and socially) active for a longer period. Increasing the effective retirement age[5] has been one of the significant policy responses in Europe, U.S, Japan, Singapore, and the U.K. Other Asian countries, most notably China, India and Indonesia, may also consider reforms designed to increase effective retirement age to reduce the number of years for which financing is needed in old age. The gradual rather than abrupt shift from full time work to retirement also merits serious consideration.

Third, awareness of productive ageing facilitates more informed debates about ageing and equitable sharing of resources and amenities between generations. This is an area where ILCs are playing a vital role. The state also has a responsibility to initiate high quality expertise and empirical-evidence based debate among all the stakeholders.

Fourth, Social Security needs of increasing number of cross border workers also need to be addressed. Officially recorded remittance flows to developing countries reached an estimated $401 billion in 2012, growing by 5.3 percent compared with 2011. Remittance flows are expected to grow at an average of 8.8 percent annual rate during 2013-2015 to about $515 billion in 2015 (Table 1: Estimates and projections for remittance flows to developing countries, Migration and Development Brief, World Bank,2013). Stock of immigrants is projected to increase from about 216 million in 2010 to 400 million by 2040 (Sutherland, P. 2013, Migration is Development).

In analyzing labour migration, Holzman and Koettl (2014) have argued that "… legal and human rights based considerations are increasingly joined by economic considerations that help underpin the social policy objectives with a more analytical and empirical framework". They propose a framework for analyzing portability of pension and health benefits across borders which incorporate risk pooling, pre-funding and redistribution to improve efficiency and fairness. Such a framework can be used both as a substitute and compliment to totalization agreements.

The totalization agreements involve recognition of social security contributions made by citizens of the two respective countries. They therefore help protect social security benefit rights of workers who divide their working career between two or more countries. They are akin to Double Taxation Treaties (DTAs) involving income taxation. In Asia, the Philippines and India have been active in pursuing totalization agreements. It will be necessary to review the social security provisions for cross border workers for each provident and pension fund scheme. This will be a challenging task.

Fiscal Space: Definition and Options

The discussion so far strongly suggests that countries will need substantial fiscal space. Fiscal space may be defined as "…the financing that is available to government as a result of concrete policy actions for enhancing resource mobilization, and the reforms necessary to secure the enabling governance, institutional and economic environment for these policy actions to be effective for a specified set of development objectives." (Roy, Heuty and Letouze, 2007). The above definition explicitly recognizes that if additional budgetary expenditure, including that for social protection, is not spent productively with outcome orientation, then the desired impact will not occur. In countries with low coverage and large informal sectors, budgetary financed and mostly non-contributory, but means, asset, or pension tested social pensions grants will be needed.

In many Asian countries, the coverage of pension and healthcare programs is relatively low. For extending coverage, social pensions, involving non-contributory benefits financed from budgetary revenue are potentially an important source. But these require fiscal space and organizational capacity by the public sector to deliver these pensions to the intended beneficiaries.

Estimates of fiscal costs of adequate social pensions alone are large. In New Zealand, fiscal costs in 2009-10 were 4.3 percent of GDP and are expected to increase to 8 percent of GDP by 2050. In Australia, the fiscal costs of means tested pensions were 2.7 percent of GDP in 2009, and are projected to be 3.9 percent of GDP in 2050 (Bateman and Piggott, 2011). ILO has estimated that modest social pensions in low and middle- income countries would be around 1 percent of GDP in the short run; but its estimates for a complete social protection package range from 3.7 percent to 10.6 percent of GDP (Barrientos, 2009). Even if additional resource needs are equivalent to around 2 percent of GDP, this will require substantial reforms in public financial management in countries with total fiscal revenue to GDP ratio of around 20 percent[6].

An argument may be made that without reforming existing formal systems and realizing real resources savings, additional fiscal (and private expenditure) space would be difficult to create without significant distortions elsewhere. Some countries such as U.K, India, Singapore, as well as some states in US have been reforming civil service schemes to bring about greater equity and sustainability. Progress will

[5] This is usually lower than the institutional or statutory retirement age.

[6] There is anecdotal evidence that state officials collect tax-like levies from individuals and businesses that do not get deposited in the state treasury, and are therefore not included in conventional measures of tax revenue. This implies that real tax burden in an analytical sense may well be much higher, which may reduce the scope for further increases in raising fiscal resources.

depend on improving design, and administrative features of pension schemes, with a view to leveraging small parametric changes, which cumulatively will have a signification impact on sustainability and fairness of the current pension and healthcare schemes.

Additional Avenues:

Additional avenues to generate resource savings and fiscal space and finance for funding expenditure on the aged are briefly noted below.

There is considerable scope for economic resource savings, which can be obtained through increased professionalism in the design, administration and structure of provident and pension funds, and health care systems, among others. The Philippines SSS (Social security system), for example, exhibits administrative costs of around 7 percent of contributions, while the estimate for Malaysia's EPF (Employee Provident Fund) is around 3 percent. A reduction in costs of the SSS through process and system reforms could thus improve benefits. The SJSN Law of Indonesia (2004) has insufficient clarity on financing, benefits etc., and does not adequately address the need for appropriate organizational incentive structures. This neglect may generate contingent fiscal liabilities. Skypala (2014) has argued that separating charges for fund investments and for administration by pension fund managers could reduce pension management costs in the UK, thus improving benefits. There is a strong case for exploring various avenues for reducing administration and compliance costs of pension and health care programs.

Enhancing competence to generate resources from unconventional sources such as utilizing state assets (land, property rights such as air-space, oil and mining resources, and carbon trading, among others) efficiently. This is likely to involve:

i. Better coordination among and between pension and healthcare sectors for increased resource savings and greater policy coherence (Bali and Asher 2012).

ii. Conventional tax reforms, and improving compliance levels and efficiency. In Europe, US, and the U.K, corporate tax reforms, particularly those provisions designed to protect the tax base have become a priority. The aggressive corporate tax planning is exemplified by reports that Google shifted € 9 Billion to Bermuda as part of its global tax planning (Houlder, 2013) In 2012, OECD created a forum on VAT (Value Added Tax) to help counter aggressive tax planning of VAT by the businesses.

    (http://www.oecd.org/ctp/consumption/firstmeetingoftheoecdglobalforumonvat.htm)

iii. Sovereign Wealth Funds (SWFs); set up to smoothen excess of current receipts over expenditure arising from energy resources, trade surpluses, and other sources, and between generations represent another avenue for funding old age needs. In Asia, South Korea, China and Singapore have been adept at using the SWFs to fund future expenditure needs, including those of the aged.

iv. Financial innovations, particularly at the pay-out phase, are accumulation schemes. The conventional practice of relying on annuities will be inadequate given limited financial instruments to mitigate longevity risk, and due to uncertainties in longevity trends due to uncertainties in medical technology breakthroughs. Such innovations, which reduce transaction costs of service delivery and provide better risk sharing between the insurance company, the individual, and the government, will be needed.

Some high income countries have attempted to finance old age by developing instruments which convert real estate into a retirement consumption stream. They have had some success, but greater research and innovations in this area is essential for it to play a significant role. In developing Asia, individuals and households will need to bear a greater proportion of increased share devoted to old age financing.

Promoting its secure and stable policy and regulatory environment for long term savings by the individuals should therefore be an important instrument for financing old age. But this needs to be undertaken without creating fiscal risks which ultimately must be borne by the citizens.

IV. Concluding Remarks

In a remarkably short period of time, Robert Butler's concept of productive ageing has inspired policymakers, researchers and other stakeholders to address the challenges arising from global ageing.

It is increasingly recognized that the issue of ageing does not just concern the aged but persons of all ages. This implies that finding economic resources, i.e. funding, for the aged will need to involve ways to sustain growth, improve productivity, finding ways to economize on resources, reduce expenditure needs, and raise additional resources from conventional and nonconventional sources.

The needs of the increasing old-age population living longer and the rising expectations of both the young and the old are at odds with the difficult global and domestic economic environment. There is a serious risk to social cohesion and state-people implicit contract if the urgency of addressing it is not recognized, and no effective initiatives are forthcoming.

The challenges in evolving appropriate policies, finding adequate resources, and sustaining public support and cohesion which could facilitate productive ageing, should however not be minimized. The role of ILCs will be critical in enhancing research capabilities and in contributing to analytically rigorous and empirical-evidence based public policy debates concerning issues related to productive ageing. The governments must be held accountable if they fail to create policy environment and provide requisite resources for facilitating such debates, and for not incorporating relevant findings in productive ageing policies and programs.

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Tables

Table 1A: Select Indicators of the Aged by Region

	Population aged 60 years or over							
	Number (millions)		Proportion of total population		Share of old-old (80+)[1]		Sex Ratio, 2010	
Area	2010	2050	2010	2050	2010	2050	60+	80+
World	764.9	2020.4	11.1	21.2	14.2	19.4	83.3	59.8
More developed regions[a]	270.8	417.4	21.8	32	19.6	29.6	74.6	50.4
Less developed regions[b]	494.1	1602.9	8.7	19.4	11.2	16.7	89.2	69.9
Least developed regions[c]	44.5	183.3	5.3	10.1	8.7	11.3	89.5	82.0

[a]More developed regions comprise all regions of Europe and Northern America, as well as Australia, Japan and New Zealand.
[b]Less developed regions comprise all regions of African, Asia (excluding Japan) and Latin America and the Caribbean, as well as the regions of Melanesia, Micronesia and Polynesia.
[c]The least developed countries, as designated by the United Nationals General Assembly in 2011, comprise 48 countries including 33 in Africa, 9 in Asia, 1 in Latin America and the Caribbean and 5 in Oceania. The least developed countries are included in the less developed regions.
[1]Persons ages 80 years or over (the 'old-old') as a percentage of the population aged 60 years or over.
Source: United Nations Department of Economic and Social Affairs/Population Division, World Population Prospects: The 2012 Revision; accessed August 2013.

Table 1B: Select Indicators of the Aged by Region

Area	Life Expectancy at age 60, 2010-2015		Proportion living independently, 60 years or over (percentage), circa 2010		Old Age Support Ratio[1]		Proportion in labor force, 60 years or over[2] (percentage), circa 2010	
	Men	Women	Men	Women	2010	2050	Men	Women
World	18	22	40	39	8.6	4.0	42	20
More Developed Regions[a]	21	25	75	73	4.2	2.3	26	15
Less Developed Regions[b]	18	20	28	25	11.2	4.6	50	22
Least Developed Regions[c]	16	17	12	13	16.2	9.2	68	43

[a]More developed regions comprise all regions of Europe and Northern America, as well as Australia, Japan and New Zealand.
[b]Less developed regions comprise all regions of African, Asia (excluding Japan) and Latin America and the Caribbean, as well as the regions of Melanesia, Micronesia and Polynesia.
[c]The least developed countries, as designated by the United Nationals General Assembly in 2011, comprise 48 countries including 33 in Africa, 9 in Asia, 1 in Latin America and the Caribbean and 5 in Oceania. The least developed countries are included in the less developed regions.
[1]Number of persons aged 15 to 64 years per person aged 65 years or over
[2]Proportion of persons aged 60 years or over who are economically active, as estimated and projected by the International Labor Organization (ILO).
Source: United Nations Population Division, available at http://www.un.org/en/development/desa/population/publications/pdf/ageing/2012PopAgeinga and United Nations Department of Economic and Social Affairs/Population Division, World Population Prospects: The 2012 Revision.

Table 2: Select Demographic Indicators of Five Most Populous Countries

Country	2013			2025			2050		
	Total Population*	60+	80+	Total Population	60+	80+	Total Population	60+	80+
China	1385.6	192.6 (13.9)	22.2 (1.6)	1449.0	289.3 (20.0)	29.3 (2.0)	1385.0	454.4 (32.8)	90.4 (6.5)
India	1252.1	103.9 (8.3)	10.0 (0.8)	1418.7	156.6 (11.0)	14.4 (1.0)	1620.1	296.5 (18.3)	37.2 (2.3)
USA	320.1	63.2 (19.7)	11.8 (3.7)	350.6	86.4 (24.6)	2.7 (1.0)	400.9	108.2 (27.0)	9.6 (3.0)
Indonesia	249.9	20.2 (8.1)	2.0 (0.8)	282.0	33.9 (12.0)	15.2 (4.3)	321.4	67.7 (21.1)	31.7 (7.9)
Brazil	200.4	22.4 (11.2)	3.2 (1.6)	217.5	35.7 (16.4)	5.2 (2.4)	231.1	66.9 (28.9)	15.8 (6.8)

*Population figures are in millions
Note: Numbers in parentheses denote the percentage of country's population over 60/80 years in a given years
Source: United Nations Department of Economic and Social Affairs/Population Division, World Population Prospectus: The 2012 Revision, Key Findings and Advance Tables

Speaker Biography


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Future of Long Term Care Financing in Japan and The Netherlands

Introduction

The OECD writes in her 2011 report on Long Term Care (LTC) that there are at least four reasons why pressure on long-term care grows. First, the demographic transformation occurs due to the rapid ageing of populations. Both Japan and The Netherlands experience increasing life expectancy. Also both countries had a baby boom after the Second World War. The baby boom generation starts to retire and within ten to fifteen years the baby boom generation will get frail. Therefore the amount of frail older people will increase rapidly. Secondly, OECD observes a change in the societal models, such as declining family size, changes in residential patterns of people with disabilities and rising female participation in the formal labour market. These are likely to contribute to a decline in the availability of informal caregivers, leading to an increase in the need for paid care. Third, as societies become wealthier, individuals demand better quality and more responsive social-care systems. People want care systems that are patient-oriented and that can supply well coordinated care services. Fourth, OECD observes a technological change that enhances possibilities for long-term care services at home but this may require a different organization of care. Therefore the care service organizations and their performance must change. Will this increase the costs? The changes will create upward pressure on the demand for long-term care services and, as a consequence, the human and financial resources necessary to provide long term care (OECD, 2011).

In this paper ILC Japan and ILC The Netherlands focus on their long-term care system and their future needs. Japanese and Dutch data on health and long-term care are described to discuss both systems in order to learn. The paper ends with conclusions and options to deal with the coming future.

Demographics

In Japan and The Netherlands the population of people above 65 years increases and between 2010 and 2025, the number of people aged 75 and older is growing rapidly. Chart 1 shows data of the increasing population above 65 years in Japan. Chart 2 shows similar data of The Netherlands.

The most challenging issue for long-term care will be the increasing number of people 75 years and older. In Japan this group has yet almost doubled from 7.17 million in 1995 to 14.07 million in 2010. It is expected to increase to 21,8 million in 15 years (2025). However, the number will flatten out after this period and will settle around 22 million (chart 1). Similar as in Japan, The Netherlands has an increasing number of people 65 years and older (chart 2). This number will double from 1995 to 2040. After 2040 the amount of people above 65 years and older will decrease. After 2055 the number of persons 80 years and older will decrease in the Netherlands (no data shown).

Both countries experience a growth in the number of older inhabitants and therefore an increasing number of people

Chart 1: Change and projections in the elderly who are over 65 years old and 75 years old in Japan (numbers, ratio among the whole population)

	Year 1995	2010	2025	2040
Over 65	18,260,000 (15.0%)	29,240,000 (22.8%)	36,580,000 (30.3%)	38,680,000 (36.1%)
Over 75	7,170,000 (5.7%)	14,070,000 (11.1%)	21,790,000 (18.1%)	22,230,000 (20.7%)

National Institute of Population and Social Security Research, "Population Projection for Japan", (January 2012)

Chart 2: Change and projections in the elderly who are over 65 years old and 75 years old or 80 years old in The Netherlands (numbers, ratio among the whole population)

	Year 1995	2010	2025	2040
Over 65	2,033,576 (13.2%)	2,538,328 (15,3%)	3,786,220 (21,8%)	4,720,560 (26.5%)
Over 75	*	*	1,806,955 (10.4%)	2,579,804 (14.5%)
Over 80	475.757 (3,1%)	647.994 (3,9%)	983.942 (5,6%)	1.554,742 (8,7%)

Central Bureau of Statistics online database (Statline)

* no data available

who will become frail and in need of long-term care. Japan and The Netherlands need to consider if their long-term care system is sustainable for the future to come. For Japan's long-term care system it is essential to consider how this country can prepare themselves in the coming years. There national policy is to make the system sustainable so it will be likely that Japan is able to continue taking care of older people properly in Japan later on. In the Netherlands in 2013 a new policy on long-term care is brought out to deal with the same issue of sustainability.

Long-term Care System in Japan

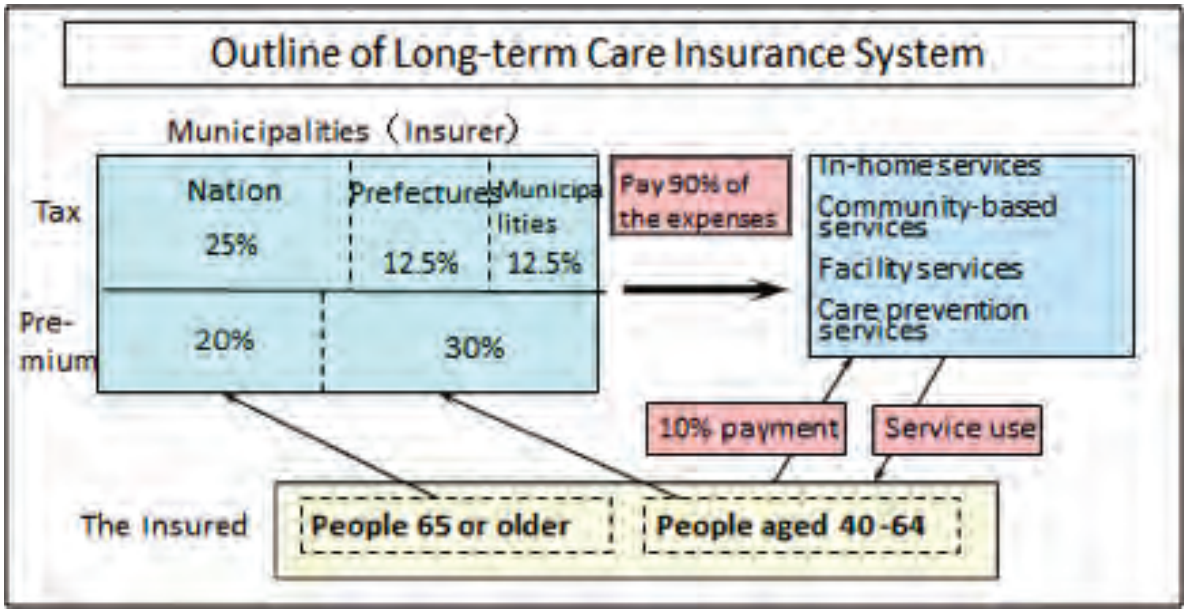
The Japanese Long-term Care Insurance System started in 2000 in response to the increased care needs of older person. Also, family size was shrinking and the family caregivers were getting old themselves, so it became more difficult for families to care by themselves. Before 2000 there had been actually a tax-funded long-term care scheme already in place, which was founded by municipal governments. Because this scheme was funded entirely by tax, the amount of services the municipalities can provide was limited and the service was often limited to low-income person. As a result, many older people who needed care for a long time found a way to get care within the medical care insurance system. Due to this shift, the spending of the medical care insurance system increased to much. Thus it was necessary to establish a long-term care insurance system, which not only meets the needs of the elderly but also encourages their independence. The new system is a social insurance system, which makes clear the relationship between benefits and responsibilities. Beneficiaries can choose various service providers including the private sector. Since its introduction in 2000, the Long-term Care Insurance System has prevailed widely. People who receive the long-term care insurance system service increase from 1.84 million which was in 2000 to 4.13 million in 2013 (Ministry of Health, Labour and Welfare, 2013).

Long-term Care System in The Netherlands

The Dutch Exceptional Medical Expenses Act (AWBZ) is a national insurance scheme for long-term care that has undergone several changes since its installation in 1967. Over the years the core remained the same: the act is established to provide care for people who cannot provide in their basic care needs independently. This can be the consequence of a physical, psycho-geriatric or psychiatric ailment, or a mental, physical or sensorial handicap. Most expenses within the AWBZ are made for (frail) older people, with or without cognitive limitations or physical/ functional limitations. Care can be provided both at the client's home or an institute where the client has it's residence. Long-term care is not given in hospitals. When any kind of care is given in the hospital, the care is funded through the Health care Insurance Act (ZVW). The fund for the AWBZ is established through fees paid by employees and the government.

Every person who wants to be eligible for AWBZ funding needs to be assessed by the Centre of Needs Assessment (CIZ). The CIZ assesses the care need of an individual according to a "funneling model". With the use of this model, the care needs of a specific patient are assessed, on which a decision is made. A positive decision (indication) gives access to care paid by AWBZ. The amounts paid to long-term care providers are standardized amounts for every indication setting (the kind and the amount of care needed). In 2008 "care-severity packages" had been developed for those who have an indication AWBZ for inpatient care , which was phased in to determine the budgets for inpatient care long-term care facilities (i.e. nursing homes, elderly homes, institutions for mentally and physically handicapped and mental care institutions). (Rolden en Van der Waal, 2012).

Figure 1.



Financing the Long-term Care System in both countries

In Japan the funding of benefits for the long-term care insurance system after excluding co-payment is provided by insurance premiums (50%) and public funds (50%). For the public funds, the national government pays 25% and the prefectures and municipalities pay 12.5% each. The insurers are local governments.

Insured persons are citizens who are over 40. People who are over 65 pay 20% of the premiums whereas people who are between 40 and 64 pay 30%. When one wants to use the service, he or she will need to pay 10% of the service fee as co-payment (Figure 1). Long-term care insurance services are provided when people aged 65 or over who require care, and when people aged 40-64 develop certain diseases, such as terminal cancer and rheumatoid arthritis. (Ministry of Health, Labour and Welfare, 2011)

In the Netherlands every citizen older than 15 years of age with a taxable income has to pay an income-related contribution to the AWBZ (2013 12,65% of the income with a maximum of a little bit more than € 4,000 per person per year). In addition, for most long-term care services covered by the AWBZ income-related co-payments are required. When the expenses made by the AWBZ fund exceed the bulk of the incoming fees, the deficits are compensated by the National government through a contribution by the national treasury (Rolden, Van der Waal, 2012)

The percentage of GDP spent on long-term services covered by AWBZ increased from 0.8 percent in 1968 to 2.0 percent in 1980 and further to 3,8 percent in 2009. This is 23 billion euro's. Part of this increase, however, is due to an expansion of AWBZ coverage (Rolden, Van der Waal 2012).

Japan in detail: Social Security System and Finance

i. Changes in Social Security Expenditure in Japan

The total expenditure of pension, medical insurance and welfare including long-term care insurance combined is increasing drastically. In 1990 the amount was 47.2 trillion yen, which rose to 109.5 trillion yen in 2012. All of these systems are funded by premiums and tax. The welfare system, which includes long-term care insurance costs, is the least expensive of the three systems, nonetheless, its increase is most remarkable and the expenditure rose to 20.6 trillion yen in 2012 while it was 4.8 trillion yen in 1990. (Chart 3)

ii. Tax Revenue and Expenditure of General Account in Japan

In 2000, tax revenue was 50.7 trillion yen and total expenditure was 89.3 trillion yen while in 2012, it was 42.3 trillion yen for tax revenue and 90.3 trillion yen for expenditure. Tax revenue has been 40-50% of the total expenditure and the shortfall is compensated by bond (debenture), which also means debt. Japanese government's

Chart 3: Total Social Security Expenditure to National Income (trillion yen)

	1990		2000		2012 (budget base)	
Total Amount of Benefits	47.2	100.0%	78.1	100.0%	109.5	100.0%
Pension	24.0	50.9%	41.2	52.7%	53.8	49.1%
Medical Care	18.4	38.9%	26.0	33.3%	35.1	32.1%
Welfare and others	4.8	10.2%	10.9	14.0%	20.6	18.8%

Ministry of Health, Labour and Welfare, Change in Social Security Benefits, 2012

Chart 4: Breakdown of General Account Expenditure (trillion yen)

		F.Y.2000		F.Y.2012	
Tax revenue		50.7		42.3	
Total expenditure		89.3		90.3	
Breakdown of expenditure	Social security, etc.	19.7	22.0%	26.9	29.7%
	Culture, education and science promotion	6.7	7.5%	5.2	5.8%
	Bond expenditure	21.5	24.0%	21.9	24.3%
	Local government finance	15.9	17.7%	16.6	18.4%
	National defense	4.9	5.5%	4.7	5.2%
	Public works	10.2	11.5%	4.5	5.0%
	Other	10.45	11.7%	10.474	11.6%

Ministry of Finance, General Account Tax Revenue, Change in total amount of expenditures and amount of government bond issuance, http://www.mof.go.jp/tax_policy/summary/condition/003.htm

debt increased to over 1,000 trillion yen in March 2013 and that is around 230% of GDP, which is the highest in the world. Expenditure for social security was 22% in 2000 and increased in 2012 to 29.7%. It is clear from the breakdown of expenditure that the government's expenditure had decreased for each item except social security related and bond expenditure (Chart 4).

iii. Comprehensive Reform of Social Security and Tax Reform

Japanese social expenditure (22.4%) is higher than that of the United States (19.2%) but lower than European nations (France 32.1%, Netherlands 24.1%, Sweden 29.8% and the United Kingdom 24.1%). Also, if you focus on burden, there is the same trend in the international comparison for the ratio of tax and social insurance premium to national income. Japan (39.9%) is higher than the United States (30.3%) but lower than European nations (France 60.1%, Germany 53.2%, Sweden 62.5% and the United Kingdom 45.8%).

Due to the current situation in Japan where social expenditure and the ratio of taxation and social security spending to national income is somewhat lower than Europe, the Japanese government decided that there is room for increasing tax. The legislative bill for the "Comprehensive Reform of Social Security and Tax" which aims to increase the consumption tax from the current 5% to 8% in 2014 and 10% in 2015 had passed the Diet (National Parliament) in 2013. Increase in the insurance premium is also expected.

Under this tax reform, 80% of what is gained from the increase will be used mainly as extra funding to cover the increase in social security expenditure due to the increase in the elderly population. It will reduce the burden on the general tax revenue and it can be used to reduce the debt as well. The Japanese government is targeting changing the finances to a budget surplus by 2020. The remaining 20% will be used for enhancing and improving the social security including medical and the long-term care (MHLW, 2012).

The Netherlands in detail: costs and usage of the system

There are three important health care laws in the Netherlands: the Health Insurance Act (ZVW), the Exceptional Medical Expenses Act (AWBZ) and the Social Support Act (WMO). Basically, medical care is arranged through the ZVW, long-term care through the AWBZ, and social and supportive services through the WMO. The total amount of money spend on health care is 87 billion. In 2010 the Netherlands counted 16,6 million inhabitants, including 2,5 million people at age 65 and older.

In the Netherlands the health care expenditure per person per year is increasing for the medical care (ZVZ), long-term care and public health (is part of government responsibility). In chart 6 the costs per person per year per domain are given. In 2010 the health care costs for a civilian is more than 5.000 euro per year. Important to notice is that health care expenditure per Dutch citizen has risen with almost 1,000 euro's in 5 year time. During the time of writing, politicians are having pre-election debates with rising health care expenses as a major subject. Different politicians are emphasizing that increasing costs should be contained while approaches differ.

Chart 5: Social Expenditure, Ratio of tax and social insurance premium to National Income (2009)

	France	Japan	Sweden	U.K.	U.S.A
Social Expenditure	32.1	22.4	29.8	24.1	19.2
Ratio of Taxation tax and social insurance premium to National Income	60.1	39.9	62.5	45.8	30.3

International Comparison of National Burden Ratio http://www.mof.go.jp/english/tax_policy/publication/tax004/E_0710.pdf OECD, National Accounts, Revenue Statistics, etc.

Note: Data for Japan are estimated figures as of FY2012, and those for other countries are actual figures as of 2009.

Chart 6: Sources and domains of health care expenditure in Euro

Source of finance	2000	2006	2007	2008	2009	2010
Government	413	502	655	689	739	751
ZVW	825	1,635	1,690	1,965	2,068	2,132
AWBZ	915	1,418	1,404	1,348	1,404	1,462
Other	792	772	807	847	874	898
Domains	**2000**	**2006**	**2007**	**2008**	**2009**	**2010**
Expenses for cure	1,683	2,489	2,643	2,830	2,955	3,041
Expenses for care	1,135	1,654	1,725	1,835	1,948	2,021
Policy & overhead	128	184	188	184	182	180
Total expenses	**2,946**	**4,327**	**4,556**	**4,849**	**5,085**	**5,243**

Central bureau of statistics, Statline, 2012

In 2010 600,000 people used long-term care in the Netherlands. In that year around 340,000 people received care in their own home. The remaining clients receive care in an institution like nursing homes. The clients who can get care covered from the AWBZ are not only older persons, but also persons with a mental or physical handicap as these handicaps are part of AWBZ coverage as well. There are around 150,000 voluntary workers active in long term care. In 2010 the total costs of the long-term care in the Netherlands amounted to more than EUR 23 billion.

In the last decade two major changes have been made concerning the AWBZ. Since 2007, some services are no longer provided through the AWBZ, but through the Social Support Act (WMO) that mainly instrumental assistance (e.g. help with cleaning) and the provision of aiding tools (such as wheel chairs) provide. In 2013 the National Government decided that nursing care (wound dressing, injecting, teaching self-care) and geriatric rehabilitation will be part of the Health Care insurance Act (ZVW). In future a policy will be enrolled that citizens pay their own costs for residence in elderly homes and nursing homes. Then the AWBZ fund will only consist of personal care (help with showering, dressing, shaving, going to the toilet), counseling (help with organizing day-to-day practical matters, such as making coffee or filling in forms), improving skills or behavior (to be able to do your own personal care as long as possible yourself) and short-term residence in certain institutions (Rolden, Van der Waal 2012).

Reform of Medical and Long-term Care Services

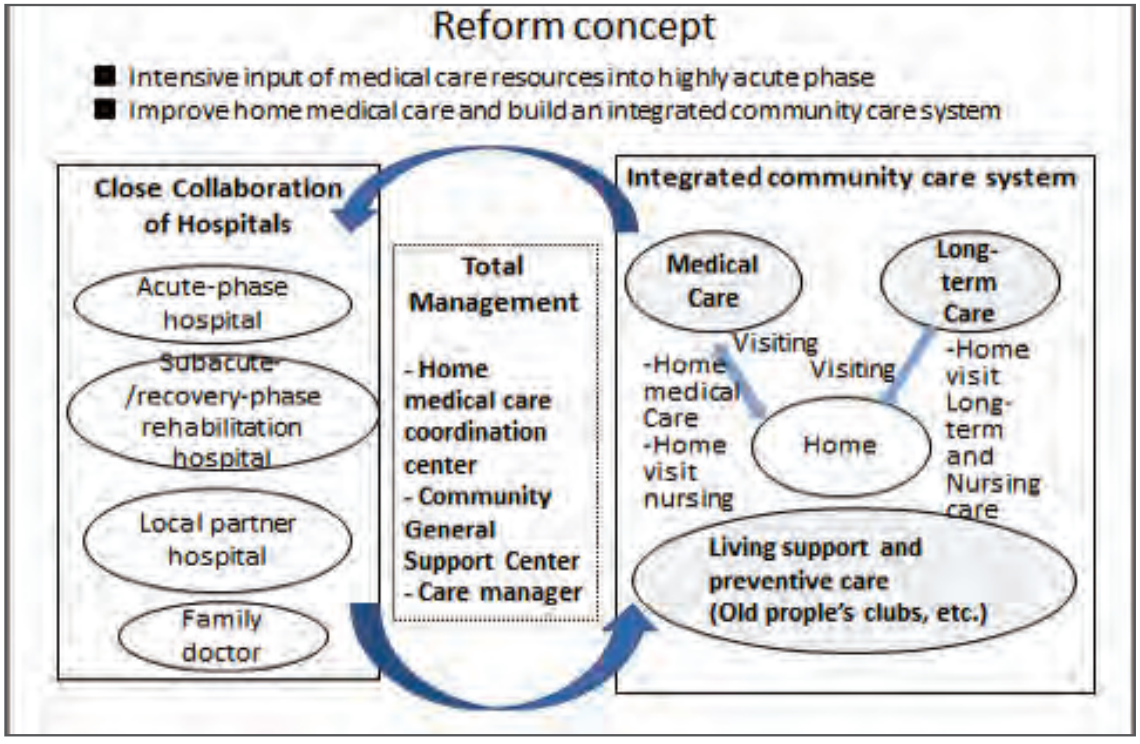
The Japanese government is planning to proceed with structural reform in the areas of medical and long-term care in order to make the service delivery system more effective. Japanese acute phase medical care is supported by fewer numbers of doctors and nurses by international standards, and some hospitals have severe working environments. At the same time, it has been pointed out that there are some patients who do not necessarily require medical care and as a result, it makes the average length of stay in a Japanese hospital quite long (chart 7). The average length of stay in the Netherlands is 5.8 days and is quite low due to strict hospital discharge policies and availability and acceptability of (long-term) care at home, rehabilitation centers or in elderly homes and nursing homes.

Chart 7: Average inpatient hospital stay (day)

	France	Germany	Netherlands	Japan	U.K.	U.S.A.
Average length hospital stay (in patient and acute care)	12.7	9.6	12,5 *	32.5	7.7	6.2

OECD Health Data 2012 Average length of stay: in-patient and acute care. Last data available in Netherlands are data 2001. Since 2002 the Netherlands registries length of stay in acute care.

Figure 2.



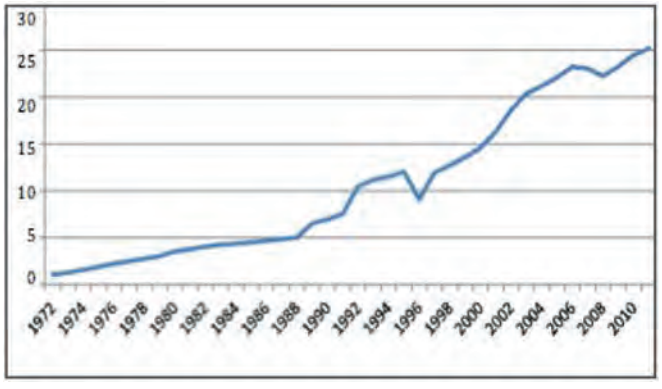
http://www.mhlw.go.jp/english/social_security/dl/social_security01.pdf.

In Japan the nowadays policy focusses on, "selection and concentration" by reducing the number of beds and allocation of more doctors and nurses to acute care hospitals. After acute care, it is necessary to collaborate with sub-acute hospitals and rehabilitation hospitals, and try to encourage patients to go back to normal life as soon as possible. One of the challenges is to focus on where the older people can go after discharge from hospital. For this challenge, setting up an integrated community care system is in progress in about 10,000 areas (one area is similar to the size of middle school district) all over Japan. One of the main pillars of this system is enhancing home medical care. That is to strengthen the function of clinics which is in charge of home medical care including end-of-life care, and enhancing home-visit nurses. Another pillar is enhancing long-term care at home which includes providing more residential services and providing better care management. (Figure 2)

In the Netherlands the reform of the long-term care is subject of discussed at this moment in our lower house. The minister of Health send a letter to the lower house on the 25th of April 2013. In this document he announces the need for reforms due to changing organizations that deliver care, the ageing population and people's changing wishes concerning quality of life and quality of care. Living in your own house instead of living in an elderly home or nursing home is getting the norm. The worries of our parliament concern loneliness, need of social support and care needs. The reform is not only based on modernizing the long-term care but also decreasing the rising costs. Figure 3 shows the costs of AWBZ from 1972 till 2012 in billion Euro's (Ministry of Health 2013).

Also compared to other countries the costs for long-term care are increasing. Therefore the government has decided a mind shift is needed. From 2014 care will be given only when you are frail and when you have no or not enough informal social support. The local government becomes responsible for the formal social support (WMO) and the long-term care. Nursing will be paid by the Medical Insurance Act (ZVW). Last year there was a huge debate on housing and if the client in future pays it's own rent. The housing cost in elderly and nursing homes are paid by AWBZ. This debate has turned into a policy that access to elderly and nursing homes is limited to severe frail people who need intensive care. This means that almost 25% of the clients will not pass the criteria anymore to get access to elderly or nursing home in future. From 2014 clients that are not frail enough will get the care they need (under the new criteria) at home. For the current clients in the elderly and nursing homes things will remain the same. Off course people who can afford it can pay for residency in a private elderly home.

Figure 3.



Future of Long-term Care System

Judging from demographics and the performance of the long-term care insurance system, it is expected that there will be far more demand for services in 2025 than now in both countries. In Japan 2012, 4.52 million people used the service but it is expected to increase to 6.57 million people in 2025 which is 1.5 times more. (Chart 8). To meet this pressing demand, various measures to raise funds and promote efficiency for medical and long-term care costs are being introduced. As previously mentioned for Japan, those are increasing the consumption tax, raising insurance premiums, cutting-down the average length of hospital stays, and enhancing mechanisms to support the elderly at the local level. As mentioned before in the Netherlands mechanisms are set to support the elderly at there own homes and at local level. Access to elderly homes and nursing homes becomes more difficult. If we can work for these measures successfully, it is possible that we can make the long-term care system sustainable.

Discussion

The need of care will increase due to increasing numbers of older people. This implies a focus on an adequate workforce. Both countries have low fertility rates. This means that the workforce of people we need to work in long-term care will compete with other sectors that are important for economic growth and stability. A shortage of workers needed in the long-term care is a serious question to deal with.

While the workforce - seen as total amount of people who are able to work per country - is decreasing, the amount of income for the health care and long-term care is decreasing while health care and long-term care needs are increasing. Measures need to be taken concerning raising pension age, increasing export of products, decreasing the costs of care by informal care givers. In the EU there is a working group called ESFAGE (www.esfage.eu). They discussed these matters and gave six examples of dealing with an ageing society: work longer and retire later, have more babies, work smarter/be innovative and increase productivity, reduce barriers to employment, start working at younger ages, bring in more migrant workers.

Chart 8: Comparison of the numbers who used and are expected to use the long-term care insurance system in Japan in year 2012 and 2025

	2012	2025
Users	4,520,000	6,570,000 (1.5 times) • Decrease of 3% as a whole due to long-term care prevention and severity prevention • Decrease of hospitalization (transition to long-term care) : increase of 140,000
In-home long-term care	3,200,000	4,630,000 (1.5 times)
Residential services	330,000	620,000 (1.9 times)
Long-term care facilities	980,000	1,330,000 (1.4 times)
Long-term care staff	1,490,000	Between 2,370,000 to 2,490,000

Source: Ministry of Health, Labour and Welfare, "Vision Sought by the Comprehensive Reform of Social Security and Tax", 2012

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Speaker Biography

Ms. Marieke van der Waal

Marieke van der Waal *(1965) studied Human Nutrition at Wageningen University. After her studies, she researched quality of care for the chronically ill. She continued her career as a program secretary at NWO-Medical Sciences (now ZonMw). Her move to NWO characterises the common thread in her career pattern. Marieke has great affinity with scientific research. However, she does not focus on the execution of research itself but on the exploitation of newly acquired knowledge so that it may benefit society. In 2002 she became director of the Netherlands Public Health Federation. In her capacity as Director of the Netherlands Public Health Federation Marieke kept focused on the content of the field in her dedication to raise awareness and funding in order to improve public health in the Netherlands.*

Since 2008 Marieke has been working on projects for the Diabetes Federation and the Dutch Institute for Healthcare Improvement (CBO). As of April 1, 2010 she is Director of the Leyden Academy on Vitality and Aging and ILC Zorg voor Later. Current know-how on ageing issues are placed increasingly in the context of higher life expectancy and healthy ageing. It is important for (future) leaders to be informed on new insights, innovations and to be guided on how to use this new knowledge in their own environment. Marieke van der Waal is eminently capable, together with Rudi Westendorp, to bring to the attention of policy makers and (future) leaders research findings on ageing issues and innovations in the field of health care of the elderly and its public use. Marieke is also a member of the supervisory board of the Welfare Foundation Lelystad.

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The Future of Health and Healthcare in an Ageing World: A Focus on Brazil, Dominican Republic and the United States

Introduction

Appropriate health services are an essential adjunct to extending life and preserving functional capacity and quality of life at all ages. Throughout the course of our lives all of us may require disease prevention, curative procedures, treatment of injuries, rehabilitation, control of chronic conditions, supportive management of disability and palliative services. Services required in younger life typically focus on prevention and cure through medical services and hospital care. The care needed by older persons are much more varied, both because the health status of older people is more heterogeneous and because needs change with advancing age. Health services for older adults can be more complex; timely intervention is more critical to prevent a downward spiral of problems that could be irreversible; and "care" that is as much social as medical becomes increasing more important than "cure". The ideal health system for an ageing world is a comprehensive and coordinated continuum of care – that is, care that "continues" over a person's health trajectory (prevention, treatment, rehabilitation, control, palliation) and that "continues" across settings. This complete network of health services is essential to preserve the health and facilitate the contributions of older people, and to manage a society's health care expenditures cost-effectively.

Achieving this ideal range of health services is a policy challenge facing all countries. Systems and practices have emerged in several countries that can provide ideas to be adapted by other countries. Yet most developed countries still face problems in delivering equitable, effective and sufficient health services for an ageing population, owing to entrenched models of care delivery and financing, and inappropriate workforce composition and training. Developing countries are striving to establish health care systems that meet the diverse needs of their entire populations in ways that are economically, socially and politically sustainable. Many of them are now fast ageing and while also dealing with still prevailing infectious diseases: the double burden of infectious and chronic disease within a context of large health inequalities.

This paper examines the overall health status and the status of health care for older adults in two "moderately ageing" (ECLAC, 2010) developing countries, Brazil and the Dominican Republic, who have remarkably similar estimates of life expectancy, both at birth and at age 60 (UNDESA, 2012). The situation in these countries is compared with that in the United States of America (USA). This country faces common as well as unique challenges compared to other developed nations, at the same time as it offers some examples of excellent care practices for older persons which, unfortunately, are not available for most. This report draws largely on the responses provided by the ILC member organizations in these countries to a short questionnaire, as well as on other background reference material.

Health Status of Older Adults

World-wide demographic changes are reflected in a major epidemiological transition, with chronic, non-communicable diseases (NCD) common in later life becoming a major health priority. In Brazil, chronic disease accounted for 74 percent of all deaths in 2008 (World Health Organization, 2011). Progress has been made in reducing smoking-related cardiovascular and respiratory disease deaths, as a result of highly successful anti-tobacco measures and improvement in access to primary health care (Gragnolati et al, 2011). However, as Brazilians have become more urbanized and wealthier, an increasing number of them have adopted the unhealthy life styles common in developed countries which are leading to higher rates of diabetes and hypertension (Schmidt et al, 2011). Negative changes in health behaviours are now resulting in increasing disability in later adulthood for both men and women: new findings from the SABE study in the city of São Paulo show that from 2000-2010 persons aged 60-64 years gained two years of life, but lost three years of life expectancy in good health (Colluci, 2013). Older Brazilians experience considerable health inequalities owing to large disparities that are reflected largely between the poorer Northeast states and the more affluent Southern states (Kalache, 2010). Within cities, both infectious and chronic diseases are more prevalent in low-income neighbourhoods (Riley et al, 2007; Schmidt et al, 2011).

The Dominican Republic is one of the poorer countries in Latin America, and the epidemiological transition is less advanced here than in Brazil or the United States. In Santo Domingo, the capital of the Dominican Republic, many chronic illnesses are as prevalent among older persons as in the United States; however, rates of obesity, diabetes and hypertension were associated with greater affluence, while anemia and physical impairments were inversely related to income (Acosta et al, 2011). Also, most chronic conditions were more prevalent among women than men.

About 80 percent of older US Americans live with at least one chronic condition (Centers for Disease Control and Prevention, 2011) and one in nine individuals aged 65 years old or more lives with Alzheimer's Disease (Alzheimer's

Association, 2013). Obesity, paralleled by diabetes, has risen steadily over the last two decades (Barnes, 2011), resulting in health problems for increasing numbers of ageing Americans. Also, as in Brazil, race, gender and related economic disparities are the major predictors of health inequality throughout life (Komisar, Cubanski & Neuman, 2012). Older persons "of colour" (black and Hispanic) are experiencing disproportionately higher rates of chronic illness and disability than whites, and lower incomes to pay for needed care. Women typically live longer than men but have less economic capacity to obtain needed health services. Socio-economic disparities in access to health care may increase as health costs in the US escalate as a result of factors such as the high costs of new technologies and a payment structure that rewards both more and more costly services (Farrell et al, 2008).

Existing Health Care Policy Framework

Both Brazil and the Dominican Republic have enshrined the rights of older persons and have specified measures to ensure their protection in national legislation. However, these countries differ in important ways in the implementation of the legislation and the net effect. In the Dominican Republic, the rights of older persons and the measures to ensure their protection by the State are guaranteed by law since 1998 (law 352-98) (HelpAge International and UNFPA, 2012). The Social Security System was established in 2002, with a three-tiered health care regime (contributory, partially-contributory, non-contributory) based on employment category. The right of older persons to health care is recognized through the provision of non-contributory health care to persons who are older, disabled or unemployed. However, although the legislation is already 10 years old, the non-contributory component of the Social Security System has not yet been implemented. The interim measure – a National Health Insurance Card – is distributed selectively based on political affiliation, and covers about 52 percent of older Dominicans only.

Since 1988, Brazil has a two-tiered health care system which guarantees the right to publicly-funded health care for all citizens through the Single Health System (Sistema Único de Saúde – SUS) while allowing a parallel private health care system. About 75 percent of Brazilians of all ages rely on the SUS (Lima-Costa et al, 2011). The right of older Brazilians to health care, including preferential treatment, was instituted in the 1996 National Policy on Older Persons, and later reinforced in the 2003 Statute of the Older Person (which is equivalent to a Bill of Rights of older persons). In addition, the Government of Brazil enacted a National Policy on the Health of Older Persons (2006) with the objective to restore, maintain and promote the autonomy of older persons. The National Health Plan (2012-2015) renews this commitment. Thus Brazil has in place a more stable and encompassing health policy framework in favour of older persons than the Dominican Republic.

The Dominican Republic does not have a universal public health system such as Brazil, but provides public health care coverage through the federally-funded Medicare program for persons over 65 years of age and for younger persons with permanent disabilities. Older adults with sufficient incomes supplement Medicare with private health insurance. Medicare is comparable to the Dominican health insurance system, although Medicare does not cover all of the costs for hospitalization, physician visits and other medical services. For low-income American older persons, state-funded Medicaid helps with expenses not covered by Medicare. Nevertheless, health care constitutes a large and growing portion of personal expenses for older Americans as both Medicare premiums and the cost of non-insured health services increase.

Primary Care Health Services

All three countries have given priority in their public systems to primary health care services. The introduction of public primary care in developing countries in recent decades has yielded clear benefits to the health of older persons.

Through the Health Insurance Card, older Dominicans have free access to medical attention and to prescription medications. Older Brazilians similarly have free access to a physician and to medication for chronic conditions through the Statute of the Older Person, plus other health promotion and disease and injury prevention services provided in the National Policy on the Health of Older Persons, including targeted vaccination campaigns, booklets to support self-care, education to prevent osteoporosis and falls and subsidies to purchase other medications and continence supplies. These ageing-specific service provisions build upon the Family Health Care Program established in 1994 that registers all SUS beneficiaries with a local health administration and provides home visits by a multi-professional team Gragnolati et al., 2011). State and municipal governments in Brazil follow federal policies and add measures of their own. For example, the Municipality of Rio de Janeiro has a free mobile eye clinic offering eye examinations and free prescription glasses for persons aged 40 and older as well as referrals for ophthalmological care.

In the Dominican Republic and Brazil the increase in primary care services has reportedly improved the health and quality of life of older people. Nevertheless, these services are far from perfect. As mentioned earlier, the Dominican Health Insurance Card is only an interim measure, and coverage is incomplete and politically biased. In Brazil, accessing the SUS services can be difficult, for reasons such as inaccessible transport, poor physical infrastructure of the neighbourhood, difficulty in making appointments, lack of priority treatment, long waiting times and a lack of home visits by health professionals (Amaral et al., 2012).

US Medicare provides access to many medical services, including prevention and diagnostic services, outpatient and post-acute care and prescription drug benefits. Nevertheless, there are deductibles for these services. Concerns about paying medical bills and accumulating medical debt lead some low and middle-income persons to delay or forego medical treatment (Komisar et al., 2012). Another issue of concern is the dearth of primary care physicians to meet the needs of ageing Americans (Sussman & Altman, 2009).

An effective model of primary care in the US is Guided Care® (Boult et al., 2008) which helps primary care practices meet the complex needs of patients with multiple chronic conditions. In this evaluated model, a trained nurse works closely with patients, physicians and other providers to provide coordinated, patient-centered care (www.guidedcare.org).

Concerns about rising Medicare costs are driving authorities to support disease prevention and health promotion among older adults. One example is the Pioneer Accountable Care Organisations initiative, which encompasses 32 healthcare organizations nationwide and aims to improve health for Medicare patients through status assessments, controlling blood pressure and diabetes and scrutinizing immunization rates and take-up of preventive services (EIU, 2012).

Geriatric Services

Geriatric specialists are required to assess and treat more complex health problems of older persons but especially to educate and to guide general medical practice. All three countries report a shortage in the supply of geriatricians and in geriatric services.

The need for geriatric specialists and for better general medical training in geriatrics has prompted action recently in both the Dominican Republic and in Brazil. After relying for many years on foreign-trained geriatricians, the Dominican Republic has established a specialization in geriatric medicine in the country's two medical schools. It is reported that the presence of trained geriatricians in hospitals has led to an improvement in the care of older persons and consequent reductions in costly hospital admissions. Brazil's 2012-2015 National Health Policy has committed to providing training in geriatric care to health care professionals through distance education. Geriatric reference centres have been established in many states, especially in the richer southern states. As part of the broader, comprehensive Age-Friendly State of Sao Paulo initiative, a significant initiative underway is the transformation of one hospital in the State of Sao Paulo into the largest medical centre in Latin America specialized in the care of older patients and make 10 large private and public hospitals "age-friendly hospitals". While it is too early to evaluate the effectiveness of this initiative, it is already being replicated.

In the United States, only approximately 1 percent of physicians specialize in geriatrics and the numbers are decreasing, notwithstanding the increase in the older adult population (Sussman & Altman, 2009). Both the supply and the demand of geriatric specialists are low. Demand for geriatricians in institutions and medical practices is low in part because the procedures performed by geriatricians are not highly reimbursed. Supply is low partly because the negative stereotypes of older adults and lower income relative to other specialties make it a less attractive choice for physicians.

Home Care/Home Support

As in the vast majority of countries, the Dominican Republic, Brazil and the United States strongly favour care within the older person's home. However all three provide minimal public assistance to control disease and maintain functional wellbeing. Mostly, older persons remain in the community, whatever their condition, with only the help of family either for lack of support services or for lack of income to pay for available services.

In the Dominican Republic, 81 percent of older persons live in extended families and only 14 percent live alone. Thus, the Solidarity Card, which provides a meagre food allowance to about 28 percent of poor older persons, contributes a little to the budget of families that support an older person. A very small number of older people benefit from domiciliary visits by a team composed of a geriatrician, a geriatric nurse and a social worker of the two medical schools offering geriatric training. Voluntary service organizations are virtually non-existent, private home care services are unaffordable for the vast majority of older people and there are no public home care services. A few public adult day centres provide community support, but they are insufficient to meet current and growing needs.

In Brazil, the old-age pension (both the rural pension and the Benefit of Continued Provision) is also indirectly subsidizing home support of older adults because the income gives older people the capacity to share resources with family members in exchange for services. Some municipalities or private health services include geriatric day centres among their services. Another public service available is caregiver training programs and educational materials offered to enhance the care provided by informal and formal caregivers. Nevertheless, the mainstay of care at home, i.e., family caregivers, is eroding, as the number of women available to provide care at home is declining (Camarano, 2008). Many of the initiatives implemented as part of the Age-friendly State of Sao Paulo are aimed at promoting the health of older people.

In the United States, Medicare covers post-acute home care, but long-term care is not a service insured by Medicare and few people have private insurance to help cover costs of home care. Informal care and support, by family and friends is the norm. It is reported that 65 percent of older persons in the community rely solely on unpaid help (Stone, 2000, cited in He et al., 2005). Outside the formal health system, a number of "ageing-friendly" community initiatives have developed to strengthen community support to enable ageing in place and access to needed local services have emerged in recent years (Scharlach, 2012). The AARP has recently become involved in working with officials and partners to facilitate and guide communities to become more age-friendly, in alliance with the WHO Global Network of Age-Friendly Cities.

An example of an innovative project within the health system is the nurse-driven model "Living Independently

for Elders" (LIFE), which was established in 1998 by the University of Pennsylvania School of Nursing. Under this model, all aspects of a patient's care are coordinated by a team that includes nurse practitioners, a geropsychiatric nurse, a home health nurse practitioners, home care nurses and day centre triage nurses (Sussman & Altman, 2009).

Institutional Care

The Dominican Republic and Brazil differ somewhat with respect to long-term institutional care provisions. As in developed countries, the Dominican Republic counts some 5 percent of older adults living in 46 long-term care residences most of which are private philanthropic or private for-profit. This surprisingly high percentage of older people living in institutional facilities may be related to the fact that many young people are emigrating. These institutions are regulated, although it is claimed that in many instances, regulation is limited to administrative measures (HelpAge International and UNFPA, 2012). Institutional care in Brazil is rare and policies in this area are very timorous. An estimated 0,5 percent of older Brazilians reside in care institutions, which also comprise public, private philanthropic and private for-profit facilities (IPEA, 2011). Institutional care is available in only 28.8 percent of Brazilian municipalities (over 6000). According to the National Policy and the Statute for Older Persons, older people are eligible for institutional placement only if they are indigent and completely lacking family support. Existing public facilities are inadequately funded and monitored and the quality of resident support and care is lacking (Giacomin, 2012).

In the United States, approximately 4 percent of persons aged 65 and older live in nursing homes, and another 2.5 percent reside in housing that provides supportive services; the vast majority are aged 80 and older (Department of Health and Human Services, 2011). Medicare does not cover institutional care, and few Americans have private insurance for long-term care costs. Thus, the majority of nursing home residents rely on state support through Medicaid because they either have low incomes, or they have spent down their assets (Komisar et al, 2012).

Conclusions: Looking to the Future

Disease trends in the three countries examined here do not portend significant improvements in the health of the increasing older populations in the near future. The current landscape of health policies and services suggests that both the Dominican Republic and Brazil will be the victims of their own success as improved primary care services increase the number of older persons living longer who will eventually require care and support for disability and frailty. However, there is a dearth of services required to support and care for older persons with chronic or increasingly complex needs as they age. In the Dominican Republic and in Brazil, both service infrastructure and financial coverage are lacking for care beyond primary and acute care. In the US, major barriers include a system that is organized around the provider rather than the patient, as well as inadequate public health care coverage. Meeting the needs of older persons in the US health care system will entail adjusting existing laws, financing and reimbursement mechanisms, insurance policies and practice models that protect existing provider practices and constrain innovations in health care delivery.

Taking into account the variations in service capacity among the countries examined here, some directions are proposed to guide policy for the future.

- Strengthen health promotion and disease prevention and self-care programs for older adults.
- Continue to strengthen primary care by improving the gerontology and geriatrics training in all streams of medicine and in all health professions.
- Implement proven care practices to favour comprehensive and flexible management of health service offered by health professional teams.
- Foster local coordinated networks of community support services. This includes creating more age-friendly settings and services to prolong and enhance functionality and wellbeing. These services should support both the older person and the informal caregiver.
- Increase the availability of affordable/subsidized good quality institutional care based on assessed levels of individual health needs. This will include adopting cost-effective models of public/private long-term care financing that exist already in some countries.
- Invest in research to evaluate the implementation and the impacts of new health policies and practices on wellbeing and on health system costs. Because Brazil has a particularly strong capacity for data collection and research, this country can contribute significantly to the evidence base for policy in countries with emerging economies.

In conclusion, there has been significant progress in some developing countries such as the Dominican Republic and Brazil to establish access to health care, and to develop health care services targeted to older persons. It is necessary for these countries now to keep building the care continuum as these older adults advance in age, and to do so in tandem with the creation of age-friendly environments. In the United States (and other developed countries with similar problems of entrenched health care delivery and financing), the challenge is to create sufficient incentives to allow the full implementation of effective models of care.

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Speaker Biography

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Predictors of Successful Ageing: A Longitudinal Study of Elderly Israelis

Introduction

The global increase in longevity has raised the proportion of older citizens in the populations of most nations, creating new needs and challenges on the personal, familial, and societal levels. One of the main challenges is to reduce the years of living with disabilities by maintaining and enhancing independency and quality of life in the later years of life.

The purpose of this longitudinal study was to assess the part that the aged individual plays in shaping his future and the course of his life in later years. We examined how various resources and coping patterns that people acquire over the course of their lives contribute to their successful aging, following a decline in health and/or function. The coping patterns we studied were divided into two groups that differ from one another along the time axis: proactive coping, which precedes the decline in health/functioning and constitutes preparation for potential scenarios of loss of health and/or functioning in later years, and reactive coping, which comes into play following such losses.

We hypothesized a negative association between a decline in health and/or function and successful aging, positive associations between coping patterns and successful aging, positive associations between certain personal resources and coping patterns, and finally a long-term influence of personal resources and coping patterns on successful aging in the presence of a decline in health and function that occurred over the course of one year.

Methods

Sample and process

We assumed that a significant number of people aged 75 and over would experience a decrease in health and/or physical functioning over the course of one year. Based on this assumption, participants were randomly recruited from three Israeli cities Haifa - located in the North, Tel-Aviv at the center, and Beer-Sheva in the south. Altogether, 352 (34.4%) persons were Haifa residents, 330 (32.3%) Tel Aviv residents, and 340 (33.3%) Beer-Sheva residents. Altogether, 1,216 elderly persons, aged 75+, were interviewed at baseline (T1).

The 2nd wave of interviews (T2) was carried out after a one-year interval, and included 1,019 participants (83.8% of the original group). Among the 194 participants who were lost to follow-up, 45% refused to continue participation, 34.5% were no longer able to participate due to health/cognitive disability, 13.9 % passed away, and 6.2 % were lost due to communication problems (no answer to repeated phone calls, or not at home when contacted).

All of the participants were interviewed in their homes by skilled interviewers. The interviews were based on structured questionnaires composed of closed questions.

At baseline, the selected participants were aged 75 years and older, independent in daily functions (ADL), mentally and cognitively competent, and able to respond to questions in Hebrew or Russian. Their average age was 81 ranging from 75 to 96. Women comprised 45.2 % of the sample.

Study variables

Five groups of variables were included in the questionnaire: (a) successful aging was evaluated by a combined measure of subjective wellbeing (SWB) including satisfaction with life [2 different scales - Carmel's scale (1997) and Neugarten et al's scale (1961)], happiness [Lyubomirsky, S. & Lepper, H.S. (1999)], the morale scale [the Philadelphia Geriatric Center Positive Morale Scale (Lawton, 1975)], will-to-live [Carmel, 2001], and depression [the Hebrew version of the Geriatric Depression Scale (GDS-SF), Zalsman, Aizenberg & Sigler (1998(]; (b) health and function was assessed by measures of self-rated health, function according to ADL and IADL and a function-specific scale [Hebrew version of the SF Short Form Health Survey, Lewin-Epstein et el. (1998)], changes in health and function during the year preceding the interview, and self evaluation of vision; (c) demographic characteristics included age, gender, and family status; (d) personal resources included education, income, self-efficacy (feeling capable of handling life problems), function-specific self-efficacy, social support [2 scales – Carmel's (1997) and the Berlin Social Support Scale, Schwarzer et al., (2003)], and satisfaction with health services; and (e) coping patterns [2 scales of reactive coping [Freund & Baltes' SOC questionnaire (2002); Worsch et al.'s Goal-Management Scale (2003)], and 3 scales of proactive coping [Sorensen & Pinquart's (2001) Preparation for Future Care Needs (PFCN); the Proactive Coping Inventory (PCI, Greenglass (1999); and Friedemann et al's. (2004) Long Term Care Planning scale], each of which included a number of dimensions.

Main Findings

Health and Successful Aging

Most of the results supported our hypotheses. Statistically significant linear correlations were found between all scores on health and function and the scores on all measures of wellbeing in the expected direction. That is, the better the health/functioning of a subject, the higher the level of reported wellbeing. In addition, significant correlations were found between a decline in health/functioning and a decline in wellbeing indicating that the steeper the deterioration in health/functioning, the worse the reported decrease in wellbeing.

Personal Resources and Successful Aging

As hypothesized, we found positive associations between most of the resources measured at Time 1 and the combined index of SWB measured at Time 2. The higher the scores on personal resources including reported feelings of self-efficacy in handling life problems, function-specific self-efficacy, social support, and economic status, the higher the scores on wellbeing. Level of education did not correlate with the combined measure of wellbeing.

In order to evaluate the unique contribution of each factor (resources measured at Time 1 and Time 2) to SWB (as measured at Time 2) while controlling for the other factors, we used a two-step hierarchical model in multivariate regression analyses. In the first step, only gender (which was statistically related to all scores of wellbeing, with lower scores for women), decline in health, and decline in function were entered into the regression equation. In the second step, all resources were added, as measured at Time 1 and Time 2.

We found that from all the resources, the contribution of self-efficacy (Time 2), economic status (Time 2), and social support (Time 2), were statistically significant predictors of wellbeing as measured at Time 2. By adding the personal resources to the multivariate analysis, the predictive power of the model increased from the 43% of prediction in the first step to 64.5% in the second step, and the negative effects of decline in health and in function weakened.

Patterns of Coping and Successful Aging

We examined the effect of reactive coping and proactive coping on SWB in the presence of a decline in health and function in a similar two-step multivariate analysis. The variables of gender and decline in health/function were entered in the first step, and all coping patterns as measured at Time 1 and Time 2 were added to the analysis in the second step. From the group of reactive coping patterns we found that when controlling for all included variables, only reengagement in new goals and optimization of the existing means and strategies had a significant contribution to the explanation of wellbeing. From the proactive coping patterns, becoming aware of future decline in health/function, expectation of future care and taking care of one's health, as well as a general measure of proactive coping were statistically significant. This model remained statistically significant and the explanatory percentage for SWB rose from 43% to 53%, while the negative influence of the decline in health and function weakened.

Resources, Coping Patterns, and Successful Aging Following Decline in Health and Function

The final analysis was similar to the previous two-step analyses, but in the second step we added resources and proactive and reactive coping variables. We found that the resources and coping patterns included in this model added 25% to the prediction of SWB (from 43% to 68%) of SWB in the second year of the study.

Among the resources and coping patterns, statistically significant contributions to the prediction of SWB (at Time 2), included self-efficacy, function specific self-efficacy, economic status, social support, satisfaction with health services, becoming aware of future needs, expectation of future care, and gathering information. However, the more elderly persons reported becoming aware of need for care in the future, and expected needing future care (as measured by some of the dimensions of proactive coping), the lower they scored on SWB, while the more they became active by gathering information regarding their future needs, their SWB increased. These results indicate that proactive coping patterns should be divided into two groups. One group covers awareness of and expectations for future care needs. The other group includes decisions made and actions taken to change life circumstances in order to be able to deal effectively with future care needs. While becoming aware of future needs for care probably causes worry and therefore weakens elderly persons' wellbeing, an active involvement in finding solutions for future needs strengthens their wellbeing.

In general, the correlations among the different patterns of coping and SWB were much weaker than the correlations between personal resources and SWB. Significant correlations were also found between personal resources and both patterns of coping (reactive and proactive). Contrary to our expectations, we found that the more resourceful people were and the more they reported feeling that they are capable of dealing with difficulties in life, the less they reported being involved in proactive coping such as planning for future care needs.

Conclusions

The conclusions drawn from these findings indicate first of all that a decline in health/function after only one year is common among people aged 75 and up. The decline in health/function has a significant negative effect on their wellbeing. However, while facing decline in health and/or function, this negative effect on wellbeing is reduced when elderly people possess personal resources such as economic means, social support, and most important, a belief in their ability to handle problems occurring in their lives (self-efficacy), as well as when they use the appropriate and effective coping patterns.

It is important to point out that during the year of our study, health and function declined, and the self-reported level of wellbeing decreased, as did self-efficacy and the use of effective reactive coping patterns. We can say that for this age group, the decline in health/function linked with aging is joined by a decreasing ability to cope with these losses. Both of these processes result in an overall negative effect on wellbeing among older persons.

Furthermore, the negative associations found between personal resources and some of the proactive coping patterns, and the negative correlations found between some of the proactive coping patterns and wellbeing, indicate that people who have more social and psychosocial resources and rely upon their abilities to cope with future losses, are more optimistic about their future and, therefore, less likely to prepare themselves for negative events. Those who become aware of future needs, but are not taking actions to

prepare themselves, have lower levels of SWB.

Recommendations

The results of the first two stages of the study lead us to the following recommendations: In order to address the challenges of old age, it is important to increase awareness of the fragility of adults aged 75 and over and to invest in prevention of decline in their health, functioning, and wellbeing.

On the level of health, functioning, and nutrition, it is important to conduct frequent evaluations in order to detect risk factors and decline as early as possible. We recommend initiating programs for maintaining and enhancing health and functioning in this age group. Some of these interventions can be implemented through medical surveillance, medications and treatment, along with education and training programs on screening, nutrition, and physical activity. These means for promoting good health have become common knowledge. Our study adds the importance of interventions directed toward strengthening psychological factors to be used before, during and after facing a decline in health and/or function. Our findings indicate that self-efficacy in general, and specifically the more specific functional self-efficacy, play an important role in maintaining older people's subjective wellbeing. In addition, certain patterns of proactive coping behaviors contribute to SWB. Such beneficial resources and coping patterns can be strengthened through appropriate interventions.

Some of these interventions can also be introduced into the existing social clubs, day-care centers, assisted living facilities, and supportive communities, which may reduce their cost. However, as many old persons do not use these facilities, it is important to create new and attractive venues to encourage more of the aged population to participate in preventive and empowering activities. Such interventions are mostly performed in group situations, thus serving the additional function of becoming support groups. In our study as well as in previous research, social support has been found to be one of the most important predictors of successful aging.

In order to achieve best results in the most effective and efficient ways, all new interventions should be evaluated and controlled. We also recommend conducting pilot studies in the various nations that would include multidisciplinary interventions to promote health, functioning, and wellbeing. Such programs are described in existing international literature with reported proven contributions to improved abilities for dealing with age-related losses.

Another location for such interventions could be dedicated centers, set up to provide comprehensive treatment by multidisciplinary teams of professionals. At such centers, old persons would undergo a comprehensive evaluation resulting in a personal treatment program. Similar centers, which focus on medical aspects, have been established by some Israeli sick funds. Despite the high costs to run these centers, if managed effectively and efficiently by qualified professionals they can lead to longer periods of independence and significantly improved quality of life for elders. Such achievements will have positive outcomes for society at large, for family members who will be relieved of some of the responsibility of caregiving, and for the workforce which will benefit from less absenteeism due to care obligations.

All of these investments on various societal levels will result in significantly reduced expenses for elders and their families, medical and welfare services, and society at large.

The purpose of this study was to examine the factors affecting successful aging on the personal level. However, our conclusion and recommendations to initiate regulated interventions act to reconnect the individual to society, and express the approach that a person does not have to age alone. Society uses socialization processes to prepare its members to enter social roles along the life course from childhood to adulthood and then to retirement. Society should also assist people to enter the realm of aging by helping them to develop capabilities to deal with the inevitable losses of old age.

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Speaker Biography

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Empowerment and Social Participation of Older People in The Future: Focus on India and the U.K.

1. The current state of play in India and the UK

The world today is increasingly ageing- and while some developed nations have foreseen this eventuality and initiated action to address the issue, there are countries, especially in the developing world, such as India, which have not yet fully awakened to this longevity revolution!

The Indian government has belatedly begun some serious initiatives in terms of policy-making, projects and programmes for the well-being of the elderly, by drafting legislation to protect the interests of senior citizens (as they are referred to in India) and in general responding to the needs of the older people. But the level of commitment is still too low and not adequate enough to meet the needs of a country which will have 315 million older persons over the age of sixty by 2050! (1). Indian society too is still slumbering as far as the issue of population ageing is concerned. Advocacy efforts by voluntary organizations and by Senior Citizens Organisations are only slowly penetrating the minds and consciousness of the Indian population. The proportion of the population aged 60 and over in India today (88 Million) is 8.8% of the total population and this is projected to increase to 20% (315 million) by the year 2050 (2). Similarly the life-expectancy at birth for males in 1996 was 61.6 years and for females it was 62.2 years, and today, in 2013, it is 66.08 years for males and 68.33 years for females.

In comparison, in the face of a rising older population, the UK has gone a long way down the road of social and economic progress, with consequent benefits to many. However in some cases certain minority groups, including some older people, have been marginalised and left on the sidelines. In the UK the plight of older people, in terms of lack of social wellbeing and isolation, especially in rural areas and on run-down inner city estates, is well understood. However, in some key policy areas the majority of older people have in the main been protected from any recessionary economic fallout, as a 2010 Parliamentary Briefing Note (3) informed us. It reported that much of the UK's total public spending on benefits is focussed on older people and in 2009/10, State benefits and the NHS accounted for just under half of government expenditure. In 2010/11, 65% of UK Department for Work and Pensions benefit expenditure went to those over working age, equivalent to £100 billion or one-seventh of total public expenditure. Growing numbers of elderly people also have an impact on the NHS, where average spending for retired households is nearly double that for non-retired households: in 2007/08 the average value of NHS services for retired households was £5,200 compared with £2,800 for non-retired. These averages conceal variation across older age groups, with the cost of service provision for the most elderly likely to be much greater than for younger retired people. The Department of Health estimates that the average cost of providing hospital and community health services for a person aged 85 years or more is around three times greater than for a person aged 65 to 74 years.

Cynically many people believe this favouring of older people by UK Politicians is in fact simply because of the 'grey' vote. For, in this respect, compared with their younger peers, older people in the UK seem to be much empowered. At the 2010 UK General Election (4) only 44 per cent of those aged 18-24 voted and 55 per cent of those aged 25-34. Contrast this with the 76 per cent of those aged over 65 who voted and it is clear to see why older people's opinions and favour weigh heavily on the mind of the UK political class, especially with the looming prospect of another hung Parliament at the 2015 General Election.

So in the UK it is older people that have benefited the most in recent years from Government tax and benefit policy largesse, but have they been empowered? The answer is generally that they have not! In the main this is because older people have been seen as a burden 'deserving' of charity and not necessarily as a benefit, or a source of value and opportunity. Thus, rather than being invested in as a source of social capital, economic value and growth, they have been maintained at a survival level, just above the poverty line. In support of this 'value' theme, a 2012 International Longevity Centre-UK (ILC-UK) report entitled Retirement in flux: Changing perceptions of retirement and later life (5), argued that retirement is changing and what it means to be a citizen in an ageing society is in a turbulent state of change. In addition to arguing that older people should expect to work longer and draw upon property wealth to help fund care costs, the report commented that society needs to abandon the notion that retirement marks the point where older people's contributions are no longer necessary or valuable. We will return to employment later, but the report asserts that older citizens have a responsibility to remain in the labour market, where possible, to enable skills retention, minimise the fiscal burdens on taxpayers and remain active in our communities.

If not in actual employment, older people can still remain occupied, active and empowered. As part of an active retirement many older people are eager to volunteer in later life and such opportunities must therefore be appropriate, flexible, enjoyable, and oriented towards utilising the skills older people have developed during their working life – especially in terms of mentoring younger people, in both the hard and softer skills of life-management.

Examples are participating in Local Government or as School Governors or similar. In the UK engagement with and by older people is at the heart of the work of the Beth Johnson Foundation (BJF) (6), who among their other aims seek to shape communities to enable older people to age well by giving older people a voice; by respecting their views, experiences and contributions; by empowering them to access the knowledge and support they need to age well and then supporting them to personally influence policies and activities affecting the health and well-being of older people.

The generations working together are very central to the work of BJF and its Centre for Intergenerational Practice, which aims to bring people together in purposeful, mutually beneficial activities which promote greater understanding and respect between generations and contributes to building more cohesive communities. Intergenerational practice is inclusive, building on the positive resources that the young and old have to offer each other and those around them. The centre seeks to underpin the development and promotion of intergenerational practice as a catalyst for social change by supporting managers, practitioners and volunteers in the Voluntary and Community Sector, policy makers, and regional and national government to develop stronger and more resilient communities. As part of this approach the BJF Centre sponsors the Intergenerational Futures All Party Parliamentary Group which was established in the UK Parliament in 2009. (The Group is chaired by Baroness Greengross, Chief Executive of ILC-UK.) In addition to MPs and Peers, the Intergenerational Futures APPG has Associate members who represent many wide-ranging, external youth and older people's organisations with an interest in intergenerational issues, who have come together to promote understanding of the impact of policy on intergenerational relationships and the way in which policy affects people at different life stages.

Helping other older people is also very much on the UK volunteering agenda, for example the SilverLine older people helpline (7) are currently looking for volunteers for their telephone befriending service as it goes nationwide over 2013. (More about SilverLine and its work in Part 3.) A website called "the Amazings" (8) hosts courses run by older people to teach the skills that the following generations might have missed out on. They offer friendly, informal, classes and courses where younger people can learn skills such as carpentry, sewing etc directly from people with lifetime know how. Classes take place everywhere, from coffee shops, to pubs etc, and the vision is a marketplace and platform for wisdom with the potential to change learning; the opportunity to re-think retirement; the possibility of bringing together communities. There are many other areas where older people can volunteer their skills – for example for those who like Cookery there is the Casserole Club (9), mentioned later in section 2.

So what evidence is there of the social exclusion of older people in the UK and what are its potential effects? Those working in the statutory and the voluntary sector are deeply concerned about the impact of isolation and loneliness on older people, because SilverLine contend it has been shown to shorten life, creating depression, hastening the onset of dementia, and causing physical effects such as malnutrition.

A very recent April 2013 report from the UK Office of National Statistics (ONS)(10), entitled Measuring National Well-being – Older people and loneliness, examined the well-being of older people and provided an analysis of reported feelings of loneliness by people aged 52 and over using 2009–10 data from the English Longitudinal Study of Ageing (ELSA). Among its conclusions the report noted that, while 66 per cent of respondents reported being lonely hardly ever or never, 25 per cent said they felt lonely sometimes. A higher percentage of those aged 80 and over reported feeling lonely some of the time or often when compared to other age groups (46 per cent of those aged 80 and over compared with the average of 34 per cent for all aged 52 and over). A 2012 ILC-UK paper, entitled: Is Social Exclusion still important for older people? (11), found that the number of people aged 50 plus being socially excluded from decent housing, public transport and local amenities rose sharply over a six year period from 2002 to 2008. ILC-UK inferred that as people age they are more likely to become more socially excluded than less. They found that over one in six people in their fifties (18%) were socially excluded in two of more areas of their life in 2008 – up from 13% in 2002. The research also found that in 2008 almost 38% of those aged 85 or older faced some two or more kinds of social exclusion, for those aged 60-64 years old, the figure was 12.4%.

Loneliness is part of the web of 'social exclusion' that some older vulnerable citizens experience; a nasty mix of living alone, no access to transport, low income and fear. According to Loneliness –the state we're in (12), a 2012 report of evidence compiled for the Campaign to End Loneliness (CTeL), a number of research studies conducted at different times in different parts of the UK, suggest that 5–16 per cent of the older population is lonely. Using these studies, it is possible to estimate that overall about 10 per cent of the general population aged over 65 in the UK is lonely all or most of the time, equating to over 900,000 older people. This figure has remained the same over decades despite a large number of organisations doing great work to reduce loneliness felt by older people. The research tells us that many older people have little contact with friends and family. 17 per cent of older people are in contact with family, friends and neighbours less than once a week and 11 per cent are in contact less than once a month. Those who live alone are more likely to be lonely. In the UK about 3.8 million older people live alone and 60 per cent of women and nearly half of the general population aged 75 and over live alone. It is predicted that between 2008 and 2033 there will be a 44 per cent increase in the number of 65–74-year-olds living alone, a 38 per cent increase in those aged 75–85 and a 145 per cent increase in those aged 84+.

As mentioned earlier, the greater mobility of modern families has also in many cases directly lead to increased isolation and loneliness. Loneliness amongst older people and impact of family connections, a survey conducted in Scotland by WRVS (13), revealed the fragmented nature of families today and the large number of over 75 year olds whose closest children live a substantial distance away, often leaving them very isolated. For 10 per cent of older people, their nearest child lives more than an hour's drive away (40 miles plus). All over the UK the declines in job security and

labour-market restructuring have increased pressure on the family and reduced location choices as younger people move, from the rural areas where they were born and brought up, away from their families into the towns and cities for education and work. As the parents they left behind in that move get older, their children are no longer around to provide companionship and informal care when required. 82 per cent of children who have moved away from their older parents have done so for work reasons. Three quarters of the WRVS sample agreed that it is harder for people today to juggle working commitments and family life. 17 per cent of older people would like to see their children more often, however, half of these people feel that their children are simply too busy to visit.

2. What is in the best interests of older people, their well-being and quality of life? How should ILC centres seek to influence/ determine policy in this regard?

The International Longevity Centre Global Alliance (ILC Global Alliance), a multinational consortium of member organizations, has a major role to play here in helping societies to address longevity and population ageing in positive and productive ways, by highlighting older people's productivity and contributions to family and society as a whole. Collectively ILC's cover a broad range of policy agendas, including high priority areas for the future, while the local ILC's work autonomously to study how greater life expectancy and increased proportions of older people impact their countries and to seek to offer solutions to mitigate the effects of those impacts.

In India the rights of an older person are seen as the means towards the empowerment of the elderly, a means to help them lead lives with dignity, participation, self-fulfilment and independence. And yet, though Daniel Thursz (14) has rightfully stated that 'opportunities must be created for self-determination of and collective action or participation by older persons' as part of the process of empowerment, it is also equally important to remember that in countries where food, clothing, shelter, money and health services are the more important concerns of those for whom mere survival is a herculean task, the concepts of self-determination and participation as the rights of the older persons, may be construed as 'unwanted luxuries.' But looking at the larger picture, unless the older persons are empowered with these rights of self-determination and participation, their right to a qualitative old age might be severely impacted. So the need for these rights is equally important and necessary even in societies where poverty and underdevelopment prevail.

James T. Sykes, in his article "Second Opinion" in the book "Empowering Older People- An International Approach" (15) feels that the concept of 'empowerment', unfortunately, embodies elements of the patronizing that set elders aside as individuals to whom "we" give certain authority or standing. We cannot, by our actions alone empower people to have and use power responsibly. It is only when elders, and people of any age, feel that they have the capacity to act responsibly, without qualification by age, wealth or special status, that they will have the sense of autonomy that will enable them to develop the confidence that they have value, a legitimate worth, a place in society, something to share with others and a rightful place in society. Human Rights thus are the security net which empowers every individual and prevent the concept of 'charity' from arising. An older person has the right to be empowered, to assume responsibility, to be active and participatory, to be independent and to lead a life of dignity and self-fulfilment. No one has the 'power' to 'empower older people -it must be established within them.

In the modern world one way of increasing social participation could be the use of the internet, social media and Skype etc. In a 2012 paper, Nudge or Compel? Can behavioural economics tackle the digital exclusion of older people? (16), ILC-UK looked to see if 'nudge' tactics can be used to reduce or remove the behavioural barriers that prevent older people getting online. The report highlighted that over 7.5 million adults have never used the internet, with the majority of non-users being older, having disabilities or in the lowest social classes. Looking at the behavioural traits which accompany internet usage among older people, among its results it found that: People who reported using the internet tended to report feeling more in control of various aspects of their lives; People who didn't own a computer were more likely to feel that they were unable to learn a new skill and people who reported not using the internet were more likely to say that they 'often' felt isolated from others. The same pattern was found for loneliness. The report went onto to recommend that service providers could attract older customers by finding ways of discounted installation and connection deals, and initial periods of free internet access and by the use of imagery of both older and younger people.

Some start-up founders are taking it further, using the internet to help bridge the age gap. The brains behind the Casserole Club (9), for example, urge members to "do something great with an extra plate", sharing spare portions of uneaten meals with people nearby who find it difficult to cook every day. The concept isn't aimed only at the elderly but it is that offline generation that is benefiting most: the site's founders report that more than 80 per cent of diners are over 80 and without regular access to the internet. For those who aren't on the internet, Casserole helps those who are offline to order meals and connect and pair up with local people - In fact most of the diners who registered had been met personally and supported through phone and text.

Regarding Financial Exclusion, Financial Citizenship, a 2012 ILC-UK report (17) noted that the UK has a chronic under-saving problem, which has been exacerbated by the financial crisis and economic downturn. The report noted that a high proportion of UK households have little or no saving or investment wealth, and these households are concentrated among those with the lowest incomes, including many older people. In the report's view, what is required is a 'financial citizenship' framework, which outlines the respective responsibilities of individuals and the state regarding saving and helps with a new approach to public policy on saving and the further empowerment of older people. Turning to health, recently the UK Design Council (18) held a design competition, which was chaired, by Baroness Greengross (Chief Executive ILC-UK), where young designers looked at

how they could enhance the lives of people with dementia through buildings, pavements, lighting, colour and even odours, which encourage them to eat. If this and similar programmes progress well, then we are moving towards, not just age friendly cities, as championed by the World Health Organisation, but to dementia friendly communities where people understand the sensitivities and opportunities of engaging with this vulnerable and growing group in our community.

3. What strategies have worked/are working in your country that have, or have not been successful in addressing challenges for older people in this area? What evidence can you share of the effectiveness and impact of these strategies – with a view to their potential for replication in other countries?

ILC-India encourages and supports the productive work done by senior citizens' and their organizations through its ILC-I Awards. Yearly since 2010, ILC-I has awarded three senior citizens' organizations for their exemplary work for the development of society under the category "Promoting Qualitative Excellence in Ageing". ILC-I also awards three senior citizens over the age of 70 years with its 'Lifetime Achievement Awards' for their extraordinary achievements in any field. Such awards also enhance the participatory and empowerment aspects of the older persons, as they undertake activities that lead to positive and qualitative changes to the lives of people, leading to a sense of self-worth and dignity. The future of Ageing in India is in the hands of the older persons of the country. The older persons have realized that it is up to them now to advocate their cause. The movement of senior citizens rising to make their voices heard, their opinions attended to, their problems addressed, has gained great momentum. It is a united front of these senior citizens, and the organizations that they represent, that is bringing the issues and concerns of the older persons to the forefront. What better example of participatory empowerment than the one that can be seen in India, where the older persons have taken upon themselves the challenge of awakening the country to their issues! ILC-I is supporting all these ventures of the older persons to accord them strength in their endeavours. Hopefully a bright future for the next generations of older persons in India is on the horizon.

In India, under the guidance of the late Dr. S. D. Gokhale, the Founder President of the International Longevity Centre-India, (ILC-I) initiated the movement of volunteerism by the elderly to effect qualitative change in society through the use of what is viewed as one of India's greatest treasures, the knowledge, wisdom and experience of its senior citizens! The concept was that older persons offer their voluntary services in their areas of skill, interest or expertise to organizations that require them. The system, administered by the Volunteers Bureau, works by matching the skills and interests of the older persons with the requirements of local organizations. For instance, a retired school teacher goes to an orphanage to assist in training and education; a retired financial expert offers his expertise and knowledge to voluntary organizations which cannot afford the relevant professional fees, while some older people run a hospital Help Desk. Such opportunities for productive engagement develop a sense of well-being amongst the older people, of still being very productive and participative members of society and helping to keep isolation and loneliness at bay. This initiative of ILC-I was officially recognized by the Ministry of Social Justice & Empowerment, Govt. of India, (the nodal ministry for population ageing), as an 'Innovative Initiative' and had commissioned ILC-I to hold orientation and training programmes for the setting up of such 'Volunteer Bureaus' in the northern and southern zones of India.

In terms of combating Isolation and loneliness, in the UK the work of CTeL has already been highlighted but several other innovative programmes have been introduced. For example in 20011 the TV personality Esther Rantzen launched The SilverLine Helpline (7) which seeks to provide a sign-posting service to link older people into the many, varied services that exist around the country and a befriending service to combat loneliness. A pilot was launched in the north- west of England in November 2012 and the launch of a national service is planned by the end of 2013. A key component of healthy ageing is the importance of helping older people remain in the workplace. Recruitment, selection, training and career advancement should be open to the best person for the job, irrespective of age. Older workers, if they are able and willing to do so, should be encouraged to delay retirement and remain in the labour market for longer. In the UK one of the policy responses to increasing longevity has been the raising of the state pension age. However in its 2011report "Extending Working Lives: A Provocation" (19), ILC-UK noted that raising the state pension age will only mitigate the economic impact of population ageing if it leads to longer working lives. The report went onto to propose that for this to occur we need to create labour market conditions that allow an older workforce to emerge and thrive. However some negative stereotypes about older workers still endure. Common perceptions include that they are prone to ill health. However, these assumptions are largely undermined by evidence about age-related changes to physical and cognitive capacities. Many employers consider their older workers to be a valuable asset: positive aspects attributed to them include a strong work ethic, reliability, loyalty, business experience and specialised skills. Looking at just one UK employer, in 2009 Lancaster University Management School compared the performance data of more than 400 McDonalds restaurants (20). Those with at least one worker aged 60 or more showed levels of customer service 20% higher than those with no employee aged over 50. In addition in a survey of 148 restaurant managers, 69% said later life workers empathise and connect well with customers and 47% cited later life workers ability to "go the extra mile" to deliver best possible customer service.

Within 20 years, ONS tell us that nearly a quarter of the UK population will be aged 65 or over (21). People are now spending an average of seven years longer in retirement than in the 1970s. However, it is unclear what proportion of these extra years will be healthy and at present ill-health is a factor

in many early retirements. The barriers and opportunities to extending working lives include health and wellbeing status. Good health and wellbeing is important in maintaining the capability to work into older age. Plainly a workplace that encourages and supports health and wellbeing at all ages will be more supportive of older workers. This is a win- win because as well as employees benefiting businesses with a healthy, engaged and resilient workforce, when wellness is combined with 'good work', – work that is secure, varied and puts employees in control – businesses can look forward to higher engagement, increased productivity and long term sustainability

Europe's anti-discrimination legislation now in place means that, in theory, older people must enjoy the same level of opportunities in employment as younger people, but unfortunately older people are often unable to seek job opportunities so successfully and are often the first in the firing line when it comes to letting staff go. In October 2012 the UK Government set out plans to extended the right to flexible working to all employees from 2014, which aim to boost the participation of women and older people in the labour market. It will give all employees the right to request reduced or part time hours and working from home arrangement' and enable people who are nearing or who have reached retirement to tailor working patterns to suit their lives.

In April 2012, ILC-UK challenged the assumption that older people should automatically cease to contribute after they have left the labour market. As we mentioned earlier, in its paper 'Retirement in flux' (5) ILC-UK debated the current purpose of retirement, and proposed that in light of an ageing population the current paradigm of contributions during working life coming to an abrupt halt on retirement is outdated and unsustainable. In the paper, ILC-UK recognised that older people must also have a right to receive support from both employers and society more generally to enable them to have longer, more fulfilling working lives. The report found support for longer employment amongst the older population; 46 per cent of over 65s would consider delaying retirement if their employer offered support for reducing their hours, or working more flexibly.

According to a 2012 Age UK report (22) flexible working would allow older workers to manage their health needs, continue looking after people in their care and enable a smooth transition to retirement. Importantly, and contrary to common belief, in terms of younger versus older employment, the situation is not "one in, one out". In 2012 the Resolution Foundation (23) asserted that boosting employment among older workers does not automatically mean younger people are deprived of work. Instead, expanding employment into older age raises incomes and stimulates demand for other services, which has a positive effect on further job creation.

A 2011 ILC-UK paper Understanding the Older Entrepreneur (24), recognising that people are going to have to work for longer under the impacts of increased longevity and inadequate pension provision, noted that the inadequacy of saving and the poor returns available at retirement meant that an impoverished "retirement" will await many in future generations. In the UK we are starting to understand that the assumptions that went behind the design of the State pension system in the 1940s can no longer be applied. In other words, the system was simply not designed to cope with today's circumstances, where most people will get to state retirement age and will live a long time after it. The policy response to these impacts include the rise in the state pension age, automatic enrolment into pension saving and the proposed abolition of the Default Retirement Age. It is too early to judge if these strategies will prove successful, but early signs are promising

Looking at our education systems, we might also ask why we segregate teenagers and adults, young or older, when they are all learning. Today, even in a small village we can watch the world's best known academics on a screen and there seems no reason why a fifteen year old and a seventy year old cannot learn politics, social sciences or languages together in a multi-generational setting. We need to look at this seriously as we proceed in this century of enhanced communication opportunities and in the UK the BJF Centre for Intergenerational Practice (6) is a good example of leadership in this important area. With regard to health services, we have had the most remarkable medical successes in recent years in curing or controlling many of the diseases which used to be fatal. In consequence we now have to provide health and social care to people with long term conditions and the co-morbidities which include high incidences of dementia. Our current health and social care services are not designed to meet these new challenges and need to be refocused to encourage long term care with older people taking an active role in ensuring that happens. The focus in health care must also change towards preventing disease and impairment and delaying the onset of disabling symptoms. For example in the UK we have some situations, as in the London Borough of Camden, (25) where older people are encouraged to keep fit outdoors through adult focused exercise equipment and activities, where older and younger people work out on the machines or in the fresh air together. This is not only good for health but also for promoting intergenerational relationships, participation and co-operation.

Collaboration between the generations is a tool to promote active ageing and can help us achieve essential goals in policy and practice. This applies to the built environment where, when we design our streets, our lighting and our homes, we must take note of how the population is changing. In modern society people are more likely to impaired by age or disability and yet remain active and older people themselves need to be included so they make their own decisions about the services they want and how they should be designed. In its 2007 paper, Towards Lifetime Neighbourhoods: Designing Sustainable Communities For All, published in partnership with the Department of Communities and Local Government (26) ILC-UK explored how a more age-friendly vision of public spaces and community could boost social engagement, good health and the chances of 'active ageing' for all. They proposed that not only can an appropriately planned built environment offer a more accessible, inclusive space for the frail or disabled, but services, amenities,

social cohesion and sense of place can play a key role in the creation of 'lifetime neighbourhoods' which help create communities that maximise health, wellbeing and social engagement. In a follow up 2008 paper Building our Futures (27) ILC-UK produced revised guidance and tools for local planners to prepare for the UK's ageing population. The guide recognised that as we age, our homes become a key environment influencing our health and our independence and, showing the key relationships between factors such as tenure, housing type, health and social class gives pointers to identifying the varied needs of different groups, set out to help local and regional planners take older people into account as they plan housing strategies. In its Social Exclusion report (11), among its recommendations, ILC-UK called on the UK Government to: Allocate the task of measuring and developing strategies to overcome material and non-material disadvantage to a specific team within government; Shift the focus of government policy on ageing towards prevention of the onset of disabling impairment. ILC-UK argues that Government should focus on 'ageing policies' rather than 'older people's policies' in order to tackle increasing exclusion among middle aged people; Improve the planning of neighbourhoods for people of all ages to reduce levels of exclusion from local amenities and decent housing and public transport.

The collected view is that awards for senior citizens or the senior citizens' organizations for doing exemplary work, is a sound strategy through which the older persons are and could be motivated to undertake activities that bring in qualitative improvements in the lives of the older persons. This is a strategy that could be replicated in countries to stimulate, to motivate and to inspire the older persons to undertake activities that impact society and the elders positively.

4. What are some other related challenges in your country?

A first step towards bringing a sea-change in Indian society towards empowerment in old age is to undertake advocacy of the cause of population ageing. However a major problem in India is the level of illiteracy in the country and it is the subsequent ignorance on the part of this illiterate section of society, coupled with the lack of interest in the issue on the part of the literate segments of Indian society, which makes the task of advocating old age empowerment more daunting. Thus an important means of developing an age-friendly society is through the older persons themselves. And fortunately for India, this has begun, there is a good degree of awareness amongst the seniors themselves that they have to be more proactive and empowered, if they want a society that is age-friendly and enables them to live a life of dignity. The draft 'National Policy on Senior Citizens' was issued in 2011 and the senior citizens movement in India has an umbrella organization, The All India Senior Citizens' Confederation (AISCCON) which has a membership of senior citizens from across India. This body, though not officially recognized by the Government of India, is the face of the older persons' organizations and the government regularly interacts with its representatives. AISCCON has been very proactive, mobilizing senior citizens to participate in productive activities which enhance the development and well-being of not just senior citizens themselves but also of society in general.

In the UK the ageing well and the active ageing programmes have a long way to go still, but the message is clear: Older people can and must make decisions for themselves. Older people can and do make a major contribution to society and working with the young can make transformative changes. This has to involve everyone and 2012 the European year of active ageing was a very positive first step in ensuring that it does take place. 2013 is the European Year of Citizenship where, hopefully, we will see more older people become aware of their rights and responsibilities. In Britain, and in the rest of Europe, there is a huge amount of work needed to educate people about what all of us can do through policy and practice to enhance the quality of life and encourage good relationships between the generations. A big prize awaits if we can improve intergenerational relationships. The Golden Economy, a 2010 ILC-UK report (24), drew attention to the importance of older people to the UK economy. Older people's spending reached an estimated £97 billion in 2008 (65 plus), around 15 per cent of the overall household expenditure. Those aged 50 or over spent £276 billion in 2008, making up around 44 per cent of the total family spending in the UK. The older consumer market is expected to grow by 81 per cent by 2030 while the 18-59 year old market will only increase 7 per cent. Yet despite the size of the market, this report finds that for many older people, the private sector does not meet their needs. This is not just a story of poverty or a lack of income to buy products, but of a consumer marketplace which frequently fails to meet the needs of an ageing population. Across a wide range of industries, the older consumer continues to be ignored or patronised, despite the fact that older people don't just buy products for themselves; they also shop for their children and grandchildren. As well as contributing to isolation and loneliness, alongside poor mobility, a lack of transport is one of the biggest barriers to older people's participation in the consumer market. Also products and services can be made more attractive to the older consumer by the simple use of inclusive design principals. In addition older people are far too often, not demanding goods and services to meet their current needs. Older consumers have been found to be less likely to complain about products and services than the consumer population as a whole.

Moving towards an age neutral society will mean that we can support those who are not able to contribute owing to their reduced capability, for example, through ill health. At the same time, we can acknowledge the considerable contribution, to local communities and society as a whole, made by many older people and work towards this model becoming the norm. Additionally, UK decision-makers need to recognise that, as well as the boost to quality of life, the benefits in physical and cognitive health that can be the result of remaining involved, engaged and empowered at all ages. Both ILC-UK and ILC-India are active on all these fronts but while we have come a long way there is still plenty of work remaining to be done before older people become sufficiently empowered to make a difference to their own outcomes and those of the citizenry as a whole.

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Speaker Biography

Baroness Sally Greengross

Baroness Sally Greengross *has been a crossbench (independent) member of the House of Lords since 2000 and chairs five All-Party Parliamentary Groups: Dementia, Corporate Social Responsibility, Intergenerational Futures, Continence Care and Ageing and Older People (Co-Chair). She is the Vice Chair of the All-Party Parliamentary Group on Choice at the End of Life, and is Treasurer of the All-Party Parliamentary Group on Equalities. Sally is Chief Executive of the International Longevity Centre – UK; Co-President of the ILC Global Alliance; and was a Commissioner for the Equality and Human Rights Commission from 2006-12.*

Baroness Greengross was Director General of Age Concern England from 1987 until 2000. Until 2000, she was joint Chair of the Age Concern Institute of Gerontology at Kings College London, and Secretary General of Eurolink Age.

Baroness Greengross is Chair of the Advisory Groups for the English Longitudinal Study on Ageing (ELSA) and the New Dynamics of Ageing (NDA). She is President of the Pensions Policy Institute and Honorary Vice President of the Royal Society for the Promotion of Health. Baroness Greengross is Patron of the National Association of Care Caterers (NACC) and Patron of Care & Repair England. She holds honorary doctorates from eight UK universities.

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Empowerment and Social Participation of Older People in South Africa and Argentina in The Future

The United Nations classifies Argentina and South Africa as "less developed" countries (LDCs) (UN, 2009); both are in the "south." Of the two countries, population ageing is more advanced in Argentina, which has 6.2 million citizens aged 60 years and over, representing 15 per cent of the total population. South Africa has an older population of 4 million, representing 8 per cent of its total population. Although the countries have several socio-demographic characteristics in common, their socio-political histories differ, and the nature of and scope for older people's empowerment and participation in the societies are examined within these contexts. The situation in Argentina, examined from a human rights perspective, is extrapolated to that of the Latin America and Caribbean region as a whole.

South Africa

People in South Africa who are old today lived through the entire four and a half decades of apartheid and before that under colonialism. Disenfranchised and disempowered until the first fully democratic elections were held in 1994, the majority remains cumulatively disadvantaged in old age. Since 1994, a number of initiatives have aimed to empower these citizens and to integrate them in mainstream social life. I examine progress made and challenges that persist in this regard, and envision ways to optimise older persons' empowerment and social inclusion in the future.

Current situation

Rhetoric on the empowerment and social inclusion of older people began in earnest in 1991 with the United Nation's declaration of the Principles of Older Persons and was boosted in 1999 with the United Nations' campaign Towards a Society for All Ages. In South Africa, the Ministry of Social Development took a lead in the empowerment drive, that focused on restoring older people's dignity and respect for them in society. A strong impetus was given to the drive with a countrywide investigation and subsequent publication of several outcome reports – a key report being Mothers and fathers of the nation: The forgotten people? (2001). A focus of the investigation was on elder abuse, and the ministry's efforts indeed lifted the lid on the insidious and parlous situation. The efforts highlighted the problem, and older persons' vulnerability and marginalisation, and offered a rationale and a vehicle for subsequent empowerment initiatives, as well as encouraged older persons' participation in all areas of social life.

However, the efforts tended to be an emotional response, or approach – although certainly earning political gain for the government because of the visibility of the efforts and emotion around the problem. Unwittingly, the efforts simply reinforced older people's segregation, highlighting them as a vulnerable group whose plight and predicament warranted sympathetic responses. Nonetheless, the efforts helped to introduce the concept of older people as contributors to society, spawned initially through work of HelpAge International in several African and other developing countries (HAI, 1999).

Although lip service is currently paid to fostering inter-generational relations (and older people's social inclusion), such programmes, that purportedly work towards building "a society for all ages," have been less prominent. Much of the government's efforts have been aimed at rekindling traditional reverence for older people, proselytising a time when families cared for (and supported) their older relatives – which, insidiously, would lessen dependent older persons' burden on government support.

The campaign to create awareness and to fight elder abuse has certainly been an important vehicle for the empowerment of older people in general. Moreover, efforts under the campaign have sought specifically to educate older people on their human rights, and how to withstand the abuse and violation of their rights.

What has proved to be another tool for older South Africans' empowerment is the non-contributory, social old age pension. The majority, being poor, are eligible to receive pension benefits equivalent to $140 monthly. Pensioners are entitled moreover to free health care at public facilities. Being a social pensioner accords the beneficiary an enviable status (Ferreira, 2004). Older persons view pension benefits as a right, rather than an entitlement, and as acknowledgement of the contribution they made to society over a lifetime and affirmation of their position in society. Pension benefits are thus a powerful empowerment tool: they earn a beneficiary respect and esteem within his/her family and community; they empower him/her financially; in turn, a beneficiary is able to empower his/her family through pension sharing, thus helping to feed, clothe and educate grandchildren, to sustain unemployed adult kin, and to contribute to development overall (Sagner & Mtati, 1999; Moller & Sotshongaye, 1996). A downside of receipt of pension benefits, however, is that in socially disorganised contexts, the income may render a beneficiary open to abuse and exploitation by family and others in the community intent on attaching the benefits.

Brief mention must be made of several empowerment-specific initiatives under way over two or three decades, such as literacy training (where a large proportion of the older population, particularly in rural areas and women in particular, is illiterate). ABET (Adult Basic Education and Training) programmes, efforts of the Ministry of Sport and Recreation to establish sports programmes for seniors, voter education programmes (Moller, 1995), activities

of groups of veterans (survivors of the struggle against apartheid – who preserve an identity and status as "struggle fighters"), activities of groups of volunteers and church groups – which similarly lend members status and a sense of contribution and participation, and victim empowerment groups – where seniors who have been victims of a crime, exploitation or abuse, or indeed victims of "torture" under apartheid, may be helped to deal with the aftermath of the events are examples of such initiatives.

A South African Older Persons Forum (SAOPF) was established early in the 2000s, but as of 2013, its future is uncertain. The forum was intended to be a spokes organ for older people, for them to articulate concerns and grievances. However, it was constituted primarily of elected managers of agencies such as NGOs and politically connected personalities, who collectively claimed to represent the voices of older people. More recently, it served mainly as a government bureau, funded by the government, which given an obvious lack of objectivity, defeated the purpose of a forum in the first place.

How might older persons' well-being and quality of life be enhanced?

What is needed first, no doubt, is for South Africans to achieve a non-ageist society, following on from which all forms of institutional discrimination against older people may be eliminated.

Second, older people's empowerment must be continued, to encourage them to view themselves as citizens with human rights, and entitled to equitable access to all organs of society and resources. Such empowerment, through "training" in human rights – inter alia, will equip them with knowledge and tools to stand up and speak out; and, at another level, to withstand and fight abuse, exploitation and discrimination, and other violation of their rights. Intrinsic to such empowerment is knowledge of access: to resources, including information, and to channels for redress, to seek justice. Strategies already in place to foster such empowerment include literacy training programmes; training workshops on human rights offered by several NGOs that serve older people; health and self-care education workshops; income generation skills training; financial literacy training; and so on.

Third, older citizens need to be empowered and helped to mobilise, or organise themselves into a group for institutional representation (Ferreira, 2004). Social pensioners, who constitute a vast body, have no representation as such; they are viewed no more than recipients of welfare and are voiceless.

Fourth, the government has historically not been receptive of information or guidance from academia, etc. It lacks expertise within its ranks and declines to consider, indeed dismisses or rejects, evidence put to it.

Fifth, greater scope might be given for older persons of different cultures, as elders, to preserve traditions, and to contribute to society through transmission of knowledge of cultural practices and rituals, in organised ways – thus heightening the visibility and importance of culture and older persons as custodians of indigenous knowledge.

Finally, in a catch-all category, initiatives are needed to enhance older people's visibility – and thus status (which includes their needs, concerns, aspirations and contributions); specific initiatives to integrate them in intergenerational programmes; improved access – as indicated above; and better protection – from exploitation, discrimination, abuse and criminality.

Overall, and importantly, older persons can be empowered and their participation in society fostered if their basic needs are met, they are no longer marginalised in state systems, they enjoy social justice, and they are accorded respect in society and enabled to live in dignity.

How, then, may ILC South Africa (ILCSA) seek to influence or determine policy in the above regard? Empowerment and social participation of older citizens have been and remain two core focal areas of ILCSA's programmes. Specifically, these programmes are aimed at a) empowering older persons through awareness of their human rights, and b) supporting grandmothers caring for adult children and grandchildren affected by HIV/AIDS, while fostering the carers' social integration. ILCSA's efforts in these regards take the form of research and intervention; training support; advocacy; and dissemination of evidence for decision support. The efforts, to influence or determine policy, are continuing, but challenges are hampering efforts, as outlined below.

What strategies work and have been successful?

Specific strategies implemented over some four decades, since the 1970s, to empower older persons, and less directly to foster their social participation, include the following: A strong movement was launched in the 1970s, by the former South African Council for the Aged, now Age-in-Action, in partnership with the Ministry of Social Welfare at the time, to establish senior centres countrywide. The centres, operated by NGOs and subsidised by the government based on membership, run seniors' clubs at congenial venues, where club members, who pay a nominal monthly membership fee, congregate during the morning on five days a week to enjoy refreshments, engage in a variety of activities – such as handicrafts, singing and physical exercises, receive health education and counselling, and enjoy a nutritious, hot lunch. Many clubs are indeed known as Luncheon Clubs. Time spent at a senior centre affords members respite from household chores and family responsibilities (the majority resides in multi-generational households), as well as an opportunity to socialise with peers, and to relax and learn. The movement has been a seminal effort to empower older persons and to recognise their personhood.

Variations of the senior centre model have proliferated. Some centres have become multi-purpose sites, and additionally may offer day care, health care monitoring (and dispense prescribed medication), life skills training, income generation opportunities, and advice. All offer peer support and recreation. Most offer training in human rights. Many organise visits to places of interest.

An example of a centre that focuses specifically on

empowerment is the NGO Grandmothers Against Poverty and AIDS (GAPA) (www.gapa.org.za), whose aim is to offer peer support and counselling to grandmothers who have lost adult children to AIDS, or whose child (or more than one child) is terminally ill from the disease, for whom they care as well as raising affected or orphaned grandchildren. Started in Khayelitsha outside Cape Town in 2000, GAPA now has branches in the Eastern Cape and Free State provinces, and training programmes in Kenya, Tanzania and Zimbabwe. Seventeen peer support groups are operated in Cape Town by grandmothers who joined GAPA initially, whose self-confidence flourished and who subsequently became group leaders. GAPA offers its members income generation opportunities, from selling second-hand clothes, to making and selling handcrafts, to food gardening and selling vegetables. More recently, it has established a bursary scheme for members' grandchildren to enable the children to attend a crèche (and to give the grandmothers respite), and has established an after school care centre, staffed by grandmothers, who read stories to the children, and oversee homework and activities for small remuneration.

Storytelling to young children is a time honoured activity of African older women. Many volunteer to tell stories at crèches, and to guide young children in appropriate and traditional behaviour and practices. Thus, such programmes are intergenerational, enable older participants to contribute in their community, and contribute to their social participation, empowerment, and sense of dignity and purpose overall.

Other programmes proven to work well include those that empower older persons politically: to know their rights, to participate in civic affairs, to vote in elections, to take a stand and speak out on community issues, and so on – referred to earlier. Older men, in particular, play important roles as civic guardians by serving on street committees and normalising behaviour in their neighbourhood.

Overall, participants in all these programmes are empowered through acquisition of skills and coping strategies, enhanced self-esteem, and encouragement to stand up, and to demand respect and respect of their rights – as well as to speak with one voice.

Persisting challenges

Challenges to the empowerment of older people and fostering their social participation in South Africa, as well as strategies that are desirable in the future in order to overcome the challenges include the following:

- Poverty eradication and implementation of the government's development agenda in general, or social justice, through effective service delivery, needs to be expedited, so that older people's livelihoods, and social and habitat environments are improved, they are afforded equitable access and opportunity, and their sense of self-worth and dignity is enhanced, or at least restored in the process.
- Part and parcel of the government's development efforts must be urgent reduction of the high unemployment rate in the young adult population, through job creation, so that younger kin may have livelihoods, and older family members, social pensioners specifically, are relieved of the burden of support and care for these kin.
- A change of mind-set is needed, on the part of the government, society and older people, away from a welfare approach to older people, towards one of individual responsibility for self-sufficiency. Successive cohorts of social pension beneficiaries – and indeed all recipients of social welfare – must gradually be weaned off a dependence on the state for their needs. At the same time, the state must shake off its welfarist attitude, whereby it largely absolves itself from additional responsibility to poor older citizens through the large cash transfer it makes to this population in the form of the social pension. Indeed, the government and politicians enjoy high visibility (and political gain) from the largesse they are seen to dispense to a perceived highly vulnerable group, but the government's function in this regard is akin to that of a nanny state: it is self-perpetuating, and does nothing to promote self-provision and self-sufficiency in older citizens. Granted, a time span of two to three generations is likely required for successive cohorts to be able to provide for themselves financially and sufficiently in old age.
- Akin to welfarist attitudes in our society are ageist and discriminatory practices which persist, and marginalise and debase, or demean older people, and render them vulnerable to abuse, mistreatment and exploitation.
- Mandatory retirement laws and practices need to be removed or relaxed, to enable older workers, who so choose, to continue to engage in the formal labour force. Such an opportunity, to continue to contribute to the economy and development, and to be financially self-sufficient, will enhance their self-esteem and earn them respect in their community.
- Older people need to be fully educated on their human rights and how to exercise them, as well as knowledgeable about accessing entitlements, and recourse they have to legal and justice resources. A more equitable dispensation is needed for older people in virtually all areas of social life.
- A final challenge lies in the government's lack of openness to information and guidance provided or offered to it by external parties and agencies, including academic institutions. Government leans on internal decision making to determine what is in the best interests of older people (and falls within the government's set priorities for fiscal expenditure). Added to the impasse, or conundrum are deep divides between various ministries with responsibility for older people, and inertia around a purported Older Persons' Desk located in the Presidency.

Argentina

Current situation

The equality agenda in Argentina, and indeed in Latin America as a whole, faces a paradox: Although the elimination of perceived differences between people is gaining visibility in political debate and public agenda, groups defined by age, gender, religion and ethnic origin are increasingly excluded in mainstream society. Negative connotations, or stereotypes attached to old age still make it difficult for older people

to achieve autonomy and independence – individually and collectively. For a large number, being 60 years and older seemingly translates into poverty, violation of their rights, loss of respect, frailty and social exclusion.

Women's longer life expectancy worldwide leads to a greater number of older women being widowed, and at risk of being poor and alone. Increasing longevity, and consequent structural changes, have profound implications for older women's human rights, and increase the urgency to address the diverse challenges and discrimination they experience, through appropriate gender and age sensitive policy, budgetary allocation and political will.

Fortunately, over the past decade, and through the employment of a human rights approach, concern about the status of older persons has been making its way into national policies in this regard. However, the policies of international and regional bodies as well as certain state agencies and other stakeholders are not legally binding, and in terms of ensuring that older persons' rights are protected, the list of censurable reasons for discrimination should be expanded to include age and gender.

The Committee on the Elimination of Discrimination against Women (CEDAW) has made a key contribution in the form of General Recommendation No. 27 on older women and the protection of their human rights, as has the Committee against Torture with its General Comment No. 2 on the implementation of article 2 by State parties, published in 2008 (Huenchuan, 2011a,b).

At the Inter-American level, in the late 1980s, specific measures to protect older persons were included in the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), which is the only binding instrument to date that specifically addresses the rights of older persons.

Recently, particularly since 2007, some LA countries have opened and/or widened channels for the Participation for Older Persons, and have encouraged them to participate in designing national plans concerning their rights. Constitutional protection and specific legislation on the rights of older persons have been discussed. Several LA countries – Argentina, the Bolivarian Republic of Venezuela, Brazil, Colombia, Costa Rica, the Dominican Republic, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, and the Plurinational State of Bolivia – have written the rights of older persons into their Constitutions. Some of these countries include protection from acts of discrimination; others focus mainly on guaranteeing economic, social and cultural rights.

Thirteen countries of Latin America – Venezuela, Brazil, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay and Peru – have specific legislation on the matter. Others are currently considering legislation. An example is a bill to ensure the rights of older persons in the Plurinational State of Bolivia. In Chile, in July 2010, the Chamber of Deputies unanimously passed a draft agreement requesting that the executive branch send a comprehensive older persons' rights bill to Congress.

In Argentina (Roqué, 2010) and Panama (MIDES, 2010) work is under way on comprehensive legislation to protect the rights of older persons. These laws are of tremendous value both nationally and regionally in that they are a first attempt to legislate rights, and so are useful tools for enforcing constitutional protections. The 13 countries with specific legislation have made a broad-based effort to set out the Rights of Older Persons.

Provisions against age discrimination cut across most of the legislation that is in place. Regardless of their stage of population ageing, virtually all the countries – Bolivarian Republic of Venezuela, Brazil, Colombia, Dominican Republic, El Salvador, Mexico, Nicaragua, Paraguay and Peru – recognise that old age itself can be a source of violation of rights, and have put measures in place to prevent and punish age discrimination.

In almost all the current legislation, rights to health, education and culture are also protected. Most of this legislation establishes the right to work, while respecting the physical, intellectual and psychological circumstances of older people.

This legislative process, along with jurisprudence in several states, reveals emerging new understanding and consensus on the rights of older persons. However, several areas of older persons' lives remain unprotected, including areas in which they are especially exposed to violation of their human rights. This omission calls for more extensive discussion, analysis and proposals for further protection of their rights, and for targeting particular groups within the older population, including indigenous people, women and prisoners.

Despite sweeping legislation, the essence and structure of older persons' rights are still under discussion. The rights to health, a decent standard of living and work do not mean the same thing in different countries. This lack of homogeneity leads to a divergence from minimum universal standards of human rights across states. Until there is a legally binding instrument, there is a pressing need to bring legislation into line with current treaties, interpretations by oversight bodies, and, above all, global and regional policies on the rights of older persons.

A growing international consensus regarding this issue provides objective and reasonable justification for taking special or affirmative action, and making specific adjustments that are proportional to the goal of achieving substantive equality. Above all, such action can lead to greater inclusion, and to the building of more democratic and pluralistic societies.

How might older persons' well-being and quality of life be enhanced?

Discrimination against any social group is unacceptable. Protection of older persons' rights can help them lead a more dignified and secure life. According them respect can facilitate the conditions that enable them to participate in

society and to contribute to their own development. Thus, there is an urgent need to intensify the call to confront the fundamental causes of discrimination against age and gender.

Numerous older people still experience isolation, poverty, violence and abuse, and have limited access to health services, education and legal protection. Over the life course, many were denied equal opportunities and worked in poorly paid jobs, in order to provide for themselves and their family dependents. Violation of their rights in old age can result in serious health problems and the consequences.

Nonetheless, the growing scourge of rights violations is leading to a universal effort to increase awareness of the magnitude of the problem, and to develop and implement prevention and intervention programmes. However, policies, and health and social programmes may promote or violate older persons' human rights, depending on how they are designed and implemented. Prevention of human rights violations requires the involvement of multiple sectors and the employment of a gender perspective for equality to be promoted.

Particularly vulnerable groups of older people include the very old, functionally disabled persons, women and the poor. Education, and the dissemination of information, formally, informally and through the media, can help to remove negative stereotypes of old age, and send out positive messages to facilitate older persons' empowerment. Empowerment should help them to act on their own accord, to exercise their rights and to advocate in their own best interests.

Challenges for the future

The Latin American region has limited time to effect changes that will result in an egalitarian and inclusive society for older people – indeed, a society for all ages. Particular challenges in this regard are as follow:

- Social and economic transformation, due to internal and external migration, and the liberation of women and their progressive entry into the labour force – for example, calls for a rethinking of the roles of the State and the private sector, and the concept of the extended family.
- Policy makers must take into account weakening family support systems and inadequate social service provision, in order to provide older people with a decent standard of living.
- The scope of the challenges means that the public sector, the private sector and academia should combine efforts and resources in innovative, multi-sectoral research.
- Older persons must be included in the equality agenda.
- Stronger political will and resources are needed to foster older people's greater participation in society.

Hence, the LA region – and Argentina in particular in this case – needs innovative solutions to enhance older people's well-being, to foster their social inclusion, and to ensure age and gender equality.

Conclusions

The examination of the situation in South Africa describes the socio-political climate that enables and impedes older people's empowerment and social participation. That in Argentina, extrapolated to the Latin America and Caribbean region, makes out a compelling case for strengthening older people's human rights and protection, and thereby empowering them and fostering their social participation. A human rights approach to all areas of older people's lives can serve as a powerful tool for their future empowerment.

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Lifelong Learning in France and in Europe

The French population is ageing with 15,2 million people aged over 60 years, or approximately 23 percent of the total population of 65,3 million. In 2030, 20 million French people will be more than 60 years old, and 15 million less than 20 years, the most dramatic increase will be observed in people over 75 years old (x 3) and over the age of 85 (x 4). This is due to the dual effect of a lower mortality and the continued decline in fertility since the 19th Century, even if it is now stabilized at 2,01 children by women. For almost 20 years, life expectancy increased by one quarter every year. The time of life without disability will increase and the average age of onset of dependence is estimated at 85 years.

The 20 or 30 years of life after retirement – in France, the statutory retirement age was 62 (2011) – are gradually differentiated: 60-75 years "active seniors", 75-85 years "poly-mini-disability and frailty " but autonomous, and people over 85 years who may be facing dependency. However, old age does not correspond to an homogeneous public, including opportunities available to advance one's knowledge. In fact, France is expected to experience one of largest increases in employment rates among persons aged 55-64 years2 – more than 20% increase, compared to a European average of approximately 16% – between 2010 and 2060; although that may be due to the fact that the country currently has one of the lowest employment rates for those aged 55 – 64 in Europe – 41,4% against 49.1% for the whole of the European Union in 2009[3-4].

Lifelong-learning is defined by wikipedia[1] as the "ongoing, voluntary, and self-motivated pursuit of knowledge for either personal or professional reasons". Within France, and throughout Europe generally, older adults have access to different types of lifelong learning opportunities: such as volunteering, increasing social interactions, general adult education classes (i.e. learning another language, computer skills), and finally professional development or on-the-job training.

French Regulations to Protect Older Workers

Mandatory regulations have recently been enacted by the French government to require employers to meet older workers' needs, including training, and to reduce barriers. In 2002, the French government passed a law requiring the recognition by universities of prior informal and work-based learning (RPL, also known as "Validation des Acquis de l'Expérience" or VAE) and other professional qualifications. The law effectively organised RPL at a national level, although universities can develop their strategy of recognition on their own, and includes competence-based awards and individual assessments. However, many organisations fail to use or finance the RPL procedure.

Another French law, passed in 2004, grants individuals the right to lifelong-learning ("Droit Individuel à la Formation, DIF), entitling all employees to access a maximum of 120 hours of training/educational sessions over a 6 year period (20 hours/year) during work or free time. DIF is financed entirely by the employer (1% of the budget is obligatory), and the cost of the learning is not considered part of the salary, therefore individuals aren't taxed on this benefit.

At the beginning of June 2006, the French prime minister presented a national action plan (National Action Plan for Seniors Employment) to reach an employment rate of 50% among people aged from 55 to 64 years and improve the conditions for older workers[2]. The plan was enforced between 2006 and 2010. In addition, the French Law for the Funding of Social Security ("Loi pour le Financement de la Sécurité Social", LFSS), enacted in May 2009, protects elders from forced retirement and requires employers to encourage senior employment – often focused on skills or professional development – or pay a penalty of 1% of earnings/profits[3].

French and European Innovative Lifelong Learning Models

Although not yet widespread, we have begun to see pockets of experimentation, out of the well-established processes for adult education, regarding lifelong learning for elders throughout France. These lifelong learning opportunities for older persons can be found in both public and private settings, and sometimes may be financed jointly by public and private sources.

Skills Training

Public:
The European Commission established a Lifelong Learning Programme (LLP) in November 2006 to increase transnational education and training activities throughout 31 European countries, reaching almost 900,000 European citizens and 50,000 organisations[3]. Financed publicly by the European Union, most of the programmes are delivered through national agencies; in France, the national agency responsible for managing projects and dispersing funds is the "Agence Europe Education Formation France[4]" .The LLP combines four well-established sub-programmes (Comenius

[1] http://en.wikipedia.org/wiki/Lifelong_learning
[2] http://www.eurofound.europa.eu/eiro/2006/08/articles/fr0608019i.htm
[3] http://ec.europa.eu/education/lifelong-learning-programme
[4] www.europe-education-formation.fr

for schools, Erasmus for higher education, Leonardo da Vinci for vocational education and training, and Grundtvig for adult education). However, except for the Grundtvig programmes – which have shown to support active ageing and intergenerational learning – participation decreases substantially for both lower-skilled and older adults. The midterm evaluation of the LLP programme acknowledges that more "progress towards a lifelong learning approach as opposed to one based on educational sectors is still quite limited", which may be a factor of insufficient budgets and other mobility-related barriers[5].

The Grundtvig projects effectively engage elders and improve the capacity of education and training systems. For example, many of the Grundtvig programmes throughout Europe focus on improving the skills and competencies needed for information and communication technology (ICT) – such as the "Learning Partnership E-Com+45 Grundtvig" project for all workers over age 45, and the intergenerational "Simulating ICT Learning for actiVE EU eldeRs" (SILVER) project[3].

The Department of Employment, Social Affairs, and Inclusion, also located within the European Commission (EC) European Social Fund, has engaged in many projects since 1957 throughout France, training older workers on job skills, such as use of information technologies[5] .

Joint:
AGE Platform Europe is a European network of around 165 organisations of and for people aged 50+ representing directly over 30 million older people in Europe since 2001[6]. Its work is co-financed by its organizational members and by the European Commission. In their attempt to create an "Age-Friendly European Union by 2020," they list what they have identified as best practices throughout Europe on topics such as employment & active ageing and education & lifelong learning. Specifically within France, they identified a few Grundtvig-funded programs, in addition to "Générations & Talents" – an intergenerational programme of Alcatel-Lucent and APEC (a French recruitment agency) revolving around skills development and mentoring/knowledge sharing.

Adult Education

Joint:
The University of the Third Age (U3A) – started in France at the Faculty of Social Sciences in Toulouse in 1973 – aims to provide continuing education and various cultural activities for seniors in order to "prolong active life". Since its formation, the model has now expanded throughout Europe – and other places, like Australia and the US. In 1993, it became known as "Union Française des Universités Tous Ages" (UFUTA[7])encouraging intergenerational exchange, in-person meetings, and less emphasis on formal registration and graduation processes. The U3A model, with the exception of one or two locations, is now open to anyone regardless of age or degree, and can use various names (such as "University All Ages", "Inter-Ages", "For All", "Retirement and Free Time", "Third Time", "Permanent" etc). In some locations, U3A is offered as a virtual community[8] – in other words, an online learning community of older people – with less curriculum structure and more group interaction, therefore making the model more accessible for those who live in isolation (due to geography, health/ physical ailments, etc.).

However, in France, the model has remained in-person and linked with either local universities or associations, and are currently available in 41 French towns. While most U3A programs are privately funded, the UFUTA programs are dependant on public funding from the Ministère de l'Éducation nationale. For example, TRANS-INNOV LONGEVITY "TIL" project[9] was certified on March 13, 2012, "Excellence in innovative training" (IDEFI) by the Ministry of Higher Education and Research. TRANS-INNOV LONGEVITY (TIL) models an innovative cross-training inter-university project for both initial training and training throughout life. It leverages a system of educational excellence based on national and international academic networks, like that of UNF3S.

TIL promotes access to new audiences in new degree university courses, offering a wide variety of models and learning paths, built on multi-and transdisciplinary skills, around a structured but flexible design IDEFI-TIL is an innovative educational project applied to business in longevity[10].

Private:
Some organisations have been developed by older persons themselves. For example, Old Up[11] focuses on intergenerational interactions of their members and training older persons for useful daily functions – including how to use the new technologies (i.e., create a Facebook account, call friends and family using Skype), how to cope with death, illness, children, etc.)

In addition, other virtual communities throughout Europe have also emerged[12], which are online community promoting active ageing through the use of ICT; however, most of these forums remain small.

[5] http://ec.europa.eu/social/esf_projects/result2.cfm
[6] http://www.age-platform.eu
[7] http://www.ufuta.fr
[8] http://vu3a.org/
[9] http://u-til.org/
[10] http://til.cerimes.fr/index2.php
[11] http://old-up.eu
[12] http://elearningeuropa.info/

Volunteering

The use of older persons – who are often more experienced, knowledgeable and motivated – for volunteer activities has the positive impact of improving quality and capacity of the programmes.

Public: The "Grundtvig Senior Volunteering Projects" are available to all European citizens aged 50+ years, and funds projects between 2 organizations in 2 different countries over a 2-year period. A large percentage of participants in Europe thought the experience increased their technical skills (43%) and language skills (just under half). During 2007 and 2009, France led another Grundtvig project, "Transfert de Competences Acquises et de Savoirs Techniques (TCAST), which offered the opportunity for younger generations to benefit from the technical skills and knowledge of older skilled artisans who are retired or about to retire. Another Grundtvig program that France partnered in, "Seniors in Action", trains older people with specific skills to informally educate school pupils[3].

Private:
The Lire et Faire Lire programme, started in France in 1999, provides older persons the opportunity to read to younger children[3]. While the program has successfully expanded across the country, there remains difficulty in recruitment of older volunteers since time-frames and locations may not be ideal.

Related Lifelong Learning Activities

Many European organisations, both governmental and private, have begun to draw attention to the importance of lifelong-learning for older persons, including multiple opportunities for professionals working with elders to learn more about the need to include, educate, and/or train older persons.

Public:
The European Union's "Cedefop[13]" (the European Centre for Development of Vocational Training) has held conferences in Brussels the past two years ("Learning Later in Life: Uncovering the Potential of investing an Ageing Workforce" in 2011, and "One Step Up in Later Life: Learning for Active Ageing and Intergenerational Solidarity" in 2012), with the aim of educating the public and professionals working in the field on why and how to continue engaging, educating, and training older persons.

Health literacy of older adults is another important area to improve the status of older workers. For example, the "Empowering Health Learning for the Elderly[14]" (EHLE), offered through the European Commission's LLP, has partnered with Italy, France, Spain, and the Netherlands to improve training so that professionals will be better able to educate elders to live healthier lives.

Private:
Road Scholar/Elderhostel[15], is an international organisation that offers travel and learning experiences – sometimes referred to as "leisure learning" – to adults age 55+ throughout the world. Although it began in the United States in 1975, it has since expanded offices to other locations, including France.

Issues to Consider to Address Best Interests of Older People

Many elders do not think about their future. If ILC Centres want to influence policy related to lifelong learning, the following must be considered:

- The recruitment of retirees is a strategy that is being increasingly turned to in France, particularly in these employees' former workplaces. Return-to-work situations may be available, since some organisations recognize the contribution that retirees can make in their capacity of "expert resources" having experience-based knowledge to pass on. However, as Aline[2] Chamahian discovered[6], major gaps still exist for older persons in access to training. Since many retirees work on a contract basis, they are often at risk of being excluded from internal training programs.
- Older workers tend to report considerably more work-related health problems: On average, in Europe in 2007, 16.8% persons aged 45-54 years report at least one work-related health problem, which decreases to 15.8% among those aged 55-64 (although this excludes France). Policymakers should consider health promotion campaigns in the workplace (or other locations) in order to improve the general health of older persons, reduce absenteeism associated with such problems, and prolong potential working lives[2].
- Responding to the economic vulnerability of the elderly: The French have one of the lowest poverty rates for elders (9.7%), compared to 15.9 % of Europeans aged 65 years or more living below the poverty line in 2010[16]. However, the parallel link between the lengthening of life and increased resources is broken; in 2005, the average standard of living of pensioners was 10% lower than that of active people because of the discontinuity of employment. Multiple lifelong-learning (educational and job training) opportunities should be encouraged for this population to keep them financial stable.
- Trend of New technologies: Beyond the generational and cultural reticence which will decrease with time, and their high cost, knowledge of ICT is increasingly becoming required to advance in the workplace. Training of new technologies should be a priority when developing lifelong-learning programmes.

[13] www.cedefop.europa.eu
[14] www.ehle-project.eu
[15] www.roadscholar.org
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