Chapter 15
Policy Responses in Asia

It is essential to integrate the evolving process of global ageing within the larger process of development. Policies on ageing deserve close examination from the developmental perspective of a broader life course and a society-wide view, taking into account recent global initiatives and the guiding principles set down by major United Nations conferences and summits.

(United Nations 2002: 6)

15.1 The Macau Plan

This chapter first discusses Asia's main international policy documents concerned with responses to aging. Later sections highlight major concerns about poverty, health and the vulnerability of the family. The chapter aims to clarify key issues in relation to the aged in Asia's developing countries. It also illustrates the importance of international inquiry, discussion and action in formulating and implementing policies. In preparation for the 1999 International Year of Older Persons, the Economic and Social Commission for Asia and the Pacific (ESCAP), a regional arm of the United Nations, convened a meeting in Macau in 1998 which developed a *Plan of Action on Ageing for Asia and the Pacific* – 4 years before the Second World Assembly on Ageing (ESCAP 1998a). The Macau Plan, which governments in the region endorsed in 1999, gave particular attention to the needs of developing countries in the region, recognizing that their priority was overall social and economic development, including the provision of basic social services for all: "Hunger, poverty, ill health, social exclusion, unemployment, and limited access to education and basic amenities are critical national areas of concern requiring corrective action and competing for scarce resources" (ibid.: 2).

Thus the Macau Plan was one of the first international policy documents to address the question of aging and development. Issues concerning aging were

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viewed within a broad developmental context, for example recognizing the aged as contributors to national development as well as a group with particular needs. Similarly, the Plan acknowledged that social and economic development was transforming national institutions and values that impact on older people, such as through changes in the nature of families and communities. Although later formulations have refined or revised parts of the Plan, it was a pioneering endeavour declaring a vision of promoting the well-being and participation of older people, with particular concern for women, the poor and people in rural areas (ibid.: 10). The needs of widows and others without family support underlay the Plan's focus on women. Some of the Plan's proposals, however, were more relevant to an urban middle class than to the urban and rural poor. While noting that governmental interest in aging and the aged varied between countries, the Macau Plan identified four issues of broad relevance for immediate action namely:

> (i) understanding of the issues and implications of population ageing on society; (ii) preparation of the population for an ageing process that is productive and fulfilling; (iii) development of a service infrastructure and environment based on traditional and modern institutions that will be able to meet present and future needs; and (iv) delivery of essential services needed by the growing number of older persons. (ibid.: 3–4).

Discussion of these ranged across a number of major subject areas including negative stereotypes, income, employment, the family and service provision. Dispelling negative perceptions was acknowledged as a prerequisite for combating marginalization of older people and fostering positive, productive roles for them in the workplace, the community and the family. Lifelong education and equal opportunity were endorsed as conducive to productive aging. The Macau Plan's discussion of income in later life mentioned the importance of life-long saving, employment opportunities for older workers and the role of the family in providing financial security. It advocated the abandonment of a rigid retirement age and legal protection to enable capable older persons to remain economically active (ibid.: 9).

The Plan emphasized the roles of the family as the basic social unit in which support is given and received and as the economic unit engaging in productive activities, especially in rural areas. It noted that in most of the region's plans for population aging the family remains the "front line institution", although there was also special mention of the contribution of older people to the welfare of the family and younger generations. The Plan recognized that the family's capacity for aged care was diminishing because of smaller family sizes, higher labour force participation of women and migration. In response to this, governments needed to enhance the care-giving capacity of the family through promotion of co-residence and provision of home-nursing, respite care and counseling. For those without family support it was necessary for governments to make special provision (ibid.: 5).

The Macau Plan's approach to health and health services was similar to that advocated for developed countries, emphasizing primary prevention, healthy lifestyles and maintenance of physical and social activity. Educating the population on good nutrition and healthy aging, and disseminating information about common illnesses such as diabetes, cataract and arthritis, were seen as affordable strategies that could be integrated with existing community health programs. These approaches, rather than high cost medical technologies, were thought to have most significance for the

Table 15.1 Major directions in the Macao, Madrid and Shanghai policy documents

Macao 1999	Madrid 2002	Shanghai 2002
Understanding of the issues and implications of population aging on society.	Older persons and development.	Older persons and development.
Preparation of the population for an aging process that is productive and fulfilling.	Advancing health and well-being into old age.	Advancing health and well-being into old age.
Development of a service infrastructure and environment based on traditional and modern institutions that will be able to meet present and future needs.	Ensuring enabling and supportive environments.	Ensuring enabling and supportive environments.
Delivery of essential services needed by the growing number of older persons.	[Implementation and follow-up].	Implementation and follow-up.

quality of life of the population generally. The Plan conveyed an optimistic view of current extensions of life in good health, the effectiveness of low cost interventions for serious illnesses, and prospects for insurance schemes to finance hospitalizations. There was no specific mention of the health issues arising from poverty, under-nourishment, malnutrition, smoking, malaria, tuberculosis and HIV/AIDS, which impact upon young and old and are the most prevalent and intractable problems for health services and family support in developing countries. Similarly, in relation to housing, transport and private-sector service provision for the aged, the discussion mainly presented a middle-class perspective rather than realistic ways of assisting the impoverished majority in many countries of the region.

Regarding the implementation of policies, the Plan highlighted the need for collaboration of governments, non-government organizations and the private sector together with the importance of encouraging volunteering by and for older persons. It gave special emphasis to the role of non-government organizations:

> The governments are aware of the critical role that non-governmental organizations play. Many of these organizations are pioneers in organizing and delivering services to older persons. In many member countries, they are the core institutions in the national infrastructure for ageing. The governments will encourage the development of a strong non-governmental sector and enhance the participation of these organizations in planning and implementing policies and programmes concerning older persons. Facilitation of the development of this sector should include the formulation of a legal framework for the establishment and registration of such organizations, and the provision of budgetary subvention and assistance in other forms to them. (ibid.: 12).

An ensuing document, *Guidelines on the Implementation of the Macao Plan of Action* (ESCAP 1998b), summarized key points from the Plan through providing concise recommendations on action in relation to the four issues or immediate tasks listed above (see also Table 15.1). The Guidelines further referred to action in specific areas such as dispelling negative stereotypes, supporting the care-giving role of families and improving health, housing, employment and social services – especially home support services (ibid.: 3–10). Overall, the Plan identified wide ramifications of population aging and developed an extensive agenda to assist Asia-Pacific governments in determining their own responses. It also laid the ground for furthering progress by advocating international cooperation in implementing recommendations.

Examples of the proposed ways of achieving this included the exchange of information and expertise by countries and organizations, United Nations' support for country-level initiatives and ESCAP undertaking periodic reviews of the implementation of the Plan (ibid.: 12).

15.2 The Shanghai Implementation Strategy

Following the preparation of the *Madrid International Plan of Action on Ageing 2002*, United Nations regional commissions undertook to formulate regional implementation strategies. These included strategies for Europe (ECE 2002), Latin America and the Caribbean (ECLAC 2003) and Asia and the Pacific (ESCAP 2003). In the same year as the Madrid conference, ESCAP organized a meeting in Shanghai to develop an Asia-Pacific regional implementation strategy for both the Madrid Plan and the Macao Plan. ESCAP's report observed that "there is a great concordance between the Macao and Madrid plans of action" (ibid.: i). Table 15.1 illustrates this, comparing their major stated policy directions as well as that of the *Shanghai Implementation Strategy*. The Madrid and Shanghai documents have similar structures. Although the Macao Plan was organized somewhat differently, the main thrust of the document was population aging and development, including the importance of maintaining health and well-being.

The structure of the documents, and the differences between them, also reflect the absence of agreed policy concepts that might provide a focus for discussion of broad subject areas, such as concepts of aging in place and productive aging. 'Active aging' (see Chap. 12), however, is mentioned in the introduction to the Shanghai Strategy as an encompassing concept: "A national strategy on how to prepare society for the challenges of aging is essential in ensuring that the goals of active aging are achieved." Similarly, one of the key actions in the report states: "Promote policies and programmes that support active aging, which is the process of optimizing opportunities for health, participation and security in order to enhance the quality of life as people age" (ESCAP 2003: 1 and 7).

The *Shanghai Implementation Strategy* presented guidelines on responses to population aging for governments in the Asia-Pacific region. While in accord with the Madrid Plan of Action, it reduced the original 239 recommendations to 66 'key actions'. The report is structured in terms of the topics shown in Table 15.1, providing recommendations for action in each of these areas. Like the other two reports, it made no mention of population policies apart from the need to take population aging into account in policy planning. In relation to population aging and development, the Shanghai Strategy revealed the extensive nature of the task and ways forward, as summarized in Table 15.2.

Taken in isolation, and without advice on accomplishing the recommended actions with minimal resources, many of the key actions seem contingent upon economic development, although this is no panacea if great inequalities persist between social groups. The most practicable means of assisting families and the aged are likely to be low-cost strategies integrated with other aspects of development.

Table 15.2 Aging and development in the Shanghai Implementation Strategy

Objective	Difficulties	Examples of key actions
Mainstreaming aging into development policy.	Lack of funds and staff, lack of staff training, ineffective interdepartmental co-operation.	Increase the efficiency of existing systems, obtain technical assistance, provide training opportunities, promote interdepartmental collaboration.
Promoting integration and participation of older persons.	Many live in rural and remote areas, lack of family and community support, under-recognition of older people's contributions and potential.	Recognize and support the contribution of older people to the family and the community, promote the social and economic participation of older persons.
Provision of social protection and security.	Except for public sector employees, there is little pension coverage, such as for the informal sector and rural areas, or people without employment or earnings. Inadequate tax revenue for universal pension schemes.	Establish sustainable social security systems for the labour force in general and older persons in particular. Gather and utilize data on living conditions, incomes and expenditure to provide a reliable basis for policies on income security.
Alleviation of poverty in old age.	High prevalence of poverty, with older persons among the poorest.	Include older persons as a target group in poverty alleviation; support their capacity to undertake income generation schemes.
Older persons and emergencies.	Older persons, especially those without families, are particularly vulnerable during natural disasters.	Provide special protection to older persons during and after natural disasters and other emergencies.
Promoting positive attitudes towards aging and older persons.	The prevalence of negative stereotypes of older people in the general population and in the mass media – as dependent, frail, troublesome and unable to contribute.	Promote, through media campaigns and school curricula, recognition of the contribution of older persons to society. Encourage the media to promote positive images of aging.
Employment of older persons.	Measures to achieve productive aging, through the continued employment of older persons in the workforce, have yet to succeed.	Provide incentives and remove disincentives for people to remain in the workforce. Seek effective measures to combat unemployment.
Recognizing gender-specific issues in aging.	Women form the majority of people aged 75 and over. They are more likely to be widowed, and to lack income security and skills. They are also the primary caregivers and in many cases work only in the home or in the informal sector.	Enhance support for family caregivers, to allow them to combine work and family life. Promote greater male responsibility in the family. Eliminate gender discrimination and increase the participation of women in the labour force through education and training.

Source: ESCAP (2003: 2–6)

Health care initiatives in developing countries point to some ways forward (see Caldwell 1986; Beaglehole et al. 2008; Kuhn 2010). Given the scope and extent of the range of actions recommended for aging populations in the ESCAP region, the means of implementation are critical to progress or even to keeping pace with population growth and social changes. The Shanghai Strategy emphasizes that governments and other national actors have a major role. The recommended approaches to implementation included data collection and research on the circumstances of older people, encouraging the participation of NGOs, the private sector, older persons' associations and other sectors of civil society, together with regional and international cooperation (ESCAP 2003: 11–12). Despite the importance of these means of implementation, more research is needed on low-cost strategies for improving the circumstances of the aged in developing countries. Successful implementation of plans of action will often depend on such initiatives. Also needed is the identification of priorities for individual countries. Like the Madrid Plan, the Shanghai Strategy identified four major policy directions and recommended actions relevant to each (Table 15.1), but it did not indicate priorities. The absence of this reflects the diversity in levels of socio-economic development within the Asia-Pacific region.

Although priorities necessarily vary between different national settings, as well as between urban and rural regions, three issues stand out as key concerns for the rapidly growing aged populations in Asia's developing countries, namely poverty alleviation, health care, and support for families. All are interwoven with other issues, but in many developing countries progress in these areas could have the greatest benefit for the welfare of older people. This needs to take place in the context of building 'a society for all ages'. As noted in the *Report on the Second World Assembly on Ageing*: "A necessary first step in the successful implementation of the Plan is to mainstream aging and the concerns of older persons into national development frameworks and poverty eradication strategies" (United Nations 2002: 39). For example, in responding to the Madrid Plan of Action, the United Nations Economic Commission for Europe (ECE) made commitments: "To mainstream ageing in all policy fields with the aim of bringing societies and economies into harmony with demographic change to achieve a society for all ages" and "To ensure full integration and participation of older persons in society" (ECE 2002: 1–2).

15.3 Poverty Alleviation

In 2005 about a quarter of the population in less developed regions lived on less than US$1 per day, compared with half of those in the least developed countries (United Nations 2010: 2). The key actions from the Shanghai Strategy that relate most closely to poverty eradication are:

- Provide adequate social protection/social security coverage for the labour force in general, including the agricultural and informal sectors, and older persons in particular, recognizing the role of government as supporter and regulator.

- Include older persons as a target group in poverty alleviation programmes at all levels, including income generation schemes and savings and credit programmes, with emphasis on high-risk groups such as women (ESCAP 2003: 3–4).

Eradicating extreme poverty and hunger is the first of the Millennium Development Goals agreed to in the *Millennium Declaration*, signed in September 2000 by 189 countries (Box 15.1). Poverty commonly entails multiple areas of deprivation including insufficient income, illiteracy and no access to adequate shelter, nutrition and health care, or to clean drinking water and sanitation (Harper 2006: 209–10). Figure 15.1 shows that a high percentage of the developing country populations in Asia have incomes less than $1 per day. Some countries have achieved marked reductions in these percentages since the early 1990s, although having more than $1 per day is no guarantee of deliverance from extreme poverty.

Box 15.1 Millennium Development Goals (MDGs)

The goals and targets of the *Millennium Development Goals* signify a partnership between the developed countries and the developing countries to promote development and eliminate poverty:

> The Goals represent human needs and basic rights that every individual around the world should be able to enjoy – freedom from extreme poverty and hunger; quality education, productive and decent employment, good health and shelter; the right of women to give birth without risking their lives; and a world where environmental sustainability is a priority, and women and men live in equality. (Ban Ki-moon, in United Nations 2010: 3).

Goal 1: Eradicate extreme poverty and hunger.
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day.
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people.
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

Goal 2: Achieve universal primary education.
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

Goal 3: Promote gender equality and empower women.
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.

Goal 4: Reduce child mortality.
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

(continued)

Box 15.1 (continued)

Goal 5: Improve maternal health.
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.
Target 5.B: Achieve, by 2015, universal access to reproductive health.

Goal 6: Combat HIV/AIDS, malaria and other diseases.
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS.
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

Goal 7: Ensure environmental sustainability.
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss.
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.

Goal 8: Develop a global partnership for development.
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. Includes a commitment to good governance, development and poverty reduction – both nationally and internationally.
Target 8.B: Address the special needs of the least developed countries. Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA [official development assistance] for countries committed to poverty reduction.
Target 8.C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the 20-second special session of the General Assembly).
Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term.
Target 8.E: In co-operation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications.

Source: United Nations (2011).

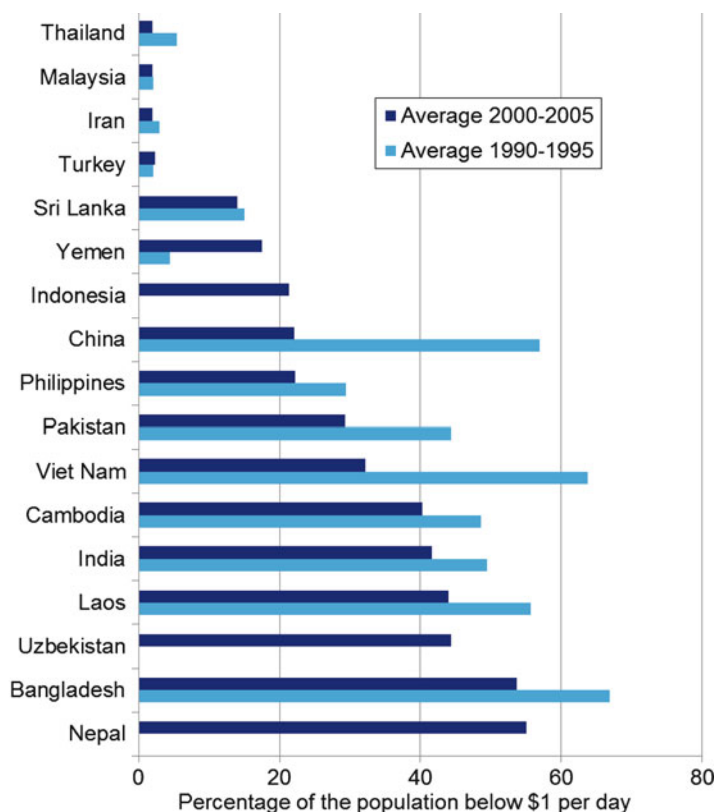

Fig. 15.1 Percentage of the population of Asian countries with incomes less than $1 per day, 1990–1995 and 2000–2005 (Source: United Nations 2011)

The causes of poverty, the means of reducing it, and the feasibility of public and private pension schemes are complex and continually debated (ibid.: 214–5 and 227–30). Nevertheless, it is clear that most developing countries will be unable to afford to construct national social security systems modeled on those of Western countries. In developing countries, coverage of these has mainly been limited to urban groups, such as government employees, while agricultural workers and the urban and rural poor have not benefitted. In developing Asian countries, formal social security coverage ranges from about 9% to 30% of the aged population. Although many countries provide social entitlements, access to those entitlements is unreachable for many of the aged, especially those most in need (ESCAP 2004: 5). Magnus (2009: 165) considered that Asian countries had 10–20 years in which to prepare or remedy their social insurance systems, but concluded

that: "no one should imagine this to be either inevitable or successful." As stated in the Madrid Plan:

> Although global attention has recently been focused more actively on poverty eradication targets and policies, older persons in many countries still tend to be excluded from these policies and programmes. Where poverty is endemic, persons who survive a lifetime of poverty often face an old age of deepening poverty. For women, institutional biases in social protection systems, in particular those based on uninterrupted work histories, contribute further to the feminization of poverty. … Special social protection measures are required to address feminization of poverty, in particular among older women. (United Nations 2002: 18).

The Madrid Plan's recommendations in relation to poverty and the aged included promoting equal access for older persons to employment, developing age and gender relevant poverty indicators as an essential means of identifying needs, and enhancing international cooperation to support national efforts to eradicate poverty (United Nations 2002: 18–19). The Madrid Plan also recommended, as a matter of urgency, the organization of systems to ensure minimum income for older persons with no other means of support, most of whom are women (ibid.: 20). Another suggested direction envisages welfare systems founded on "household and community contributions, diversification of economic activity and improvement of market functioning" rather than built through government programs alone (Burgess and Stern 1991, cited by Harper 2006: 215–6). Transfers of assistance within and between households are a significant form of social security in developing countries, but supplementation from community and government tiers of support is needed when whole families are destitute. Consequently, some envisage a multifaceted approach to pensions and poverty alleviation, combining individual contributions from employment or savings, family and community support, together with government pensions targeting the most needy. Financial assistance for the impoverished aged can have significant flow-on benefits, enhancing intergenerational support and raising the living standards of entire households (ibid.: 216 and 229). Lack of government revenue, however, is but one of the obstacles confronting progress in these directions. Others include expensive and inefficient administrative procedures, as well as non-compliance and corruption – all of which increase developing countries' difficulties in responding to social and economic issues.

For a majority of the aged at any time, later life is not a period of dependency and decline, but one of continuing participation in the family and the community (Heisel 1984: 61). The aged who are not in the mainstream labour force make many contributions to society, or have the potential to do so if afforded opportunities. Communities can benefit from their knowledge, experience and free time through providing opportunities for volunteer work to those who want it, and through recognizing and acknowledging their contributions. Volunteer work, however, will be of little use to people who are struggling for their own existence; their need is for paid work or practical help. In relation to paid employment, another dilemma for less developed countries is whether to maintain the labour force participation of older workers in the modern sectors of the economy – potentially to the disadvantage of younger and better educated people – or to foster older workers' early retirement and prolong their time lived as a possible tax burden.

15.4 Health Care

People in developing countries not only have lower life expectancies than people in developed countries, but also live a higher proportion of their lives in poor health (Lopez et al. 2006: 7). Yet health care for older people in developing countries was long neglected amid much-needed concern for child survival and the health of mothers. The forthcoming increase in dementia cases is part of the more general sustained surge in the numbers of older people with chronic illnesses and disabilities. This is associated with progress towards the third stage of the epidemiologic transition in developing countries. For example, WHO projections indicate that Africa, Asia, and Latin America will have more than 55 million people with senile dementia in 2020 compared with 29 million in 1998 (WHO 1998). Other projections for Asia envisage the prevalence of dementia in China rising from 5.5 million cases in 2005 to 27 million in 2050. The corresponding figures for India are 3.2 million and 16.3 million (Access Economics 2006: v). Senile dementia, due to Alzheimer's disease and other causes, is one of the most incapacitating afflictions of later life and even more moderate cases may require high levels of personal care.

Other chronic illnesses – including heart disease and cancer – are also among the most challenging aspects of population aging. They require provision for a new and expanding group of vulnerable people. They also call for preventive actions to ameliorate trends. The emphasis in developing countries has long been on infectious diseases and primary health care for mothers and infants, which is especially appropriate for countries in the second stage of the epidemiologic transition. Population growth and aging are now bringing a rising need for attention to chronic and degenerative diseases and care of the aged. This trend coexists with the persistent scourge of diseases such as malaria, HIV/AIDS, and tuberculosis. Emerging priorities for health systems are disease prevention and primary care for all age groups. Key actions from the Shanghai Strategy include strengthening primary health care and bolstering family care of dependent relatives:

- Ensure a continuum of health-care programmes based on a primary health systems approach, including locally based health-care practices, health education, health promotion, disease prevention and a coordinated referral system to hospital and other health-care services.
- Improve access to and the quality of long-term care for older persons and develop social support systems to enhance the ability of families to take care of older persons within the family.
- Adopt a comprehensive planning approach taking account of available resources within the community, such as neighbours and volunteers, and direct efforts towards developing interdepartmental as well as intersectoral collaboration. The active involvement of NGOs and the private sector are vital in this regard (ESCAP 2003: 7–8).

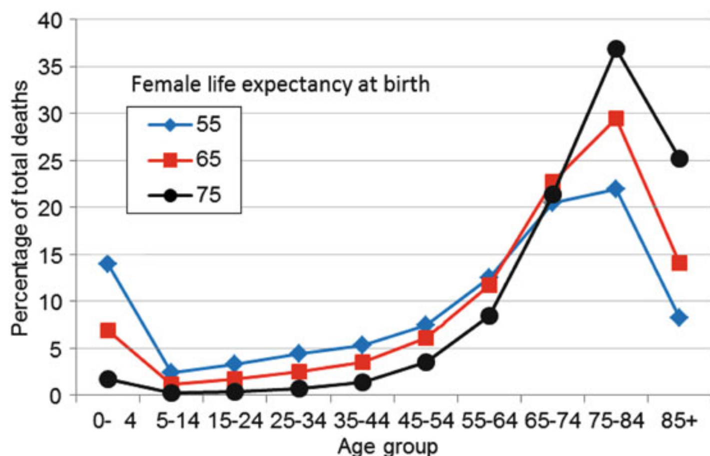

Fig. 15.2 Age distribution of female deaths at different life expectancies (Source: West model life tables (Coale and Demeny 1983; Rowland 2003: 316–319))

The Shanghai Strategy described primary health care as the most efficient and cost-effective way of addressing needs including those of the aged, for whom non-communicable or chronic diseases are the leading causes of morbidity, disability and mortality. Some related key actions entail promoting active aging and healthy lifestyles as well as the development of community based services – which have the potential to relieve the aged care burden on family members (ibid.: 9–10). The Madrid Plan also recommended the strengthening of primary health care services through measures such as training health care workers and social workers in basic gerontology and geriatrics, including traditional medicine in primary health care programs where appropriate, and enabling local communities to provide health support services for older people (United Nations 2002: 27).

Figure 15.2 uses model data on mortality to illustrate aspects of the transformation of the demand for health care in Asian countries. Mortality data are partial indicators of the burden of care because people nearing the end of their lives are especially likely to need health services and personal assistance. Already well under way are the diminishing peak in early childhood mortality and the rising peak in deaths occurring at ages 75 and over. The only constant is that the deaths in the young-old ages (65–74) remain around 20–23% of the total. Over time, differences in national age structures will result in considerable departures from these model figures, which refer only to stationary, zero growth, populations. Nonetheless, as populations experience longer life expectancies the health issues of later life will loom larger and the numbers of deaths at older ages will continue to increase rapidly. The changing age distribution of deaths has major implications for family and community care, because ill health among the elderly contrasts with ill health in early childhood in its causes, treatment and the nature and duration of support required.

15.5 Support for Families

Family care for the aged is a major element of policy proposals for health care in developing countries, and indeed is one of the foundations of overall responses to aging. The Shanghai Strategy discussed the question of supporting the family in its caring responsibilities mainly in the section on "Ensuring enabling and supportive environments" (ESCAP 2003: 8–11). In the past, emphasizing family responsibility provided justification for inaction, but enlightened approaches now recognize the importance of supporting the family, especially in relation to aged care and poverty alleviation. Although the Shanghai Strategy describes the role of governments as vital in improving health services, some developing country governments in the region have had only a minor role in health care for the aged. The family has borne much of the burden, with religious, community and other organizations providing a little additional support. The Shanghai Strategy described community resources for the long-term care of dependent older persons as "scarce" and constituting "a serious challenge".

The importance of supporting the family is reflected in the Strategy's relatively large number of key actions relevant to this issue, one of which was quoted in the previous section:

- Provide integrated care services which allow individuals to remain in their communities for as long as possible.
- Develop and/or strengthen a range of community-based services that support older persons with or without families and family caregivers in which caring responsibilities can be shared among individuals, families, communities, NGOs and government.
- Promote and provide direct support to family caregivers in the form of material aid, tax reduction, subsidized housing or training on home care and develop an integrative model combining both formal and informal care in enhanced community care to help to relieve the care burden of family members.
- Promote and encourage community-based programmes which assist and act as relief mechanisms for family members and caregivers.
- Promote support systems for elderly caregivers of people living with HIV/AIDS in general, AIDS orphans and older persons living with HIV/AIDS (ESCAP 2003: 8–10).

The Madrid Plan made similar recommendations (United Nations 2002: 32ff), but the emphasis on the family is stronger in the Shanghai Strategy. Importantly, the latter described prospects as unfavourable because caregiver support was a relatively low priority in parts of the Asia-Pacific region. The Shanghai Strategy also noted that: "the numbers of older persons at high risk of dependency and disability are increasing at the same time as the ability of families to provide care is decreasing". Moreover, the HIV/AIDS pandemic is adding greatly to the burden on caregivers, including elderly caregivers (ESCAP 2003: 7–10). Given the diversity of family living arrangements and traditions in Asia, as well as the extent of demographic,

social and economic changes, it is misleading to assume that the family has the capacity to function independently as the provider of aged care. Participants at a 2004 seminar on the Shanghai Strategy concluded that "there is a need to build on existing informal support systems with formal schemes" (ESCAP 2004: 5).

Finally, another concern, raised in the Madrid Plan of Action 2002, included whether backing for aging in place sometimes arose from financial considerations and the assumption that families would provide the bulk of the care:

> Without adequate assistance, family caregivers can be overburdened. In addition, formal community care systems, even where they exist, often lack sufficient capacity because they are poorly resourced and coordinated. As a result, residential care may be the preferred option of either the frail older person or the caregiver. In view of this range of issues, a continuum of affordable care options, from family to institutional, is desirable. Ultimately, the participation of older persons in assessing their own needs and monitoring service delivery is crucial to the choice of the most effective option. (United Nations 2002: 35).

Women are likely to experience to a greater extent than men the consequences of disadvantaged families and deficiencies of aging in place. This reflects that women have greater longevity and higher risks of chronic illnesses, discrimination and marginalization. They are also more likely to be caregivers. Significant for the future of aging and the family in Asia is an emerging recognition of over-reliance on informal and family sources for long-term care (ESCAP 2003: 8–9). This acknowledges changes within the family as well as its growing and already greater burden of responsibility for aged care than ever existed in the past. Better information is needed about the nature and extent of intergenerational care, its adequacy, the difficulties faced and the availability of formal and informal assistance, including when family support is unavailable. There has been increased investment in in-depth and longitudinal surveys to answer such questions (United Nations 2005: 111).

15.6 Conclusion

This chapter has sought to discern, from the many policy recommendations in the Shanghai Strategy, three broad issues most relevant to developing countries generally. Through a focus on matters directly relating to better survival, the 'short list' omits other issues often deemed to be of prime importance, such as ageism and gender inequality. It also omits positive aspects of the growing numbers of healthy, independent older people, such as their present and future potential contributions society. Although short lists inevitably vary, it is clear that the wide-ranging nature of international policy documents on aging calls for attention to prioritizing recommendations for particular countries. The United Nations Department of Economic and Social Affairs engaged in a more extensive exercise of this type in its *Guide to the National Implementation of the Madrid International Plan of Action on Ageing* noting that: "The scope of the Madrid Plan is rather broad, covering a variety of topics and incorporating 239 separate recommendations; this Guide addresses the most crucial areas requiring particular policy attention" (United Nations 2008: 1).

The Guide nonetheless traversed a broad agenda including social and economic development, social protection, health policy, long-term care and social inclusion. As in the Madrid Plan, a key theme of the Guide was the integration of aging and the aged into mainstream policy making. An important aspect of this is enhancement of the status of the aged in Asian societies. The Guide emphasized that "the most fundamental requirement for change involves eliminating negative attitudes and stereotypes associated with older persons" (ibid.: 7). Perceptions of low status contribute to ageism, expectations of disengagement of the aged from society, under-resourcing of their needs and failure to engage in proactive planning for their future.

References

Access Economics. (2006). *Dementia in the Asia Pacific Region: The epidemic is here.* Report for Asia Pacific Members of Alzheimer's Disease International. Canberra: Access Economics. http://203.89.197.244/common/files/NAT/20060921_Nat_AE_FullDemAsiaPacReg.pdf. Accessed May 2011.

Beaglehole, R., et al. (2008). Alma-Ata: Rebirth and revision 3 – Improving the prevention and management of chronic disease in low-income and middle-income countries: A priority for primary health care. *The Lancet, 372*, 940–949.

Burgess, R., & Stern, N. (1991). Social security in developing countries: What, why, who and how. In A. E. Dreze, J. Hills, & A. Sen (Eds.), *Social security in developing countries* (pp. 41–80). Oxford: Clarendon Press.

Caldwell, J. C. (1986). Routes to low mortality in poor countries. *Population and Development Review, 12*(2), 171–220.

Coale, A. J., & Demeny, P. (1983). *Regional model life tables and stable populations*. New York: Academic Press.

ECE (Economic Commission for Europe). (2002). *Regional implementation strategy for the Madrid International Plan of Action on Ageing 2002*. UNECE Ministerial Conference on Ageing, Berlin. http://www.un.org/ageing/impl_map.html. Accessed Aug 2010.

ECLAC (Economic Commission for Latin America and the Caribbean). (2003). *Regional strategy for the implementation in Latin America and the Caribbean of the Madrid International Plan of Action on Ageing*, Santiago. http://www.un.org/ageing/impl_map.html. Accessed Aug 2010.

ESCAP (Economic and Social Commission for Asia and the Pacific). (1998a). *Plan of action on ageing for Asia and the Pacific*. Bangkok: ESCAP. http://www.unescap.org/ageing/macau/plan_of_action.htm. Accessed Dec 2009.

ESCAP. (1998b). *Guidelines on the implementation of the Macao Plan of Action on Ageing for Asia and the Pacific*. Bangkok: ESCAP. http://www.unescap.org/ageing/macau/guidelines.htm. Accessed Dec 2009.

ESCAP. (2003). *Shanghai Implementation Strategy: Regional implementation strategy for the Madrid International Plan of Action on Ageing 2002 and the Macao Plan of Action on Ageing for Asia and the Pacific 1999*. Bangkok: ESCAP, E/ESCAP/1280.

ESCAP. (2004). *Regional review: Report of the regional seminar on follow-up to the Shanghai Implementation Strategy for the Madrid and Macao Plans of Action on Ageing*. Bangkok: ESCAP. http://www.unescap.org/esid/psis/meetings/AgeingJuly2006/Macao%20report%2026%20Jan%20draft.pdf. Accessed Jan 2010.

Harper, S. (2006). *Ageing societies: Myths, challenges and opportunities*. London: Arnold.

Heisel, M. A. (1984). Aging in the context of population policies in developing countries. *Population Bulletin of the United Nations*, (17), 49–63.

Kuhn, R. (2010). Routes to low mortality in poor countries revisited. *Population and Development Review, 36*, 655–692.

Lopez, A. D., Mathers, C. D., Ezzati, M., Jamison, D. T., & Murray, C. J. L. (2006). *Global burden of disease and risk factors*. Washington, DC: Oxford University Press and the World Bank.

Magnus, G. (2009). *The age of aging: How demographics are changing the global economy and our world*. Singapore: Wiley (Asia).

Rowland, D. T. (2003). *Demographic methods and concepts*. Oxford: Oxford University Press.

United Nations. (2002, April 8–12). *Report of the second world assembly on ageing*, Madrid. New York: United Nations.

United Nations. (2005). *Living arrangements of older persons around the world*. United Nations Department of Economic and Social Affairs, Population Division. New York: United Nations, ST/ESA/SER.A/240.

United Nations. (2008). *Guide to the national implementation of the Madrid International Plan of Action on Ageing,* New York: United Nations. http://www.un.org/esa/socdev/ageing/documents/papers/guide.pdf. Accessed Jan 2010.

United Nations. (2010). *The millenium development goals report 2010*. New York: United Nations, Department of Economic and Social Affairs. http://www.un.org/millenniumgoals/pdf/MDG%20Report%202010%20En%20r15%20-low%20res%2020100615%20-.pdf. Accessed Jan 2011.

United Nations. (2011). *Millenium development goals indicators: The official United Nations site for the MDG indicators*. United Nations, Department of Economic and Social Affairs. http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm. Accessed May 2011.

World Health Organisation. (1998). Population ageing: A public health challenge. *Fact Sheet* No. 135. https://apps.who.int/inf-fs/en/fact135.html. Accessed June 2011.