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Population ageing

Towards an Improvement of the Quality of Life?

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Prefaces

by

Robert CLIQUET & Guillaume WUNSCH

On 1 March 2007, the Belgian Platform on Population and Development organised its yearly international conference on the theme "Population Ageing. Towards an Improvement of the Quality of Life?" The conference was hosted at the premises of the Ministry of the Flemish Community in Brussels.
As usual the subject was related to the annual special theme of the United Nations Commission on Population and Development, the 40th session of which was dedicated to "Changing age structures of populations and their implications for development".

The conference of the Belgian Platform on Population and Development concentrates on the implications of population ageing for quality of life in sub-Saharan Africa, but at the same time includes a number of contributions on the European experience.

The idea of the organisers to concentrate on the population ageing problems in sub-Saharan Africa, which still struggles so heavily with getting its fertility under control, mastering its HIV/AIDS epidemic, and tackling its developmental problems in general, might, at first sight, seem somewhat strange, but from a demographic and societal point of view this is fully justified.

Population ageing is, as a matter of fact, a universal phenomenon, and one which raises many challenges in all countries. Although many developing countries will not experience their big ageing wave in the immediate future, their population ageing is progressing at a much higher speed and occurring in a social, economic and political context characterised by the absence of a generalised social protection system requiring special policy attention.

The 2007 conference of the Belgian Platform includes a series of extremely interesting contributions on specific aspects of population ageing in sub-Saharan Africa — the social situation of elders, the specific problems of older women, the impact of the HIV/AIDS epidemic on the elderly. The conference was introduced by an excellent general overview of the socio-demographic aspects of population ageing as a global phenomenon. It was closed by several presentations on European experiences and challenges with population ageing in domains such as residential care, budgetary sustainability, pension, health and employment policies, and research. A great merit of the conference was that most contributors included in their conclusions relevant policy recommendations.

The present book, based on the presentations made at the 2007 international conference of the Belgian Platform on Population and Development, form a very useful

contribution to the important societal challenges developing countries are facing regarding the forthcoming ageing of their populations.

Prof. em. Dr. Robert CLIQUET

Population and Social Policy Consultants (PSPC)
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Population ageing is a natural consequence of the demographic transition. First the decrease in fertility and secondly the increase in survival, not only at young and adult ages but also at the oldest ages, have brought about a considerable growth in the developed countries in the 'grey population', and an increasing share of the elderly in the population. Population ageing is also associated in the developed countries with very low or negative rates of natural increase, due to below-replacement fertility. But population ageing is not restricted to industrialised countries only. As several chapters (Chapters 2-4) in this book indicate, the fertility transition under way in most less developed countries will bring about a significant ageing of the populations in these countries too. In fact, as Ronald Schoenmaeckers points out in the first chapter of this volume, in a couple of decades from now, the vast majority of older people in the world will live in the "South", *i.e.* in what are presently the least developed countries.

When speaking of population ageing, many people are concerned with the funding of pensions, the lower productivity of aged societies, the soaring health care costs. In fact, health expenditures are due at least as much to the increasing sophistication of medicine with its accompanying costs and to consumer behaviour, than to ageing. Furthermore, most countries where productivity and innovation are the highest (*e.g.* Japan) are also those where populations are the oldest. As to pensions, the load is more dependent upon economic growth than upon ageing, and it can be counterbalanced to a large extent by changing the retirement age and the sources of funding, and by increasing the labour force participation rate (see Chapters 7 and 9). One must also consider the positive fact that decreasing mortality often means increasing survival in reasonably good health, both physical and mental. In addition, the oldest age groups are now much better educated than their predecessors. Moreover, as the share of the young population diminishes, so will the expenditures geared towards this age group, particularly in education. This will compensate to some extent the increase in expenditures for the older age groups.

The comments above do not mean that societal changes will not be necessary in order to take into account population ageing and the growing care needs (Chapters 5 and 6),

but human history is characterised by successive adaptations to challenges and a changing world. Moreover, it is most probably easier to deal with population ageing than with global warming and environmental issues: depleted resources can hardly be renewed. In fact, longevity and ageing are two sides of the same coin: if one wishes to live longer, one must accept the fact that the population (and the individual!) ages, barring changes in fertility levels and migration. Ageing could also have a positive impact on the economy, by spurring the development of new products and services better suited to older ages. It could stimulate inventions, innovations, and employment. Actually, due to population decrease, one might face labour shortages in the future and possibly need greater recourse to immigration. Finally, a population decrease would not be such a bad thing for the environment and for our energy supplies. Ageing is like Aesop's tongue: "it is at once the best and the worst entertainment". The reader of this interesting volume should not forget the former when dealing with the latter.

Prof. em. Dr. Guillaume WUNSCH

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Publisher's Note:

As illustrated in the chapters by Lieve Vanderleyden and by Micheline Lambrecht, in Belgium 'population ageing' is high on the political agenda at both regional and federal level. This is not at all surprising given that Belgium belongs to the group of countries that has the highest proportion of elderly people.

A direct consequence is that 'population ageing' — more particularly the care of elderly and its socio-economic consequences — has become one of the 'core' research themes of the SVR. Collaboration in international projects such as the DIALOG project (see the chapters by Schoenmaeckers and by Vanderleyden), has indicated that 'population ageing' is a truly international phenomenon. Many countries face similar consequences and a better understanding of the processes and an interchange of 'best practices' are both instrumental in developing national and regional policies (see also the chapter by Jolanta Perek-Bialas regarding the importance of EU projects).

Keeping these considerations in mind, it made sense to assist the Belgian Platform on Population and Development in organising its annual conference bearing the title "Population Ageing. Towards an Improvement of the Quality of Life?" As already stated in the Preface by Prof. Cliquet, the conference was held on the premises of the Ministry of the Flemish Community. Ultimately, we also decided to have an English publication based on the presentations made at the conference in order to reach a larger audience.

We hope — and believe — that reading it will be an inspiring exercise.

Josée LEMAITRE

Administrator General SVR

PS The Belgian Platform was established in April 2000. Every year, the Platform organises an international conference on the annual theme of the UN Commission on Population and Development (CPD). The findings and conclusions of the various presentations are used as a starting point to formulate a series of '*Recommendations for Action*'. These *Recommendations* are presented in a brochure, which eventually is disseminated to the participants at the CPD.

The PowerPoint presentations of the various conferences, including those presented at the 2007 Conference, are available on the website of the Belgian Platform: http://www.platformpopdev.be.

Ronald C. SCHOENMAECKERS & Lieve VANDERLEYDEN

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Chapter One

Population ageing: A Global Phenomenon with Multiple Faces

Ronald C. SCHOENMAECKERS

Contents:

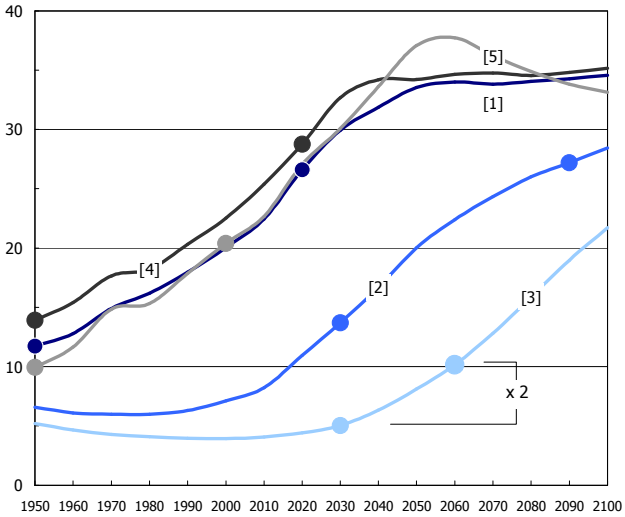
1. Introduction

The world population is ageing. At around 2000, the share of the people age 60 and over had reached the 10 per cent mark [1]; by 2050, 20 per cent of the population will be elderly [2].

With the exception of countries in sub-Saharan Africa, as of 2020, all major world regions will have a population with at least 10 per cent older people (see figure 1.1). However, until the end of the 21st century, there will be important differences. In around 2030-2040 the share of elderly in the more developed regions will still be twice as great as the share in the less developed regions (31% against 15%).

Figure 1.1 — Evolution of the proportion of elderly, with indication of doubling time, 1950-2100, by major region (selection)

SOURCE: Results simulation exercises (see text and table 1.2 below)



Key:
[1] More Developed Regions, [2] Less Developed Regions *minus* Least Developed Regions, [3] Sub-Saharan Africa, [4] EU15, [5] EU12

More important perhaps are the differences that exist between the more developed and the less developed regions in increases in the proportion of older people. In the more developed regions it will take about 70 years to double the proportion from 11.7 per cent (in 1950) to 26.6 per cent (in 2020) [3]. In the less developed regions, it will only take about 40 years to double the proportion from 6.3 per cent (in 1990) to 13.7 per cent (in 2030). In the sub-Saharan region [4] the doubling time will be even shorter:

only 30 years. In addition, before the end of the century, the less developed regions (and the countries of sub-Saharan Africa) will experience another doubling of the share of elderly in their population. The evolution will be different in the more developed regions. Indeed, as may be observed in figure 1.1, the increase in the proportion of older people in the more developed regions will level off and stabilise at around 35 per cent. Clearly, the increase in the proportion of older people starts later in the less developed than in the more developed regions, but once under way the pace of increase is far more rapid.

A population age structure is determined by its mortality and fertility levels (we deliberately ignore the possible effect of migration). An increase in the proportion of elderly, generally known as 'population ageing', shown in figure 1.1 is therefore the result of changes in mortality and fertility. Obviously, these changes do not occur simultaneously in all regions. Our aim in the present chapter is to describe the differences and their effects on the evolution proportion of elderly (section 3). The differences and effects will be explained later in the context of the 'demographic transition' (section 4). To conclude, we argue for a need for greater international co-operation in the field of 'population ageing'.

First, let us look at the evolution in the numbers of elderly in the world.

2. Observed and future evolutions in the proportions of older people

Table 1.1 and figure 1.2 below show that the increase of the number of elderly in the world is more rapid than total population growth and that the great majority of older people live in the less developed regions.

- ***The rapid growth of elderly***

Between 1950 and 2000, the world population increased by a factor of nearly two-and-a-half (from 2.5 billion to 6.1 billion). Between 2000 and 2050 an additional increase of 50 per cent will occur (to 9.1 billion). Over the same periods, the number of people aged 60 and over triples twice (from 205 million in 1950 to 609 million in 2000, and close to 2 billion in 2050). The increase in the number of people aged 80 and over — the 'oldest old' — occurs at an even faster pace: the numbers grow no less than five times in each 50-year period (in fact, close to six times between 2000 and 2050).

The number of elderly is clearly growing at a much faster pace than the population as a whole. Moreover, the difference is widening. Both are related to the fact that the 'population explosion', as rapid population growth became known in the sixties

(Ehrlich, 1968), is gradually disappearing. The growth rate of the 1950s of close to 2 per cent annually — corresponding to a doubling of the population size after 35 years — has decreased to around 1 per cent and will continue to decline in the coming decades to 0.6 per cent. However, although the 'population explosion' may be over, the world population will continue to grow for a long time. According to recent long-range population projections prepared by the Population Division of the Department of Economic and Social Affairs (DESA) of the United Nations Secretariat (United Nations, 1999, 2003b, 2004), the world population could stabilise between 9 and 10 billion individuals somewhere between 2200 and 2300, depending on the future evolution of fertility levels [5]. At any rate, world population is likely to grow by at least another 38 per cent — and possibly even 54% — compared to its current size of 6.5 billion. Demographers refer to the process whereby populations continue to grow despite falling fertility rates as the 'population growth momentum', or simply the 'population momentum' (see, for example, Keyfitz, 1971) [6].

Table 1.1 — Size of the world population and number of older people, by sex, for selected years

	1950			1975			2000			2025			2050		
Sex	All ages	60+	80+	All ages	60+	80+	All ages	60+	80+	All ages	60+	80+	All ages	60+	80+
	Absolute numbers (in millions)														
Male	1,257.1	91.3	5.2	2,046.9	153.4	11.6	3,060.3	273.5	24.8	3,960.7	545.2	59.6	4,523.5	901.7	150.0
Female	1,262.4	114.1	8.5	2,026.9	196.4	19.9	3,025.2	335.8	45.5	3,944.5	647.4	100.6	4,552.4	1,066.4	244.2
Both sexes	2,519.5	205.4	13.8	4,073.7	349.7	31.5	6,085.6	609.2	70.3	7,905.2	1,192.6	160.2	9,075.9	1,968.2	394.2
	Relative values by sex (%)														
Male	49.90	44.44	38.00	50.25	43.85	36.73	50.29	44.89	35.24	50.10	45.72	37.21	49.84	45.82	38.05
Female	50.10	55.56	62.00	49.75	56.15	63.27	49.71	55.11	64.76	49.90	54.28	62.79	50.16	54.18	61.95
Both sexes	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
	Annual rate of increase in 25 preceding years (%)														
Male	---	---	---	1.95	2.08	3.16	1.61	2.31	3.05	1.03	2.76	3.52	0.53	2.01	3.69
Female	---	---	---	1.89	2.17	3.38	1.60	2.15	3.31	1.06	2.63	3.17	0.57	2.00	3.55
Both sexes	---	---	---	1.92	2.13	3.30	1.61	2.22	3.21	1.05	2.69	3.30	0.55	2.00	3.60

SOURCE: *UN World Population Prospects. The 2004 Revision* (own calculations)

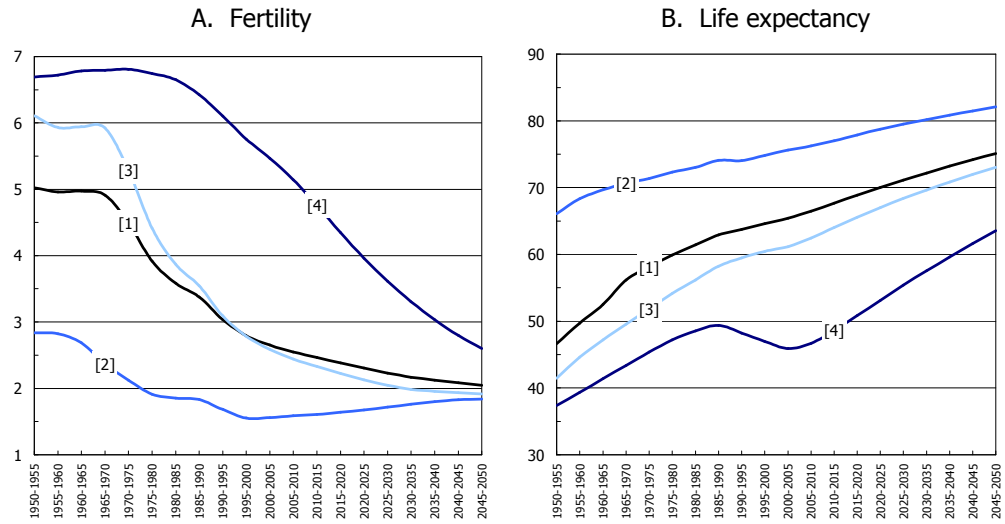
- ***Different evolutions in mortality and fertility***

Let us return for a moment to the observation that the way in which proportions of elderly increase differs between regions (figure 1.1). As said, the age structure of a

population (and as such also its proportion of older people) is determined by fertility and mortality. Figure 1.2 shows their evolution from 1950 to 2050; total fertility rate is shown for fertility and life expectancy for mortality.

Both total fertility rate and life expectancy indicate a convergence of their levels. By 2050, TFR-levels will be close to 2 children (only SSA will still show a higher number). Likewise, life expectancies seem to converge to the level of the more developed regions. The simultaneous convergence — coinciding with patterns of declining fertility rates and increasing levels of life expectancy — explains the increase in the proportions of elderly observed in all regions. At the same time however, despite the convergence, fertility and levels of life expectancy continue to show important differences; this is especially true in the case of life expectancy. The differences that continue to exist in the levels of fertility and mortality are the explanation for the differences in the increase in the proportions of older people between regions.

Figure 1.2 — Evolution of fertility (TFR, total fertility rate or average no. of children per woman) and of life expectancy at birth, both sexes (in years), 1950-2050, world and selected regions



Key:
[1] World, [2] More Developed Regions,
[3] Less Developed Regions *minus* Least Developed Regions, [4] Sub-Saharan Africa

SOURCE: *UN World Population Prospects. The 2004 Revision* (own adaptation)

Moreover, changes in mortality and fertility do not occur simultaneously. As a result, the way in which they may affect the proportion of elderly in the population is likely to be different. A specific objective of section 3.2 will be to assess the relative impact of each. It may already be hypothesised that the important regional differences in fertility at the 'starting point' must be largely responsible for the differences in the changes in the proportions of older people thereafter. A drop from a TFR of 6.69 to 2.60 (SSA) is bound to have a different effect on the population age structure than a drop from 2.84 to 1.84 (MDR).

- ***Some cautionary remarks regarding future trends***

Before continuing our exploration it must be noted that some of the data shown in figure 1.2 are based on assumptions; only the data for the years 1950-2005 are based on observed estimates. In other words, there is no guarantee that, for example, sub-Saharan countries will by 2050 experience a fertility level of only 2.60 children. Assumptions concerning future developments are therefore regularly adjusted taking into account the most recent trends. This need for adjustment is the reason why the *World Population Prospects* are reproduced biannually.

The assumptions regarding the evolution of mortality, fertility (and at individual country level) migration that are used in the population projections will be primarily responsible for the future size and structure of the world population. The data in figure 1.2 indicate three critical areas in this regard. Any slower decline in fertility rates will eventually imply that world population growth will last longer than what is currently believed; it would imply that world population eventually stabilises at more than 9 or even 10 billion individuals (as estimated on the basis of long-range projections (see above)). On the other hand, many demographers are fairly pessimistic as to whether the low fertility rates for the more developed regions will increase as assumed. These low rates are mainly the result of exceptionally low rates (below replacement level) in many European countries. They are associated with what has become known as the 'second demographic transition' (Lesthaeghe & Van de Kaa, 1986; van de Kaa, 1987). At around 2005, 12 of the 27 EU country members (44%) still experienced a TFR of less than 1.3; only 6 had a TFR of more than 1.7 (UN Pop. Division, 2005). In the light of these observations it is somewhat doubtful that the EU countries will attain, on average, a TFR of 1.85 children by 2050 [7].

The third assumption that may be criticised is an increase in the life expectancy of the countries of sub-Saharan Africa. The curve in figure 1.2 shows a clear regression for the years 1985-2010. This pattern stems of course from effects of the AIDS pandemic. Precise and reliable estimates are unavailable. However, in some eastern and southern

African countries the HIV prevalence rate among women aged 15-49 would be no less than 20 to 40 per cent (UNFPA, 2007) [8].

A key question here is to what extent it is realistic to assume that the AIDS pandemic will be 'under control' by 2010. A reason for optimism is that some breakthroughs have occurred in recent years in treatment for HIV patients (WHO/UNAIDS, 2007). However, there can be no guarantee that life expectancy will increase after 2010 at a pace similar to that observed in the 20th century, i.e., an improvement of about 4 months *every year*.

The high levels of life expectancy that were reached in many Western-European countries and Japan during the 20th century have been investigated widely and have given rise to speculation about the theoretical limit of longevity. By and large, researchers accept the possibility of further increases; indeed life expectancies of 90 or 95 years, or even higher by the year 2050 are viewed as plausible (Vaupel & Lundström, 1994). We will return to this issue in section 5.

- ***A majority of elderly in the less developed regions***

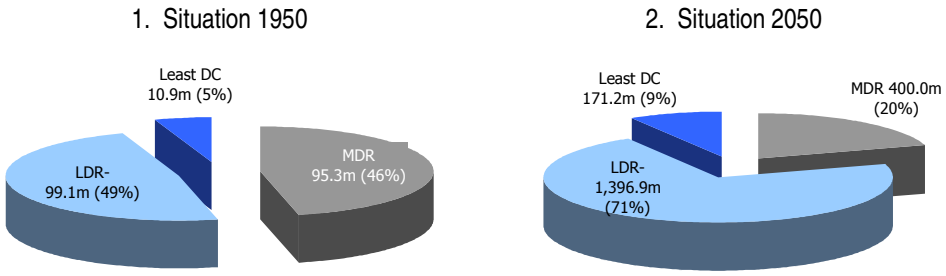
The high proportions of elderly in the more developed regions have led to a popular belief that 'population ageing' is fairly limited to industrialised countries. Such a belief is clearly erroneous, as demonstrated in the data in figure 1.1. However, an even less known fact is that the majority of older people live in the less developed regions. This observation is not new: as can be seen in the data in figure 1.3, already in 1950 the majority of elderly (54%) lived in the less developed regions (of which slightly over one tenth in the least developed regions).

By 2050 no less than 80 per cent of all people aged 60 and over in the world will reside in the less developed regions; by that time the share of older people in the least developed regions will have increased to 12 per cent.

In other words, in a couple of decades, the vast majority of older people in the world will live in poor countries in the 'South', i.e., countries in which social protection systems are by and large non-existent or inadequate, or benefit only a few older citizens.

According to ILO (2002), only 20 per cent of the world's population has adequate social security coverage, while more than half lacks any kind of social security protection at all. Those without coverage are generally not protected in old age by social security. The situation is not likely to improve in the foreseeable future. Indeed, those without coverage tend to be part of the informal economy. In developing countries, it is precisely this sector that appears to grow fastest.

Figure 1.3 — Distribution of elderly in the world, by major region, as observed in 1950 and projected in 2050 (in millions)



SOURCE: *UN World Population Prospects. The 2004 Revision* (own adaptation)

3. The relative impact of changes in fertility on the proportions of elderly

It is thus clear that the changes in mortality and fertility greatly contribute to the increase of elderly. We investigate below what the relative impact of each is and how this impact may differ between regions.

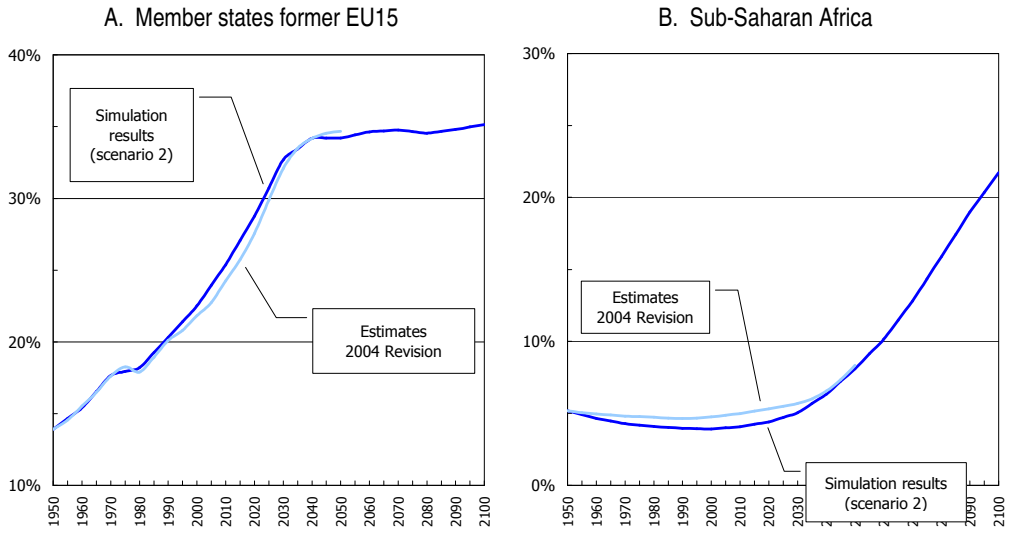
A reason for assessing the relative impact of fertility on an increase in the proportion of older people stems from an observation that, especially in the European context, policy makers and the media often associate 'population ageing' with low fertility. (See, for example, in the 'green paper' entitled "Confronting demographic change: a new solidarity between the generations", issued by the Commission of the European Communities in 2005) [9]. As will be seen below, in most countries (although not European countries) a fertility decline is indeed the main 'motor' for an increase in the proportion of older people in the population. But this is the short view. For countries with high levels of life expectancy (such as European countries) mortality is the main cause of 'population ageing'. This finding is not new: it has already been demonstrated by Calot & Sardon (1999) using theoretical models. The simulation exercise applied in this chapter is a more intuitive approach. The results obtained with the simulation exercise provide some indices that may be used in identifying the stage that has been reached in the 'demographic transition'. The importance of the 'demographic transition' within the context of 'population ageing' is discussed further in section 4.

The simulation exercises consist of (a) projecting a population from 1950 to the year

2100 while assuming changing life expectancies but keeping fertility constant at its initial level (scenario 1); and (b) repeating this projection but this time with changing levels in mortality *and* fertility (scenario 2). The 'baseline' population corresponds to the age population structure as observed in 1950. The projections are 'simplified' projections in the sense that, where applicable, the changes in life expectancy and fertility follow a linear trend. The 'pivotal' years are given in table 1.2. In spite of this simplified approach, the proportions of elderly resulting from scenario 2 closely follow the proportions available in the *2004 Revision* for the years 1950–2050 (figure 1.4).

All projections have been carried out with the use of the application 'PROJCT' of the demographic software MORTPAK developed by the UN Population Division [10].

Figure 1.4 — Evolution of the proportion of older people: comparison between estimates of the *2004 Revision* (limited to 2050) and results of scenario 2 of the simulation exercises. Two examples: Member States of the former EU15 and countries of sub-Saharan Africa

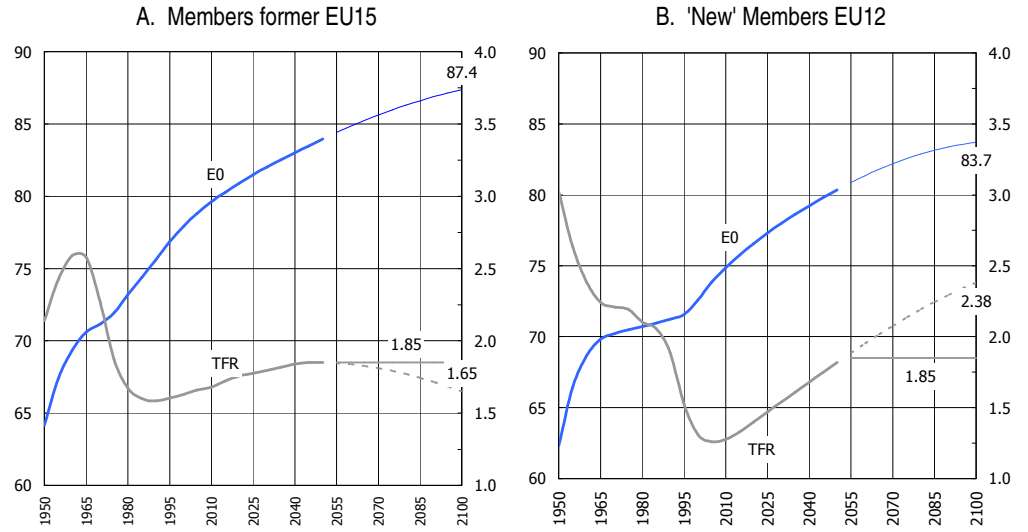


NOTE: Use of different scale between panels

Making the projections until the year 2100 demanded an extrapolation of the levels of life expectancy and fertility (the World Population Prospects provide only data until 2050). Essentially, this was done on the basis of a graphical extrapolation. Examples of the extrapolation are given in figure 1.5, which includes the data for the two groups of

EU Member States. However, there were some constraints. The first constraint was a deceleration in the increases in life expectancy for the years 2050-2100. The second constraint was the imposition of a limit on the level of fertility. For the low-fertility countries (such as the European countries), the limit was a TFR of 1.85 children. For the high-fertility countries (such as the African countries) the limit was 2.1 children.

Figure 1.5 — Assumptions regarding the evolution of mortality (life expectancy, both sexes, in years, left axis) and fertility (TFR, right axis) as used in the simulation exercises. Two examples: Members former EU15, and 'new' Members EU12



SOURCE (data years 1950-2050): *UN World Population Prospects. The 2004 Revision*

The numerical results of the simulation exercises are given in table 1.2. Table 1.2 does not include the results for all countries; for some, the results are used in figure 1.7 further below [11]. In addition to the assumptions regarding mortality and fertility and the proportions of elderly as estimated with scenarios 1 and 2, table 1.2 includes two rows of 'indices'. The first index corresponds with the ratio of the proportions obtained in scenario 2 over those obtained with scenario 1, and as such may be interpreted as the 'extra' impact of fertility over mortality. The second index indicates the relative change (as a percentage) in the proportions (obtained in scenario 2) with 10 years earlier. Both are displayed in figure 1.7. Before turning to figure 1.7, we will comment on the results in figure 1.6.

Table 1.2 — Scenarios and results simulation exercises for several groups of countries and some individual countries

More Developed Regions (MDR)	1950	1960	1970	1980	1990	2000	2010	2020	2030	2040	2050	2060	2070	2080	2090	2100
A. Scenarios (changes in mortality and fertility)																
Mortality E0 - Male	61.48	66.10		68.96		71.50					79.13					83.26
E0 - Female	66.11	71.75		76.26		78.93					85.03					90.61
Fertility TFR	2.85	2.75		1.88		1.56					1.85					1.85
B. Results: percentage of persons aged 60 and more																
(a) Changes in mortality alone	11.73	12.48	14.00	14.21	14.96	15.35	15.38	16.23	16.63	17.11	17.93	18.54	18.98	19.56	19.88	20.04
(b) Changes in both mortality *and* fertility	11.73	12.79	14.91	16.19	17.96	20.04	22.45	26.61	29.93	31.87	33.54	34.00	33.83	34.05	34.28	34.56
(c) With TFR = 2.1 by 2100												33.95	33.65	33.63	33.47	33.18
C. Indices																
Impact of change in fertility (or b/a)	---	1.03	1.06	1.14	1.20	1.31	1.46	1.64	1.80	1.86	1.87	1.83	1.78	1.74	1.72	1.73
Tempo (% change with 10 years earlier)	---	9.06	16.51	8.63	10.90	11.60	12.00	18.56	12.48	6.48	5.24	1.35	-0.49	0.65	0.68	0.83

Less Developed Regions (LDR-) (without Least Dev. Countries)	1950	1960	1970	1980	1990	2000	2010	2020	2030	2040	2050	2060	2070	2080	2090	2100
A. Scenarios (changes in mortality and fertility)																
Mortality E0 - Male	37.89	45.32				59.16		64.52			70.94					77.51
E0 - Female	38.78	46.49				62.54		68.11			75.22					81.92
Fertility TFR	6.28	5.94				2.68		2.18			1.92					1.92
B. Results: percentage of persons aged 60 and more																
(a) Changes in mortality alone	6.58	6.06	5.75	5.37	5.06	4.81	4.52	4.78	4.79	4.83	4.97	5.08	5.16	5.27	5.38	5.50
(b) Changes in both mortality *and* fertility	6.58	6.10	5.98	5.99	6.31	7.11	8.23	10.96	13.70	16.69	20.02	22.40	24.34	26.00	27.20	28.43
(c) With TFR = 2.1 by 2100												22.38	24.23	25.74	26.68	27.51
C. Indices																
Impact of change in fertility (or b/a)	---	1.01	1.04	1.11	1.25	1.48	1.82	2.30	2.86	3.46	4.03	4.41	4.71	4.94	5.06	5.17
Tempo (% change with 10 years earlier)	---	-7.25	-2.00	0.09	5.38	12.67	15.77	33.18	25.00	21.83	19.93	11.89	8.64	6.83	4.63	4.52

Figure 1.6 presents the proportions of people aged 60 and over as obtained in scenarios 1 and 2. The figure includes the results for the Members of the former EU15 (panel A) and the countries that make up sub-Saharan Africa (panel B). Both groups of countries may be seen to represent the two most extreme situations regarding 'population ageing' (cf. figure 1.1). The two groups of countries show striking differences. For the countries of sub-Saharan Africa, the proportions of elderly corresponding to scenario 1 hardly show an increase. In fact, the highest proportion

Table 1.2 — *Continued*

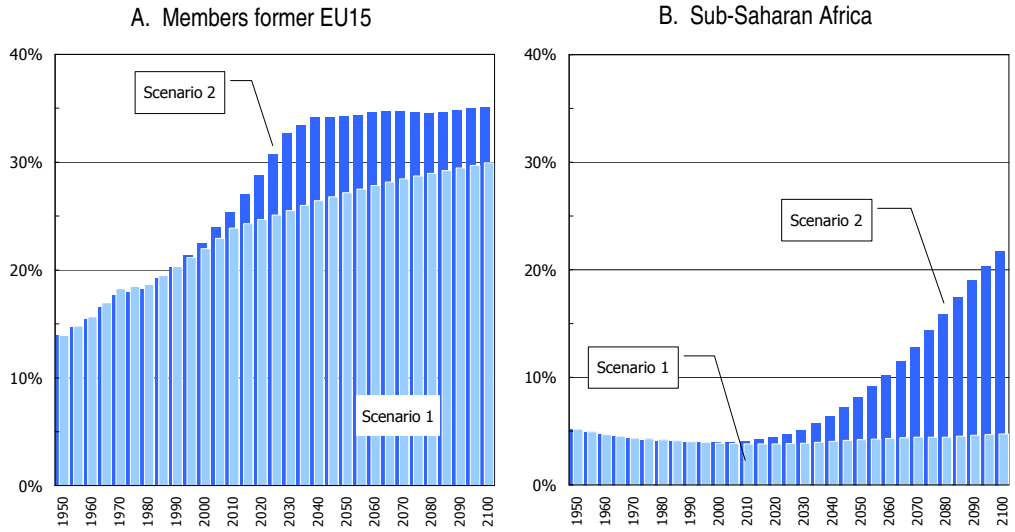
Sub-Saharan Africa	1950	1960	1970	1980	1990	2000	2010	2020	2030	2040	2050	2060	2070	2080	2090	2100
A. Scenarios (changes in mortality and fertility)																
Mortality E0 - Male	34.09		42.83	46.25		45.42	47.16				62.23		69.88	72.20		74.79
E0 - Female	36.67		45.92	49.52		47.46	48.08				64.94		72.06	74.46		77.13
Fertility TFR	6.66		6.80	6.70		5.61	4.95				2.55		2.12	2.10		2.10
B. Results: percentage of persons aged 60 and more																
(a) Changes in mortality alone	5.19	4.68	4.36	4.20	4.03	3.87	3.81	3.80	3.88	4.05	4.21	4.32	4.44	4.45	4.62	4.73
(b) Changes in both mortality *and* fertility	5.19	4.66	4.28	4.09	3.97	3.92	4.08	4.41	5.04	6.33	8.11	10.16	12.81	15.88	18.98	21.72
(c) With TFR = 2.1 by 2100												---	---	---	---	---
C. Indices																
Impact of change in fertility (or b/a)	---	0.99	0.98	0.97	0.98	1.01	1.07	1.16	1.30	1.56	1.93	2.35	2.88	3.57	4.11	4.59
Tempo (% change with 10 years earlier)	---	-10.29	-8.09	-4.39	-2.99	-1.30	4.02	8.22	14.25	25.64	28.01	25.26	26.14	23.96	19.51	14.43

Member States former EU15	1950	1960	1970	1980	1990	2000	2010	2020	2030	2040	2050	2060	2070	2080	2090	2100
A. Scenarios (changes in mortality and fertility)																
Mortality E0 - Male	61.10	66.85	68.02	69.79			76.71				81.30					84.46
E0 - Female	66.70	71.85	74.15	76.51			82.58				86.48					90.37
Fertility TFR	2.14	2.59	2.27	1.67			1.68				1.85					1.85
B. Results: percentage of persons aged 60 and more																
(a) Changes in mortality alone	13.91	15.65	18.27	18.65	20.33	21.97	23.86	24.68	25.51	26.43	27.16	27.82	28.45	28.95	29.44	29.93
(b) Changes in both mortality *and* fertility	13.91	15.41	17.66	18.21	20.31	22.52	25.39	28.76	32.69	34.19	34.22	34.64	34.76	34.55	34.81	35.14
(c) With TFR = 2.1 by 2100												34.60	34.58	34.13	34.00	33.77
C. Indices																
Impact of change in fertility (or b/a)	---	0.98	0.97	0.98	1.00	1.02	1.06	1.17	1.28	1.29	1.26	1.25	1.22	1.19	1.18	1.17
Tempo (% change with 10 years earlier)	---	10.80	14.60	3.10	11.54	10.85	12.76	13.30	13.66	4.60	0.07	1.24	0.35	-0.60	0.73	0.97

New' EU12 Member States	1950	1960	1970	1980	1990	2000	2010	2020	2030	2040	2050	2060	2070	2080	2090	2100
A. Scenarios (changes in mortality and fertility)																
Mortality E0 - Male	59.65	65.88			67.40	68.77	71.01				76.82	77.62				80.04
E0 - Female	65.20	71.17			75.41	77.27	79.01				83.57	84.91				87.55
Fertility TFR	3.03	2.39			1.89	1.31	1.28				1.82	1.85				1.85
B. Results: percentage of persons aged 60 and more																
(a) Changes in mortality alone (scenario 1)	9.93	11.39	13.89	13.55	14.48	14.65	13.88	14.73	15.01	15.13	15.77	16.13	16.53	16.97	17.23	17.55
(b) Changes in both mortality *and* fertility (scenario 2)	9.93	11.66	14.85	15.31	17.87	20.39	22.67	27.06	30.08	33.61	37.07	37.74	36.22	34.90	33.82	33.13
(c) With TFR = 2.1 by 2100													36.17	34.67	33.29	32.13
C. Indices																
Impact of change in fertility (or b/a)	---	1.02	1.07	1.13	1.23	1.39	1.63	1.84	2.00	2.22	2.35	2.34	2.19	2.06	1.96	1.89
Tempo (% change with 10 years earlier)	---	17.36	27.38	3.10	16.73	14.11	11.18	19.35	11.17	11.74	10.30	1.81	-4.03	-3.66	-3.08	-2.04

(5.2%) is observed in 1950. Only a (very) slight increase is seen for the years 2020 to 2100 (from 3.8% to 4.7%). By contrast, changes in mortality alone produce a substantial increase in the European countries, from 13.9 per cent in 1950 to 29.9 per cent in 2100.

Figure 1.6 — Results of the simulation exercises: comparison of the proportion of older people between results from scenarios 1 and 2. Two examples: Member States of the former EU15 and countries of sub-Saharan Africa



NOTE: Changes in mortality and fertility corresponding to scenarios 1 and 2 are described in text above (cf. also figure 1.5)

Scenario 2 shows higher proportions of elderly for both groups of countries. There is however a remarkable difference. Whereas the increase may be viewed as relatively small for the EU countries (the greatest increase, 29%, is observed for 2040), the increase in the sub-Saharan countries attains no less than 306 per cent by 2100. The observed trend suggests even higher values after 2100. Such a continued increase is not likely to happen in European countries. Rather, here one observes a levelling off: by 2010, the increase that results from scenario 2 has declined to no more than 17 per cent. (Note that although at a somewhat slower pace than in the first years, the proportions continue to increase in scenario 1).

How should one interpret these differences? The sustained increase in the proportion

of elderly observed for the European countries in scenario 1 is related directly to those countries having reached high levels of life expectancy (cf. figure 1.2). At such levels, any additional gain in life expectancy is largely the result of increased survival after age 60 (and not a reduction in child mortality, which is indeed the most important factor at lower levels of life expectancy such as those still experienced by, for example, the sub-Saharan countries).

The decline in fertility of the 1960s, directly after the 'baby-boom' years of the 1950s (see figure 1.5), has, as is shown with the results of scenario 2, only a limited effect. For the European countries, the 'motor' of 'population ageing' is clearly the continued increases in life expectancy. Moreover, a fertility rate of 2.1 children would lower the proportion of elderly only slightly; in 2100 the difference would be no more than 1.4 percentage points.

The situation is entirely different in the sub-Saharan African countries. In spite of a rapid increase, by 2100, SSA countries will experience levels of life expectancy still lower than those of the European countries (the simulation exercise is based on a life expectancy of 76 years for both sexes, by 2100; a full 11 years less than the life expectancy for the EU15). At such levels, an increase in life expectancy is not immediately translated into higher proportions of older people. Here, as is shown with the results of scenario 2, the real 'motor' of 'population ageing' is fertility decline. The smaller number of children produces a shift in the age structure. The high numbers of population in the older age groups, which are the result of high fertility rates, are no longer replaced, because of lower fertility rates. As result, the number of older people (those aged 60 and over) is progressively gaining more 'weight' in the age structure.

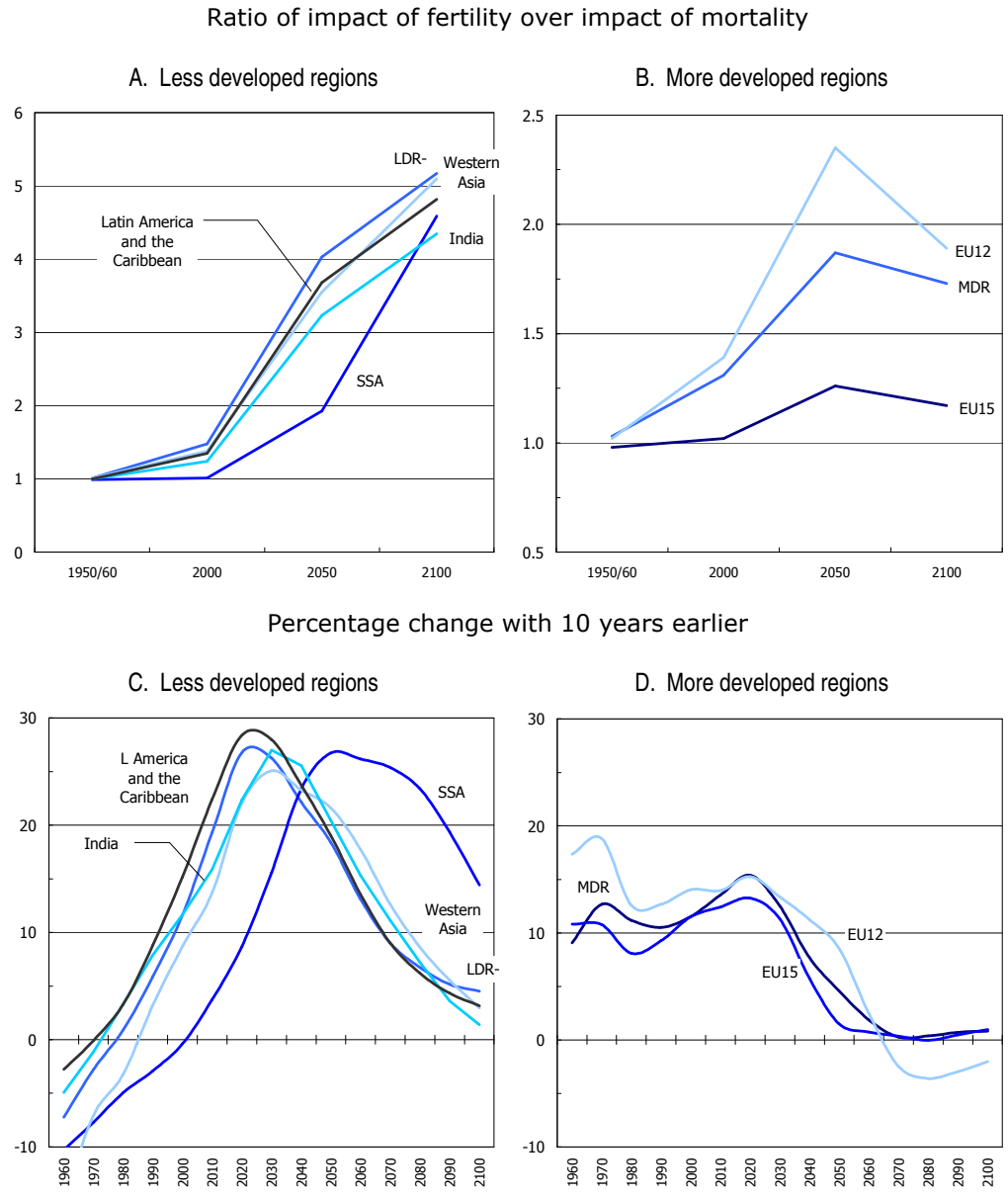
Let us now turn to the two series of indices. Each series is presented in figure 1.7. Less developed and more developed regions show specific patterns.

The pattern of change in the first series — the relative impact of fertility over mortality — is best understood by re-ordering the values into three periods: 1950/60-2000, 2000-2050, 2050-2100.

For less developed regions, the first period shows a slow start, i.e., the impact of fertility is growing slowly. The second period is a period of acceleration, while in the third and last period the impact of fertility is weakening. The sub-Saharan African countries would follow a similar pattern, but with a time lag of about 50 years (which would be consistent with the late onset of fertility decline as shown in figure 1.2).

The more developed regions show a somewhat similar pattern, of slow growth in the first period and accelerated growth in the second period. However, in the third period

Figure 1.7 — Evolution of the indices with respect to the relative impact of fertility on the increase in the proportion of older people (cf. table 1.2)



NOTE: Use of different scales for panels A and B; and use of smoothed values in panels C and D [12]

there is a clear deceleration, suggesting that, eventually, the impact of fertility could disappear altogether. The other major difference is that the effect of fertility is by all means much smaller for the more developed than the less developed regions (to such an extent that it was judged appropriate to use different scales).

The important differences between the groups EU15 and EU12 would stem from the differences in fertility decline (cf. figure 1.5). Only for the EU15 is there a clear 'baby-boom', pattern and the decline afterwards is much less pronounced than the one observed for the EU12, not just in relative terms (54% vs 42% [13]) but also in absolute terms: the lowest levels (TFR values of below 1.3) were observed for the EU12 countries.

Another explanation for the differences between the EU15 and EU12 is that the latter show lower life expectancies. Already in the years following the Second World War, Eastern European countries experienced lower levels of life expectancy than the countries in Western Europe [14]. However, a major cause for the differences throughout the 21st century would be the collapse of the health care systems experienced by many 'countries with economies in transition' in the aftermath of their communist regimes ending. The collapse of the health care systems would indeed be a cause for a stagnation (and in some countries even regression) in the improvement in life expectancy (cf. figure 1.5). These events are well-known and have been described elsewhere (for a summary, see Schoenmaeckers, 2004). A remarkable observation is that the deterioration of the health status was more severe for men than for women. An explanation would be that much of the poor health was the result of social isolation of which men suffered more than women (Bobak, 1999).

4. 'Population ageing': the last leg of the 'demographic transition'?

It is clear that the proportions of older people are increasing in both the more developed and the less developed regions (cf. figures 1.1 and 1.3). The simulation exercises also show that the 'forces' behind the increase are not the same in each region. In the more developed regions the major 'force' would be the (further) increase in life expectancy; in the less developed regions, particularly in sub-Saharan African countries, the major force would be the decline in fertility.

To understand the differences between the regions, it is necessary to assess the stage that has been reached in the 'demographic transition'. The 'demographic transition' is a theoretical concept. The theory was derived from demographic changes that had started in Europe some two centuries ago and which included a decline in both mortality and fertility rates.

Warren S. Thompson (1929) was the first to elaborate a 'demographic transition' theory. In this early work, Thompson gave much attention to the fact that the 'new balance', more particularly the lower birth rates, would lead to slower growth rates. However, in general, Frank Notestein (1945, 1953) is considered to be the 'father' of the 'demographic transition': he was indeed the first to formulate the concept. According to classic demographic textbooks (see, for example, the work by Chenais,1986), the 'demographic transition' refers to the transition of a demographic regime characterised by high mortality and high fertility to a regime characterised by low mortality and low fertility. In short, the term refers to the existence of a new demographic balance.

For centuries, the world population increased at (very) slow rate. Some 200 years ago, the world population is estimated to have been around 300 million. At around 1000 A.D. it would have increased to no more than 310 million. This very slow growth was the result of a 'natural' balance between high fertility and high mortality. Things started to change thereafter. By 1800, the world population size had increased to about 1 billion; after another 120 years, at the beginning of the 20th century, it had increased to 2 billion. In 1965-70, the annual growth rate had reached no less than 2 per cent, which corresponds to a doubling of the population after only 35 years (between 1950 and 1987/88 world population increased from 2.5 billion to 5 billion).

However, the high population growth — the 'population explosion' — that the world experienced in the 20th century (current growth rates have dropped to about 1.2% annually) was mainly confined to the less developed countries. Indeed, during the same period, more developed countries experienced only moderate growth rates, of around 0.5 per cent annually (median value 1950-2000). The reason is that the more developed regions experienced much lower fertility rates that the less developed regions (cf. figure 1.2). Indeed, already some 200 years ago, towards the end of the 18th and the beginning of the 19th century, at the time of the Industrial Revolution, fertility levels had already started to decline. According to the theory of the 'demographic transition', the decline of fertility was the result of declining mortality. Improvements in food supply and sanitation related to the Industrial Revolution had resulted in the reduction of disease and, eventually, in increased life expectancy. In fact, the Industrial Revolution would have been the starting point for the second epidemiological transition, i.e., the transition from infectious to degenerative diseases, which lasted from ca. 1750 to the mid-twentieth century (Horiuchi, 1999) [15].

According to the 'demographic transition' theory, the fertility decline followed the decline in mortality. The reasoning would be that, because of lower mortality, high fertility was no longer necessary. However, this assumption is rarely supported by the available statistics (which are scarce). We reached a conclusion rather that mortality

and fertility declined more or less simultaneously. After all, the consequences of the Industrial Revolution were not limited to the improvement of hygiene and better medical treatment; it also lead to sociological change (including a change from 'petty' industry to wage labour) and cultural change.

This conclusion appears to be in line with the findings of Ron Lesthaeghe (1977), in his study on "The Decline of Belgian Fertility". In this pioneering work, Lesthaeghe was the first to point out the importance of values and cultural change in explaining changes in fertility behaviour. According to his findings, the 'secularisation' of society is a key factor in explaining fertility decline. Thus it may be explained why the first signs of fertility decline were observed for France, in the early 19th century, more than 60 years earlier than in England and Wales, the birthplace of the Industrial Revolution (Belgium was the second country to show signs of a sustained fertility decline). It may also explain why it took another 150 years, until the second half of the 20th century, before fertility started to decline in the less developed countries.

The key element to trigger a fertility decline would be 'empowerment', or the acceptance of a more individual outlook, implying that women (and men) start to decide freely, independently from social norms, the number of children they want. 'Empowerment' is a basic idea in the Plan of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994 (see further section 6). In Western European countries 'empowerment' would be the result of a more secular outlook; in less developed countries the key factor appears to be schooling [16]. A more 'modern' environment alone, in which men became wage labourers and many families moved from their ancestral villages to live in the cities, was apparently not sufficient to bring fertility downwards in the less developed regions. It did not change the position of women in society; their role continued to be limited to that of wife and mother. 'Modernisation' only contributed to a breakdown of traditional practices such as child-spacing and post-partum taboos (Page & Lesthaeghe, 1981), which eventually limited the number of children a woman would have. The result was that, in many African countries, such as in, for example, Kenya, one could observe a fertility increase, rather than fertility decline (Schoenmaeckers, 1984).

The slow progress that was made in Africa in school enrolment, especially of girls, as compared to the other less developed regions, is likely the main reason why a sustained fertility decline could not be observed before beginning of the 1990s.

Since the turn of the century, all countries, including therefore the countries of sub-Saharan Africa, have fully embraced the process of 'demographic transition'. In the long term, the new equilibrium between mortality and fertility will lead to zero population growth; but first, the countries will face the prospect of 'population

ageing'.

From the above, it should be clear that the 'demographic transition' is a theory that is based on European experiences — or in more general terms, 'Western' countries. It should therefore not be surprising that the theory is not automatically applicable to the situation in less developed regions. Nevertheless, the 'population explosion' of the 20th century, which resulted from declining mortality rates and persisting high fertility in the less developed regions, puzzled many researchers and policy makers. One 'popular' explanation was that non-Western societies were economically less rational, so that, in spite of lower mortality, a high number of children continued to be socially acceptable and even valued. In an article published in 1976, John Caldwell tried to make the bridge by stating that in 'pretransitional' societies too, a high number of children corresponds with rational behaviour. As long as the intergenerational wealth flows indicate a net balance from child to parent, it is 'beneficial' for parents to have many children.

The importance of Caldwell's article is to have indicated that — similar to what Lesthaeghe has done for European countries — 'technological' or 'economical' changes alone cannot explain changes in fertility behaviour; equally important are values and social norms.

This is also the unavoidable conclusion to draw from what has become known as the 'second demographic transition' (Lesthaeghe & Van de Kaa, 1986). In addition, the 'second demographic transition', which, as we will see, is again based on experiences in Western countries, indicates that the precise parameters of the 'new demographic balance' as suggested by the (first) demographic transition so far remain unclear. One implication is that there is uncertainty whether the decline in fertility, which has become general in all less developed regions, will come to a halt once the replacement level will have been reached.

- ***The 'second demographic transition'***

The 'second demographic transition' refers to the rather sudden (and unexpected) fertility decline that more developed countries, particularly Western European countries (and Japan [17]), experienced in the 1960s and 1970s (cf. figures 1.2 and 1.5). As seen in section 2, in many countries the decline resulted in fertility levels far below replacement level.

Similar to the changes in the 19th century, the fertility decline this time could also be explained by a shift in values. According to Lesthaeghe & van de Kaa (1986) the old 'bourgeois family model' (associated with the 'first' demographic transition) was gradually replaced by an 'individualistic family model'. The shift in family model not

only affected childbirth but the whole family formation and dissolution processes. The changes in fertility levels were accompanied by fewer and later marriages and more divorces; alternative forms of family formation also emerged (see, for example, Corijn & Klijzing, 2001). Equally important is an observation that fertility rates did not simply drop, but were accompanied in all countries by a postponement of childbearing. Between 1960 and 2000, on 'average', the mean age at birth of the first child has increased by 11.4%, from 25.0 to 27.9 years (CoE, 2003) [18]. The changes may be viewed as an expression of a more 'individualistic' life-style and self-fulfilment (Lesthaeghe & Surkyn, 2002).

In the last 20 years European social demographers have investigated the 'second demographic transition' fairly extensively. This interest is not surprising since a sustained level of fertility below replacement must lead to the prospect of population decrease (cf. figure 1.9). Much research has investigated the chances that fertility would again attain the more acceptable level of 2.1 children [19].

Some researchers (Cliquet, 1991; Hoffman-Nowotny, 1988) have criticised the 'second demographic transition'. Their main argument is that, contrary to the (first) demographic transition, the fertility decline of the 1960s-1970s did not follow (or was the consequence of) falling mortality rates.

A more important argument perhaps is the observation that fertility decline that is associated with the 'second demographic transition' can be interpreted as the 'natural' extrapolation of a trend that started some 100 years earlier. This view is what may be derived from data collected by Festy (1979) in his historical reconstitution on fertility trends for Western European countries. These statistics show a gradual decline in the number of children from about 5 around 1870 to slightly more than 2 at the beginning of the Second World War [20]. This reasoning is consistent with findings from our own research (for example, Cliquet & Schoenmaeckers, 1976) based on Belgian fertility data of the 1960s and 1970s [21]. The findings based on these data show that many women at the end of their reproductive age span faced the problem of 'excess' fertility i.e., they had more children than the number they initially hoped for. Twenty years later, data again show a mismatch between the numbers of wanted children and realised fertility, only this time the difference is in the opposite direction: many women seem to have fewer children than the number they ideally would like to have (Van Peer, 2000). The explanation would be the changing position of women in society after the Second World War, more particularly their increased labour force participation and the availability of the contraceptive pill since the 1960s. The consequence of an increased labour force is that more and more women (and hence couples) are being confronted with an incompatibility between work and family life; a consequence of the availability of the contraceptive pill is that for the first time, women fully control their fertility, with

a postponement of childbearing as a result (cf. above). The incompatibility between work and family life has become a key area for research relating to the 'second demographic transition'; on the other hand, the importance of the effect of the postponement of childbearing on the final level of fertility appears to be overlooked. There are indeed serious reasons to contend that the postponement of childbearing must have the unwanted effect of lowering the number of children (Lodewijckx & Schoenmaeckers, 1994); moreover, the phenomenon would constitute a social problem insofar as it affects especially women with a lower educational degree (Schoenmaeckers *et al.*, 2001). In other words, appropriate social policies — in both the areas of work and medical assistance — could lead to higher fertility levels. Such optimism seems to be warranted by the situation in some countries. France and Sweden are two countries with a state-subsidised system of crèches. This provision, together with the fact that in both countries there is no longer the social stigma from illegitimate births may be an explanation for their relatively high levels of fertility (Schoenmaeckers & Lodewijckx, 1997) [22]. The situation in France and Sweden illustrates the importance of social values in determining the level of fertility once again.

Bearing these arguments in mind, there is no reason to assume that low fertility is 'here to stay'. From this perspective, the 'second demographic transition' would be an overstressed term (it has however the merit of identifying the occurrence of major social changes, with what is indeed a lasting effect). At any rate, from the simulation results it is clear that its effect on the proportion of older people is only limited. If fertility again rises to 1.85 (as is assumed in the simulation), or even to 2.1, its increase on the proportion of older people would be less a result of extreme low fertility and more one of the fertility increase after the Second World War known as the 'baby-boom'.

To conclude the preceding sections, the theory of the 'demographic transition' (and of the 'second demographic transition') is insufficient to fully explain the changes in fertility. Both theories are important in providing a metaphor in identifying long-term demographic developments. The important conclusion is to realise that at the beginning of the 21st century nearly all countries (there are a few exceptions) are on the path to low fertility, and that, although levels and tempo differ, all countries will experience changes in their age structure. From this perspective, 'population ageing' has become a global development and is unavoidable.

5. Specific issues relating to 'ageing' in the less developed regions

It should be clear that 'population ageing' is not a 'neutral' demographic development. On the contrary, it will have far-reaching societal consequences (hence the vast literature trying to explain the origin and consequences of the demographic transition). A good overview of the socio-economic consequences is given in the *World Economic and Social Survey 2007: Development in an Ageing World* from the UN (which became available during the time of writing these proceedings).

The predominant concern worldwide is the economic vulnerability of older people, which in many countries would imply abject poverty. This is especially true in the less developed regions. As noted toward the end of section 2, many less developed countries simply do not have an adequate social security protection at older age. With the prospect of increasing numbers of older people setting up appropriate institutional mechanisms are becoming a priority policy concern. The developed countries have a similar concern. However, in this case it is the fear that 'population ageing' may undermine the sustainability of *already existing* social security systems; we will return to this in section 7.

In view of the rapid rise in the proportion of older people (cf. the results of the simulations in figure 1.1 and table 1.2), the establishment — or the improvement — of a social security system requires urgent attention in many developing countries. This already difficult task (in many cases because of the meagre resources of the countries) is moreover being complicated by specific issues. The following lines present an overview of the most relevant ones.

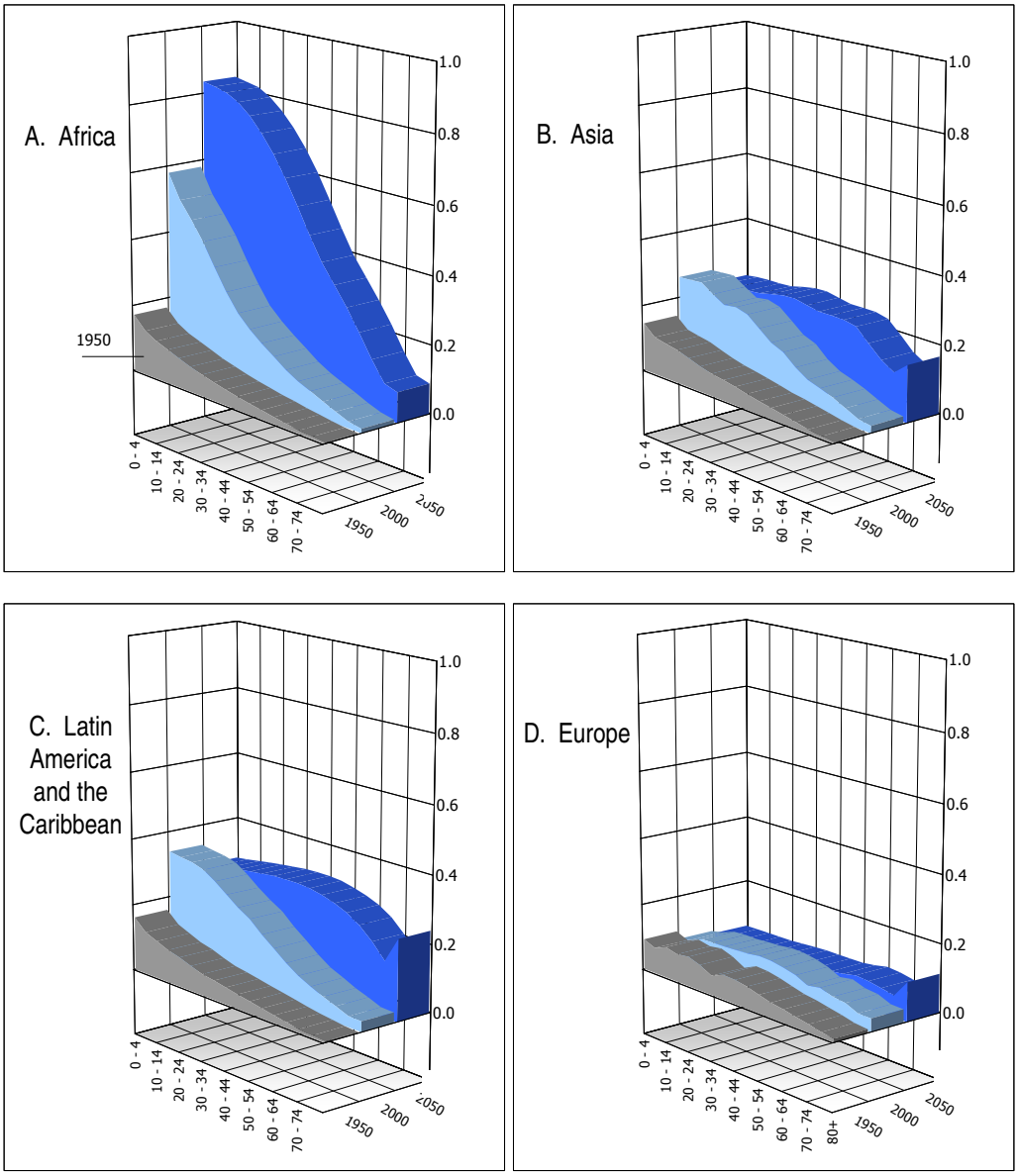
- ***Continued rapid population growth***

Figure 1.8 gives an overview of the changes in the age structure for Africa, Asia, Latin American and the Caribbean, and Europe between 1950 and 2050. A particularity of figure 1.8 is that the 'planes' which represent the age structure [23] are scaled to the population size in 1950. The use of planes allows for a full grasp of changes in the age structure and the population size at the same time.

Figure 1.8 shows that Africa will experience the highest population increase. Indeed, between 1950 and 2050 its population will multiply by no less than 9, leading to a total population size of 1.8bn (more precise values are given in table 1.3, which also includes data for Northern America and Oceania). Most of this increase (66%) occurs between 2000 and 2050.

Although the rates of increase are more modest, between 2000 and 2050, the populations of Asia and Latin America and the Caribbean will increase by about 50 per

Figure 1.8 — Population age structure in 1950, 2000 and 2050, with relative values scaled to total population size (ref =1950 =1), selected continents



SOURCE: *UN Population Prospects. The 2004 Revision* (own adaptation)

Table 1.3 — Total population size and numbers by broad age groups, by continent, years 1950, 2000, and 2050

Continent	All ages	0-19	20-59	60+	80+	All ages	0-19	20-59	60+	80+	All ages	0-19	20-59	60+	80+
	A. Absolute numbers (in millions) on top row and relative values (italics, in %) on bottom row														
	1950					2000					2050				
Africa	224.1	116.7	95.6	11.8	0.6	811.7	436.2	334.7	41.6	2.9	1,929.4	734.4	1,009.7	192.9	20.1
	100.0	*52.1*	*42.6*	*5.3*	*0.3*	*100.0*	*53.7*	*41.2*	*5.1*	*0.4*	*100.0*	*38.1*	*52.3*	*10.0*	*1.0*
Asia	1,396.3	649.8	651.9	94.5	4.4	3,665.4	1,453.6	1,899.7	322.4	30.0	5,112.3	1,276.2	2,709.8	1,231.2	234.9
	100.0	*46.5*	*46.7*	*6.8*	*0.3*	*100.0*	*39.7*	*51.8*	*8.8*	*0.8*	*100.0*	*25.0*	*53.0*	*24.1*	*4.6*
Europe	547.4	189.3	291.8	66.3	6.1	717.9	178.4	402.3	147.7	21.4	618.8	131.2	296.7	225.4	62.8
	100.0	*34.6*	*53.3*	*12.1*	*1.1*	*100.0*	*24.9*	*56.0*	*20.6*	*3.0*	*100.0*	*21.2*	*48.0*	*36.4*	*10.1*
Lat. Amer./ Caribbean	167.3	83.3	74.1	10.0	0.7	520.8	220.0	260.6	42.3	5.2	762.5	190.5	403.8	188.7	40.3
	100.0	*49.8*	*44.3*	*6.0*	*0.4*	*100.0*	*42.2*	*50.0*	*8.1*	*1.0*	*100.0*	*25.0*	*53.0*	*24.7*	*5.3*
N. America	171.6	59.0	91.3	21.3	2.0	310.4	89.3	174.6	51.1	10.1	418.8	100.9	219.0	118.1	33.0
	100.0	*34.4*	*53.2*	*12.4*	*1.1*	*100.0*	*28.8*	*56.2*	*16.5*	*3.2*	*100.0*	*24.1*	*52.3*	*28.2*	*7.9*
Oceania	13.0	4.9	6.8	1.4	0.1	30.7	10.9	16.2	3.7	0.5	46.2	11.8	24.7	11.0	2.4
	100.0	*37.7*	*51.9*	*10.5*	*0.8*	*100.0*	*35.5*	*52.9*	*12.2*	*1.6*	*100.0*	*25.5*	*53.5*	*23.7*	*5.2*
	B. Increases in absolute number on top row, and multiplier (in italics) on bottom row														
	1950-2000					2000-2050					1950-2050				
Africa	587.6	319.5	239.2	29.7	2.3	1,117.7	298.2	674.9	151.3	17.2	1,705.3	617.7	914.1	181.1	19.5
	3.62	*3.74*	*3.50*	*3.51*	*4.88*	*2.38*	*1.68*	*3.02*	*4.64*	*6.90*	*8.61*	*6.29*	*10.57*	*16.30*	*33.64*
Asia	2,269.1	803.8	1,247.8	227.9	25.6	1,446.9	-177.4	810.0	908.8	204.9	3,716.1	626.4	2,057.8	1,136.7	230.5
	2.63	*2.24*	*2.91*	*3.41*	*6.85*	*1.39*	*0.88*	*1.43*	*3.82*	*7.84*	*3.66*	*1.96*	*4.16*	*13.03*	*53.69*
Europe	170.5	-10.8	110.5	81.4	15.3	-99.1	-47.2	-105.6	77.6	41.4	71.4	-58.1	4.9	159.0	56.7
	1.31	*0.94*	*1.38*	*2.23*	*3.52*	*0.86*	*0.74*	*0.74*	*1.53*	*2.93*	*1.13*	*0.69*	*1.02*	*3.40*	*10.33*
Lat. Amer./ Caribbean	353.5	136.7	186.5	32.4	4.6	241.7	-29.6	143.2	146.3	35.1	595.2	107.1	329.7	178.7	39.7
	3.11	*2.64*	*3.52*	*4.25*	*7.98*	*1.46*	*0.87*	*1.55*	*4.46*	*7.70*	*4.56*	*2.29*	*5.45*	*18.94*	*61.50*
N. America	138.8	30.3	83.2	29.8	8.1	108.4	11.6	44.4	67.0	23.0	247.2	41.9	127.6	96.8	31.1
	1.81	*1.51*	*1.91*	*2.40*	*5.16*	*1.35*	*1.13*	*1.25*	*2.31*	*3.28*	*2.44*	*1.71*	*2.40*	*5.55*	*16.93*
Oceania	17.6	6.0	9.5	2.4	0.4	15.5	0.9	8.5	7.2	1.9	33.2	6.9	18.0	9.6	2.3
	2.35	*2.21*	*2.40*	*2.75*	*4.42*	*1.51*	*1.08*	*1.52*	*2.93*	*5.00*	*3.54*	*2.40*	*3.66*	*8.04*	*22.12*

SOURCE: *UN Population Prospects. The 2004 Revision* (own adaptation)

cent. For Asia this represents a numerical increase of 1.4bn people; for Latin America and the Caribbean, 242m. Europe is the only continent where the population increase appears negligible. Indeed, between 2000 and 2050 Europe's population will decrease by about 10 per cent (note that 70% of the decrease will happen after 2025). This decrease is of course a consequence of the fact that fertility rates will remain below replacement (cf. figure 1.5).

Figure 1.8 also shows the differences in the changing age structures between the continents. By 2050 Africa is the only continent to still have a broad base in its age structure, a clear remnant of high levels of fertility. By 2050, both Asia and Latin America and the Caribbean will have a more 'flat' age structure — the classical age 'pyramid', still fairly present in 2000, will have disappeared. Both in Asia and Latin America and the Caribbean, fertility decline will have led to a decrease in the numbers

of younger people, by 177m in Asia and by 30m in Latin America and the Caribbean. However, in spite of this decline, in both continents the age group 0–19 years still represents one quarter of the population and for Asia it corresponds to no less than 1.3bn people. In Africa, between 2000 and 2050, the number of young people will increase by 298m, bringing it to a total of 734m, still representing 38 per cent of the population. Note, however, that because of a decrease in fertility the increase is smaller than between 1950 and 2000.

In all three continents, the numbers of older people are rising rapidly and the increases are accelerating. Even in Africa, where by 2050 older people will represent no more than 10 per cent of the population, their *number* will nearly quintuple. Both in Asia and in Latin America, by 2050 older people will represent about 25 per cent of the population; in Asia this percentage includes 1.2bn individuals. As seen in figure 1.3, by 2050, the majority of older people will reside in the less developed regions.

The changes in the age structure and the increases in the numbers that accompany the changes represent enormous challenges. These challenges span various domains and include a search for solutions to specific needs for each age group. More schooling facilities and better medical care will be needed, as well as more job opportunities (with the exception of Europe, in all continents the numbers of people at working age will increase). More social security and the development of specific health care services will be needed for older people.

Finally, the data in table 1.3 reveal that the numbers of 'oldest old' — those aged 80 and over — are increasing more rapidly than the group aged 60 and over. This process is often referred to as 'double ageing'. Although, as may be derived from table 1.3, the process is universal (being part of 'population ageing'), only in more developed regions has it thus far resulted in a significant rise in the proportions of 'oldest old'.

- ***Important proportions of 'oldest old': thus far a characteristic limited to the more developed regions***

Table 1.3 shows that by 2050 the proportion of 'oldest old' in Europe will have risen to 10.1 per cent of the population and in North America to 7.9 per cent. In all other continents the proportions will remain below 5.3 per cent (in Africa it will be 1%).

As already mentioned in section 3, when life expectancies are high, the main cause for further improvements is an increase in survival at higher ages. The pattern is evident in recent observations for the Member States of the former EU15 (which together with Japan enjoy the highest levels of life expectancy). Statistics from the Council of Europe (CoE, 2003) show increases for the period 1980–1995 in life expectancy *at birth* of 4.5 per cent and *at age 65* of no less than 12.3 per cent (median values between 15

Member States). The *2004 Revision* assumes an even more optimistic evolution for the next 50 years. Between 2005 and 2050 life expectancy at birth would, on 'average', increase by 6 per cent while life expectancy at age 65 would increase by 17 per cent, giving an E0 of 84 years and an E65 of 21 years for 2050 (implying that about one quarter of one's life time occurs after age 65). These prospects are quite optimistic, but are in line with long-term observations (see, for example, Caselli & Lopez, 1996; Schofield *et al.*, 1991; Vallin, 1989;); they also correspond with insight and conclusions of specific research on the subject of longevity (see, for example, Coale, 1996; Horiuchi & Wilmoth, 1998; Vaupel & Lundström, 1994) [24].

The 'oldest old' constitute a particular group of older people with specific needs and social-demographic characteristics (Schoenmaeckers, 2004). Many 'oldest old' (far more the case than 60- to 70-year-olds) are frail or impaired; a majority are women (living alone), and after age 80, many relocate to a nursing home (Lodewijckx & Jacobs, 2002). As may be expected, the situation of the 'oldest old' is receiving special attention from policy makers and the research community.

At present the 'oldest old' represent 17 per cent of all old people in Europe. By 2050 they will represent 28 per cent. As of 2050, more and more countries in less developed regions will start facing similar situations.

- ***The old poor: predominantly a woman's world***

It is well known that women outlive men. According to the *2004 Revision*, at around the turn of the century, the difference in life expectancy was about 7.4 years in the more developed regions (79.31 v 71.91) and 3.5 years in the less developed regions (65.19 v 61.71). The majority of older people are thus women [25]. This difference is especially notable in the 'oldest old': by 2050, no less than 62 per cent of the 'oldest old' will be women (figure 1.10).

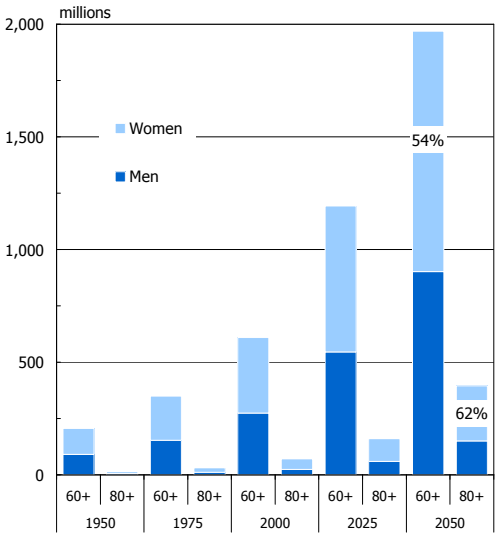
This simple 'demographic' fact may have far-reaching societal implications. Women have a relatively great risk to be widowed, not simply because they outlive men, but also because men tend to marry younger women. The problem then arises because older women are less prone to remarry (than men), with the result that they need to spend the rest of their lives without a spouse providing support. "Thus, older women frequently suffer multiple disadvantages arising from discrimination on account of old age, widowhood and gender. In societies that value childbearing capacity and sexual married status more than old age, older women may be particularly vulnerable" (Stloukal, 2001: 4).

The particularly vulnerable position of women in especially rural areas would be related to the patriarchal system of traditional societies (Boserup, 1990; McNicoll & Cain,

1990). Not surprising therefore, that FAO (and also UNFPA) plead for the provision of more gender-disaggregated data (Ogbuagu, 1996) [26].

Figure 1.10 — Observed and prospected evolution of the number of older people in the world, by age group and sex

SOURCE: *UN Population Prospects. The 2004 Revision* (own adaptation)



In the less developed regions, the vast majority of women live in rural areas. In spite of rapid urbanisation, according to the latest UNFPA State of the World Report (on the subject of urbanisation; UNFPA, 2007), a majority (56%) of inhabitants in the less developed regions indeed lives in rural areas; in the least developed countries, the figure is as high as 72 per cent [27].

It would a mistake to believe that issues of gender discrimination would be limited to the less developed regions. Although in the more developed regions the social position of women has improved greatly compared to the start of the 20th century when they were still claiming for the right to vote, some forms of gender discrimination are still prevalent. For example, on average, salaries of women are less than those of men, and women continue to be underrepresented in legislature and so forth. As a result, the more developed countries count many women's lobby groups that are very active and some European governments include a ministry of 'equal opportunities'. On the positive side, however, one must recognise that, at present, older women's position largely depends on individual characteristics, rather than on being female (see, for example, Vanderleyden & Dooghe, 1993). One consequence is that the decision to relocate or not to a nursing home is not gender-specific, but would largely depend on whether one is living alone (single, widowed) or (still) living with one's partner or other

relatives (people living alone decide to move to a nursing home earlier in life). The pattern is observed in recent Belgian data (Lodewijckx, 2006) and may be general [28].

- ***The effect of rural-urban migration***

In many less developed countries, rural populations have a tendency to age faster than urban populations (Kinsella, 2001; Marcoux, 1990; Martin & Kinsella, 1994; Skeldon, 1999; Stloukal, 2001) [29]. Based on data in the UN Demographic Yearbook, Stloukal has calculated the ratio between the percentage of people aged 60 and over in rural areas over urban areas (Stloukal, 2001: table 1). For sub-Saharan Africa, the results show a percentage about twice as high for the rural areas (median value between countries). The reason is of course that a large part of the migratory flows is undertaken by younger people looking for better job opportunities in the cities. In some rural areas, ageing may be further accelerated when older people return to the ancestral village upon retirement from their urban-based job (Stloukal, 2004).

A particularly worrisome consequence of rural to urban migration is that older people who are left behind in their ancestral village lack support of able-bodied kin to help till lands and sow and harvest crops, and that they become socially isolated.

- ***The additional burden of HIV/AIDS***

It is increasingly recognised that the HIV/AIDS epidemic is a threat for all members of society, irrespective of their age. For example, in the latest WHO/UNAIDS Report (2007), HIV transmission from mother to child is treated as a major concern in the fight against HIV/AIDS. However, most statistics on HIV prevalence such as those available in UNFPA's *State of the World Report* are limited to the 15- to 49-year-olds. This is the part of the population that is most sexually active. It is also the age group that is the most economically active in the population. Therefore, in addition to being a major health issue, the HIV/AIDS epidemic is in many countries also seen as a threat to economic development. The epidemics have also had serious social consequences.

The effects on family structures are indeed devastating. People living with HIV/AIDS are unable to take care of their spouse and children — nor of their elderly parents; when they die they leave behind widows, widowers and orphans. Most less developed countries lack the financial reserves and/or the infrastructure to take care of an increasing number of orphans. In the majority of cases, grandparents become primary care providers to orphaned and vulnerable grandchildren. Sample data from Eastern African countries indicate that up to one-third of all orphans may be taken care of by grandparents (Stloukal, 2004).

As indicated in section 2, the AIDS epidemics and the excess mortality of adults cause a severe drop in life expectancy. The countries with the highest estimates for HIV prevalence rate, Botswana, Lesotho and Swaziland (UNFPA, 2007) [30], would, according to the *2004 Revision*, experience life expectancies in the coming 20-25 years that are 14-20 years below the (already low) African average (cf. figure 1.2). This prospect is disturbing, especially when taking into account that until 1995-2000 all three countries enjoyed above-average life expectancy.

6. The need for more international collaboration

The UN has thus far convened two international assemblies on 'ageing'. The First World Assembly was held in Vienna in 1982; the Second World Assembly took place twenty years later in Madrid. In both cases, the outcome was an international plan of action on ageing (the latter is known as the *Madrid International Plan of Action on Ageing* or MIPAA [31]). The MIPAA includes recommendations for realising the specific contributions and concerns of older people within — in accordance with universal principles of the UN — the context of improving the economic and social conditions of all (see specifically section 12). The MIPAA recommendations are also discussed in Chapter 10.

Being a major 'demographic development' the issue of 'population ageing' also deserves the fullest attention within the context of the follow-up of the ICPD Programme of Action. The ICPD, the third international conference on population convened by the UN, took place in Cairo in September 1994. The first two international conferences were held in Bucharest (1974) and Mexico City (1984) [32]. The population conferences are organised as part of the activities of the Commission on Population, one of the UN's oldest 'technical' commissions (established in 1946), and in the 'aftermath' of the ICPD renamed Commission on Population and Development or CPD [33].

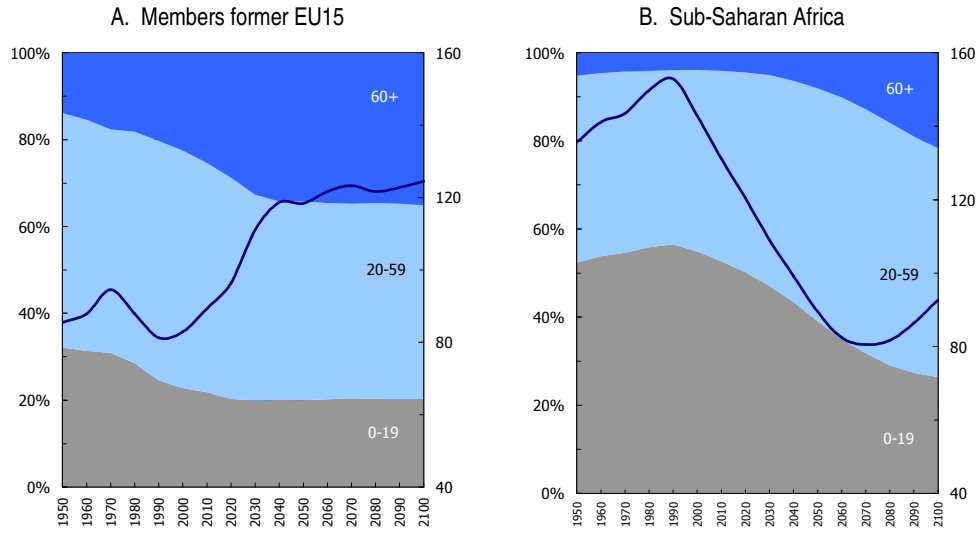
The mandate of the CPD is to follow-up on the implementation of the ICPD Programme of Action. Within this context more attention given to 'population ageing' — or, in more general terms, to 'changing age structures' — seems justified since, as we have seen in previous sections, the entire process must be interpreted as the 'last leg' of the 'demographic transition' and is, as such, the precursor to a 'new demographic world order' (with a population size of around 10 billion as a main characteristic).

- ***The 'window of opportunity'***

The 'window of opportunity' refers to the evolution of the dependency ratio, i.e., the ratio of the number of people of 'inactive' age over the number of people of (economically) 'active' age [34]. The higher its number (generally calculated per 100 'inactive' people) the easier it may be to meet the needs of the 'young' and 'old'. Its evolution depends on the changes in fertility and mortality. As will become clear below, the evolution in the dependency ratio is a key element in the discussion regarding the socio-economic impact of 'population ageing'.

Figure 1.11 shows the evolution from 1950 to 2100 for the member countries of the former EU15 and the countries of sub-Saharan Africa.

Figure 1.11 — Changes in the age structure by broad age groups (0-19, 20-59, and 60 and more; in %, left axis), evolution in the 'dependency ratio' (per 100 population, right axis; see formula at bottom), and the 'window of opportunity' (not shown), for Member States of the former EU15 and countries of sub-Saharan Africa, 1950-2100



NOTE: Dependency ratio = 100 x [(nb. people aged 0-19 + nb. people aged 65+) / (nb. people aged 20-59)]

SOURCE: Results simulation exercises

In the case of the EU countries, after a short decline between 1970 and 1990, the dependency ratio increases steeply from 81 to about 118 in 2040 after which the

increase more or less levels off, reaching 125 by 2100. The short decline is the result of the fertility decrease that started in the 1960s and the increase captures the increasing number of older people as the result of increasing levels of life expectancy. The end of the steep increase after 2040 coincides with the fact that, by that time, the presence of the children of the baby boom in the population starts fading out (the smaller increases thereafter are the result of the continued increase of the proportion of older people). The main message is the prospect of an ever-growing number of 'inactive' people in the population per 100 people of working age (with the specific characteristic however that the greatest change will occur in the next 30-35 years).

From a purely economic point of view this is a worrisome development. It is a cause of fear for the sustainability of existing social security systems: pensions will no longer be guaranteed and because of the assumed poorer health of older people, health expenditures could reach unacceptably high levels. A popular solution among policy makers is to postpone retirement age. Needless to say that one and the other are the subject of much research in recent decades. For example, we have ourselves argued (Schoenmaeckers, 2005) that the negative demographic developments can largely be compensated for by increased employment rates (especially by women) and increased productivity. Others (Lutz & Scherbov, 2003; Kieffer, 2004) have questioned the hypothesis that the health status of older people will lead directly to higher health expenditures. Their findings show that the majority of added years of life expectancy are years in good health. And according to the results of attitude surveys, the proposed policy measure of increasing the legal age of retirement would be quite controversial among European citizens (Schoenmaeckers *et al.*, 2006a, 2006b; see also Schoenmaeckers *et al.*, *forthcoming*).

In sum, the precise socio-economic implications of an older population structure are not known. However, there can be no doubt that Europe is on the eve of profound demographic changes which will have a serious economic and social impact. As of 2040, over one third of Europe's population will be aged 60 and more (compared with only 15% in 1950). This expanded older population will require major adaptations; and, as suggested in the title of the 'green paper' by the European Commission on demographic change (CEC, 2005), it is most likely that solutions will not be workable without intergenerational solidarity.

The evolution of the dependency ratio is quite different in sub-Saharan Africa. Here one observes a rapid *decline* in the dependency ratio between 1990 and 2070: the number of 'inactive' people per 100 'active' people drops from 153 to 80. This drop will then be followed by a steep increase…

The decline in the dependency ratio is referred to as the 'window of opportunity' (alternatively as the 'demographic bonus'). When the labour force must support fewer dependants, savings can increase, which is expected to stimulate economic growth. Both are based on experiences in East Asia, where the rapid decline in the dependency ratio observed after 1975 is likely to have contributed to the region's rapid economic growth (Bloom & Williamson, 1998). However, a declining dependency ratio alone will not be sufficient. An economic and institutional environment that facilitates taking advantage of the demographic situation is also needed (Higgings & Williamson, 1997). Put more simply, the 'window of opportunity' does not translate automatically into improved economic output; it is only, to paraphrase Sinding (2000), an opportunity.

The implication is that many less developed countries with poor economic and fragile institutional environments will not be able to seize the opportunity fully. This is the situation for most countries in sub-Saharan Africa, of which many are part of the group of least developed countries (see endnote 4). Without international assistance, for many the 'window of opportunity' is likely to remain a theoretical concept. This was the view of the spokesperson of the group of G77 and China — say, the group of less developed countries [35] — at the 40th session of the Commission on Population and Development (see below), held at the UN Headquarters in New York on 9-13 April 2007, with the annual theme of "The changing age structures of populations and their implications for development" [36].

The task for sub-Saharan African countries in this regard is huge. The 'window of opportunity' corresponds to a relatively high number of people in the population at working age. Between 2010 and 2070 (the year in which the 'window of opportunity' will close) the population aged 20-59 will according to the simulation results grow by some 800m individuals. Consequently, to fully benefit from the 'demographic bonus', SSA governments will need to create as many additional jobs during this period. However, its effect will be more than stimulating economic growth. Those who constitute the labour force of 'today' will supply the numbers of older people of 'tomorrow'. In other words, the creation of job opportunities for the 20- to 59-year-olds, must also be seen as a first step to reduce the risk of potential dependence in old age (an objective included in the MIPAA, and repeated in the resolution adopted at the 40th CPD session).

- ***'Population ageing' and the ICPD Programme of Action***

The Population Commission (now the Commission on Population and Development or CPD — see above) was established in 1946, at a time when the annual growth of the world population was close to 2 per cent (implying a doubling after 35 years). High

population growth was regarded as a threat for world peace and development. Curbing the rapid population growth has been a main objective of the three international conferences on population convened since the inception of the CPD.

At the time of the first population conference, most less developed countries opposed the idea that rapid population growth was an obstacle to economic development. The idea was viewed as a 'conspiracy' theory from the industrialised countries; to them, the real issue was not population growth, but the fact that wealth was unevenly distributed between countries of the North and South (Cliquet & Veys, 1974). Attitudes started to change with the second conference (Cliquet & Van De Velde, 1985). However, a real turning point occurred only 10 years later with the ICPD-conference in Cairo in 1994 (Cliquet & Thienpont, 1994, 1995; Singh, 1998; for a critical note on the ICPD-Conference, see Van de Kaa, 1996) [37].

Unlike the first two conferences, the accent of the ICPD was not on *numbers* (and the need to reduce population growth through the implementation of family planning programmes); the focus of the ICPD Programme of Action lies rather on the *well-being* of the individual (and of couples). A key issue of the ICPD-Programme of Action is 'reproductive health'. In sections 7.2 and 7.3, reproductive health is defined as follows (UN, 1995; own italics) [38]:

> 7.2. Reproductive health is *a state of complete physical, mental and social well-being* […], in all matters relating to the reproductive system […]. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the *right* of men and women to be *informed and to have access* to safe, effective, affordable and acceptable methods of *family planning* of their choice […], and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a *healthy infant*. […]. [Reproductive health] also includes sexual health, the purpose of which is the enhancement of life and personal relations […].
>
> 7.3. Bearing in mind the above definition, reproductive rights embrace certain *human rights* that are already recognized in national laws, international human rights documents and other consensus documents. *These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so* […].

Based on a first reading, one may conclude that reproductive health is essentially a matter of *human rights* and *free choice*, and that the main objective is to enhance the chances of having a healthy child. However, by including the right of couples to decide on the number and spacing of their children — to be realised through the use of acceptable family planning methods — it becomes clear that an ultimate objective is to lower the number of children — and, as such, curb population growth. In fact,

reproductive health as defined in the ICPD Programme of Action is nothing but a modern version of the traditional postpartum taboos. Anthropological evidence teaches us that the underlying reason for these taboos — including prolonged breast-feeding and sexual abstinence — was to enhance the survival of the already born infant (Schoenmaeckers *et al.*, 1981).

What, one may ask, is the connection with 'population ageing'? Gradually, family planning programmes — whether related to 'reproductive health' or not — became successful and birth rates declined: first in Asia, and some 30 years later in Africa as well (cf. figure 1.2) [39]. As the results of the simulation exercises showed, with the exception of Europe (and North America), it is precisely fertility decline that acts as the main 'motor' for the increases in the proportion of older people. In other words, it is family planning programmes — or, to use the 'agreed language' of the CPD, reproductive health programmes, *including family planning* — that are largely responsible for the increase in the proportion of older people [40].

Unfortunately, in the ICPD Programme of Action, not much attention is given to the fact that fertility decline will ultimately lead to 'population ageing'. As a matter of fact, the issue of 'population ageing' is hardly dealt with in the ICPD Programme of Action. Only one of the 16 chapters (chapter VI) of the Programme is on 'Population Growth and Structure', and the part in the chapter on the issue of 'Elderly People' has, to our knowledge [41] never been given much attention.

A reason for the lack of attention to 'population ageing' could be the relatively low proportions of older people in the world (of not much more than 10%; and of hardly 7-8% in the less developed regions — see figure 1.1). However, a more profound explanation might be that, as already mentioned, the key objective of the ICPD Programme of Action is the *well-being of the individual* (rather than dealing with 'numbers', as was the case with the previous conferences); as a consequence the importance of general principles such as (the respect of) 'human rights', the 'empowerment' (of women), and in the aftermath of the Rio Conference of 1992 on sustainable development, the 'interrelationships between population, sustained economic growth and sustainable development' are underlined throughout the Programme.

These are laudable and respectful principles in their own right. But by emphasising them — in both the Programme of Action and in debates during the CPD sessions — the ICPD has become known as the conference of 'reproductive *and sexual* health' (own italics), with the result that the more demographic aspects — for which the Commission and the international conferences were initiated in the first place — have gradually been overlooked. As the present author has written elsewhere [42], to some

extent "the ICPD has become victim of its own success".

Thus far, international programmes on 'population ageing' do not exist. This situation is regrettable, as such programmes would be most needed in poorer countries where social security programmes are virtually non-existent or are inefficient (cf. section 2 above). Moreover, programmes that foster the 'exchange of best practices' — which should be the key characteristic of programmes regarding 'population ageing' — might be beneficial for all countries, from both North and South, and hence, constitute a basis for effective international collaboration.

Finally, programmes on 'population ageing' would contribute to more general objectives included in the MDGs, such as the eradication of extreme poverty and hunger and the promotion of gender equality. In short, international programmes on 'population ageing' would be a direct contribution to more socio-economic development — one of the basic principles, together with respect for human rights, of the UN.

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Endnotes Chapter One:

1 The United Nations Population Division defines a population as being 'old' when the percentage of its members aged 65 and over has reached 7 per cent or more (see, for example, Mirkin and Weinberger, 2001). By and large, this percentage corresponds with 10 per cent of people aged 60 and over.

2 Throughout this chapter 'elderly' or 'older people' are defined as those aged 60 and over.

3 Note that in reality it took even longer than 70 years as the increase started before 1950. The year 1950 is the 'base line' of the simulation exercises and is the earliest year available in the *Population Prospects* that are prepared biannually by the Population Division. All data in this chapter are based on the medium variant of the *2004 Revision of the World Population Prospects* (UN, 2005). The medium variant corresponds with the 'most likely' scenario regarding the future evolution of mortality and fertility. The chosen fertility scenario largely determines the size of the future population.

4 The sub-Saharan African region corresponds closely with the group of least developed countries. The least developed countries include a total of 50 countries, of which a majority (60%) is African. The categorisation (used in the *Population Prospects*) corresponds with a definition of the UN General Assembly in 2003.

5 The 10 billion estimate is consistent with the *1998 Revision* (showing a stabilisation of the world population at around 2200); the 9 billion estimate is consistent with the *2002 Revision*. The differences are largely due to the adoption of different scenarios regarding the future evolution of fertility. "Beginning with the *1998 Revision*, countries with fertility below replacement were no longer constraint to rise to replacement level by 2050. […] In the *2002 Revision*, in light of increasing evidence that many less developed countries are experiencing below-replacement fertility, it was no longer assumed that countries with intermediate levels of fertility would see their fertility declines stop at 2.1 children per woman." (United Nations, 2004: 1).

6 The process can be explained in a fairly simple way. Countries that experienced high fertility levels before the onset of the fertility decline have vast numbers of women of reproductive age. Even when these women have fewer children than their mothers the number of children they will bear will far exceed the number of their own parents. It will take several generations for this mechanism to fade out and population size to stabilise (the precise number of years it takes to reach stabilisation will depend on the initial level of fertility and on the pace of the decline).

7 A rise in fertility to 1.85 children by 2050 may appear doubtful but is, however, not entirely unrealistic. According to recent statistics (for 2005 and 2006), Finland, France, Denmark, and the UK experience a total fertility rate of 1.85 children per women or more (see websites national statistical Institutes). In

France, the level of 1.92 children in 2005 followed a period of about 10 years of growth (Pison, 2006). On the basis of these examples, an increase of up to 1.85 children by 2050 is therefore not to be ruled out.

The very low levels of fertility in Europe have been the subject of extensive research (see, for example, endnotes 19-21 below). Some optimism in believing that fertility levels may increase seems warranted given that surveys of the 1990s indicated that a mismatch existed between desired and actual number of children (Van Peer, 2000). It is not unreasonable to contend achieving a life/work balance and the availability of crèches could produce an upward shift. Another important factor could be the non-stigmatisation of illegitimate fertility, which would explain the relatively high levels that have been observed in France and Sweden (Schoenmaeckers and Lodewijckx, 1997).

[8] Clearly a much higher rate that those recorded for European countries: 0.1 to 0.6 per cent (UNFPA, 2007).

[9] Another example is an article in *The Economist* (June 16, 2007) on "Europe's population", which states that because of higher fertility rates, France and Britain will by 2050 have a far more favourable age pyramid (than, for example, Italy), with more than two workers per pensioner. As such, the article refers indirectly to the (in-)dependency ratio. Changes in the dependency ratio are treated in more detail in the last section.

[10] Required input data of PROJCT are the base year population by age and sex; the start and end levels of life expectancy by sex; and the start and end levels of fertility for the projection period. In addition, the programme requires the indication of the model life table pattern and the fertility pattern. For mortality, the 'general' model of the UN life table models was used (in some cases, for high levels of life expectancy, the 'West' model of the Coale and Demeny models was used). Fertility patterns were derived from the regional patterns given in the *2002 Revision* (UN Pop. Division, 2003a). For sub-Saharan Africa, estimates were derived from data readily available for Kenya (Schoenmaeckers, 1984) and Togo (Locoh and Adaba, 1981).

[11] Note that it was not a purpose of this contribution to provide an exhaustive set of simulation exercises. These exercises have been limited to a set of countries (or group of countries) that may be viewed as sufficiently illustrating the heterogeneity regarding the process known as the 'demographic transition' (see section 4).

[12] Based on the following 'EDA' formula (Tukey, 1977): $x_{i}^{\text{smoothed}} = \frac{1}{4} * [\, x_{i-1}^{\text{obs}} + 2 * x_{i}^{\text{obs}} + x_{i+1}^{\text{obs}} \,]$

[13] The percentage difference between the highest and lowest levels. As is the case for the graphs in figure 1.5 these figures are based on the median values of each group of countries.

[14] The EU15 or 'old' EU Member States are: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxemburg, Portugal, the Netherlands, Spain, Sweden, and the UK ; the 'new' Member States are: Bulgaria, Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovenia, Slovakia, and Romania.

[15] Horiuchi (1999) distinguishes in total five epidemiological transitions (between brackets the type of society and the period of occurrence):

1. from external injuries to infectious diseases (from a hunting and gathering society to an agricultural society, from ca. 12,000-10,000 BC to 8,000-4,000 BC);

2. from infectious to degenerative diseases (industrial society, starting ca. 1750 to mid-twentieth century);
3. the decline of degenerative diseases: the decline in cardiovascular disease mortality (high-technology society, late twentieth century);
4. further decline of degenerative diseases: the decline of cancer mortality (high technology society, since ca. 1990);
5. the slowing of senescence, or the delay of 'old-age frailty' (now and the future).

[16] There is a vast literature explaining changes in fertility behaviour. In some we have collaborated personally (see Cliquet and Schoenmaeckers, 1976; Page and Lesthaeghe, 1981). It is impossible to present a detailed overview here.

The majority of articles (incl. our own Ph.D. dissertation) on fertility behaviour in less developed countries has been based on data of the WFS (World Fertility Survey) of the 1960s and 1970s and the DHS (Demographic and Health Survey) initiated in the 1980s.

Studies regarding the early changes in European countries were undertaken under the *Princeton European Fertility Project* in the 1970s by the Office of Population Research at Princeton University, in collaboration with numerous European researchers (of which Lesthaeghe's work on the Belgian fertility decline was part of); an overview of the results is available in Coale and Watkins (1986).

[17] Note that Japan's demographic history is unique. "During the first quarter of the 20th century, Japan experienced the high mortality and fertility levels characteristic of present-day developing countries. In 1925, life expectancy at birth was about 45 years and women gave birth to a total of 5.1 children […]. By 1950, life expectancy had increased to 60years and the total fertility rate […] had fallen to 3.7 children" (Martin, 1989: 7). After the Second World War, Japan's mortality and fertility continued to lose all characteristics of those of a less developed country. By the turn of the century it showed the highest life expectancy in the world (81.9 years, both sexes combined, a full 1.5 years more than Switzerland or Sweden, which ranked second and third respectively) and one of the lowest fertility levels (of 1.4 children, just above Italy or Spain with 1.2 children).

[18] Values based on the median for the former 15 EU Member States. In 2000, the highest value (28.6 years) observed was for the Netherlands.

[19] The literature relating to the 'second demographic transition', its causes and especially the question whether (very) low fertility would be a temporary phenomenon or not, is so vast that, once again, it would be inappropriate to try to present a summary of the literature within the scope of this contribution. However, by way of summary (or introduction), we would commend reading the discussion paper by Francesco Billari *et al.* (2004) on the paper by John Caldwell and Thomas Schindlmayr (2004) regarding a 'common explanation' for the low levels of fertility in European countries.

One may also note that much of the research (to explain the 'second demographic transition') has been based on FFS data (Fertility and Family Survey) that were collected during the 1990s in many European countries. Annotated tabulations are presented in a series of 'standard country reports published in 1996-2001 (UNECE & UNFPA). An evaluation of the project is given in Festy and Prioux (2002).

[20] The described trend is consistent with the evolution of the median value for 7 Western European countries that are currently Member States of the EU: Denmark, Finland, France, Germany, the Netherlands, Sweden, and the UK.

Note that the *2004 Revision* indicates for the fertility level in 1950 of all 15 'old' Member States a median value of 2.33 children.

[21] The data stem from the so-called 'NEGO' surveys (National Surveys on Family Formation) conducted through the 1960s, 1970s and 1980s in Belgium. They were based on the National Fertility Study conducted in the US in the mid-1960s by Norman B. Ryder and Charles F. Westoff (1971). The Belgian NEGO-surveys may be regarded to be the predecessor of the international FFS surveys of the 1990s (see endnote 19 above).

[22] According to the *2004 Revision*, France and Sweden had a TFR-value in 2000-2005 of 1.89 and 1.65, respectively, in both cases significantly higher than the median of 1.28 for the southern EU15 Member States (Greece, Italy, Portugal, Spain).

[23] 'Planes' are actually similar to the more classical age pyramid, with the difference that no distinction is made between the numbers of men and women.

[24] Note, however, that all researchers are careful in their predictions. In view of recent developments one can no longer agree on a maximum life span. In fact, researchers now question the existence of a biological maximum. There is agreement, however, based on analyses of data on mortality for populations with high levels of life expectancy (such as Sweden and Japan), that mortality in old age is slowing down; and that the increase in life expectancy is decelerating (cf. the assumptions made in the simulation exercises for the evolution of life expectancy after 2050).

[25] Note that with rising life expectancies, the difference between men and women could be narrowing. The observation was first made for England and Wales and is thus far limited to some European countries (Grundy, 1996). There is no clear explanation. A plausible explanation could be that women have adopted and risky life-styles usually associated with men (Schoenmaeckers, 2004).

[26] Note that the subject of the older poor, and especially the situation of older women, is also treated in two UNFPA reports from 2002, published jointly with the CBGS (Population and Family Study Centre), with financial support from the Belgian Directorate General for Development Co-operation).

[27] Note that the subject of the older poor, and especially the situation of older women, is also treated in two UNFPA reports from 2002, published jointly with the CBGS (Population and Family Study Centre), with financial support from the Belgian Directorate General for Development Co-operation).

[28] It can also be derived from results in the country reports for, for example, Canada (Légaré, *et al*. 1998), Finland (Lindgren *et al*., 1999), and Switzerland (Bongard and Sauvain-Dugerdil, 2002) in the UNECE/PAU series on the *Socio-Economic Status and Living Arrangements of Older Persons*.

[29] Note, however, that Martin and Kinsella (1994) suspect that the difference would be decreasing because of lower mortality rates in the cities.

[30] The UNFPA statistics are based on a UNAIDS Report from 2006 and refer to the situation in 2005.

[31] A full report on the Second World Assembly on Ageing, including the MIPAA, is available at www.un.org/esa/socdev/ageing.

[32] These were preceded by two more 'technical' conferences (i.e. implying that no international programme of action was adopted by participating countries): the first organised in Rome in 1954 and the second organised in Beograd in 1965.

[33] More information is available at www.un.org/esa/population/cpd/aboutcom.htm (the website of the UN Population Division).

[34] An alternative to the dependency ratio is to measure the ratio of the number of 'older people' over the number of people of working age. We prefer to include the number of younger people in the equation.

[35] The denomination 'G77' dates from 1964 when the group was established at the end of the first UNCTAD-meeting (UN Conference on Trade and Development). Today, the group includes over 130 member countries.

[36] The full text of preparatory section 11 of the resolution that was eventually adopted at the CPD-40 is as follows:

> "Recognising further that the second stage of the demographic transition [referring to the decline in fertility, the first stage being the decline in mortality according to the classic theory: see section 4] presents a window of opportunity for development and that the translation of this window of opportunity into benefits for development requires national policies and an international economic environment conducive to investment, employment, sustained economic development and further integration and full participation of developing countries in the global economy."

[37] For an overview of the three international UN conferences, their differences and significance for the international community see Sinding (2000).

[38] The complete version of the ICPD Programme of Action is available on the website of UNFPA: www.unfpa.org/icpd.

[39] The first signs of fertility decline in Asia were observed in 1955-1960; Latin America and the Caribbean followed in 1965-1970; it was not before 1985-1990 that all the Africa regions showed signs of a fertility decline.

A vast literature exists on the reasons for the success of family planning programmes and fertility decline. A key research question is to what extent family planning programmes can be successful independent of economic development. Much of the early literature is based on WFS-data (for an overview, see WFS, 1981). Current research is based on DHS-data (more info available at: www.measuredhs.com/start.cfm).

[40] We do not discuss whether FP programmes alone have led to fertility decline or in conjunction with socio-economic development. We tend to agree with Cleland (2005), as stated in his keynote address at the XXVth IUSSP International Population Conference in Tours, 18-23 July 2005, that FP programmes (and the availability of contraceptives) alone are unlikely to be sufficient for women to have fewer children. This conclusion is in line with the historical fertility decline as observed in Europe and the role of values (cf. Lesthaeghe, 1977).

[41] The author has attended, as a member of the Belgian delegation, the ICPD Conference and nearly all subsequent CPD sessions (which are organised annually at the UN Headquarters in NY).

[42] In mission reports and unpublished 'essays', most available only in Dutch.

Chapter Two

The Socio-economic Implications of Ageing for West African Countries.

The Elderly in Africa Today and Tomorrow: Living Conditions, Participation in the Labour Market and Alternative Sources of Income.

Mathias KUEPIE and Yacouba YARO

Contents:

1. Introduction.

Elderly people (those aged 60 or over) currently represent 2 to 4 per cent of the population in African countries south of the Sahara, compared to over 15 per cent in regions with an ageing population. While, in relative terms, the proportion of elderly people remains relatively low in Africa and will not begin to increase significantly until 2025-2030, in absolute terms the number of elderly people is growing at least as strongly as the total population [1]. This growth — and likewise the growth of the entire population — is giving rise to concerns, as it is taking place in a context marked by nearly three decades of stagnation or even a regression in living standards that were already low to start with. In fact, since the mid-1970s, the majority of sub-Saharan African countries have experienced deterioration in the living conditions of their populations, a deterioration that continues today. This deterioration has been at least partly due to economic growth that has been structurally very weak compared to demographic growth. Between 1975 and 1999, GDP increased by an average of 2 per cent a year in sub-Saharan Africa, while population growth was close to 3 per cent, which meant that *per-capita* GDP fell by approximately 1 per cent per annum. As a comparison, from the 1960s to the end of the 20th century, real GDP per capita in the African countries fell, while that of high-income countries grew by 2.4 per cent and that of countries in East Asia and the Pacific increased by 5.6 per cent (World Bank 1981; World Bank 2005). By the end of the century, sub-Saharan Africa was creating only 1 per cent of global wealth, although it accounted for around 11 per cent of the population. As well as suffering from this sluggish economic performance, sub-Saharan Africa is one of the regions of the world where inequalities in the living standard are most pronounced (Cogneau *et al.*, 2006), which helps to maintain the vicious circle of poverty (Bourguignon, 2004; Kuepié *et al.*, 2006). The consequence is that 46 per cent of the African population lives below the extreme poverty level of less than one dollar a day. This percentage is much higher than the world average (less than 23%) or the percentage that is found for the developed countries, which is 0 per cent. Even the slight progress that had been made in certain social sectors (increase in life expectancy from about 40 years in 1960 to around 50 years in 2000, decrease in mortality among children under five from over 200 ‰ in 1980 to 150‰ in 1999) is under threat from the effects of the AIDS pandemic.

While the economic performance of sub-Saharan Africa does not seem conducive to a "peaceful retirement" for the elderly, nor is such a retirement favoured by the socio-cultural changes, economic production methods, rural exodus etc. Indeed, in traditional Africa, old people enjoyed considerable prestige and the only route to social advancement, apart from one's birth family, was to change age class. Elderly people

had a monopoly on access to land, a vital factor of production in an economy that is essentially based on subsistence agriculture.

They were also the holders of political and religious power and of wisdom in a context in which the experience gained with age played a key role in access to knowledge. People looked forward to old age so that they could enjoy the prestige and power that it conferred upon them (Uzoma, 2002). According to Singleton (2002), this "golden age" of seniority, which moreover was not peculiar to Africa, declined in this continent with colonisation and independence, which brought significant demand for qualified staff — civil servants, managers and employees of all kinds — that was satisfied at that time by young educated people. Since then power has been held by this educated minority of people who have been able to carve out places for themselves as managers and senior managers [2].

Finally, the African context is characterised at the demographic level by the strong growth in the number of elderly people and at the economic and socio-cultural levels by profound changes that are not always beneficial to the elderly. It is therefore important to analyse their present and future situation in order to put forward possible outlines for an appropriate policy.

The objective of this study is to set out, in a fairly general way, the socioeconomic and demographic conditions for elderly people in Africa. First of all, an initial section will focus on the terminology used and the perception of the elderly. This will be followed by a situational analysis of the realities and the socioeconomic and living conditions of elderly people: do they live in better conditions or are they disadvantaged compared to other adults? We will then see how retirement, exercising an economic activity and transfers from other households may be factors that contribute to improving living conditions. On the basis of the biographical data, a diagnosis will be made of the changes in urban labour market conditions from the parents' generation to the children's generation.

2. Definition and evolution of the concept of the third age in Africa

Claudine Attias-Donfut and Léopold Rosenmayr (1994) point out that the structuring of society on the basis of age is difficult to apply in sub-Saharan Africa. Their view is that if the third age evokes the division of life into three distinct periods — education, work and retirement — this division is meaningless in Africa. Indeed, the few organisations for retired people that mobilise to defend their rights in cities such as Dakar, Ouagadougou and Abidjan are of little significance and are unlikely to lead to old age taking on the western sense of the term.

Box — *Data sources*:

As suggested in the introduction, the initial intention of this study was to provide an analysis including all sub-Saharan Africa countries (with the exception of South Africa). This has not been feasible, however, because of the lack of a database covering all countries (except the large international databases on demographic, economic and social indicators). Consequently, we have been forced to limit the analysis to those countries for which relevant data are readily available.

The data for the analysis of socioeconomic living conditions stem from household surveys carried out during the 1990s in the following countries: Côte d'Ivoire (1985-87, 1993, 1998); Burkina Faso (1994 and 1998); Ghana (1988-1992); Guinea Conakry (1988-1992); Senegal (1994): and Mali (1994, 2001).

Most of these surveys were financed and supported by the World Bank and were carried out by national statistics offices. They include a "household expenditure and consumption" section. The total amount of annual expenditure for each household is estimated on the basis of this section, and a living standard indicator is calculated by relating consumption to household size. With the exception of Senegal in 1994 and Mali in 2001, the amounts of household expenditure in all the other surveys used have been harmonised and adjusted for inflation (between regions and over time) by a DIAL team [3] (see Cogneau *et al*., 2006). Based on this adjusted and harmonised living standard indicator [4], we constructed a relative poverty indicator. For each country, we considered the 40 per cent of households with the lowest living standard as poor. It should be pointed out that this level is quite close to the proportion of 46 per cent of people living in extreme poverty of less than a dollar a day as used by the World Bank. One may therefore assume, we believe, that even if the daily experiences of poor households in these various countries is not always similar, the 40 per cent threshold should include those who are indeed deprived, especially taking into account the fact that all countries in the study are poor and highly indebted.

For participation in the labour market, we used the 1-2-3 surveys carried out between 2000 and 2002 in the seven capitals of UEMOA [5] Member Countries (Abidjan, Bamako, Cotonou, Dakar, Niamey, Lomé and Ouagadougou) [6], by the national statistics offices with support from Afristat [7] and DIAL (Brilleau *et al.,* 2004). Although the data collected relate only to cities, they have two advantages. On the one hand they are completely comparable and, on the other hand, by using an appropriate methodology, they capture in detail the working situation of all individuals, even those who only marginally participate in the economic activity. They therefore provide an opportunity to study the characteristics of the work being done (wage received, number of hours worked, etc) and also to estimate alternative sources of income (pensions, transfers, investment income).

Although they contain a great deal of information on people's work, the data from the 1-2-3 surveys remain cross-sectional and do not enable the changes that have occurred in the urban labour market over a long period to be studied in order to describe the conditions of integration into the labour market for successive generations and thus forecast how trends in the living conditions of the elderly will evolve. To do so, we have used biographical data collected in several African capitals — Abidjan (1996), Lomé (2001), Dakar (2001) and Yaoundé (1996). These data make it possible to track the career paths of different generations throughout their lives.

Finally, the databases used in this study are numerous and concern countries that are not always the same. In fact this heterogeneousness protects us from individual results that would be too specific to a particular country as it should be remembered that our objective is to make a general diagnosis of the living conditions and integration into the labour market of elderly people in Africa.

While ageing in the demographic sense is now measured by the ratio of the number of people aged over 60 to that of the whole population, it is important to note that barely

a quarter of a century ago, the age threshold that was usually used was not 60, but 65 years. Why has it decreased in this way while life expectancy has increased almost everywhere? In fact, the ageing criterion is simply retirement. As the retirement age has fallen in developed societies, the "old age" indicator has followed suit. This same indicator is the basis for historical comparisons, as well as comparisons between countries. But is this comparing like with like? A single statistical comparison is applied to realities of age that are as different as those in France today, where the life expectancy is 81 for women and 75 for men, and in contemporary sub-Saharan Africa, where life expectancy at birth barely exceeds 50.

Therefore, when dealing with ageing in Africa, where chronological age does not have the same relevance or the same meaning as in societies that view life chronologically, such a comparison leads us to criticise the relevance of the categories used, not only when transposed to other cultures but also for the culture producing them.

Claudine Attias-Donfut and Léopold Rosenmayr (1994) thus agree with Georges Ballandier (1974) in recognising that in Africa *there are no old people, there are elders*. For these authors, the idea of elders gives a different perspective to that of old age. While old age evokes an age category and the corresponding social category, the term "elders" refers to the respective positions of ages and generations and the hierarchical principle under which they are organised. The concept of elders at community level sheds light on the social distribution based on the relationships between several generations headed up by i) the elders or old people or the patriarchs, the heads of families, ii) younger siblings or adults who are also heads of households, iii) children or young people who are forces of production, and iv) very young grandchildren. The concept of elders is key to the different positions between generations. In short, strictly speaking, taking retirement from all economic activity as the sole age criterion to define the third age is very inappropriate in the African context, as the lack of a social security system means that the elderly continue to work unless they are ill. Elders are still working even when they are over 70, often acting as the main managers and organisers of economic production within their families and communities.

In any case, the ILO (International Labour Organisation) estimated that the population of retired people rarely exceeded 10 per cent of the elderly population in sub-Saharan countries, as opposed to 81 per cent in industrialised countries with a market economy, in 1980. In addition, out of these 10 per cent of people, only 3 per cent actually receive any benefits. This shows that the pension system is not only a long way from becoming generalised in Africa, but also that there is no clear development in this regard. These systems are in fact imported from societies in which they are based on a monetary economy, a well-developed wage-earning class, a tradition of

taxation and powerful administrative infrastructures — sectors that are fragile or non-existent in Africa.

In short, the concept of the elderly person in the sociological or even demographic sense of the term is completely relative, as it depends on the social organisation being considered. Despite this relativity, advancing in age, in all societies, always brings specific concerns, which justifies taking a particular interest in the living conditions of this social category.

3. Living conditions of the elderly

Old age is a period of life where an individual is physically more vulnerable and more fragile and might therefore be exposed to a risk of poverty or impoverishment. But it also occurs after an "adult" life during which everyone — depending on the constraints and opportunities of his or her environment and abilities — has been able or unable to put something away for his or her old age. In France, for example, elderly people at the end of the 1990s had a poverty rate that was lower than the population as a whole (4 per cent for retired people compared to 7 per cent for adults) while the opposite was true thirty years ago (28 per cent compared to 15 per cent) (Hourriez *et al.,* 2001). What about the living standard for the elderly in Africa?

- ***Higher rates of poverty***

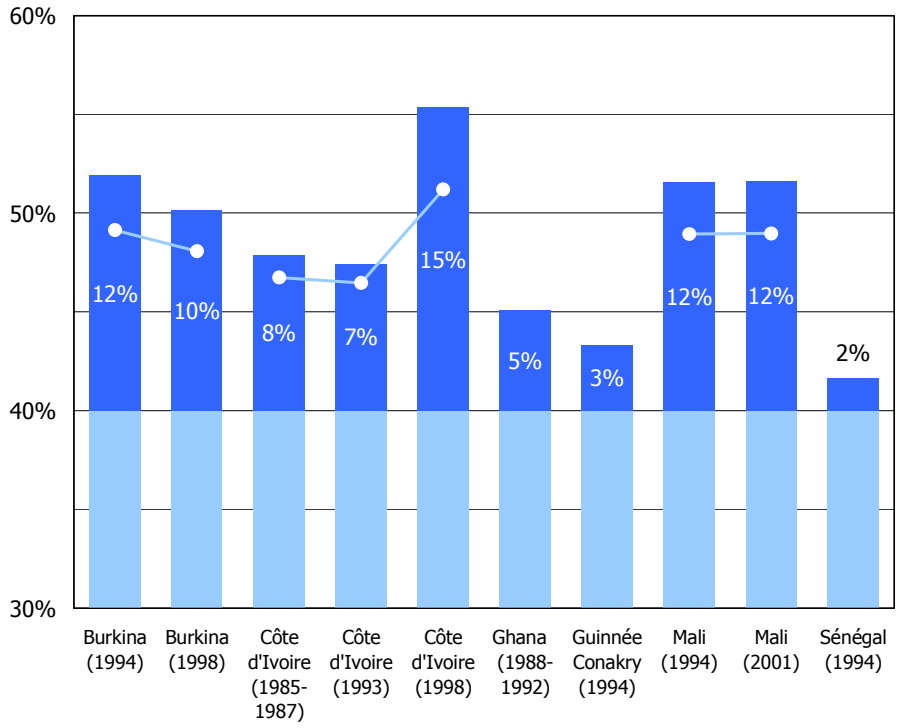
Irrespective of the country being considered, households headed up by elderly people are proportionately more likely to be in a situation of poverty (figure 2.1). This is particularly true in Mali, Burkina Faso and Côte d'Ivoire where the households of elderly persons have poverty rates that are 10 to 15 percentage points higher than the national average (set at 40 %) [8].

The situation varies greatly between countries. In the case of Côte d'Ivoire, the situation clearly worsened between 1993 and 1998 as it was during this period that the extreme impoverishment in the households of elderly persons doubled, increasing from 7 to 15 per cent. On the other hand there was a (slight) improvement in Burkina Faso over the same period. As for Mali, there was no change between 1994 and 2001. Finally, in Ghana, Guinea Conakry and Senegal, the difference in poverty, at 5 per cent at the most, is clearly lower. This relatively heterogeneous pattern from one country to another is the result of a range of economic, social and cultural factors that we cannot go into here.

- ***Generalised poverty in the rural environment and unequal poverty in the urban environment***

Poverty is a massive presence in the rural environment (see table 2.1). The level of poverty is at least twice as high in the rural environment compared to the urban environment (with the exception of Ghana, where there the ratio is 1.4). Despite its relatively low level in the urban environment, poverty there is the most unequal, disfavouring the elderly with the notable exception of Senegal (figure 2.2).

Figure 2.1 — Relative poverty rates for households headed by an elderly person compared to the national average (set at 40 %), situation in the 1990s (survey year in brackets), selection of countries



SOURCE: see box

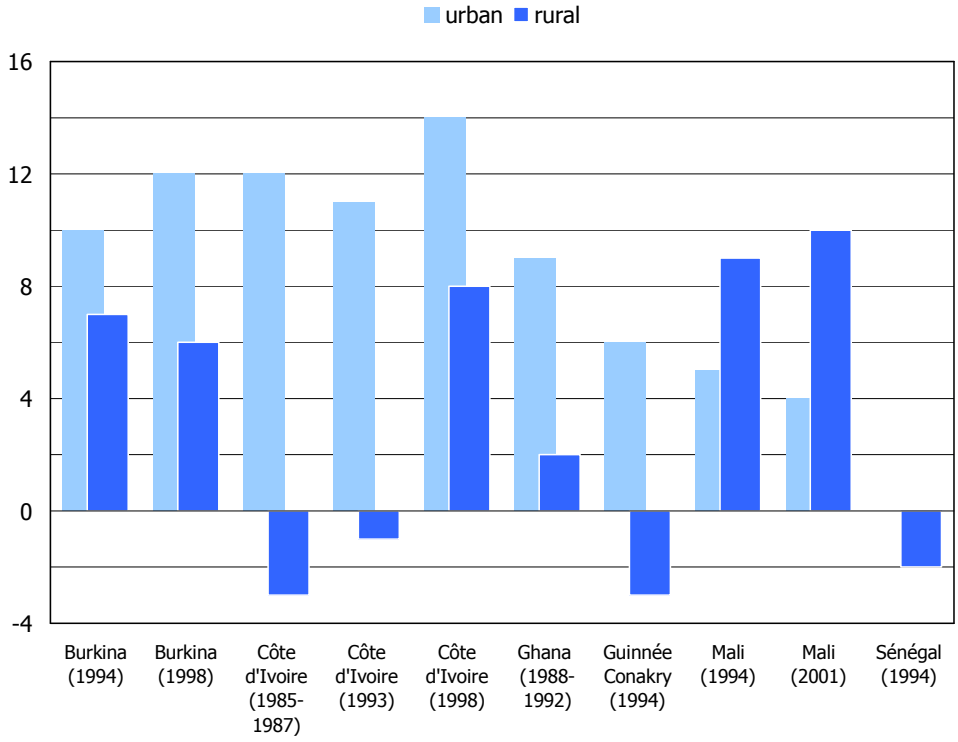
In the rural environment the patterns are clearly more mixed with — on the one hand — Burkina Faso, Mali and Côte d'Ivoire (only at the end of the 1990s), where poverty has a particular impact on the households of elderly people, and — on the

other hand — Guinea Conakry and Senegal where mass poverty affects the same proportion of the households of elderly people as of households as a whole in the rural environment.

Table 2.1 — Proportion of poor households, according to the environment in which they live and the sex of the head of household, for “all ages” households and households made up of “elderly people”, in five UEMOA countries (survey year in brackets)

		urban/rural residence			sex head of household		
		urban	rural	*ratio*	man	woman	*ratio*
Burkina Faso (1994)	"all ages" households	8%	48%	*6.0*	41%	27%	*0.7*
	"elderly people" households	18%	55%	*3.1*	55%	30%	*0.5*
	ratio ("old-age" excess poverty)	*2.3*	*1.1*		*1.3*	*1.1*	
Burkina Faso (1998)	"all ages" households	11%	48%	*4.4*	41%	30%	*0.7*
	"elderly people" households	23%	54%	*2.3*	53%	28%	*0.5*
	ratio ("old-age" excess poverty)	*2.1*	*1.1*		*1.3*	*0.9*	
Côte d'Ivoire (1985-1987)	"all ages" households	20%	56%	*2.8*	41%	28%	*0.7*
	"elderly people" households	32%	53%	*1.7*	48%	50%	*1.0*
	ratio ("old-age" excess poverty)	*1.6*	*0.9*		*1.2*	*1.8*	
Côte d'Ivoire (1993)	"all ages" households	22%	54%	*2.5*	40%	37%	*0.9*
	"elderly people" households	33%	53%	*1.6*	48%	45%	*0.9*
	ratio ("old-age" excess poverty)	*1.5*	*1.0*		*1.2*	*1.2*	
Côte d'Ivoire (1998)	"all ages" households	22%	55%	*2.5*	41%	34%	*0.8*
	"elderly people" households	36%	63%	*1.8*	58%	46%	*0.8*
	ratio ("old-age" excess poverty)	*1.6*	*1.1*		*1.4*	*1.4*	
Ghana (1988-1992)	"all ages" households	32%	45%	*1.4*	39%	40%	*1.0*
	"elderly people" households	41%	47%	*1.1*	44%	47%	*1.1*
	ratio ("old-age" excess poverty)	*1.3*	*1.0*		*1.1*	*1.2*	
Guinnée Conakry (1994)	"all ages" households	12%	53%	*4.4*	43%	23%	*0.5*
	"elderly people" households	18%	50%	*2.8*	50%	19%	*0.4*
	ratio ("old-age" excess poverty)	*1.5*	*0.9*		*1.2*	*0.8*	
Mali (1994)	"all ages" households	12%	47%	*3.9*	43%	9%	*0.2*
	"elderly people" households	17%	56%	*3.3*	55%	11%	*0.2*
	ratio ("old-age" excess poverty)	*1.4*	*1.2*		*1.3*	*1.2*	
Mali (2001)	"all ages" households	10%	52%	*5.2*	41%	27%	*0.7*
	"elderly people" households	14%	62%	*4.4*	56%	18%	*0.3*
	ratio ("old-age" excess poverty)	*1.4*	*1.2*		*1.4*	*0.7*	
Sénégal (1994)	"all ages" households	12%	60%	*5.0*	42%	27%	*0.6*
	"elderly people" households	12%	58%	*4.8*	44%	24%	*0.5*
	ratio ("old-age" excess poverty)	*1.0*	*1.0*		*1.0*	*0.9*	

Figure 2.2 — Poverty gap between households whose head is an elderly person and all households, according to the environment in which they live, situation in the survey year (stated in brackets) in a number of West African countries



SOURCE: see box

Finally, this summary analysis shows that households headed by elderly people are more vulnerable, even though the indicator used is an indicator of expenditure which, for this reason, includes any support that the elderly might have received. These results contradict those who argue that there is an unshakeable African solidarity, particularly with regard to the elderly.

The over-representation of poor people amongst the elderly is more apparent in the urban environment than the rural one, which may mean that the urban environment is the suitable place for the expression of individualism. In the rural environment, this individualism is restricted by the fact that, even if an elderly person's ability to work fades, he very often continues to own the land, which is the main factor of production. This control of the land enables him to group a number of dependants around him and

to have a certain degree of control over their production. In towns, on the other hand, the elderly took care of their children or relatives during their working life, and now these children or relatives have started work but they find themselves in a position of insolvency (Marie A., 1995) compared to their elders due to the economic crisis and deterioration in the conditions of integration into the labour market. This means that these young people are not able to come to the assistance of their parents in need and hence perpetuate family solidarity. In the following sections we will analyse the factors that contribute to this living standard: participation in the labour market, receiving pensions and investment income, transfers between households.

4. Integration of elderly people into the urban labour market in Africa: levels and conditions

The analysis of elderly people's integration into the labour markets will be carried out for urban areas only. This is partly due to the availability of data, given that the information at our disposal comes from labour market surveys and relates only to the capitals of West African countries. Another reason is that in the rural environment there are specific issues with regard to the labour market, particularly as far as the elderly are concerned.

- ***A not insignificant level of activity amongst the elderly***

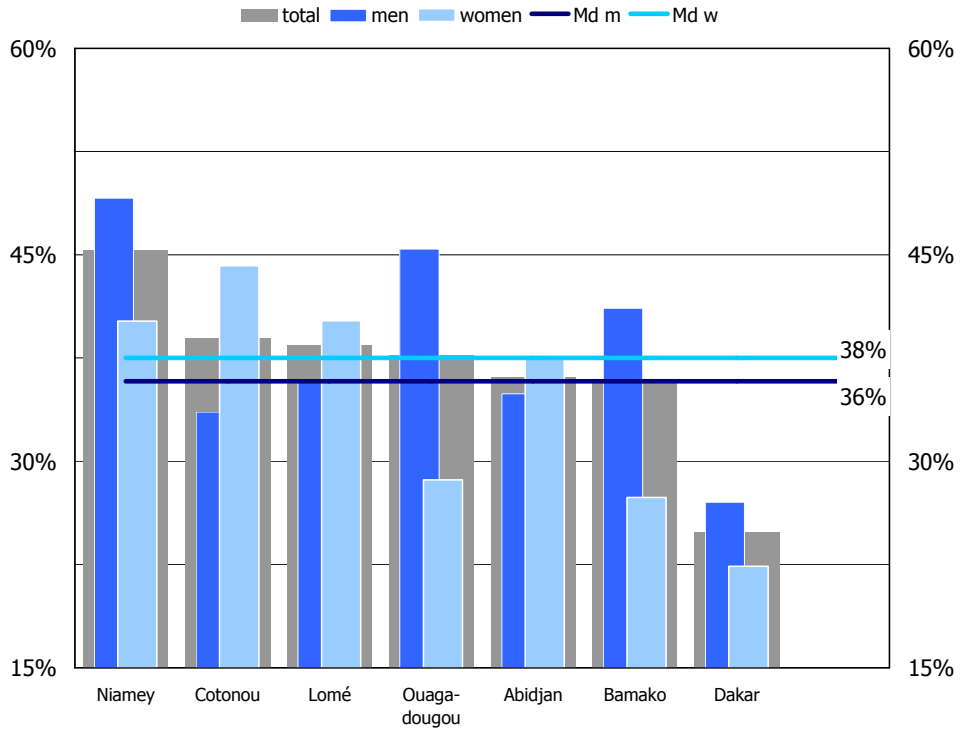
In African towns, the official retirement age varies between 55 and 60. However, as shown in figure 2.3, activity rates are not insignificant above these ages. In West African cities overall, almost 38 per cent of people over 60 have a job (36 per cent of men and 38 per cent of women) [9].

Three different groupings are apparent for these cities. The first comprises Cotonou, Ouagadougou, Abidjan, Bamako and Lomé, where for both sexes together activity rates are between 36 and 39 per cent. This group of cities, which are very similar in terms of elderly people's activity, is flanked by Dakar, where only a quarter of people over 60 work, and Niamey, where up to 45 per cent are working. These activity levels for elderly people in Africa are higher than those for developed countries with a strong social welfare system (France, Belgium) but lower than those for countries with a more liberal system (Japan, USA) (cf. Antoine, 2006). Two thirds of people over 60 who are not working explain their inactivity by the fact that they are "retired", even if in reality only a small minority of elderly persons receive a work pension (as we will see later).

Generally speaking, elderly women are somewhat more active than their male counterparts (with a median value of 38% as opposed to 'only' 36%). In the total

population of working age this difference is reversed and men are much more likely to be working (there is an activity rate of 48% for women compared to 64% for men). It must be said that it is very unusual for elderly women to receive a pension as they spent their adult lives looking after children and taking care of domestic tasks (Adjmabo and Antoine, 2004), or else they always worked in the informal sector which does not offer a pension scheme. It is interesting to analyse the working conditions of retired people who work and to compare them with those of adults.

Figure 2.3 — Proportion of elderly people working in the urban environment, by sex, in 6 capitals of the member countries of UEMOA, situation in the 2000s



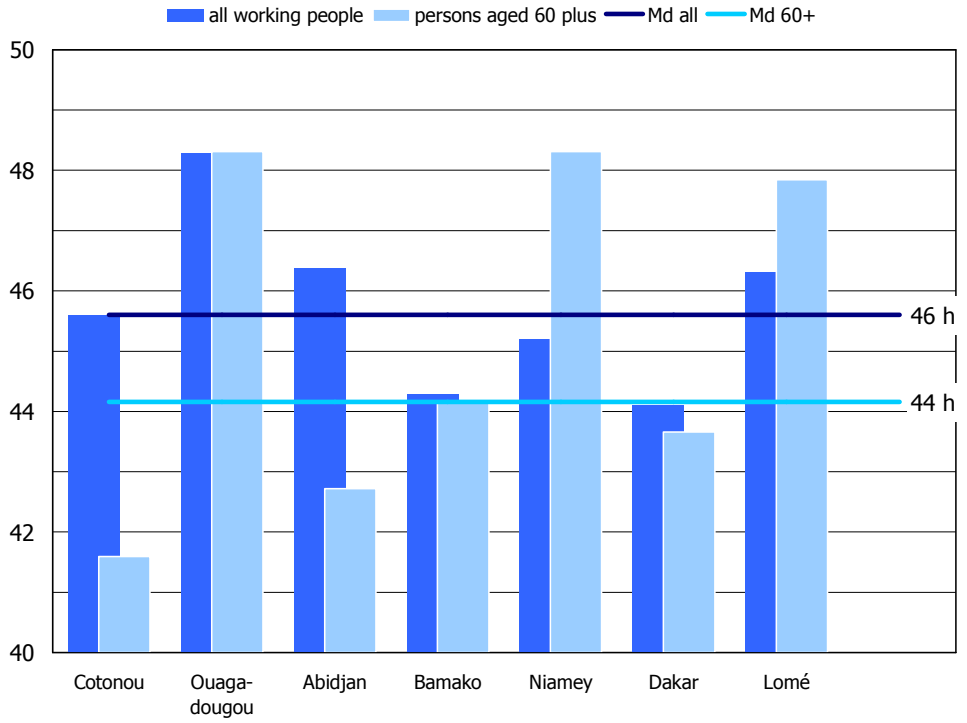
SOURCE: see box

- ***Working hours that are similar to normal but with lower pay***

Due to their advanced age and the fact that they are in the process of gradually leaving the labour market, it might be expected that elderly people who continue to exercise

an activity would have considerably shorter working hours than adults. The reality of the situation is different, as shown in figure 2.4.

Figure 2.4 — Weekly working time for all working people and for elderly people aged 60 plus in 7 capitals of the member countries of UEMOA, situation in the 2000s



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For all 7 capitals in question, the weekly working time (median value) is 44 hours for elderly persons as opposed to 46 hours for the total working population over 15 years of age, i.e. only two hours shorter. As can be observed in figure 2.4, in almost all the capitals of the member countries of UEMOA, in general terms, the elderly work practically as many hours as other working people, or even more, as is the case in Niamey and Lomé. The only cities where people aged 60 or over work significantly fewer hours are Abidjan and Cotonou (four hours less). One can only wonder what the effects of this full-time work might be on the health and well-being of the elderly,

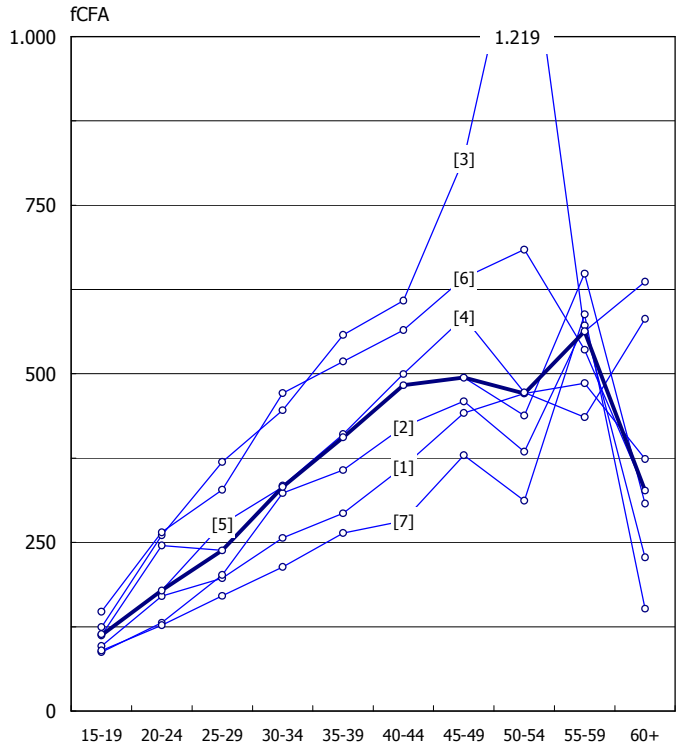
especially when considering that their work is often carried out in difficult conditions (outdoors, requiring physical effort etc). The fact remains that this excessive working time for individuals of the third age conveys their need to live 'by the sweat of their brow'.

If the elderly work as much as adults, it would be expected that they would receive adequate wages, but is this actually the case?

Elderly people in the seven West African metropolises may work on the whole in the same way as other working people, but that does not mean that they always receive comparable pay (see figure 2.5a).

Figure 2.5a — Changes in hourly pay according to age in 7 capitals of the member countries of UEMOA, situation in the 2000s

SOURCE: see box



Key: [1] Cotonou; [2] Ouagadougou; [3] Abidjan; [4] Bamako; [5] Niamey; [6] Dakar; [7] Lomé

With an hourly income of approximately 409 CFA francs [10], elderly people earn more than young workers under 30 who do not receive more than 231 CFA francs an hour on average. However, comparing the elderly to very young people who have only just

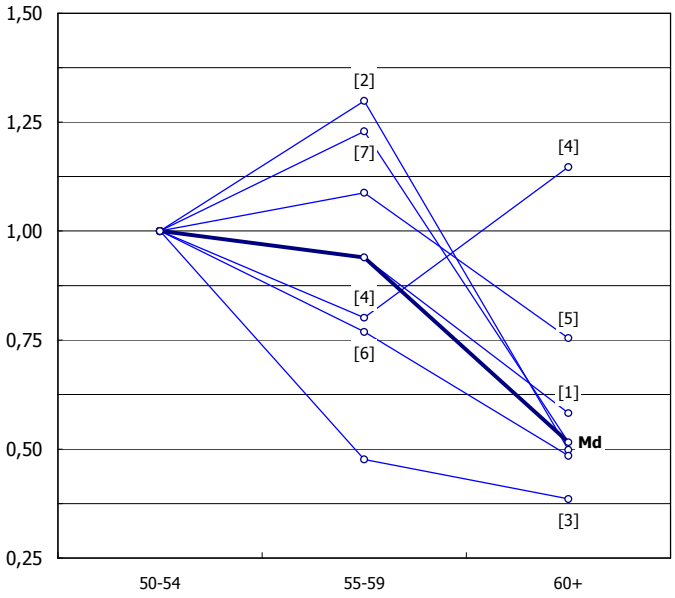
entered the labour market is not particularly appropriate. They should be compared instead to people who entered the labour market in the same context as them, for example to working people aged between 50 and 59.

The comparison shows that for the metropolises as a whole, the elderly are paid 40 per cent less than those aged 50-59 (409 compared to 677 CFA francs an hour). This difference in remuneration is essentially due to the predominance of the lower-paid informal sector (66% of jobs for those aged 50-59 as opposed to 87%). The over-representation of the elderly in the informal sector could be explained by the fact that when they retire, some working people in the modern sector are obliged to turn to the informal sector as self-employed workers because they cannot rely on their pension (Antoine, 2006). Therefore they come to swell the ranks of those who have always worked in this sector. The under-payment of the elderly is a constant feature in each metropolis when they are considered individually, with the exception of Bamako where the over 60s earn 25 per cent more than those aged 50-59. This exception is essentially explained by the fact that some elderly people in the Malian capital earn high incomes.

The differences in remuneration are shown in detail in figure 2.5b.

Figure 2.5b — Relative differences in pay in the age groups 55-59 and 60 plus compared to the 50-54 age group (=1), in 7 capitals of the member countries of UEMOA, situation in the 1990s

SOURCE: see box



Key: [1] Cotonou; [2] Ouagadougou; [3] Abidjan; [4] Bamako; [5] Niamey; [6] Dakar; [7] Lomé

In general terms, hourly pay decreases above the age of 55. However, in three cities (Ouagadougou, Dakar and Niamey) there is initially a (slight) increase for those aged 55-59. In all the cities, though, with the exception of Bamako, it can be seen that those aged 60 or over are considerably less well paid than those aged 50-54; their pay is 50 per cent lower based on the median value.

5. Alternative sources of income: pensions, investments and family solidarity

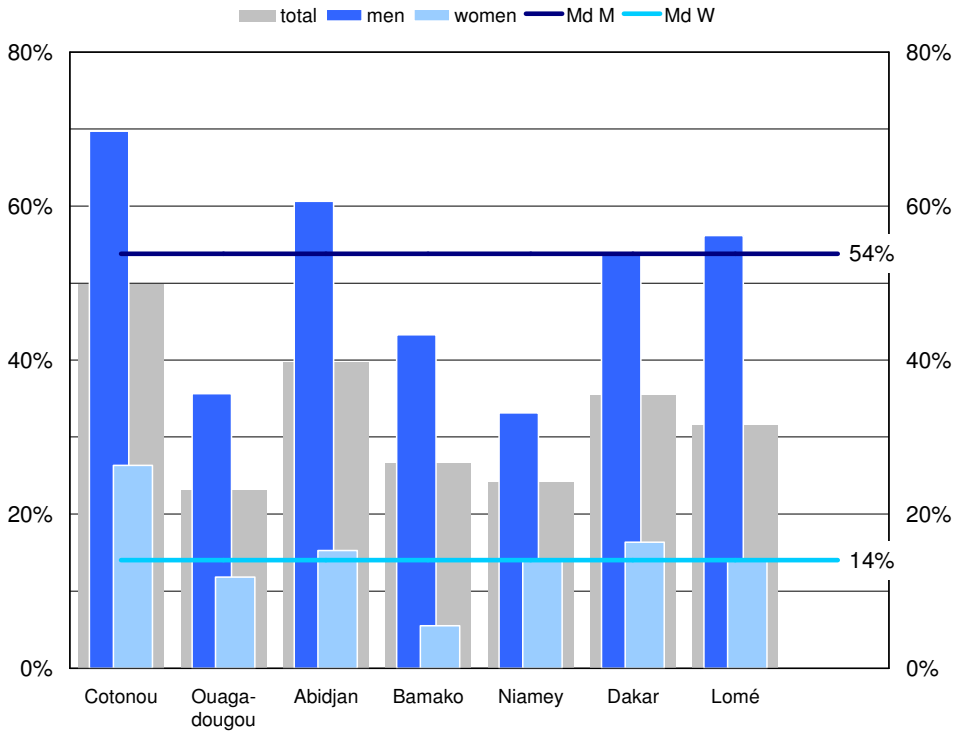
In theory one might expect that income from work would not be the only source of subsistence for elderly people, as during their young and adult life they might have made investments and/or paid money into a pension plan. Almost all of them brought up children with whom they could maintain mutual aid links. This section will explore all these alternative sources of income to which elderly people can turn.

5.1. Few elderly people benefit from a retirement pension

Very few of the elderly who do not work benefit from a retirement pension (figure 2.6).

For the cities as a whole, only a third of non-working people over 60 stated that they have a pension. With 50 per cent of the elderly receiving a pension (i.e. 70 per cent of men and 26 per cent of women), Cotonou is by far the city where the elderly are best protected. Then come Abidjan and Dakar with 40 per cent and 35 per cent respectively in receipt of a pension, while in the other cities this rate varies from 31 to 23 per cent. These levels reflect the conditions that prevailed in the labour market 20-30 years ago. The cities (Abidjan, Cotonou and Dakar) in which the elderly receive the highest rates of pension provision are doubtless those that created a significant number of modern jobs in the past. All the cities under consideration now have informality rates in excess of 70 per cent. This suggests that the proportion of elderly people benefiting from a pension will decrease in the future. Dividing the beneficiaries by sex clearly shows the strong inequality that exists with regard to women.

Figure 2.6 — Percentage of people aged 60 plus receiving a retirement pension, by sex, in 7 capitals of the member countries of UEMOA, situation in the 2000s



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- ***Elderly women excluded from the retirement system***

Whereas 52 per cent of non-working elderly men are able to rely on a pension to survive, this proportion is only 15 per cent for their female counterparts. In Mali in particular, women seem to be totally excluded from the retirement system (or a survivor's/widow's pension) as only 6 per cent of women over 60 have access to a pension. The situation in other cities is not so extreme but is just as unequal, with the rates varying from 12 per cent in Ouagadougou to 26 per cent in Cotonou. This significant under-representation of women amongst those benefiting from pensions can be explained historically by the sexual division of roles that prevailed in the African urban environment, with the man being the breadwinner and the woman doing domestic tasks and rearing children. Even when a woman exercised an economic

activity, this was very often in the informal sector so was less well-paid and not covered by the social welfare system. As they did not work or pay contributions for their retirement, elderly women find themselves completely dependent on their husbands or on help from their children or other members of their family.

- ***Few elderly people have both a pension and work***

In view of the fact that pensions are low in Africa and are sometimes paid irregularly, one might think that elderly people with a pension would seek work in the labour market as much as those without a pension in order to receive additional income. This assumption is not supported by our data, as in the metropolises under consideration here as a whole, only 16 per cent of the elderly with a pension also have work, while the rate of activity amongst those without a pension is two and a half times higher. With only 9 per cent, Abidjan is the city where the fewest number of people have both. In Ouagadougou and Niamey, on the other hand, almost a quarter of retired people with a pension work.

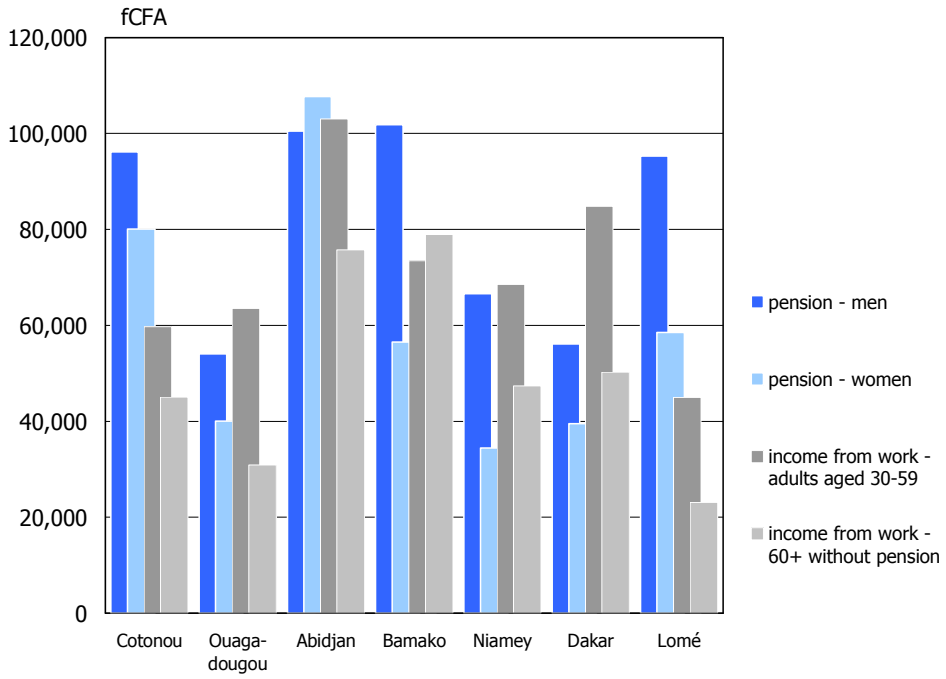
- ***Relatively comfortable pension levels***

As can be seen in figure 2.7, pension levels are quite comfortable when compared to the salaries of working people as a whole.

This means that for the cities as a whole, the average pension amount is 78,000 CFA francs per month, while the average wage for the adult population (aged 30 or over) is 81,000 CFA francs. It is obviously important to emphasise that only a third of people aged over 60 without a job benefit from such a pension. Irrespective of the city in question, the average pension amount is never lower than 50,000 CFA francs, except in Dakar and Niamey where it is 40,000 CFA francs and 35,000 CFA francs respectively. It exceeds the remuneration of adult workers in Lomé, Cotonou and Bamako. The not insignificant level of pensions can be explained by the fact that retired people tend to belong to a class of city dwellers who have been able to enter the labour market's most protective segments.

If only a third of elderly people have access to a more or less decent pension, are the other two thirds able to rely on alternative sources of income, and in particular on any income from investments that they built up during their working life?

Figure 2.7 — Average amounts for different categories of income, by sex, in 7 capitals of the member countries of UEMOA, situation in the 2000s



SOURCE: see box

5.2. Investment income almost non-existent

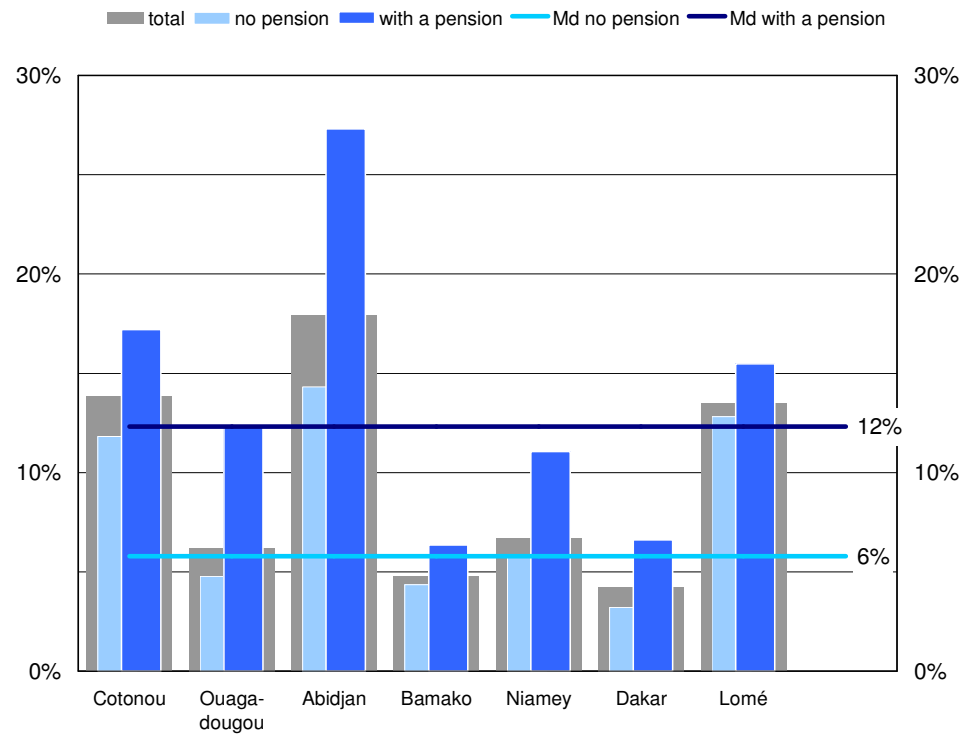
Elderly people who receive income from property or financial investments are quite rare (see figure 2.8). In the West African cities as a whole, only 7 per cent of elderly people are in this situation [11], and there are large differences between the cities.

Nearly one out of five elderly people (18%) in Abidjan is able to rely on this type of income, while this is the case of only 4 to 6 per cent of the elderly in Dakar, Ouagadougou, Bamako and Niamey. Lomé and Cotonou occupy intermediate positions with approximately 14 per cent of people aged over 60 receiving investment income.

Taking all the cities together, only 6 per cent of those who do not receive an old age pension have access to investment income, compared to 12 per cent of those in receipt of a pension. This situation, which is the one found in the majority of cities, reflects an accumulation of hardship. Because their work did not pay them enough, those who did

not contribute to their pension could not afford to build up private savings for their old age either, while conversely those who contributed to a retirement pension had a little extra leeway that enabled them to acquire investments, a sort of additional pension.

Figure 2.8 — Percentage of people aged 60 plus with investment income according to whether or not they receive a pension, in 7 capitals of the member countries of UEMOA, situation in the 2000s



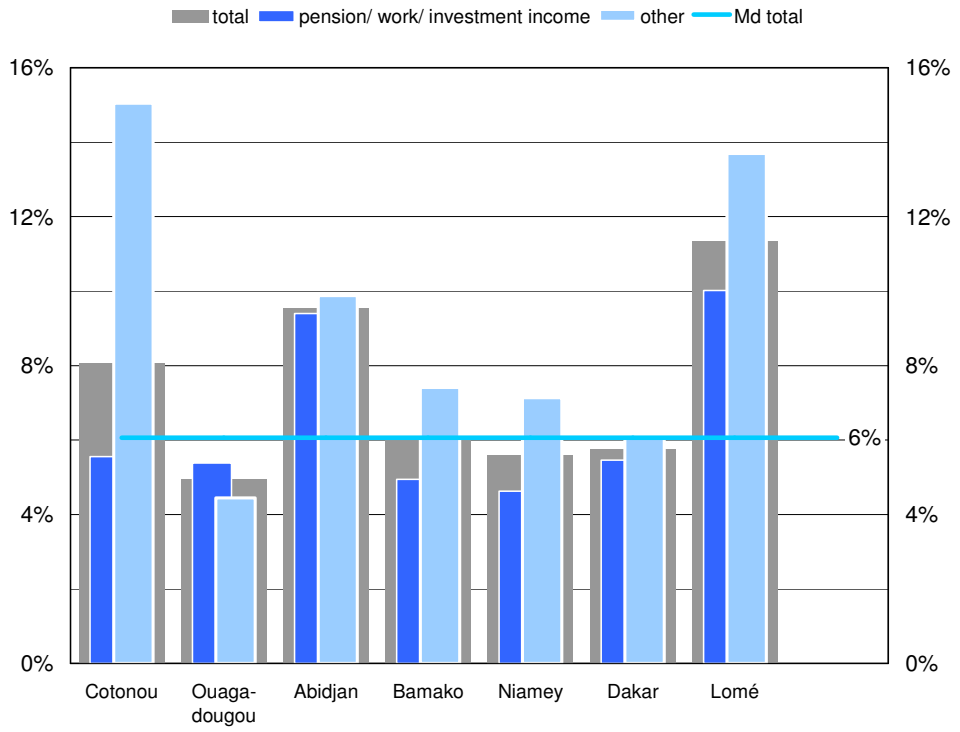
SOURCE: see box

- ***Moderate effects of private transfers***

Some studies on solidarity in Africa stress the importance of mutual family or private aid in general terms, arguing that this makes up for the lack or low level of public social welfare. If this is the case one would expect elderly people who do not have income from an annuity or pension to benefit more than others from transfers from other households [12]. What is the reality?

The proportion of elderly people who stated that they receive income from people outside their households is about 6 per cent in the cities as a whole (figure 2.9).

Figure 2.9 — Percentage of people aged 60 plus who receive help from outside the household in 7 capitals of the member countries of UEMOA, situation in the 2000s



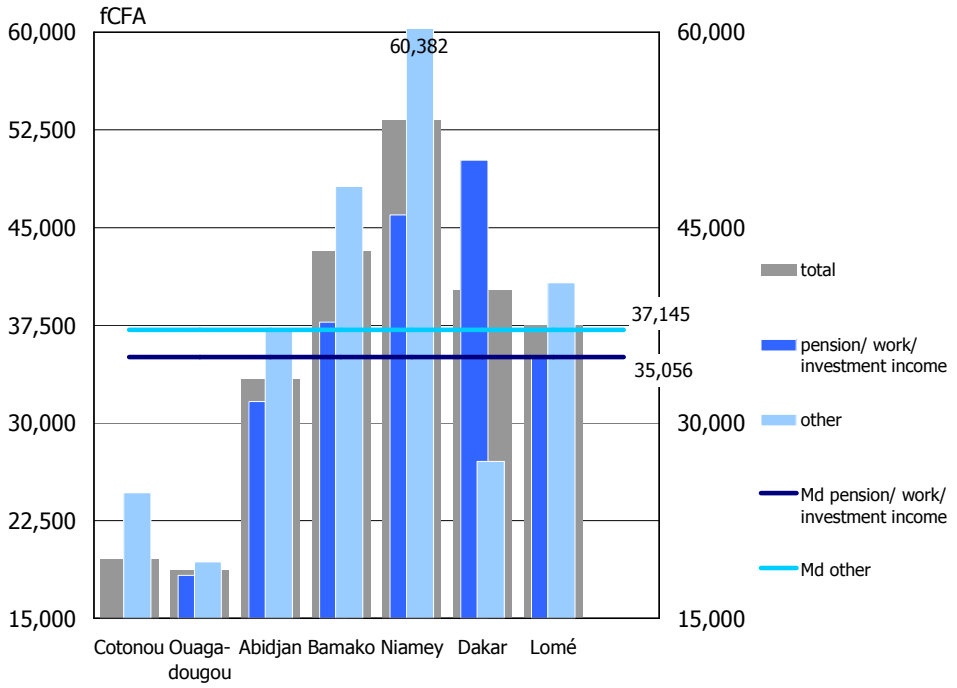
SOURCE: see box

This proportion is at its highest in Lomé, Abidjan and Cotonou (11%t, 10% and 8%), while it ranges between 5 and 6 per cent in the other cities. As is the case for investment income, the elderly who do not have other sources of income (work, pension, investment income) are not particularly favoured. In the cities as a whole, 8 per cent of elderly persons with no other source of income had received income from people outside the household, compared to 7 per cent for those having one of the three sources of income. It is in Cotonou and Lomé that many elderly people without

resources receive help (14 and 15% respectively, as opposed to 6% for those who already have other resources in Cotonou and 12% in Lomé). In the other cities, they are not favoured more than the others.

As is the case for certain sources of income, the people who benefit from transfers received not insignificant monthly amounts (figure 2.10).

Figure 2.10 — Average monthly amount of private transfers (in CFA francs) received by elderly people in 7 capitals of the member countries of UEMOA, situation in the 2000s



SOURCE: see box

In the West African cities as a whole, the average transfer received was 36,000 CFA francs per month and per person in question, i.e. more than half the sub-region's average monthly wage. Apart from in Cotonou and Ouagadougou where the average transfer amount is half the size (about 17,000 CFA francs) of the amount for the cities as a whole, the other cities show amounts that are at least 34,000 CFA francs. It

should be emphasised that the beneficiaries who do not have other sources of income do not receive significantly different amounts from those who do.

5.3. Dependants and economic situations of the elderly

The subject of the dependants of the elderly or, to be specific, of retired people is worth tackling at this point. However, an analysis of dependants requires more detailed demographic data to be taken from past censuses or national surveys that included the question of elderly people. Nevertheless, at the current stage of the analysis of the dependants of the elderly, we referred to secondary data from the study by Tao and Diallo [13] with regard to the average family size for retired people. These data are to be regarded with a certain scientific caution, however.

According to this study, elderly people are responsible for an average of 8 children under the age of 15, while this average generally varies between 3 and 6 children under 15 in the majority of sub-Saharan African countries. This situation can be partly explained by the practice of polygamy which enables men to procreate for practically their whole life. It is evident that the large number of dependants that these elderly people have in their households requires domestic expenditure that should be above the national average. How can the needs of children – especially their needs in terms of schooling and health – be met when one is retired? It may be assumed that children in households whose main breadwinner is a retired person have difficulties in going to school or receiving any health care. Therefore the contributions made by young people and women in households headed by retired people cannot be ignored. As a result of this contribution mutual aid links may be established between the young people and the head of household who is retired or cannot really afford to provide for the needs of his family, especially the youngest members.

It is from this point of view that one could investigate in more detail the question of work carried out by children and women as an additional source of income for the domestic economies of households headed by retired people. Thus Tao and Diallo in the case of the retired found that 62.3 per cent of retired people stated that they had at least one working child under the age of 18. However, having children who work does not necessarily mean that these retired people expect to receive any support from them. These two authors mentioned that some surveys show that the important thing is not so much the support that they may receive from the children but the fact that their children are not dependent on them; in other words the key point is that the child ceases to be a burden.

6. Some general problems encountered by the elderly in Africa

The problems encountered are found at several levels. At the administrative level, retired people consider that there is a lack of information with regard to setting up a file for the pension: "*I didn't know you had to set up a file – I waited a year to get my pension*" (man, Ouagadougou). Some people also lament the high cost of files to which is added the difficulty of providing all the documents requested. The problems encountered by retired people also relate to the change in the way wages are received, being paid on a quarterly basis instead of a monthly one. This comes as a shock for some people who are no longer able to organise themselves and therefore to meet their basic needs properly. In addition it is impossible for retired people to take out loans with their bank.

Furthermore, retired people mention a certain contempt towards them from their former colleagues and the authorities: "*If you say you are retired people see you as somebody who is worn-out*" (man, Ouahigouya). "*People turn their backs on you when they see you coming. The Territorial Authorities are particularly ungrateful; when a retired person dies they don't even bother to announce it.*" (man, Ouagadougou). Therefore they feel that there is a lack of recognition for them on the part of the authorities.

At the level of health, retired people state that their main ailments are rheumatism and sight-related health problems. Other retired people explain the deterioration in their health by other factors – malnutrition and a feeling that they have been abandoned by members of their families, or more specifically their children. This affects them psychologically.

7. Looking ahead: what does the future hold for the elderly of tomorrow in Africa?

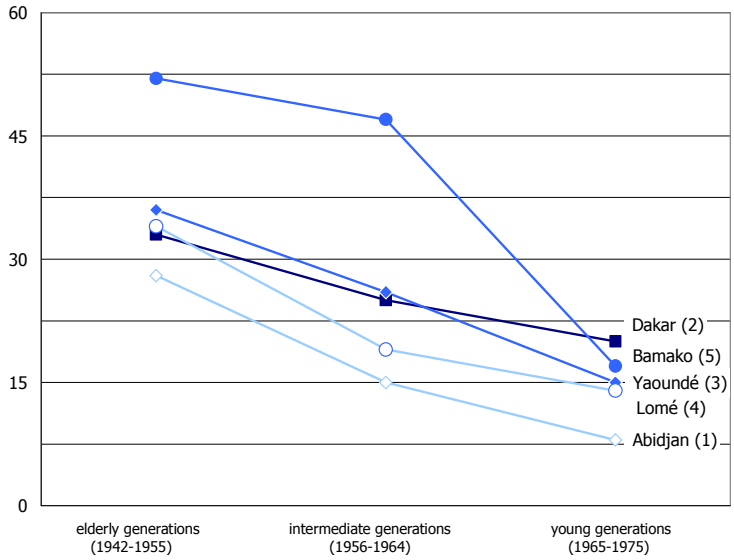
We have shown above that those who have a pension or a fairly comfortable retirement represent only a minority of the elderly. The chance to receive a pension is largely determined by the conditions under which a person entered the labour market during his youth and adult life. Likewise, the labour market situation for young people and adults today will determine, to a large extent, their living conditions in old age. In order to look at what these conditions might be like in the future, we use the biographical data collected between 1996 and 2001 in Yaoundé (1996), Abidjan (1996) Dakar (2001) and Lomé (2001) (see figure 2.11). For each individual surveyed these data track all the changes — including professional changes —that occurred in their life from their birth to the time of the survey. They cover generations in which the youngest people are 25 at the time of the survey and the oldest are 45 (for Abidjan)

and 55 or over (for Yaoundé and Dakar). Therefore it is possible to determine the conditions under which the oldest generations entered the labour market during their youth and to compare them to the conditions for the younger generations.

In order to know whether or not a job enables a person to benefit from a pension in his old age, there would have ideally been a question in each survey on whether or not contributions were being paid to a pension fund. Only the Abidjan biographical survey and, to a certain extent, the Yaoundé survey asked this exact question. In the other cities, we have to decide whether a job would offer a pension according to the type of undertaking: public sector (administration or company) or a large private firm. It should be emphasised that not all individuals working for large formal companies have pension contributions. Therefore the results must be regarded as an estimate of the maximum number of working people putting money into a pension.

Figure 2.11 — Changes in the proportion of people who, at the age of 30, contributed or were in a position to contribute to their pension, in 5 capitals of the member countries of UEMOA, situation in 2000

SOURCE: see box



NOTE: (1) pension contributions only; (2) formal sector, men; (3, 4) large companies or public sector; (5) social security contributions

It is apparent from the analysis that there has been a significant decline from one generation to another in the proportion[14] of individuals who will be able to receive a pension during their old age. Irrespective of the metropolis under consideration, the

proportion of men [15] who will be able to benefit from a retirement pension is at least halved when going from the oldest generation group, that of the parents, to the youngest group, i.e. that of the children. Thus, in Abidjan, the proportion of men contributing to a pension changes from 45 per cent for people born between 1950 and 1954 to 11 per cent for those born between 1965 and 1972, i.e. a fourfold decrease in the space of thirty years. In Yaoundé, for roughly similar generations, the decline is less severe but remains sizeable nevertheless, with the number of those belonging to a social security organisation reducing by "only" half. It decreases from a figure of 55 per cent in the cohort born between 1942-1951 to just 22 per cent in the cohort born between 1962 and 1971.

In the other cities, the questions asked make it possible instead to identify the type of firms where people work and here too the changes are a sharp reduction in the proportion of individuals working in the modern sector, where it is known that a good proportion would be able to aspire to a pension upon retirement. Between the generations of the parents and those of the children in Dakar, the fall is also substantial (from 53% to 35%).

Women's membership of pension or social security funds has never been significant. In the older generations 10 to 15 per cent — those who worked in the modern sector — belonged to the social security scheme. This situation — already far from brilliant — deteriorated in the children's generation in which a maximum of only 8 per cent of women can hope to have a pension in their old age. The decline is less marked only in Dakar, where 14 per cent of young women work in the modern sector.

Finally the situation of today's young people has deteriorated on the labour market in comparison to that of young people in the 1960s and 1970s. Other data, specifically the data from the work surveys that we used above (cf. paragraphs 4 to 5.2), even if they do not make it possible to define the time dimension, also reach the conclusion that young people occupy very precarious positions on the labour market, with over 80 per cent of them heading straight to the informal sector (Brilleau *et al.*, 2004). Even if they obtain jobs with firms in the private or public modern sector, they are not always covered by social welfare (Merceron and Torelli, 2007). These latter authors show that, in the case of the city of Yaoundé, over half of the wage-earners in the modern sector do not have an employment contract and that even in the public sector around 6 per cent of workers are in this situation.

We saw above that only a proportion of the elderly who entered the labour market on relatively favourable conditions, could rely on a retirement pension or investment income. Furthermore, some elderly people, particularly women, only survived thanks to the solidarity of other members of the family, presumably adults who are working.

Increasingly large cohorts of individuals will reach the third age (cf. Schoenmaeckers' chapter). In fact, according to demographic projections, sub-Saharan Africa, which currently has close to 40 million people over 60, will have over 80 million in 2025 and almost double that in 2050. If the conditions that exist on the current labour market continue, almost all of these 160 million elderly people will run an enormous risk of living under extremely harsh conditions as:

- they will not have contributed to a pension or have been able to make investments;
- in a precarious labour market, they will not be able to rely on family solidarity from those of working age.

8. Conclusions and recommendations

Given the population momentum, it is practically certain that the next cohorts of elderly people will be increasingly large. Enabling these people, who are vulnerable due to their age, to have decent living conditions will require strong policy actions at the level of the labour market, which is far from being the case at the current time. In our opinion two additional measures could be implemented:

- The first would consist in extending social security from a tiny minority of beneficiaries to all working people, including those in the informal sector. For several years the ILO has been initiating discussions on this subject but they have always hit a stumbling block with regard to how such a system would be financed. While external support may be necessary to develop the system in the short-term, it must be able to be self-financing in the medium-term in order to be viable. This self-financing could come from adding a social security deduction onto any direct or indirect tax. With regard to the informal sector, in particular, the African States have been encouraged for around a decade, at the instigation of the Bretton Woods institutions (World Bank, IMF), to cover the whole of this sector via appropriate taxation. It is absolutely essential to graft deductions with a social dimension onto this taxation, which would enable all working people to benefit from a minimum level of cover for illness and old age, regardless of their sector of activity. As a precondition to making and managing the deductions in an appropriate manner, institutions and good governance must be strengthened, and this is our second recommendation.
- It is true that at the present time the majority of African countries are suffering from a lack of good governance and vitality in the various institutions and authorities. The international organisations have also put strengthening the institutions and democracy at the heart of new development policies. In the area of retirement

benefits in particular, sound and rigorous management of the funds collected is a requirement that is far from being observed in Africa, as is demonstrated by the pension fund failures in certain African countries during the 1990s. The absence of reliable and efficient institutions creates a climate of suspicion towards the State on the part of the population. Therefore, according to the results of phases 2 in the 1-2-3 surveys used above, only half of people working in the informal sector say that they would be prepared to pay tax and would like this tax to be used in social services (health, education) (Brilleau *et al.,* 2004) and not for any operating costs. It will therefore be necessary to restore a genuine climate of trust and to give those making payments a guarantee that their contributions will be used for the social needs of all and not to fund the lifestyle of a small favoured minority.

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Endnotes Chapter Two:

1 See, for example, Chapter 1 of Schoenmaeckers.

2 Other strategies to gain access to prestige and power are based on success in the world of business and/or politics (the two very often go hand in hand).

3 DIAL (Développement, Insertion et Analyses de Long terme - Development Institutions and Long-Term Analysis) is a Paris-based centre for research in developing economies.

4 Except for Mali 2001 and Senegal 1994 for which we use a living standard indicator that is not adjusted for inflation.

[5] UEMOA: Union Economique et Monétaire Ouest Africain (West African Economic and Monetary Union). The member countries of UEMOA are: Benin, Burkina Faso, Côte d'Ivoire, Guinea-Bissau, Mali, Niger, Senegal and Togo.

[6] As some readers may not be familiar with African geography, Abidjan is the capital of Côte d'Ivoire; Bamako of Mali; Cotonou of Benin; Dakar of Senegal; Lomé of Togo; and Ouagadougou of Burkina Faso.

[7] AFRISTAT (Economic and statistical observatory of Sub-Saharan Africa) is a pan-African statistical institute based in Bamako. Its objective is to promote the harmonisation of statistical data and the use of statistical data in Africa.

[8] As we made clear in the box, for each country, the 40% of households with the lowest living standard are regarded as poor. This proportion is not very far from the 46% put forward by the World Bank on the basis of the 1$ a day threshold.

[9] Values derived from the median values between the cities.

[10] At the time this paper was written 100 CFA francs (Communauté Financière Africaine – African Financial Community) was equivalent to 15 Euro cents or 23 USD cents.

[11] Median value between the cities for the 'total' statistic (not shown in figure 2.8).

[12] By considering only material transfers between households any solidarity within the household is not taken into account. This kind of solidarity may, however, be quite important. Other forms of support that are not taken into account are, for example, psychological, help with domestic tasks, care, …. It is clear that the data available do not allow a thorough exploration of all aspects of 'solidarity'.

[13] Results from the survey on the profile of elderly people in Burkina Faso: the case of retired workers, Ouagadougou.

[14] For each generation group, this proportion is calculated for all the individuals in the cohort and not only for working people.

[15] In this section, we present the situation for men first and then the situation for women.

Chapter Three

Ageing Women in a Poor Economic Environment

Nana Araba APT

Contents:

1. Introduction

The well-being of older women has been a prominent item in the agenda of conferences of the United Nations (UN) and women and age care organisations since the First World Assembly on Ageing in 1982. "Elderly women" constituted a key issue of concern in the Assembly's deliberations then, as they were again in the Second World Assembly in 2002, from which emanated the Madrid International Plan of Action on Aging. In a UN resolution, 1982/23 of May 1982, entitled "Elderly women and the World Assembly on Aging", the Economic and Social Council emphasised that elderly women worldwide had suffered from past discrimination and a lack of opportunity, and that in many cases their economic plight was becoming even more serious. The resolution urged that special problems faced by older women such as income security, education, employment, housing and health and community support services, be given explicit and full attention by the Assembly. These concerns were reiterated in the General Assembly Resolution 38/27 of 1983, in which it was recognised that women have a longer life expectancy than men and will constitute an increasing proportion of the older population. Subsequently, governments were urged in the ensuing Plan of Action to develop social services and other policy measures to safeguard the special needs of older women.

This paper reviews the situation of ageing women in economically depressed regions using Africa as an example. In this chapter the words 'ageing', 'older', and 'elderly' are used interchangeably.

2. Women and longevity

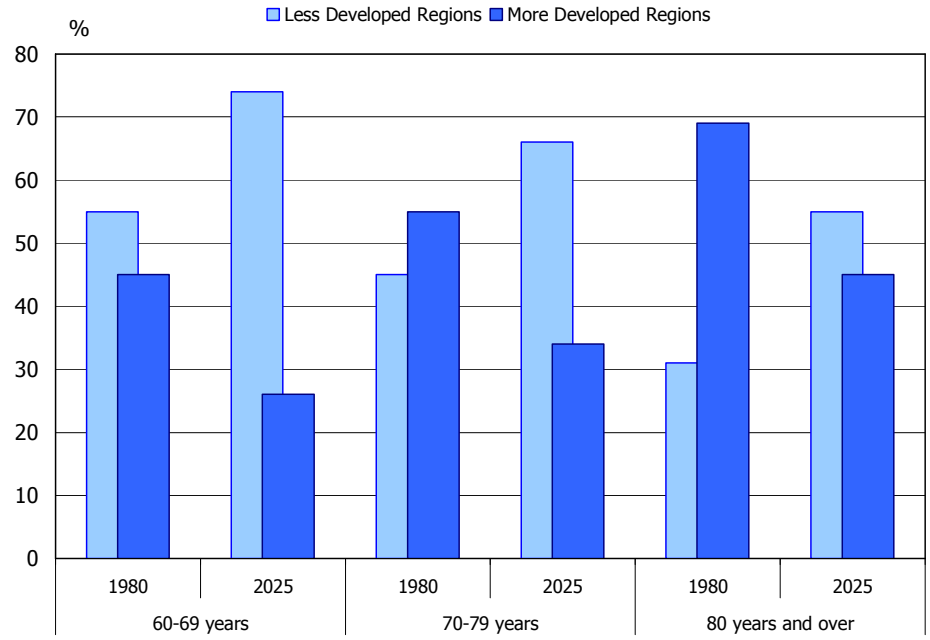
In most parts of the world, women comprise the majority of the ageing population due to their longer life expectancy. At younger ages there are more males than females alive in every age group, but the ratio begins to shift in mid-life. Because men die at significantly younger ages, the gender differential favouring them reverses. This reversal accelerates with age, changing the US population for example from approximately 80 males to every 100 females among 65 year olds to 44 males for every 100 females among 85 year olds (Gist & Hetzel, 2004). Thus, the study of older people, especially the oldest old, increasingly involves the study of older women. Therefore, an 'ageing society' is predominantly a woman's world.

It has not always been like that. Until one hundred years ago, globally, many women died at childbirth. Even though this situation persists in some of the poorer regions of the world, as a result of improved medical science and preventive medicine, life

expectancy of women is now about 10 per cent greater than that of men. This trend is becoming increasingly visible in less developed regions, including Africa.

The discrepancy in life expectancy between men and women is greatest in the more developed regions. Nevertheless, also in the less developed regions, in the next decades, the number of ageing women is expected to rise dramatically. The US Bureau of the Census (2000), for example, projects that by 2025, the number of women aged 60 years and over will increase by 150 per cent in the less developed regions. It is worth noting in this dramatic increase of older women the fact that older women in the world will be living in the less developed regions. At around 1980, the proportion of women aged 60–69 living in less developed regions was not more than 55 per cent; for ages 70–79 years is was 45 per cent; and for ages 80 and over not more than 31 per cent. By 2025, still according to the prospects made by the US Bureau of Census, these percentages will have increased to 74, 66, and 55 per cent, respectively (see figure 3.1).

Figure 3.1 — Changes in the distribution in the world (%) of women aged 60–69, 70–79 and 80 and over, from 1980 to 2025



SOURCE: U.S. Census Bureau (2000)

The policy implications of this dramatic increase of older women in less developed regions should be a subject of great concern, especially since the countries in this part of the world are by far the least prepared for this important demographic shift.

Many theories have been put forward to explain a growing difference in male and female longevity, presently set at approximately 5-8 years in favour of women in the more developed world and 3-5 years in the less developed world. Genetic differences as well as socio-economic factors have often featured in the theoretical debates as affecting men's longevity more than that of women. Nevertheless, longevity in itself is not necessarily desirable for women. Indeed, the fact that a woman may live longer does not always indicate that she is healthier than a man, or that the woman has a better quality of life than a man.

Women's greater longevity often results in a world of older people where a great majority of women are poor, who are often widowed or divorced, and who all too often face physical suffering, economic disadvantage and social exclusion (Heslop, 1999; De Haan, 1998). This situation is especially true in many less developed countries with harsh economic environment. Clearly the problems affecting elderly women in these countries are inseparable from the poverty and chronic hunger, unsanitary living conditions and environmental hazards which confront the population as a whole. With advancing age, women run the greatest risk of suffering from poverty, and are therefore particularly vulnerable to the adverse effects of precarious socio-economic conditions prevailing in their country (Aboderin, 2001).

Globally, older women face many hardships, which are directly linked to their economic condition. Women have a different work history over their working life, and in old age they are disadvantaged by gender-related differences in the allocation of pensions and other benefits. Moreover, in less developed countries, women's work history is typically characterised by low paid jobs and frequent interruptions for reasons of childbearing, child care and family responsibilities. Also, women who were not employed in the formal sector have little or no access to a pension. Especially in African countries pension coverage is limited to a small proportion of the population generally, and to an even smaller proportion of the female population. By contrast, in more developed countries, widows' pension levels are linked to that of their deceased husband

Thus, the added years that women supposedly enjoy over men can in fact disadvantage them. By comparison, older men are frequently cared for by a wife; in polygamous African societies, by multiple wives even. But in order to simply survive, many older women must continue to work into very old age; often they must work not only to support themselves, but also to support younger family members. In Africa, many

elderly women work harder physically after their childbearing years and after they become widowed or divorced, than when they were younger.

3. Ageing women in a poor economic environment: The African context

Sub-Saharan Africa ended the millennium poorer than it was in 1990 (UNDP 2003; 2004). Of the 53 countries that constitute this region, 23 are poorer today than they were in 1975. More so, over 50 per cent of the population lives on less than $1 per day; the large majority live on less than $2 per day (Aboderin, 2005). Bad governance, corruption and ethnic wars continue to deplete scarce resources. Africa has the worst human development indicators in the world (UNDP, 1999; 2005): It has the lowest primary school enrolment (only 60% of children). Only half the population has access to improved water sources. Globally, the continent has the 20 worst performing health systems. HIV and AIDS erode capacity for economic growth. Between 1992 and 2002, South Africa lost $7 billion annually to AIDS-related mortality; in 11 African countries, the disease reduced annual GDP growth by 1.1 per cent (ILO, 2000). Together with the burden of malaria and TB, HIV undermines the potential of human capital. The most economically active segment of the population (those aged 20-44) also tends to have the highest rate of infection. In other words, population ageing in Africa is occurring at a time when its human resources are most depleted. As can be expected, this situation must have negative socio-economic implications for older persons, especially older women (Okatcha, 1999).

Africa's impoverishment is resulting in a deterioration of individuals' living conditions. In many countries, women carry a triple responsibility of raising a family, working to generate income and upholding community structures. Entire generations of African women have been assigned the role of homemaker from a very young age (Apt, 2006). Mothers and their daughters have been responsible for housekeeping chores and food preparation. In rural Africa, the latter entails carrying water, growing and procuring food and providing fuel. As already pointed out, even in old age, women must continue to be economically productive until they are physically or mentally incapacitated and unable to continue their homemaker's tasks.

Throughout their lifetime, African women, especially those living in rural areas, have poor access to resources. The cumulative effect means that in old age they have insufficient resources for a decent quality of life. Their task overload throughout their life also takes its toll on their health. While physical disabilities are often cited as a primary reason for diminished quality of life in old age, it is increasingly apparent that factors such as mental health, retirement policies, social expectations and family

structure, may have a greater impact on whether older women are able to maintain a productive and meaningful place in their society.

3.1. Lack of education

In most African countries, women have little or no formal education. Although education for women may have recently become more equitable for women in urban areas, older women's gravest disadvantage in modern Africa is that they lack education (Apt, 1996). They are less likely to participate in and benefit from national development efforts. Education is an important variable in development not only in its own right but also because it is related to occupation, income, access to credit, fertility and mortality behaviour, health status and health practices, political awareness and participation. A low level of education, or none, has several consequences for them. Informal education may be considered still quite important in an African setting but it needs to be realised that most high-level skills and training can only be acquired through formal education. The level of participation in social and political activities, openness to social change and acceptance of new ideas are all influenced by formal education. Consequently, only formal education may prepare women properly to aspire a decent place in society when they will have reached older age.

3.2. Impact of migration

As already pointed out in Chapter 1 by Schoenmaeckers, because most rural-urban migrants are 'economically active' and relatively young, rural populations have a tendency to age faster than urban populations. In Africa, the heavy rural-urban migration does not only affect the age structure of the rural population, but also undermines the traditional kinship structures that are the basis for the provision of income and care for elderly family members (Kinsella, 2001; Apt and Grieco, 1994). Male-dominant migration strongly reduces the potential of economic support that mothers in rural areas can aspire to obtain from sons. Older women without the support of male offspring have to confront additional challenges for survival, thereby weakening their already frail position in a rural environment.

3.3. Older women's health

Health problems of older African women may be linked to their economic insecurity and social rejection. Often, after many years of physical toil to keep her family going, a frail older woman may be identified by persons in her village or community as a witch and will suffer the consequences (Apt, 1996). This behaviour has been ascribed to a

lack of education and unfavourable traditional practices. The woman, who typically is widowed or divorced, the childless woman, and even married elderly woman, may be displaced (hounded from her home and village), at a time when she most needs care and consolation. An area of concern therefore is the mitigation of marriage norms and unfavourable cultural practices that impact negatively on older women in Africa.

Health and welfare are important elements in women's social participation. In Africa, a woman's health status is compromised from childhood and may suffer poor health throughout her life. This situation is culturally inspired in societies that value males more than females. Inequality among male and female children is widespread. Occupational socialisation begins very early for girls: girls are expected to work with their mother, while boys are allowed to play. As boys need energy, they are encouraged to eat more. Frequently, girls have to leave school in times of a family economic crisis, in order to work to support the education of their brothers (Apt van Ham *et al.*, 1992; Apt, 2006). Some girls must undergo the agony of circumcision with all its implications for sexual health, simply for the benefit of their future spouse. Many girls enter reproductive age without the physical and social maturity needed for childbearing and parenthood and some girls are forced into marriages with partners three to four times their age and reluctantly become mothers. Thus, a girl child who survives the drudgery and pain of childhood must still face challenges posed by long-term implications of the risk factors that women face in a less developed region such as Africa.

Existing and emerging health conditions such as maternal anaemia and malnutrition, sexually transmitted diseases (in particular HIV infection) and repeated pregnancies, compromise women's health in Africa long before old age. Numerous health concerns are specific to women at specific ages, which influence older women's health. For example, vaginal infections, infertility, cancers of the reproductive organs and fibroids have a direct effect on their morbidity and mortality, and increasingly cumulative effects on their already weakened health as a result of numerous (and frequently excessive) childbearing.

Nonetheless, in spite of these chronic health conditions, many older women feel forced to function in supportive roles. They continue to provide important social services such as health care, food and herbs preparation, child care, and continue to take care of their grandchildren. Many act as economic anchors holding the fort while young parents work, or they contribute through unpaid work to the household budgets of the young (HelpAge International, 1999).

3.4. Vulnerability of ageing women

In many African societies, women have unequal and inadequate access to basic services, food and nutrition. They have no rights to land ownership; widowed and divorced women may suffer degradation and extreme deprivation. Due to existing social inequalities, women are often disproportionately vulnerable to hunger. While they produce 60-80 per cent of food in most developing countries and more than 80 per cent in Africa, they own only 1 per cent of the land and receive only 7 per cent of agricultural extension time and resources (Sanchez *et al.*, 2005: 5). Although some elderly women's needs may still be met by family members, there is growing evidence of a weakening of support systems. Widowed, divorced and childless women are at greater risk of hardship than married women with children in old age. All these factors have a disproportionate impact on the health of ageing women, most of who depend upon their families for economic support.

Those without children and able relatives are most vulnerable. Increasingly, to a large extent, ageing women without spouse or children are experiencing lack of abilities and declining social power (Apt, 1992; 1995).

The following case studies, from Kenya, Egypt, Ghana and Mozambique depict instances of cultural victimisation of older women who are widowed, single or divorced. Miriamu, the first case study, represents a typical case of an unschooled ageing widow without pension or any other securities, who must continue to eke a living from the land for herself till physical disability renders her unable to continue working and now survives on the charity of occasional visitors. Samia Nasser, the second study, is a typical case of an African woman divorced to make way for a younger wife. She is cast out of her erstwhile comfortable family home without reasonable financial support from her husband and is forced by her circumstances to share a crowded flat with another divorcee. Zinabu Wumbli represents a typical African case of cultural branding as a witch and driven out of her home and village, while Firmina also branded as witch is cut off from her son's family:

> ***Mariamu*** *was born around 1900 and lived among the Samia of Kenya. Miriamu's husband had died many years before and she was forced to live without significant resources in the village compound (along with two co-wives). Of the four children to whom she gave birth, two grew up to maturity but one, a son, died in 1965. Miriamu's co-wives, younger and stronger, still grew their own food and lived in separate houses. Mariamu however was nearly blind from cataracts and in generally frail condition – unable to leave her tumbledown dwelling. Her roof leaked and there was a gaping hole in the wall (letting in the cold night air). She was naked save for a dirty, ragged blanket. She survived as a result of occasional visit from her daughter (who was*

married and lived a day's journey away), occasional food from her co-wives and a nearby stepson and the receipt of a little assistance from outsiders.

[from Maria Cattell, 1990]

Samia Nassar *was 61 years old, living in Melt-Okba in the governorate of Giza in Egypt. She was divorced but had two daughters whom she saw frequently. She rented a shared apartment on the ground floor of a three-floor building with another woman who was 65 years old and also divorced. Their apartment consisted of two regular rooms, a hall, a bathroom and a kitchen. Samia Nasser's room was about 3x3.5 meters. It was not well ventilated, with only a small window covered with a net to keep out insects. The room had a tiled floor and contained a small bed with a mattress, a cushion and a sheet. In different corners of the room were a sofa, a closet, a sewing machine, a refrigerator, a stove, a cooker and a cupboard. The kitchen was used as a storeroom and the hall as the other woman's kitchen*

[from Adel Azer and Elham Afifi, 1990]

Zinabu Wumbli *was a woman of approximately 60 years. Her real age is unknown. Zinabu lived in the Kukuo Witches Home in the Bimbilla district of the Northern Region of Ghana. Zinabu who looked much older than her estimated age, was married and had seven grown up children, four males and three females. Until five years ago, Zinabu was living with her husband, her sons, their wives and children in their patrilineal home in Bimbilla. Why was Zinabu living as an outcast in the witches' home? She said there had been an outbreak of cholera in the section of the town where she used to live with her family resulting in massive deaths of young adults and children. Through soothsayers, she was accused of being the witch responsible for the deaths and was banished from her home. Zinabu lived in a single small round mudroom roofed with thatch. There was no furniture in the room but a mat, which she used as a bed. She lived with her granddaughter, the child of her eldest son, given her by her son to assist her while in banishment. This old woman virtually lived from hand to mouth through her own initiative and that of her granddaughter. To eat, she either worked on the village chief's farm in return for food or gathered firewood for sale*

[From Nana Araba Apt, 1996].

The northern region of Ghana is the most economically deprived region in the country. In its rural areas, disruptions in the health, wealth or fortune of a community can lead

to allegations of witchcraft against older women in particular. Witchcraft accusations are not unusual events in Africa. They are certainly not limited to Ghana (or western Africa), as the following interview in Mozambique illustrates:

> ***Firmina T.*** [72 years old and accused of being a witch]: *"I don't know how many grandchildren I have because my son doesn't tell me when they are born, nor even show me the child. I have asked them many times to give me a grandson who could take care of me, but they refuse saying I am a witch. I don't know who started this story, my son or my daughter in law".*
>
> [from da Silva, 1999].

3.5. The burden of AIDS: care of orphans

Regionally, the following grim picture on HIV/AIDS exists (UN 2001; UNAIDS/WHO, 2004). Africa currently has 10 per cent of the world's population but 63 per cent (12 million) of global HIV/AIDS cases. As a result, the pandemic is over-burdening the already scarce resources that are available as, on average, 3,800 adults in Africa are infected daily with AIDS. The regions that are being most affected are Eastern and Southern Africa. Older persons are increasingly at risk of contracting the disease. AIDS has lowered average life expectancy levels by as much as 10-17 years in some African countries. Hardest hit is Zimbabwe where AIDS has reduced life expectancy by more than 20 years. Expected increases in life expectancy may not occur if AIDS-related mortality continues at present rates.

World Bank (1999) estimates of the increased life time risk of dying from AIDS in selected African countries are as follows (in increasing order):

Ethiopia	11%	Malawi	43%
South Africa	24%	Botswana	44%
Kenya	31%	Zimbabwe	53%
Uganda	35%	Zambia	68%
Tanzania	39%		

Since the start of the AIDS pandemic in the eighties, some 13 million children in Africa have been orphaned through their parents' dying as a result of AIDS. The number of AIDS orphans will continue to grow in countries where the epidemic is still gathering

momentum. A striking feature in AIDS orphan care in Africa is the proportion of older women who fill the role as family care givers.

In Africa, grandparents, most particularly grandmothers, must take responsibility for the cost of medical expenses and then of the care of orphaned children when their adult children die of the disease. In all circumstances taking care of infected adult children and the general care of grandchildren after the death of their parents, would be a source of added stress for the already vulnerable older women. But in an impoverished region with limited and unequal health care systems, such a situation has serious implications for the health status of the older women themselves.

Above all, it is estimated that 95 per cent of Africans infected with HIV/AIDS live in abject poverty and upon the death of economically active breadwinners no resources are left behind for caregivers who are mostly grandmothers, old, and disadvantaged (HelpAge International, 2003). The socio-economic impacts of raising their grandchildren, providing financial and material support at a time when they themselves might need care and have lost old age support provided by their deceased children have not yet been fully appreciated by policy makers. The physical and emotional stresses endured by these grandmothers doing their duty nevertheless are examples of the sacrifices women in Africa make throughout their lifespan.

4. Conclusions and policy recommendations

How significant is the impact of global ageing on women in poor economic environments? The impacts are overwhelming and the UN recognises this. As mentioned in the introductory paragraphs, at the Second World Assembly on Ageing in 2002, a new Action Plan on Ageing was adopted namely, the Madrid International Plan of Action on Aging, or MIPAA. It was adopted by no less than 159 countries of both the developed and developing regions [1]. Among others, the Plan calls for changes in attitudes, policies and practices to benefit the growing number of older populations. Implementation of the Plan requires commitment and political will from all governments, from both 'North' and 'South' of the globe including developing regions.

The implementation of the Plan will be extremely difficult. This will be especially the case for the poorer countries in the 'South'. For one thing, they will be facing limited resources; and financial assistance from the richer countries of the 'North' is scarce. In spite of the dramatic increases in the numbers of older people, the fact that, compared to the proportions of older people in the more developed regions, the proportions in the less developed regions are still relatively low [2] is apparently the explanation for the

lack of an international programme on population ageing that could be the basis for coordinated action at the global level.

It cannot be denied that the proportions of persons aged 60 and over in Africa are still relatively low (5.3% at current estimates for Africa; 4.9% for sub-Saharan Africa). However, to correctly assess the seriousness of the situation one also needs to take into account the economic and cultural context in which the demographic changes take place. This is what we have tried to do (briefly) in this chapter.

To conclude, it is clear that the increase in the overall numbers of older people will strain every aspect of our global society from families, to communities, to nations. It is, therefore, critical that systematic programs of research, training and welfare services be developed that attend to every dimension of our society affected by population ageing. We wish especially to formulate the following recommendations for further actions:

Recommendations:

- Improved quality of life for older women can only be achieved through an understanding of the relationships between biology of ageing, age-related conditions and social characteristics. While the impact of rapid socio-economic change on traditional support systems is becoming more manifest, there is a serious lack of data documenting the conditions and needs of ageing women, particularly those left behind in rural areas where most of the older population lives. Studies in this respect could provide a basis for social policy actions.
- Income generation opportunities need to be created for older women to tackle their poverty situation. The ageing of African societies requires a change in traditional gender arrangements where women's financial position was mediated through their male partner. Programmes and policies which endow women with social and economic resources at the point of widowhood provide an opportunity for women to negotiate better care and support within their own kinship structure. Thus, women's greater longevity calls for the development of appropriate education and training based on gender considerations.
- Gender and ageing should be critically discussed as part of poverty alleviation strategies in Africa. The domestic character of women's life in Africa frequently leaves them unprepared for entering the public sphere on the death of a spouse. Strategies must be developed to enable older women to participate actively in public life through training. Orientation and self esteem courses are needed for women within their education at younger and older ages.

- How to enable older women to be less poor and to take an active part in public life should constitute social policy questions on ageing in Africa. Investment in women in earlier life stages within families and communities and at macro-level institutions can generate the capital needed to sustain ageing women as agents and beneficiaries and for reinvestment back into society for continuing development.
- Finally, building public awareness about the demographic shift and the issues that surround the rapidly increasing ageing populations in developing countries can provide leaders of these countries with the mandate and support they need to take action.

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Endnotes Chapter Three:

1 The MIPAA is available at http://www.un.org/esa/socdev/ageing/madrid_intlplanaction.html.

2 See the comparison of the evolution and the current proportions of people aged 60 and over in Chapter 1 by Schoenmaeckers.

Chapter Four

HIV/AIDS in an Ageing Society: The Challenge of Care for Older People in Africa

Dolline BUSOLO and Tavengwa M. NHONGO

Contents:

1. Introduction

The HIV/AIDS pandemic has had devastating consequences for families across the African continent. In 2006, almost two-thirds (63%) — or no less than about 24.7 million — of all people in the world living with HIV were found in sub-Saharan Africa. The 2.1 million AIDS-related deaths in sub-Saharan Africa represent 72% of global AIDS deaths. In 2006, about 2.8 million adults and children became infected with HIV in sub-Sahara Africa; this number outnumbers the total of infections in all other parts of the world (UNAIDS, 2005) [1].

As young and middle-aged kin infected with the HIV virus have succumbed to AIDS-related diseases, family structures are being affected. Older family members have had to assume care responsibilities for affected young children. Indeed, numerous older persons are now central to the survival of the increasing numbers of orphaned and vulnerable children as well as the care for sick adult children. Many older women have become Africa's 'newest mothers'; they have become responsible for providing economic, social and psychological care and support to orphaned grandchildren.

The care responsibilities these older people must assume place an enormous burden on them. Often they assume these responsibilities without adequate knowledge, resources or support. They commonly suffer physical, health and emotional effects from the strain of care-giving. The roles they play and the contributions they make through care giving are typically unrecognised and/or unsupported. They are often unable to meet their own health care needs – let alone those of the people for whom they are caring (Nhongo, 2005).

The African continent is bedevilled with multiple effects of economic decline, natural and man made disasters and changes in cultural and social values. Many countries in the continent equally and typically lack policies and legislation to protect the needs and rights of older people. Older people's health and the provision of health care constitute a huge challenge while the negative impact of HIV/AIDS has made their situation even more critical.

This chapter highlights the situation of older people in Africa affected by the pandemic; examines some of the issues that affect older people, especially their health; and highlights the burden that the epidemic and its consequences place on them as carers of Persons Living with HIV/AIDS (PLWHA) and Orphaned and Vulnerable Children (OVC). Recommendations are focused on how their situation may be addressed.

2. The situation of older people in Africa

The population aged 60 years and over [2] is increasing rapidly in all parts of the world. In the more developed regions, persons aged 60 and over currently already represent one-fifth of the total population (UN, 2005). Sub-Saharan countries show much smaller proportions: the highest proportion is observed in South Africa and is below 8 per cent (see table 4.1). However, other Sub-Saharan countries are catching up fast with the more industrialised countries. According to the US Census Bureau (2007), over the next 25 years the annual growth rate of the population aged 60 and over will increase from slightly more than 2 per cent today to nearly 4 per cent. (By contrast, for developed countries the annual growth rate is currently less than 2% and will decline to less than 1% over the same period.)

Table 4.1 — Per cent population aged 60 and over in selected sub-Saharan Countries, in 2006

Country	Percentage	Country	Percentage
South Africa	7.9	Mali	4.9
Lesotho	7.0	Senegal	4.7
Central African Republic	6.0	Tanzania	4.4
Botswana	5.5	Kenya	4.0
Ghana	5.2	Burkina Faso	3.9
Zimbabwe	5.1	Zambia	3.7
Cameron	5.0	Uganda	3.3

SOURCE: US Census Bureau (2007)

Over the next 25 years, sub-Saharan countries will experience a near doubling of the number of people aged 60 and over, from over 35 million in 2006 to over 69 million in 2030. Table 4.2 shows the number of persons aged 60 and over in 2006 and projected in 2030 for countries where the current number is one million or more.

With 6.6 million in 2006, Nigeria has by far the largest number of older persons of all sub-Saharan countries. It is closely followed by South Africa and Ethiopia each with over three million older people. Nigeria, with a population of 134m as of 2006, also ranks among the top 20 countries in the world with respect to total population size.

The increase in the population of older people has implications for governments and other stakeholders to include ageing into the development agenda and make provisions to address the emerging needs of older people, the most important ones being related to health, housing and food security. Furthermore, these broad

demographic processes are accompanied by other changes — shifting disease patterns and new health threats, macroeconomic strains, emergent technologies, changing work patterns, social norms, and cultural practices within and between societies.

Table 4.2 — Population aged 60 and over in sub-Saharan African countries with a number exceeding 1 million

	Number of people aged 60 and over (in millions)	
Country:	as observed in 2006	as projected for 2030
Nigeria	6.6	12.3
South Africa	3.5	6.6
Ethiopia	3.3	4.8
RDC (République Démocratique du Congo, *Democratic Republic of the Congo*)	2.6	6.1
Tanzania	1.7	3.3
Kenya	1.4	3.7
Ghana	1.2	2.9

SOURCE: US Census Bureau (2007)

- ***Social and cultural changes***

Older people worldwide suffer neglect, abandonment, destitution, homelessness, diminished participation and loss of status. In sub-Saharan Africa, the combined effects of modernisation, industrialisation, urban to rural migration, social and political instability, and lately HIV/AIDS have significantly changed societal and cultural views on older people. The negative views that society has on ageing and older people and the weakening family support structures are contributing to the major factors that exacerbate their plight. From a position in Africa, for instance, where older people were respected and honoured and it was a blessing to have them around, they are now seen as a burden, an inconvenience and targets of elder abuse (Nhongo, 2004). In many African countries including Tanzania, Burkina Faso and Ghana, older people have been accused of witchcraft leading to their isolation, assault and murder. This has contributed to their insecure livelihoods as well as feelings of worthlessness and powerlessness (see HelpAge International or HAI, 2006a) [3].

- ***Rising poverty levels***

Between 1990 and 2001, the proportion of those living on less than US$1 per day has risen from 44.6 per cent to 46.4 per cent (Chronic Poverty Research Centre, 2005; May, 2003). Preliminary findings in the same report indicate that, on average, 30-40 per cent of the poor in sub-Saharan Africa are chronically poor. According to the International Labour Organisation (ILO, 1997 [4]), older people are the poorest in every community. In the case of sub-Saharan Africa, the situation of older people has been compounded by poor economic policies and discrimination against them.

The absence of any form of social security provision in the majority of countries has worsened the situation of older people. As a consequence, the majority of older people in the continent lack any form of regular income. Moreover, they are routinely denied employment opportunities and typically do not participate in income generating activities supported by governments or donor organisations. Informal and rural agricultural sectors in which the majority of older people engage are generally neither regulated nor supported. Only in five sub-Saharan African countries do eligible older citizens receive social pensions; these countries are: Lesotho, South Africa, Namibia, Botswana and Mauritius. Other countries have pilot cash transfer initiatives, which have potential to contribute significantly to poverty alleviation in affected households. Zambia currently has five pilots with the most celebrated one being in the Kalomo District (Schubert, 2004)

- ***Exclusion in emergency responses***

When nations are caught up in political strife, conflicts and coups, older people's well-being and security are threatened. Disasters such as earthquakes, droughts, and other natural calamities heavily disrupt the existing survival patterns of any community group, but older people are always hardest hit (Apt, Bester & Insley, 1995). Moreover, when older people are displaced to live in camps as refugees, their needs and circumstances are not always given due attention (Nhongo, 2000).

The disruption and/or loss of support structures have a negative impact on older people's ability to access food. Once these structures are broken down, community capacity to care for its most vulnerable members becomes untenable. The disruption of family structures result in older people experiencing major changes in their roles, responsibilities and social status. Furthermore, it is often harder for older people to adapt to new and unfamiliar foods than it is for young people.

- ***Policies and legislation***

It is almost without doubt that the plight of older people in Africa is directly linked to the absence of policies and legislation aimed at protecting their interests. As shown in table 4.3, only a handful of countries in Africa have developed policies on ageing with a few others in the process of doing so.

The absence of such policies in many sub-Saharan African Countries has impacted negatively on the health and general welfare of older people. There is minimal provision for older people within national budgets particularly for social protection provisions (Nhongo, 2005).

Table 4.3 — Policies on older people in Africa

Country	Policy status
Benin	In progress
Cameroon	Process initiated
Ghana	In progress
Guinea	In progress
Kenya	Submitted to Cabinet
Mauritius	In progress
Mali	Completed
Mozambique	Completed
South Africa	Completed (Bill)
Tanzania	Completed
Tunisia	Completed
Uganda	Before parliament
Zimbabwe	Back to Ministry for wider consultation (Bill)

SOURCE: Nhongo (2005)

- ***Poor access to health care***

Health care is a cause of considerable concern for most people in sub-Saharan Africa, especially older people and their dependents. The World Health Organization has reported (WHO, 2005) increases in dementia, cardio-vascular diseases and Alzheimer's. Poor living conditions, unfamiliarity and inadequate access to the nearest health care services, few geriatric and psychiatric professional centres and facilities compounded by limited mobility and language barriers constrain access to health care for older people and their dependents. By far the biggest problem that older people

face in the area of health is the cost and access to health services (Nhongo, 2005). The attitude of health personnel is so negative that older people are reported to prefer to die rather than go to the nearest clinic (HAI, 2007a). Health care providers abuse older people by denying them their rights to health. In Ghana for instance, the National Health Insurance Scheme (NHIS) exempts older people over 70 and their dependents from paying minimum premiums, yet eligible older people continue to be indiscriminately charged for the premiums since they are unaware of these exemptions.

- ***Traditional medicine***

Traditional medicine is lately experiencing a dramatic renaissance. The phenomenon is not limited to developing countries but also occurs in Western countries (WHO, 2005). Worldwide, traditional medicine is used to treat chronic pain and to improve the quality of life of those suffering from incurable diseases. Current estimates suggest that, in many developing countries, a large proportion of the population relies heavily on traditional practitioners and traditional medicines (WHO, 2005).

Traditional healers play a key role in reproductive health and in the care paradigm for HIV/AIDS in sub-Saharan Africa. Many older carers are more predisposed to access health care from traditional healers for themselves and dependents given its proximity and familiarity to them. In Benin a high proportion (44.1%) of older men and women access the services of traditional healers irrespective of their illnesses, particularly those in rural areas. According to Nadia and colleagues (2004) traditional healers in the rural areas are easily accessible. Flexible debt payment, proven record of healing, confidentiality, privacy and care accorded to the clients by traditional healers lure older people to their services. Many traditional healers however tend to acknowledge that they have limited information about the transmission, prevention and treatment of HIV/AIDS (HAI, 2004a); many relate HIV/AIDS to the practice of witchcraft or generational curses.

In its work with Traditional Healers in such countries as Zimbabwe and South Africa, HelpAge International (HAI) has observed that the challenge is that traditional medicine is often linked to conventional medicine and this makes it difficult for its full benefits to be realised (Nhongo & Tewodros, 2007).

- ***The Impact of HIV/AIDS***

Overall, it is clear that the pandemic has a devastating health, economic, social and psychological impact on older women and men (Ferreira 2002). The disease and resulting deaths of young adults are shifting the responsibility of care of orphaned and

vulnerable grandchildren, as well as PLWHAs (People Living with HIV/AIDS) to older persons [5]. Besides, older persons are themselves increasingly at risk of infection with the HIV/AIDS virus. Prevalence data on HIV/AIDS have been limited to the 15-49 year age group. Older persons are typically presumed to be sexually inactive and are not suspected of infection. They do not enter routine surveillance systems and the infection goes undetected. An understanding of their risk to infection and the prevalence of the disease in the older population is critical in policy and programme responses to the pandemic. However, insignificant data and anecdotal evidence gathered on infections of people attending VCT (Voluntary Counselling and Testing) centres are pointing to the fact that older people over 50 years are infected. In Uganda for instance people aged 50 or over seeking VCT-services increased from 3 to 30 per cent between 1992 and 2002 of whom over 20 per cent tested positive (Mukasa, 2006). Data collected from the Lesotho Senkatana Counselling Centre in March 2005, showed that 17 of the 28 people over 50 years old (61%), tested HIV/AIDS positive (HAI, 2005).

- ***The burden of care for ill people living with HIV/AIDS***

Whereas the old paradigm of care at household level in sub-Saharan Africa was for younger generations to take care of older people, HIV/AIDS has seriously reversed this traditional model to the detriment of older people. The capacity of the families to provide care is stretched to the limit by the increasing levels of poverty. Breakdown of traditional support mechanisms due to civil wars, mass population displacement and migration have made the situation worse with grave consequences for older people (HAI, 2000). As can be seen from figure 4.1, quite a high proportion — the median value across countries is 31% — of PLWHA are cared for by older persons (Kalanidhi and Coury, 2003; HAI, 2006b).

WHO (2002) highlighted the long hours devoted to care of PLWHA by older carers. Home-based care, which entailed bathing the sick, washing their clothes, feeding them, turning them in bed, assisting them to the toilet, administering their drugs, accessing health care for them and psychosocial counselling are all borne by the older carers. Accessing and preparing nutritious food, ensuring good hygiene and sanitation with limited potable water are indeed major challenges to the majority of carers in environments with poor infrastructure. In addition, the carers often have impaired mobility and reduced strength due to ageing.

Stress, stigma and trauma resulting from caring for PLWHA and their eventual death contribute to older carers' self-exclusion from the community and social events (WHO,

2002). Their limited skills and knowledge of home-based care and psychosocial counselling, particularly how to deal with the physical, emotional and spiritual needs of the sick, frustrates their care efforts. Stress due to care-giving compromises their health status. While anti-retroviral therapy (ART) may be available and free in some communities, the cost of transport for PLWHA to access the treatment and drug adherence remains a major challenge to older carers.

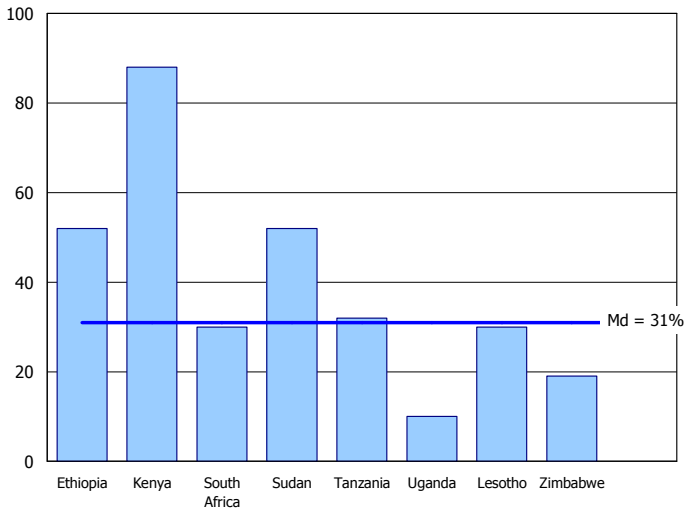

Figure 4.1 — Percentage of ill persons and PLWHA cared for by older people, for selected countries, situation around 2006

SOURCE: HAI (2006b)

The failure of PLWAS to disclose their HIV status to older carers and the culture of older people unwilling to wear gloves during the caring process needs to be recognised as predisposing issues. Evidently HIV/AIDS education and awareness campaigns sideline older care providers as they assume that older people are sexually inactive. Exclusion of older people from mainstream information systems implies that they are not likely to provide correct information to those in their charge, nor can they participate in conveying HIV prevention messages targeted at the youth. These prejudices increase their vulnerability to infection.

A lack of national policies on ageing and exclusion of older people in national HIV/AIDS policies, sector plans, and response programmes, particularly health programmes, further marginalises older carers while bestowing on them the monumental task of caring for PLWAS and OVC.

- *The burden of care for Orphaned and Vulnerable Children (OVC)*

The AIDS epidemic has given rise to a dramatic increase in the number of orphaned children in Africa. More than 13 million children under 15 years have lost one or both parents to AIDS, 11 million of them in sub-Saharan Africa, accounting for 32 per cent of all orphans worldwide (UNICEF, 2004). Across Africa the family is still expected to provide care for most orphaned children (Mupedziswa *et al.*, 2004). A variety of informal mechanisms providing care for orphans and vulnerable children have sprung up lately in response to the OVC crisis without due consideration to existing community-based alternatives for care.

In Kenya, the Children's Department of the Ministry of Home Affairs (Government of Kenya, 2007) is currently running a cash transfer programme for 20,907 caregivers (17,288 female, and 3,619 male), in charge of 64,734 OVC, living in 17 districts all characterised by high poverty and high HIV/AIDS prevalence. The age-sex distribution of the caregivers is given in table 4.4.

Table 4.4 — Proportion of OVC-caregivers by age group and by sex

Age group (years):	Percentage of caregivers	Percentage distribution by sex	
		male	female
Less than 17	0.6	42.0	58.0
18-24	4.9	23.3	76.7
25-49	55.2	15.5	84.5
50 and over	39.3	18.7	81.3
All ages	100.0	17.3	82.7

SOURCE: Government of Kenya (2007)

Most caregivers are found in the age bracket 25-49 (55%) and in the bracket 50 and over (39%). The statistics in table 4.4 also clearly show that the great majority (over 80%) of caregivers are women. In one-third of households, the head is an older person aged 55 and over.

According to the United Nations Children's Fund (UNICEF, 2003) over 60 per cent of the orphans in South Africa and Zimbabwe are living in a household headed by a grandparent; in Tanzania their number corresponds to 61 per cent; in Ethiopia and in Uganda to 35 per cent. In the Cape Flats, South Africa, a study of older carers found that 156 grandchildren below 19 years of age were living with 43 older people. Of the children, 19 had AIDS (Ferreira, 2002). In Mozambique HAI found that 774 older

people were caring for a total of 2,187 orphans (HAI, 2004a). Evidence of extreme physical, emotional and economic strain experienced by older people as a result of HIV/AIDS, and the need for practical interventions to address consequences for older people were highlighted by older people and their families (HAI, 2004a).

Evidence from HelpAge International's work on HIV/AIDS in Africa (HAI, 2006b) has further highlighted the proportion of OVC under the care of older carers. The statistics are presented in figure 4.2. On 'average', no less than 60 per cent of OVC persons would be cared for by older people.

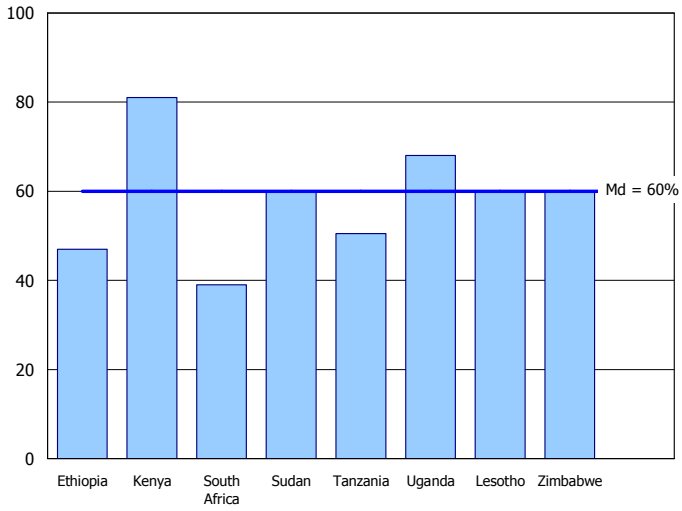

Figure 4.2 — Percentage of OVC persons cared for by older people, for selected countries, situation around 2006

SOURCE: HAI (2006b)

Older people find it difficult to cope with certain childcare responsibilities, such as ensuring regular health check-ups and immunisation against childhood illnesses. This is evidenced by the low immunisation rates registered in families headed by older carers.

Teenage children are under increased pressure to support their siblings by leaving school to find work and earn income to support older carers. Older carers cannot adequately ensure education in their 'new families'. As a result, the rate of OVC school drop out is high and children are often forced into unsafe and poorly paid jobs, or into illegal activities. For example, adolescent girls were reported to engage in transactional or survival sex in Kawempe (Uganda) putting them at increased risk of contracting HIV/AIDS (Mukasa, 2006). Without knowledge and targeted programmes to assist older

carers of OVC, older carers are unable to adequately educate and protect their grandchildren.

The financial security of households headed by older people is compromised when they are caring for dying adult children and very young children. This is because valuable time is spent away from income-generating or -saving activities which in turn lowers the quality of care. The economic cost of supporting the grandchildren often starts as soon as the children start living in the household, but becomes the full responsibility of the older persons following the death of the parents.

Caring for sick children involves considerable expenditure on medical support, both from traditional and hospital-based practitioners. In many cases older people find it a challenge to meet these costs. In rural Mozambique an average monthly cost of care for an OVC is US$21 while the monthly income of an adult is US$12. In Tanga, Tanzania, an older person required US$19 per month in order to care for one OVC, while in an estimated 10 per cent of households supporting OVC are reached by community-based or public sector support programme (HAI, 2006b).

Frequently, older people in sub-Saharan Africa have few forms of support outside the family. Pensions are only available to a minority with jobs in the formal economy or government civil service. Even with the most recent national old age pension schemes such as in Lesotho where pensioners are entitled to US$25, sharing of the income with OVC means it lasts half way through the month. Older carers sell assets (livestock and land) to meet the costs of caring for the sick. With the sale of assets their economic base is depleted and their families are left more impoverished. Loss of remittances that supported ageing parents and OVC has exacerbated household poverty. Older people have limited alternatives to generate income, for example through petty trading. A lack of a national identification card or title deed, particularly in the case of widows who cannot own land and assets and thus have no collateral, limit their ability to secure a loan from micro finance institutions to start a small business or meet contingencies. Prohibitive interest rates of commercial bank loans worsen the situation for older carers.

3. Policy and programme initiatives to support older carers

Since around 1992, a number of initiatives have been implemented all over Africa in an effort to address the effects of HIV/AIDS among older people. HelpAge International has supported programmes aimed at increasing the understanding of older people on HIV/AIDS, increasing incomes and enabling older people to cope with the burden of

care of PLWAS and OVC. The initiatives have also been aimed at influencing the integration of older people in the policies and programmes of other organisations.

- ***Improving the caring role of older people through advocacy and direct programmes***

HelpAge International is engaged in advocacy to influence local, national and international level policy that aim to bring lasting change for older people. Advocacy activities are undertaken in many ways including through the generation and dissemination of research-based evidence information, conducting awareness raising workshops, publications, lobbying with policy makers, etc. These activities have included the engagement of HelpAge International partners at local, national and regional levels in order to mainstream the issues of older people. Taking a rights-based approach, partners have been able to ensure the expansion of services to older people in many countries. The *Older Citizens Monitoring* project undertaken in Kenya, Ghana, Sudan, South Africa and Tanzania is a good example of action taken by older people themselves to influence access to health services.

At the international level, HelpAge International participates and lobbies the inclusion of older people's issues at the UN, the African Union and other forums. Due to HelpAge International's advocacy, the AU Africa Health Strategy for 2008/2009 now has sections recognising older people's role as carers of PLWAS and OVC. The advocacy is concentrated around the following specific activities:

- ***Increasing access to income:*** To respond to the income needs of older people, HelpAge International and its partners have developed programmes that provide intergenerational livelihood support through the provision of grants to enable households headed by older people to generate income. Older people and grandchildren have worked together to run small businesses based on areas of skills older people have and activities that are relevant to them. These have included uniform making, chicken rearing, irrigation, heifer revolving scheme, petty trading such as food vending, retail shops, selling water and goat keeping. A large number of older people have benefited, enabling them to care for their families and send children to school. A review of these activities in 2004 revealed significant impacts on older people such as increased access to health care, increased levels of nutrition and increased participation in community and other activities.
- ***Improving food security:*** In order to enhance food security among older people, HelpAge International has worked with older people and its partners in Zambia, Kenya, Tanzania, Ethiopia, Zimbabwe, Malawi and other countries to provide support to older headed households in the form of agricultural inputs. The support provided has included agricultural training, provision of seeds and fertilisers and support in identifying and accessing markets for the produce. Older people have been able to

plant food through community and family support and entering crop sharing arrangements. These activities have resulted in older people accessing enough food, generate income to support their families and increase community status.

- ***Renovation and rehabilitation of shelter:*** Construction and repair of shelter have been carried out in many countries in Africa to address the shelter needs of older people, PLWAS and OVC. Older people have reported having better acceptance and respect within their communities as evidenced by their ability to host visitors, organise traditional functions at their homes and mix with others.
- ***Social Funds:*** Social Funds are a form of locally generated and owned funds that older people can access to meet their basic needs. The basic premise of the 'social fund' is to provide a resource that communities can use to help meet the immediate needs of their most vulnerable members. These are found in many countries across Africa in which HelpAge International is working, but are quite prominent in Eastern and Southern Africa.
- ***Access to entitlements:*** In countries such as South Africa, Ghana, Kenya, Zambia and Tanzania, there are state provisions that older people are often not aware of but which can provide vital support to older carers and households affected by HIV/AIDS. HelpAge International and its partners has been implementing programmes to create awareness of the existence of the entitlements and how they can be accessed as well as working to support individuals to access the entitlements.
- ***Improving older people's ability to care and support PLWAS and OVCs:*** HelpAge International and partners have conducted HIV/AIDS awareness programmes for older people with basic key messages of transmission, prevention and care to ensure that older people have the resources and skills to protect themselves while providing care. Such training programmes have been crucial in demystifying HIV/AIDS that was often linked to curses and witchcraft issues by a majority of older people.

In support of older people caring for PLWAS, HelpAge International and its partners have designed training programmes that often last between 3 to 5 days to train older people as home-based care givers. Older people are trained on key care skills such as opportunistic infections, basic hygiene, feeding, bathing, turning the sick in bed, basic nutrition requirements, emotional and psychological needs of PLWAs. Trained older people not only care for their own children but also provide advice and support to others in the community. The home-based care givers also receive home-based care kits to supplement their care work. These kits contain pain killers, cleaning detergents, linen, gloves and other basic items.

Following consultations with traditional healers, training programmes were developed and peer support forums established for traditional healers. Traditional healers have been trained to promote safe healing practices – introduced to the concept of gloves, sterilisation of equipment and the non-use of razor blades more than once. By so doing traditional healers are not only protecting the clients but also preventing infecting themselves. Traditional healers have also been introduced to basic symptoms of opportunistic infections such as TB to encourage the referrals of clients to VCTs and TB Treatment centres. Positive results have been achieved in South Africa, Kenya, Zimbabwe and Tanzania where traditional healers have made a number of referrals to other services such as VCTs, TB centres and clinics.

To alleviate the burden faced by older people with respect to sending children to school, HelpAge International is implementing a programme in 13 Eastern and Southern African Countries, providing school fees, uniforms, books and other materials. In addition to supporting the formal education of OVC, HELPAGE INTERNATIONAL and partners is also providing vocational training for orphans that drop out of school increasing their potential to compete in the job markets. Training programmes in vocational skills have been supported with grants that allow the establishment of small businesses.

- ***Recommendations***

(a) Given the increasing number of older people in sub-Saharan Africa and the challenges posed by increased poverty, conflict, HIV/AIDS, a relative lack of income security, poor access to health care, and the devastating effects of living in an unsupportive policy environment, in communities with broken down socio-cultural support systems, it is recommended that African governments and civil society adopt and incorporate the following key policy and programme initiatives in their work with older caregivers.

(b) *Mainstream ageing into planning and policy frameworks:* HIV/AIDS policies and programmes should simultaneously deal with poverty reduction and other development issues; these should promote intergenerational cohesion, and target the needs of infected and affected persons in different age groups simultaneously and comprehensively.

(c) *Mainstream ageing into health sector plans:* Support older people's access to health care for themselves and those under their care from both orthodox and non-orthodox health providers; thereby promoting primary health care for older people and their dependents.

(d) Integrate traditional medicine into the mainstream health care services in order to

promote complementarity of the two and ensure that traditional practice is safe. Enact laws and regulations that protect their work as active and formal players in the HIV/AIDS continuum of care.

(e) Governments must introduce and implement policies that make anti-retroviral therapies available to all who need them, including older people and those in their care; for these purposes, age-friendly VCT are imperative.

(f) *Develop policies that support and assist older carers:* All home-based care policies and programmes, including standards of care guidelines must address the specific economic, health and psychosocial needs of older carers and support them in their care-giving roles. Agencies designing and implementing HIV/AIDS programmes must ensure that older carers are systematically involved at all stages in the design, implementation, training and monitoring of prevention, care and treatment, at both household and community levels.

(g) *Include data of persons of age 50 and over in the HIV/AIDS data:* Further research and collection of age and gender-disaggregated data for people over 50 are urgently needed in order to design and implement appropriate HIV/AIDS policies and programmes that meet the rights and needs of older carers.

(h) *Provide educational support for OVC:* Policies and programmes must provide for the education needs of orphaned and vulnerable children and other needs of affected, infected families and households at risk; legal support to carers on property for OVC; provide legal advice separate issue/recommendation to carers with particular emphasis on advocacy for custody of the property for OVC by older carers.

(i) *Provide more HIV prevention and care-giving knowledge to older carers:* Older carers have an equal right as other population groups to information on HIV prevention, transmission, care and treatment, which is age-appropriate and accessible, in order to protect and care for themselves and their dependents. Older women carers must be provided with and involved in the design of appropriate care-giving information and training, including the delivery of ARTs.

(j) *Governments to honour declarations and commitments:* Governments must honour their international and regional commitments on older people and HIV/AIDS, such as the United Nations General Assembly Special session on HIV/AIDS (UN, 2001), the Africa Union Policy Framework and Plan of Action on Ageing (AU, 2002), the Madrid International Plan of Action on Ageing (UN, 2003), the 2001 Abuja Declaration on HIV, TB and malaria, and the Yaoundé Call for Action (AU, 2006).

4. Conclusions

African populations are ageing and the number of older people is increasing. While the older people are facing an increasing number of socio-economic and political problems, HIV/AIDS is one of their biggest challenges. As demonstrated, the epidemic has devastating effects on the health, economic, social and psychological lives of older women and men, particularly where they care for PLWAS and OVC. Older persons are themselves increasingly at risk of infection with HIV. With the death of young adults, the responsibility of care for orphaned and vulnerable grandchildren is shifted to older persons. Inaccessibility and costly medical treatment and palliative care for PLWAS, compounded with negative attitudes of health care personnel towards infected patients and their families exacerbates the problems which older carers face. The majority of governments in sub-Saharan Africa have not acknowledged the impact of HIV/AIDS on older people and the contributions they make in the care management of the epidemics in their policies.

Greater attention given to the specific challenges that older carers experience will be a significant step taken in the efficient and inclusive implementation of existing HIV/AIDS policies and programmes relating to poverty reduction, social and economic development.

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Endnotes Chapter Four:

1 UNAIDS is the joint United Nations Programme combating HIV/AIDS.

2 Using age 60 as the demarcation into old age is arbitrary. There is no general rule. In European countries age 65 is often used as the demarcation because it usually corresponds to the legal age at retirement. In the case of the countries of sub-Saharan Africa, 60 may be considered quite low considering that in over 80 per cent of these countries life expectancies at birth are below 55 years of age (US Census Bureau, 2007).

3 HAI stands for HelpAge International

4 NEPAD stands for Partnership for African Development.

5 For a comprehensive report on the situation in Tanzania, see HAI (2004b).

Chapter Five

Health Systems, HIV/AIDS and the Development Agenda in Sub-Saharan Africa: Implications for Ageing Populations

Isabella ABODERIN

Contents:

1. Introduction

This brief chapter follows the previous chapter's discussion of adverse impacts of the HIV/AIDS crisis on older people in sub-Saharan Africa (SSA). It specifically examines the ways in which current health systems and mainstream development agendas in SSA compound the harmful impacts of HIV/AIDS on older people and offers recommendations for policy and practice.

2. Background: HIV/AIDS in sub-Saharan Africa

Sub-Saharan Africa (SSA) is the epicentre of the worldwide HIV/AIDS crisis, being home to 63 per cent of all adults and children with HIV globally. 2.1 million adult and child deaths due to AIDS (72% of the global total) occurred in SSA in 2006 and a total of 24.7 million adults and children infected with HIV are estimated to live in the region — 1.1 million more than in 2004.

Approximately 12.2 million children in SSA lost one or both parents to AIDS in 2005. Within SSA, the sub-regions of Southern Africa and, to a lesser extent, East Africa are hardest hit by the HIV/AIDS epidemic (UNAIDS/WHO, 2007; UNAIDS, 2008).

While declines in HIV prevalence are now observed in some countries, prevalence is rising in others and, overall, the positive trends are 'neither strong nor widespread enough to diminish the epidemics' overall impact in this region' (UNAIDS/WHO, 2006).

AIDS disproportionately kills adults in the prime of their lives (i.e., at 'working' age) and — especially in the hardest hit countries in SSA — affects the structure, fabric and functioning of whole populations. Yet, as the Commission for Africa has noted, "the full human, social and economic implications of the crisis are not even now fully clear" (CfA, 2005).

What is certain, however, is that the epidemic critically affects social and economic development prospects and well-being at both the societal and the familial level:

- At a societal level HIV/AIDS diminishes a country's capacity for economic growth tangibly. South Africa, for example, lost USD 7 billion annually to the epidemic between 1992 and 2000. Across 33 countries the disease is estimated to have reduced annual GDP growth by 1.1% (ILO, 2004, 2006; UNDP, 2002). Moreover, current estimates are that between 20 per cent and 40 per cent of the workforce will be lost in the most affected counties (ILO, 2006).
- At a family level, effects of the epidemics severely affect the well-being of *all* generations — not only those immediately infected with the virus or dying from the

disease. In recent years, particular attention has begun to be paid to the serious impact which the crisis has wreaked on the welfare of older people in SSA (see UN, 2002; AU/HAI, 2003; Ferreira, 2006; Williams and Tumwekwase, 2001; Knodel, Watkins & Van Landigham, 2003)

3. Impact of HIV/AIDS on older people in sub-Saharan Africa

International research and policy debate have viewed these impacts as occurring mainly on three key levels:

First, the additional care burden placed on and new roles of older people who are increasingly called upon to act as (often sole) carers and supporters for/of their younger generation kin (especially children or grandchildren) diseased or orphaned by HIV/AIDS. Such care giving, often rendered at great personal cost, has been shown to affect older people's material, psychosocial and physical well-being in particular (see Ferreira, 2006; Knodel, Watkins, & Van Landingham, 2003)

Second, older people's own risk of infection with the HIV virus, which is typically overlooked in formal surveillance statistics, which focus only on the worst-affected age group (15-49 years). A common and erroneous assumption is that older people are sexually inactive and thus not at risk of infection (Clark, 2004).

Third, older people's loss of children, grandchildren or other younger generation kin who die of HIV/AIDS related causes. Such loss impacts not only their emotional and mental well-being, but erodes the material or other intergenerational family support which they require for their livelihoods.

In view of these impacts, recent years have seen mounting calls for policy responses to address the impacts of HIV/AIDS on older people.

4. The functioning of health systems' in sub-Saharan Africa: key role and features

However, these appeals have thus far paid little explicit attention to the present functioning of health systems and their key role in effecting or intensifying much of the impact. Neither have appeals given much consideration to the additional *indirect* impact of the HIV/AIDS crisis on older people that, again, are mediated by the present functioning of health systems. To be sure, no research has so far explored the precise patterns and scope of the health systems' effects in different country contexts.

However, indications are that there are *three key cross-cutting features* of the functioning of health systems in SSA that, together, mediate the effects of HIV/AIDS on

older people. These are: (1) The limited capacity of health systems; (2) core agendas and priorities for health service delivery; and (3) specific programmatic foci of current HIV/AIDS related service provision.

The subsequent sections set out the major elements of these three features briefly and delineate various 'pathways' along which they effect the impact of HIV/AIDS on older people.

4.1. Limited capacity

Health care delivery systems in many SSA countries are largely dysfunctional and under-resourced (WHO, 2006a; UN/DESA, 2007; Sanders *et al.*, 2005). The erosion of health systems is a consequence of cuts in public spending that were part of the neo liberal structural adjustment programmes (SAP) in the 1980s and 1990s. Virtually all SSA nations underwent SAPs as conditions for obtaining loans and financial support from the International Monetary Fund (IMF) and World Bank (Soludo & Mkandawire, 1999). The grave effects of this under-investment are illustrated poignantly in SSA's survival indicators today:

- Average life expectancy at birth in SSA is only just recovering to the 'high' of 50 years last achieved in 1985. In some nations, such as Swaziland, life expectancy at birth remains below 40 years (UN, 2008) In all countries, at least a quarter of children born today cannot expect to survive to age 40.
- One in 10 babies die before the age of one year, and almost two out of 10 will die before the age of five years (see UNDP, 2006; WHO, 2006b).

The key limitations that currently afflict health systems in SSA are a severe lack of financial resources and a 'crisis' in human resources, i.e., the lack of sufficient skilled health professionals.

- ***Financial resource constraints***

The scale of the financial resource constraints in SSA health systems is well illustrated in current per capita government expenditure on health. The World Health Organization (WHO) estimates that a minimum of USD 34 per capita are needed in SSA to provide even the most essential public heath interventions (see WHO, 2006a). However, presently, in 35 nations (out of 45 SSA countries for which WHO data exists), expenditure is lower than USD 34. Indeed, in 27 nations it is below USD 10, and in 16 countries it is USD 5 or less. This contrasts with an average of USD 2,000 in OECD

countries (table 5.1).

Table 5.1 — Per capita government expenditure on health, selected SSA and OECD countries

SSA countries		OECD countries	
Nigeria	6	Belgium	1,880
Ghana	5	UK	2,081
Zimbabwe	14	US	2,548
Uganda	5		

SOURCE: *WHO World Health Report 2006*

In the countries most affected by HIV/AIDS, the financial constraints on health systems are exacerbated by the increasing number of people seeking health care as a result of HIV/AIDS and the fact that treatment for HIV-related illness is more costly than treatment for many other diseases.

- ***Human resource 'crisis'***

Health systems in SSA are facing what has been termed a human resource 'crisis' — i.e., severe shortages of skilled health professionals (WHO, 2006a). In all but one country, the number of physicians is less than 1 per 1,000 inhabitants. In 20 countries there is less than 1 doctor for 10,000 inhabitants. The number of nurses is relatively higher, but nonetheless woefully inadequate: in all but one country there are less than 5 nurses per 1,000 inhabitants. Thirty-one countries have less than 1 nurse per 1,000 inhabitants. These average figures, moreover, mask the even greater scarcity of health personnel in rural areas where, typically, the majority of older people reside. The scale of the human resource scarcity in SSA health systems is, again, well illustrated through comparison with what pertains in OECD nations (see table 5.2)

The three specific causes that have given rise to the health worker shortages in SSA are, *first*, the loss or 'brain drain' of health workers due to the emigration of workers typically to OECD countries in Europe, North America (especially the UK, the USA, Canada and France) to access better conditions of service and remuneration (see Eastwood *et al.* 2005; WHO, 2006b) [1]; *second*, the loss of staff due to illness and death; and*, third*, the growing disease burden in SSA, which means more staff are required.

Table 5.2 — Health personnel per 1,000 population, selected SSA and OECD countries

SSA countries			OECD countries		
	Physicians	Nurses		Physicians	Nurses
Nigeria	0.28	1.70	Belgium	4.49	5.83
Ghana	0.15	0.90	UK	2.30	12.12
Zimbabwe	0.16	0.72	US	2.56	9.37
Uganda	0.08	0.61			

SOURCE: *WHO World Health Report 2006*

Importantly, in the countries most affected by HIV/AIDS, these factors are exacerbated by some of the effects of the epidemic itself, namely:

a) the growing numbers of people seeking HIV/AIDS-related health care;

b) stress and low morale of health workers due to the increased HIV-related pressures on health services, leading to migration of health staff;

c) AIDS related illness and death among health workers themselves. For example, between 1997 and 2001, 14% of health staff (principally nurses) in South Africa died as a result of AIDS. Botswana is expected to have lost 17% of its health workforce between 1999 and 2005, by 2010 the percentage of health care workers dying (in case they are not treated) may reach 40% (see ILO, 2004; WHO, 2006a, 2006b).

4.2. Core agendas and priorities for health service delivery

In response to the grave survival indicators in SSA, a number of key international and African agendas have in recent years formulated priority directions to guide the improvement of health services in SSA, as part of broader plans for overall development and poverty reduction in the region. Major agendas include:

- 2000 UN Millennium Development Goals (UN, 2000);
- 2001 Abuja Declaration of Leaders of African countries (see UNECA, 2007);
- 2002 NEPAD Health Strategy (see WHO, 2006a);
- Recommendations of the Commission for Africa (CfA, 2005).

The directions set by these agendas include, *first*, pledges to address the severe financial constraints in health systems African nations have undertaken to increase their health spending to 15 per cent of national budgets; while major donor countries have pledged to increase their development aid to 0.7 per cent of their GNP (part of this to boost funds for health). However, no African countries and, with some exceptions, no donor countries have so far met these pledges [2].

Second, and crucially, all agendas agree on three priority areas that short- to medium-term mobilisation and spending of scarce health sector resources in SSA are to focus on, namely the three 'health-related' Millennium Development Goals (MDGs):

- MDG 4: Reduce by two-thirds mortality among children under 5 years;
- MDG 5: Reduce by three-quarters the maternal mortality ratio;
- MDG 6: Halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases (UN, 2000) [3].

Highest priority among these is given to the fight against AIDS (i.e., MDG6), as expressed in the African Union's Abuja and Maputo Declarations (OAU, 2000; AU, 2003):

> *"Containing and reversing the HIV/AIDS epidemic, tuberculosis and other infectious diseases should be our top priority for the first quarter of the 21st century ... as an integral part of our continental agenda for promoting poverty reduction"*
>
> (OAU, 2000)

This prioritisation is underpinned by potent economic rationales. Tackling the HIV/AIDS epidemic and related infectious disease such as TB, is intended to lead to enhanced human capital, labour productivity, educational attainment, and ultimately to economic growth (WHO, 2006a; ILO, 2006; see UNECA, 2007).

4.3. Specific foci of HIV/AIDS related health programmes

Health funding [4] and strategies to tackle the HIV/AIDS crisis in SSA have (almost exclusively) focused on four areas — reflecting the top four priorities set out in the 2001 UN Declaration of Commitment on HIV/AIDS and the MDGs and reaffirmed in the UN's 2006 Political Declaration on HIV/AIDS (UN, 2001, 2007):

- Prevention: i.e. reducing HIV prevalence especially among the young (15-24 yrs);
- Stopping mother to child transmission;

- Providing treatment to all those infected;
- Caring for all whose lives have been devastated by AIDS, particularly orphans [5] .

Moreover, implicitly — and often explicitly — the priority focus is on children and reproductive age adults (aged 15–49), who comprise the large majority of people living with HIV/AIDS.

In practice, these programmatic foci have been implemented largely through investments in three key programmes.

- ***Expansion of anti-retroviral (ARV) treatment***

This has in many ways been the most prominent area of action. ARV reduces complications and prolongs the life of HIV infected individuals, and prevents mother to child transmission. The framework for the expansion of such treatment has been provided by the WHO/UNAIDS '3 by 5' programme, which began in 2003 and aimed to place 3 million people worldwide — of which 2.3 million in SSA alone — with HIV/AIDS on ARV by end 2005.

Though this goal has not been achieved, some progress has been made. At the end of 2005, 810,000 people received ARV in SSA, up from 100,000 in 2003 and most SSA countries are engaged in efforts to further expand ARV provision. This includes the need for the training and deployment of tens of thousands of health workers to carry out the delivery and monitoring of treatment (ILO, 2004; WHO, 2006b).

- ***Voluntary counselling and testing (VCT)***

Such programmes have aimed to reduce the large percentage of people currently living with HIV/AIDS in SSA who are unaware that they are HIV positive. It is believed that the proportion could be as high as 90 per cent.

- ***Support to families affected by HIV/AIDS, especially to orphaned children***

Such initiatives have involved, for example, child support grants, education, health or psychosocial support to orphans. Twenty SSA countries have completed National Plans of Action (NPA) on orphans and vulnerable children, and several others have nearly completed and launched their NPAs (UNAIDS/WHO, 2007).

5. Health systems and impacts of HIV/AIDS on older people: Three main pathways

The resource constraints, core agendas and specific HIV/AIDS-related programme foci of health systems in SSA combine to (i) exacerbate the direct impacts of the HIV/AIDS epidemic on the well-being of older people; but also (ii) cause often overlooked indirect impacts on their well-being.

These impacts can be seen to operate through three main pathways.

First, little, if any, attention is given addressing HIV infection or AIDS among current cohorts of older people. Although routine surveillance data on the HIV zero-status among people aged 50 or over is not available, existing evidence suggests that such inattention is unwarrantable. Indicative data show HIV prevalence among this age group in SSA to be 5-7 per cent, and AIDS-related mortality to be on the rise, in particular among women aged 50-64 years (Knodel *et al.* 2003; Kahn *et al.* 2006; Clark, 2004; Shisana *et al.*, 2005).

Second, there is very little service provision to support (terminal) care for AIDS sufferers, which is often provided by older people. As a result, older caregivers receive little material, educational or skills support needed to address the physical and emotional strain — and ill-health — often associated with their care-giving role (see WHO, 2002; Knodel, Watkins & Van Landingham, 2003; Ferreira, Keikelame & Mosaval, 2001).

Finally, the resource limitations of health systems together with the core priority given to the fight against HIV/AIDS (achieving MDG 6) result in a crucial indirect impact on the well-being of older people, which has received little explicit attention. This is the lack, or 'crowding out' of service provision to respond to the rising burden of age-related non-communicable diseases (NCDs).

NCDs — such as heart disease, stroke or diabetes — are the leading causes of ill-health, disability and mortality in old age in both the developed and the developing world, and they occur at earlier ages in the latter (WHO, 2002, 2006a). Indications are that NCD prevalence especially among older age groups is rising in SSA and contributing an increasingly substantial share of the overall burden of disease in the region. For example, in South Africa, heart disease and stroke are the leading causes of mortality among adults (Steyn *et al.,* 2006).

Effective health service responses to NCDs — which are currently 'crowded out' — would require provision on two levels. Firstly, the prevention, control, management of manifest NCD and risk factors in middle-aged or older people, as well as rehabilitative care for advanced disease and associated functional limitations. Secondly, it would

involve primary and primordial prevention strategies to cope with the emergence of risk factors among children and youth and thus disease among future cohorts of older people. Such early prevention is critical as the risk of developing NCD is shaped by factors and exposures (e.g., diet, smoking, physical activity etc.) at all stages of life, including childhood, youth and young adulthood (Aboderin *et al.*, 2001). Yet present SSA youth and health strategies pay virtually no attention to NCD prevention (see AU, 2006; Aboderin & Ferreira, 2008)

6. Conclusion and recommendations

The discussion in this chapter has sought to highlight the central role played by the current functioning of SSA health systems in giving rise to many of the adverse impacts of the HIV/AIDS crisis on the well-being of both present and future cohorts of older people in the region.

Efforts to address the impacts of the HIV/AIDS crisis on the older population in SSA must, much more than thus far, take account of this role and include a focus on measures to enhance the operation of health systems. Above all, such measures need to consider two key levels:

First, the expansion of current HIV/AIDS-related programmatic foci, to include, first, the detection and treatment of HIV/AIDS among those aged 50+ and, second, extended support provision (education, material, practical) to caregivers of home-based (terminal) care for AIDS sufferers. In practice this might mean expanding community home-based care (CHBC) schemes, which have been initiated in some countries (e.g., Botswana), but have been of limited benefit to older caregivers given the lack of financial and human resources available to these schemes (Shaibu, 2006; Lindsey, Hirschfeld & Ncube, 2003; Jacques & Stegling, 2003).

Second, there is the need to expand the broad priority agenda for health systems, beyond the focus on MDGs 6, 5 & 4 and to include affordable service provision for age-related non-communicable disease for present and future cohorts of older people. This should build on an appreciation of the fact that, over the longer term, survival gains made through tackling HIV/AIDS and other infectious diseases will be lost to NCDs if these are not addressed. However, the suggested health system responses to NCDs will not happen without the implementation of the following complementary strategies. There is the need for primordial prevention, which encompasses broad political, fiscal or legislative efforts to reduce exposure to risk inducing environments. These include, for example, controlling the sale and marketing of tobacco (e.g.,

implementation of the WHO Framework convention on tobacco control), alcohol and unhealthy foods (see Aboderin *et al.*, 2001; WHO, 2002; WHO, 2006a).

The explicit attention given to the need to forge such effective NCD responses in Africa in the international scientific literature (Daar *et al.*, 2007; Sanders, Todd & Chopra, 2005), WHO regional reports (WHO, 2006) and national health policy frameworks in several SSA countries (see Aboderin, 2008), are encouraging. They signal a growing awareness and readiness — at least at a rhetorical level — to tackle NCD in SSA. The critical question is whether — and to what extent — this will translate into concrete policy action and budgetary allocation.

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Endnotes Chapter Five:

[1] Recent years have seen growing international concern and intensified debates on the implications of the 'Brain Drain' for African Health Systems, and on approaches to ameliorate these (see e.g. Eastwood *et al.*, 2005; WHO, 2006b; CfA, 2005).

[2] Only five countries have so far met or surpassed the 0.7% target: Denmark, Luxembourg, the Netherlands, Norway and Sweden. Six other countries have committed themselves to a timeline to reach this target before 2015: Belgium, Finland, France, Ireland, Spain and the United Kingdom (UNDP, 2007).

[3] Given that most SSA countries are far off track for achieving the MDGs by 2015, the focus is on redoubling efforts to at least put countries firmly 'on the path' to achieving the goals as soon as possible (UN, 2005).

[4] Substantial international funds have been made available for the fight against AIDS in SSA among others through the Global Fund and the US President's Emergency Plan for HIV/AIDS. Nonetheless, resources remain constrained given the scale of the tasks.

[5] A fifth priority is to redouble efforts to search for a vaccine for HIV/AIDS.

Chapter Six

Home Care and Residential Care: The Case of Flanders

Lieve VANDERLEYDEN

Contents:

1. Introduction

The ageing of the population is a demographic phenomenon with profound societal consequences. According to some, 'population ageing' is a threat; according to others it is rather an opportunity or a challenge because never before in history has mankind experienced so many elderly people in such good health.

In some developed countries such as Belgium, already in 2007 about one-fifth of the population was aged 60 or over — 22.9 per cent to be precise — and the numbers continue to grow. According to the United Nations (2007), by 2050 1 in 3 people in Belgium may be aged 60 or over [1].

The fact that more and more people become old and reach a high age confronts the society with a two-fold challenge. How many people will attain the age of 60 and over in the future? And how can we succeed in keeping people in good health as long as possible? It is a question of quantity as well as quality.

This chapter starts (section 2) with some demographic indicators concerning 'population ageing' in Belgium and its three Regions: Flanders, the Dutch-speaking region in the north of the country; Wallonia, the French-speaking region in the south; and the Brussels-Capital Region. As will be seen, the three Regions show quite different demographic (and also economic) characteristics. Where possible, some time series are used. As is known, demographics are a 'dynamic' process. The likelihood of prospected changes can only be interpreted in the light of past and present trends.

Given the demographic situation, what will therefore be the number of elderly people in need of care? We focus on this question in section 3.

Next (sections 4-5) we restrict the discussion on the situation in Flanders and focus on the policy discourse related to care as observed in the last 25 years. More specifically, what have been the normative goals that the various governments have wanted to reach with regard to home care and residential care? And what have been the instruments to realise these normative goals? Both pieces of information should allow to asses the extent of incongruity between the policy measures and the realisations on the ground.

In section 6 we compare the situation related to home care and residential care in the Flemish Region with the situation in several European countries. As we will see, any differences need to be interpreted with caution because the definitions are not always identical. However, the exercise provides some indication of the differences between the countries with respect to home care and residential care of older people.

The chapter ends (section 7) with some concluding remarks.

2. Some demographic indicators: Belgium and the Regions

As already mentioned in Chapter 1 by Schoenmaeckers, the phenomenon of 'population ageing' is not limited to the developed countries. On the contrary, 'population ageing' is rather a worldwide phenomenon. In the long term, all regions and continents will experience huge proportions of older people in their populations. Moreover, the increase in the proportions of older people might happen at a much higher pace in the less developed countries than what the developed countries have experienced so far.

Europe is the continent in the world with the highest proportions of older people in the population (United Nations, 2007). Outside of Europe, only Japan experiences even higher proportions.

Belgium is part of the top-ranking countries with respect to the proportion of older people. With 22.9 per cent of its population aged 60 or over, it's only preceded by Japan (27.9%), Italy (26.4%), Germany (25.3%), Sweden (24.1%), Greece (23.4%), Austria (23.3%), and Bulgaria (22.9%). We will not discuss here the mechanisms of 'population ageing'. These are presented in the first chapter of this book. Let it suffice to state that, in a first stage, the phenomenon is 'triggered' by declining fertility, but that eventually, in countries that have already experienced low fertility levels for longer periods — such as European countries — the most important factor of 'population ageing' is the continued increase in life expectancy — or longevity.

2.1. Evolution of the mean age

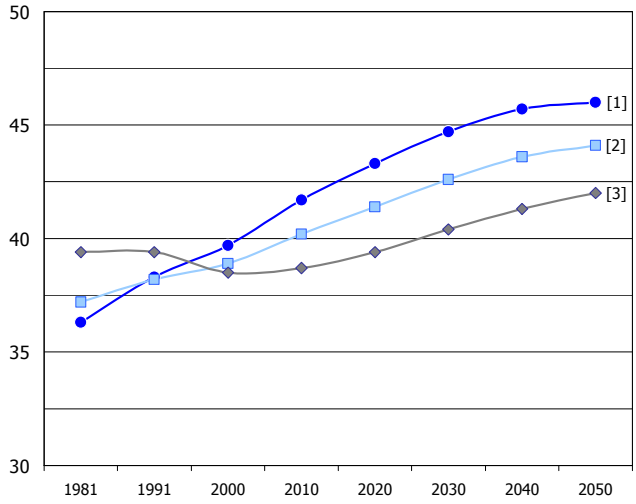
The simplest indicator for 'population ageing' is the mean age (figure 6.1).

In 1981 the lowest mean age was observed in the Flemish Region and was 36.3 years. The highest mean age (39.4 years) was observed in the Brussels-Capital Region and was about three years higher than in Flanders. With 37.2 years, the Walloon Region occupied an intermediate position. After 10 years, from 1981 to 1991, the mean age in Flanders and in Wallonia had increased by two and one year respectively; by contrast, in the Brussels-Capital Region the mean age had remained unchanged. In 2000 there is a reverse in the situation. The highest mean age is now observed for Flanders (39.7 years) and the lowest for the Brussels-Capital Region (38.5 years). With 38.9 years Wallonia continues to occupy an intermediate position. This situation is expected to remain unchanged until 2050. However, between 2000 and 2050, in all three Regions the mean age will increase considerably, between 9 per cent in the Brussels-Capital Region and even 16 per cent in Flanders (in Wallonia the mean age will increase by

13%). As a result, by 2050 the mean age of the population will reach 46 years in Flanders, 44.1 years in Wallonia, and 42 years in the Brussels-Capital Region.

Figure 6.1 — Evolution of the mean age in Flanders, Wallonia, and the Brussels-Capital Region, 1981-2050

SOURCE: FOD Economie - ADSEI, Dienst Demografie



Key: [1] Flemish Region; [2] Walloon Region; [3] Brussels-Capital Region

2.2. Dependency ratios

Another, somewhat more detailed way to investigate the process of 'population ageing' is by looking at so-called 'dependency' ratios. In essence, dependency ratios correspond to the ratio of the number of older people over the numbers of people in other age segments in the population. These are usually the 0-19 (young people) and 20-59 (people at 'working' age) age groups.

One specific dependency ratio is the 'ageing index'. This corresponds to the ratio of the number of older people (aged 60 or over) over the number of young people (ages 0-19). Figure 6.2 presents the evolution of the ageing index for the three Regions and the country, from 1975 to 2050.

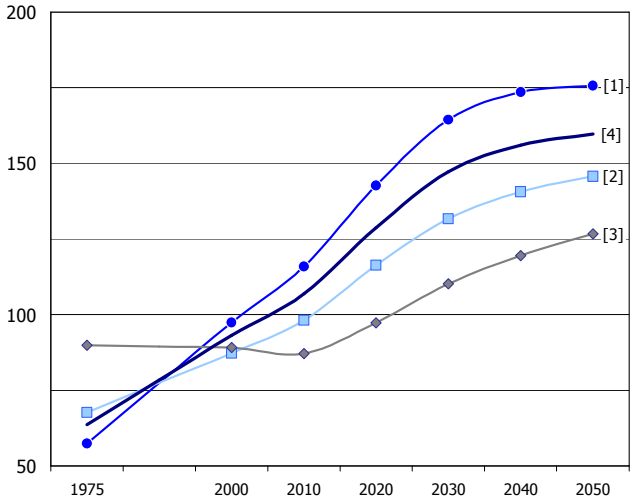
In 1975 Flanders had an ageing index of 57.4. In other words, at that time the population in Flanders counted 57 people of 60 years or over for every 100 people below the age of 20. The relative 'weight' of the number of older people compared to the young sharply increases in all three Regions until 2050. By that time there will be

no less than 175 older people in Flanders for every 100 people below 20 — about three times the number that was observed in 1975. The relative increases are less important in the two other Regions. In Wallonia, with a value of 146 older people for every 100 people younger than 20, the ageing index will be double its 1975 value (67.7). For the Brussels-Capital Region, the increase is smaller still, a multiplication of about 1.5, from 89.9 to 126.7.

The 'turning point', or the year in which the number of older people about equals the number of younger people, was reached in Flanders in around 2000. This turning point will occur later in the other two Regions: in around 2010 in Wallonia and around 2020 in the Brussels-Capital Region.

Figure 6.2 — The ageing index [(60 years or over)/(0-19 years)] in Belgium and the three Regions, 1975-2050

SOURCE: FOD Economie - ADSEI, Dienst Demografie



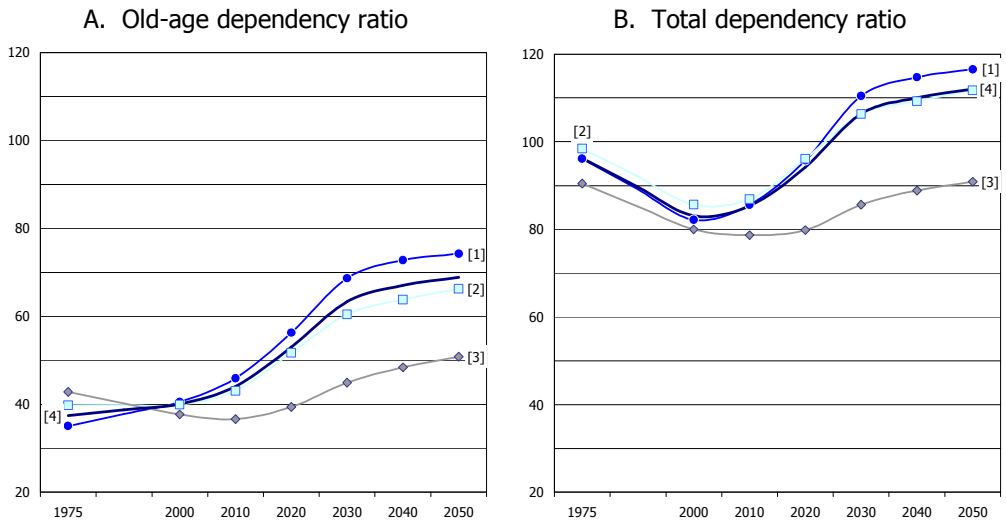
Key: [1] Flemish Region; [2] Walloon Region; [3] Brussels-Capital Region; [4] Belgium

Wallonia and especially the Brussels-Capital Region showed higher ratios in 1975 than Flanders, but from 2000 on the situation is reversed. This is particularly the case for the Brussels-Capital Region, which is characterised by its younger population. In 2006, according to the General Direction of Statistics and Economic Information (*Algemene Directie Statistiek en Economische Informatie* — ADSEI) the Brussels-Capital Region showed the highest birth rate and the highest natural growth (number of births minus number of deaths). Relatively speaking the migration from abroad to the Brussels-Capital Region is the highest: one third of all migrants settle in the Brussels Region.

The move from the city, already high and getting higher every year, is compensated by the external migration and the high birth rate.

The old-age dependency (the ratio of the number of older, in general economically inactive people, to the number of people at working age; figure 6.3A) and the total dependency ratio (the number of younger and older people in relation to the number of people at working age; figure 6.3B) are useful indicators of trends in potential support needs, although they should be interpreted with caution. Not all children and older people require support, nor do all people of working age provide direct or indirect support to children and elderly.

Figure 6.3 — Old-age dependency ratio (60 years or over / 20-59 years) and total dependency ratio (60 years or over + 0-19 years / 20-59 years), Belgium and the three Regions, 1975-2050



Key: [1] Flemish Region; [2] Walloon Region; [3] Brussels-Capital Region; [4] Belgium

SOURCE: FOD Economie - ADSEI, Dienst Demografie

On the regional level, the ratios confirm what has already been shown. In 1975 the relation between the older population and the population of working age was more favourable in Flanders than in the two other Regions. The turning point was attained in the year 2000 and the old-age dependency ratio became less favourable in Flanders

than in Wallonia and the Brussels-Capital Region. As a result, Flanders will have 75 older people per 100 people of working age in 2050; in the Brussels-Capital Region the ratio will be 1 to 2.

As was mentioned before, the old-age dependency ratio is only a rough indicator of the relation between older people on one side and the active population on the other. The (Belgian) Federal Planning Bureau (FPB) points to the sometimes simplistic use of dependency ratios: 1) the pure demographic ratios only focus on the dependency of one age group while others are dependent as well; and 2) they neglect the fact that older people are care providers in many cases and not only care receivers. Therefore the Planning Bureau proposes other ratios. One of these is the social demographic old-age dependency ratio, linking pensioners to potentially active people (those having a job + those who are unemployed) and the social economic old-age dependency ratio, linking pensioners to those effectively at work [2].

As can be seen from the index in table 6.1, and although there is some similarity in the increase of the demographic and the social demographic ratio, the rise is less pronounced in the social demographic ratio. This is not the case for the social economic ratio where the growth is less steep, especially due to the future evolution of the female employment rate. Between 2005 and 2030 the increase in the social economic ratio will be 39 per cent against 53 per cent in pure demographic terms and 59 per cent against 73 per cent in the 2005-2050 period.

Table 6.1 — Demographic, social demographic and social economic old-age dependency ratio: Belgium (in % and index)

	Year					
Kind of Dependency ratio	2005 (1)	2010(2)	2020(2)	2030(2)	2040(2)	2050(2)
Demographic (65+ / 15-64) (3)	26.2	26.4	31.7	40.0	44.6	45.4
Index (2005=100)	100	101	121	153	170	173
Social demographic (pensioners / active persons)	44.6	45.1	53.5	66.3	74.0	76.3
Index (2005=100)	100	101	120	149	166	171
Social economic (pensioners / those effectively at work)	52.0	51.5	59.3	72.1	80.5	82.9
Index (2005=100)	100	99	114	139	155	159

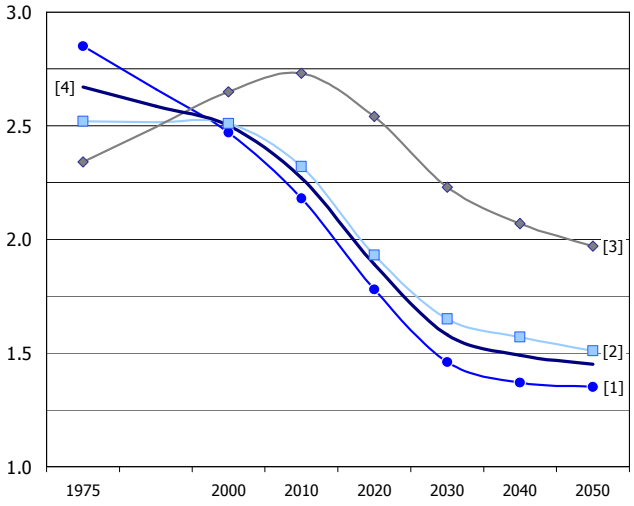
SOURCE: FPB (M. Englert *et al.*, 2002, updated by N. Fasquelle) and own calculations

NOTE: (1) Observations; (2) Projections; (3) the FPB changed the age limits in order to meet international agreements; in former calculations the age groups were 60 and +/20-59

The potential support ratio (the number of people at working age (20-59) over the number of older people) will be halved in a 75-year period in Flanders. In 1975 there were 2.8 people of working age taking care of one older person; in 2050 this number will be 1.3 to 1 (see figure 6.4). In Wallonia the ratio is projected to decrease from 2.5 to 1.5, whereas the situation is less dramatic in the Brussels-Capital Region: in the long term (in 2050) there will still be twice as many people of working age in relation to older people.

Figure 6.4 — Ratio of potential support [(20-59 years) / (60 years or over)] in Belgium and the three Regions, 1975-2050

SOURCE: FOD Economie - ADSEI, Dienst Demografie

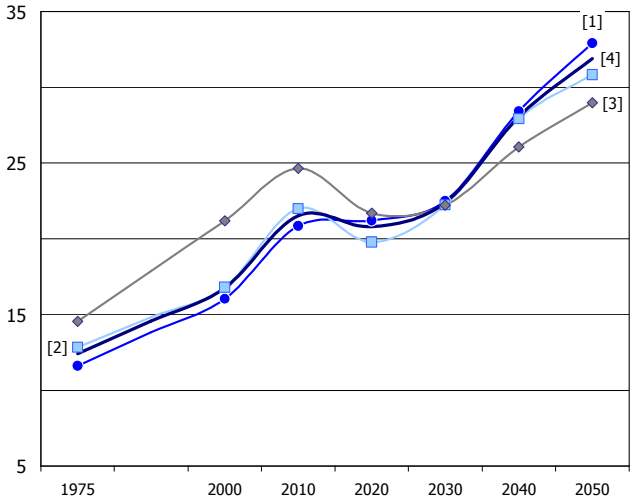


Key: [1] Flemish Region; [2] Walloon Region; [3] Brussels-Capital Region; [4] Belgium

Looking at the intensity of population ageing (which refers to the 'ageing of the second degree'), the results point in the same, above-mentioned direction although the differences between the Regions are less pronounced in this case. The results indicate that the ageing of the second degree is a problem that will affect all Regions (see figure 6.5).

Figure 6.5 — Ratio of intensity of greying [(80 years or over) / (60 years or over)] in Belgium and the three Regions, 1975–2050

SOURCE: FOD Economie – ADSEI, Dienst Demografie



Key: [1] Flemish Region; [2] Walloon Region; [3] Brussels-Capital Region; [4] Belgium

2.3. Household types

In order to better understand the relevance of home care and residential care, it is important to have a picture of the household composition of older people. The household types of men and women evolve according to the stage of the life course of the individual. Older men and women in most cases live together as a couple but because life expectancy is higher for women than for men, the household composition differs by sex. Far more men than women have a spouse in old age (figures not shown in table 6.2).

The data for Flanders show an increasing share of elderly living with spouse/partner only (one out of two in 2006) while the proportion living alone is decreasing between 1991 and 2006. Co-residence with children is decreasing as well, a trend that is observed from the seventies on in Flanders (Lodewijckx & Jacobs, 2002; Vanderleyden, 1987) and in many Western European countries (de Jong-Gierveld *et al.*, 2001). As could be expected, the proportion living with spouse or partner is lower at a higher age.

These findings apply also to Wallonia and the Brussels-Capital Region with one exception: in Brussels the proportion living together with children is increasing instead of decreasing in all age categories. The percentage of people 65 years or over living in

an institution doubled between 1991 and 2006 (from 2.3% to 4.5%) whereas in Flanders and Wallonia the rise in the rate of institutionalisation is rather marginal. A possible reason may be the rather weak development of home care in the Brussels Region compared with Flanders.

Table 6.2 — Household composition of elderly people in Flanders, Wallonia and the Brussels-Capital Region, 1991 and 2006 (in %)

	Age group and year							
	65-74 years		75-84 years		85 years and over		65 years and over	
Household composition	1991	2006	1991	2006	1991	2006	1991	2006
				A. Flemish Region				
living alone	22.5	20.2	39.3	34.4	43.3	40.9	30.3	27.3
with spouse/partner only	56.0	63.1	36.1	45.9	12.6	18.0	45.0	52.5
with children	16.8	13.5	14.6	11.6	20.9	12.9	16.5	12.8
with others	3.0	1.8	3.6	2.1	4.5	2.4	3.3	1.9
institutionalised	1.8	1.5	6.4	6.0	18.7	25.8	4.9	5.4
N (= 100%)	465,362	586,106	290,651	395,840	77,508	102,300	833,521	1,084,246
				B. Walloon Region				
living alone	26.3	25.3	43.3	38.3	45.6	42.7	33.8	32.1
with spouse/partner only	52.7	55.6	32.7	40	11.2	16.4	42.2	45.6
with children	16.6	15.5	14.4	13.2	20.7	14.7	16.2	14.5
with others	2.9	2	3.7	2.4	5.1	3.1	3.4	2.3
institutionalised	1.5	1.6	5.9	6	17.4	23.2	4.4	5.4
N (= 100%)	287,083	290,824	167,585	222,363	45,302	57,039	499,970	570,226
				C. Brussels-Capital Region				
living alone	39.3	35.0	57.5	46.2	69.7	55.7	49.4	42.1
with spouse/partner only	47.8	45.6	32.4	38.4	13.2	17.8	38.2	39.1
with children	10.7	16.5	6.1	9.6	7.1	8.1	8.6	12.7
with others	1.5	1.7	1.4	1.6	1.4	1.6	1.5	1.6
institutionalised	0.7	1.3	2.6	4.2	8.5	16.8	2.3	4.5
N (= 100%)	87,293	73,540	60,611	60,621	19,286	20,384	167,190	154,545

SOURCE: State Register 1991 and 2006, calculations by E. Lodewijckx

In Flanders, the proportion of older people living in an institution amounts to 5.4 per cent in 2006; this figure is slightly higher in 2006 compared with 1991. The increase is almost entirely the result of the rising trend at a very high age. At the age of 85 years and over, more than 1 out of 4 people in Flanders are institutionalised. Among others, the greater availability of nursing home beds may be one of the reasons for this increase (Vanderleyden, 2004) (see also section 4.3). At younger ages, the proportion of elderly living in an institution remains constant over time or even decreases.

In 2006 the percentage of institutionalised elderly is nearly the same in Flanders compared with Wallonia and it is somewhat higher than in the Brussels-Capital Region. Data from the Federal Institute of Health and Invalidity (*Rijksinstituut voor Ziekte en Invaliditeit* — RIZIV) reverse the picture: the share of older people living in an institution is larger in Wallonia and the Brussels-Capital Region than in Flanders. There may be two reasons for the difference: 1) the state register is an administrative source: people who change their place of residence (from home to an institution) do not always report this properly; 2) data from the RIZIV are based on the real numbers of people who are entitled to a lump sum payment for being in need of care; as such these figures are more reliable (see section 6).

3. Number in need of care?

The general hypothesis concerning the evolution of the number of disabled elderly in the near future is an increase in the proportion. Some exploratory calculations of Europe's future disabled population indicate that the number of elderly people who will be in need of assistance and care will not necessarily increase as a consequence of population ageing. Lutz and Scherbov (2003) developed different scenarios according to the shift in the degree of disability by one, two or three years. In the first two scenarios there is indeed an increase in the proportion of disabled people, but in the case of a shift by three years per decade, Europe would experience a real decline in the number of disabled people, despite the rapid population ageing. The authors conclude: *'The key factor will be the future trend in age-specific risks to become disabled. This seems to be an area where preventive medicine and changing lifestyles and public health measures can make a big difference'* (Lutz & Scherbov, 2003: 19).

According to an OECD study assessing the most recent evidence on trends in severe disability among elderly people in 12 OECD countries, the conclusion is that in only 5 of the 12 countries studied — Denmark, Finland, Italy, the Netherlands and the United States — is a decline in disability among people 65 and over found (Lafortune *et al.*, 2007: 56). Disability or dependency was defined as one or more limitations in basic activities of daily living like eating, washing/bathing, dressing, getting in and out of bed [3]. In three countries, Belgium, Japan and Sweden, there is an increasing rate of severe disability among people aged 65 and over during the past 5 to 10 years. Australia and Canada report a stable rate while in France and the United Kingdom the material did not allow any definitive conclusion on the direction of the trend to be reached.

More important is the future trend in disability: the results of the projections to the year 2030 show for all countries that the number of elderly people with severe

disabilities and in need of long-term care will rise due to the ageing of the population and the greater longevity of individuals [4], even though disability prevalence rates have declined in recent years in some countries. Policy-makers must be alert and it would not be prudent to count on future reductions in the prevalence of severe disability among elderly people. In order to reduce the demand for long-term care, greater policy emphasis is needed to prevent or postpone as much as possible the onset of chronic diseases and disabilities among people in OECD countries. In that sense the conclusions of the report coincide with the statement of Lutz and Scherbov who mentioned that prevention and a change in lifestyles is needed in order to reverse the trend of a rising proportion of disabled people. More specifically dealing with the macro-economic cost, Pacolet (quote in: Avramov & Cliquet, 2005: 162) argues that 'time bomb' scenarios are useless because they do not consider the evolution in medical sciences. Furthermore, there are reasons to believe that the cost explosion will be within reasonable boundaries because of the potential of prevention and of deinstitutionalisation.

4. Evolutions in the care policy of elderly people in Flanders, 1980-1999

4.1. The political discourse

Based on an examination of government declarations and the associated coalition agreements for the 1980-1999 period (for an extensive review, see: Vanderleyden, 2004), we found that shortly after the transfer of the person-related matters from the federal state to the communities [5], Flanders was the first in promoting the stay of older people in their own homes. Increasing the capacity for self-reliance became an important goal. The discourse was undoubtedly inspired by financial preoccupations (home care is cheaper for the state than residential care) but also the humanitarian aspect was underlined and defended. According to the government declarations, the care in residential homes should be reserved to those with no other possibilities. The intention, expressed by the government in the seventies, to reduce the number of acute beds in hospitals in favour of nursing or long-term care beds [6], was resumed. The criteria to be admitted in rest homes were defined as follows: other services are inadequate, nursing care beds should be reserved to dependent elderly people with a long-term disorder (standard and programme figure for nursing beds were installed at the end of 1982).

The emphasis on home care and the further development of the services of family and elderly aid [7], home care, service centres, meals-on-wheels, etc, are part of a policy promoting older people staying at home as long as possible. The services should be as close as possible to the person and most of all to the family. From the nineties on,

home care became the basic facility and 'tailor made' care was introduced in the policy talk as a new concept: just the amount of care one needs at the right place and the right time.

The government declarations and associated coalition agreements focus on the need for cooperation between different services but also between the services and the informal network in order to strive for an optimal service. But the policy documents emphasise the importance of home care, so this does not mean that residential care becomes redundant. One can however observe that the world of home care and that of the residential care are two separate worlds, with no connections in between. The service flat where older people live independently and, if necessary, can call upon support and services, is promoted as a new concept. Also the further development of service centres is underlined. Day care, night care and short-term care are brought to people's attention as new alternatives.

In the discourse of the eighties and onwards, there has been a shift from quantity to quality. The call for more services is mitigated and is slowly being replaced by a demand for better care. This discourse fits in with the slogan that it is not about prolonging life but that it is more important to spend the added years in optimal conditions.

As a result of scientific research regarding financial implications of the use of different kinds of care (see Dooghe *et al.*, 1998; Spinnewyn, 1990), it became evident that medical and non-medical care are an important part of the expenses of elderly people. Medical costs, i.e. the cost for a hospitalisation, the use of medicines, are partly refundable, but non-medical expenses such as family aid, cleaning help, nursing tools, meals-on-wheels etc are not. [8] Furthermore, a great part of the care at home is offered by the informal network, which is still the case today [9]. Because this care is by no means qualified for any payment, the idea of introducing social care insurance was launched at the beginning of the nineties and was meant to be part of the social security system in order to cover specific risks associated with the long-term care needs of elderly people. Such social care insurance would also be recommended for older people in rest homes, who lack a sufficient income.

4.2. The achievements [10]

In this section, we first look at the legislative initiatives concerning elderly care policy in the 1980-2000 period and then try to accentuate the common themes.

- ***Legislative initiatives***

After the transfer of the personal-related matters from the federal level to the regional/community level, the Flemish Community took the lead with the implementation of a new decree (the *'bejaardendecreet'* or old-persons decree of 1985) which was very innovative for that time. It is till today the predominant legislation with respect to ageing policy in Flanders [11].

The aim of the decree was a shift away from residential care to transmural and extramural aid through the installation of sheltered housing, specific independent living for elderly, service centres and day care. The service flats and houses providing services were a good example of the functional approach, a new concept within care of the elderly. At first it was common to deliver housing and care in one package (like in rest homes); according to the new concept, the two functions are separated (only 'needed' care is provided). Service flats primarily provide accommodation, the usual family and domestic care is facultative: older people can choose to use or not to use these services. Throughout the years, though, it appeared that the concept of service flats is fleshed out differently, in a few service flats there is no facultative care.

Services centres allowing older people to live independently as long as possible and as such to integrate them into society through adequate support have been a cornerstone of the new policy in Flanders. In the first legal arrangement of service centres, developed at the national level in the second half of the seventies, the meeting and relaxation function was more important than the assistance function. The decree of March 1985 puts the assistance first; the function of cultural and recreational service is not retained in the description of the service centres.

In spite of the necessity to support and to relieve the informal network as much as possible, the day and night care or short-term stay were not included in the decree of 1985 (a revision of the base decree made the legal existence of day care centres possible in 1991).

The second milestone in the Flemish elderly policy was the home care decree of July 1998. This decree clustered services, like family aid, service centres, day centres and short-term-stay centres, and focused on the maintenance of the user in the natural home environment, regardless of his or her age. The importance of informal aid was also formally acknowledged (the union of informal aid was subsidised for the first time).

With regard to the programming of services, two innovations stand out. The first one is the introduction of age-specific programme figures by which was taken into account the fact that a greater need exists in relation to an increasing age (use risk is included).

The second innovation is the anticipation of future demographic developments: the norms are calculated based on the population projections of the fifth year following the year of the admission (this is not the case for family aid, probably because the preview is less compelling given the fact that no infrastructure is involved). The legal arrangement also foresees evaluation figures in order to have a better planning of services (for example, one has to take into account the location and accessibility of the service). Furthermore, cooperation with other services is required.

The programme figures for rest homes, too, were modified and became age-dependent at the beginning of 1998. The figures for service flats remained the same.

Although the idea of a contribution for non-medical costs was already launched at the beginning of the nineties (see section 4.1), it took another ten years before the decree on care insurance became a fact (decree of March 1999). Care insurance however was not inserted in the social security system [12]. From 2001 onwards the decree was executed: under restricted circumstances but regardless of the care location (at home, rest home or nursing home) severely care-dependent people receive a subsidy to cover the non-medical costs.

In the second half of the nineties, a quality decree was voted on the Flemish level (decree of April 1997), which imposes services to meet quality requirements in order to obtain a recognition.

- ***Interpretation***

To evaluate and to interpret the realisations in the field of elderly care, the scheme of Gilbert and Terrell (2002), containing different dimensions is used. These dimensions may be expressed in the form of the following questions: 1) Who can obtain the social allocation? 2) What is the nature of the allocation or service? 3) What about the organisation? 4) How are the services financed? 5) What is the position of each service?

Ageing policy in the 1970-1980 period during which the federal level was competent for all elderly affairs, could generally be described as 'categorical selective'.

The services were addressed to elderly people and those elderly could claim a provision of services under certain conditions. In other words: priority rules were installed for the use of a number of services. From 1980 on, the guiding principle is 'selectivity within universality'. This means that a number of services focuses on all categories of users (and not only on the elderly), but the principle of selectivity is enforced by the introduction of the user's risk within the programme figures.

The services are not only offered 'in kind' as was the case in the previous period (the seventies and before), but also 'in cash'. Besides the care offered by services such as

family aid, meals-on-wheels, home nursing, there is also the care insurance to cover the costs of non-medical services. This care insurance, of which the amount is dependent on the location of the care, supplies to people in need of care a monthly payment of € 105 (in the case of home care) or € 125 (in the case of residential care). Nowadays, the monthly payment is equal to € 125 regardless of the location of care. Most services are still offered in kind.

A personal assistance budget introduced in the sector of handicapped people was not applied here, in spite of many advantages shown by scientific research. For example, such a system contributes to the transformation from a supply-oriented to a demand-oriented care system; furthermore, it gives the person involved a great decisive power and it also gives him/her great responsibility in organising the care in order to increase his/her welfare; and last but not least the principle of free choice is respected. Surveys have shown that greater choice and consumer direction can contribute to better quality of life at similar cost compared with traditional services, under the condition that these programmes are targeted at the people most in need (OECD, 2005). The rejection of the system within elderly care was partly due to the cost factor and to the opposition of the socio-political groups who feared for their existence (the personal assistant takes over the role of the formal carer).

The production of services is mostly on the account of the private non-profit initiative. Because of the rich tradition in social profit organisations in Flanders, the private initiative is more important than the public one. Services like family aid were developed by ideologically oriented organisations. In that way the government proceeds according to the principle of subsidiary: what can be done by internal networks should not be taken over by the government.

From the point of view of the consumer, the user pays a contribution for most services, depending on his income: this applies to family aid, meals-on-wheels, etc. In 2006 the average contribution per hour of family aid for example amounted to € 3.91 per user. As to residential care, the elderly person is charged per day irrespective of the income. In case of insufficient means, the local government can intervene in the costs of the daily in-patient accommodation and services. But the financial accessibility of residential care is problematic: empirical data show that only one third of the residents are able to pay the bill themselves, in one third of the cases the children contribute and in all other cases the resident appeals to the Public Centre of Social Welfare (OCMW).

As to financing, a mixed economy of welfare is still in place, which means that elderly care is financed through different sources. Nevertheless, insufficient budgets accelerated the search for alternative financing (such as, for example, leasing). Also

private capital was used for speeding up the realisation of some initiatives such as service flats.

In the period under study, several initiatives in Flanders have been taken to resolve the problem of coordination and integration of the care system. But in the case of cooperation, the services of the welfare sector are involved rather than health care services. No interface between social care and health care is realised. The institutional context of Belgium and the absence of homogeneous jurisdiction do not favour this process.

4.3. Congruence or incongruence between the normative and the realised policy?

The substitution from residential care to home care, so often reinforced in the policy discourse, was not realised within the field of elderly care. The transformation of residential care into intermediate facilities (like service flats and housing with service accommodation; service centres) did not take place. The realisation of the programme figure for service flats stays beneath expectations (at the beginning of 2000, only 34% of the programme figure was realised). There is hardly any external substitution to speak of.

On the other side there has been some substitution within the residential sector itself. The conversion from 'normal' rest home beds into nursing beds (special beds for severely dependent old people) did take place, although rather gradually and thanks to the protocol agreement between the federal state and the communities. As a result of the protocol agreement of 1997, the increase in the number of nursing beds must be compensated by a decrease in the number of 'normal' beds for the elderly. Between 1998 and 2000 the number of these decreased by 3,881 units and the number of nursing beds increased by 5,730 units, which means a replacement of 70 per cent.

By overlooking and calculating the state expenses for residential care versus home care, we have to conclude that the budgets for residential care are much higher than for home care although great emphasis had been put on home care. We calculated that the public cost for an elderly person being cared for in a rest home amounted to € 8,957 per year (figure applies to the year 1999); for an older person in home care the equivalent was € 6,431.

In the period studied, some innovative tendencies were observed; first of all, an organisational innovation. At the end of the seventies and the beginning of the eighties, an important differentiation in the care system took place. Previously the ageing care policy was based on two pillars: family and elderly care services versus residential homes. From the eighties on, many other services were introduced and

developed [13], resulting in a growing and maturing mix of care provision. On the ground and despite the obligation to cooperate, the collaboration of different services was hard to realise. It is remarkable that the government exercises its supervision function by means of process steering instructions at the same time the state aspires to better control the costs of elderly care.

Another innovation regards the organisation of the care system. The market as an actor entered the welfare sector. In the residential care sector the free market process was already present (in 2000 27% of the rest homes in Flanders were commercially managed but because of the small-scale of those commercial homes, it regarded only 15% of the beds). There are some indications that private service providers also enter the home care segment: for example several companies are offering cleaning services.

Furthermore some techniques and approaches from the management of private companies are implemented in the welfare sector, be it with some adaptations to the specific needs of welfare organisations. The decree regarding the quality of the welfare services may serve as an illustration: the implementation of quality care means clarity in the structure of the organisation, procedures concerning decision-making and consultation, transparency in the processes within the organisation (for example, with respect to the care aspect) as well as the efficient application of resources.

5. Further developments in discourse and on the ground between 2000 and 2007

In 2000-2001 the start was given to review the legislation on elderly care. The aim was to formulate some recommendations regarding the integration of home care and residential care and in that sense realise a care continuum. The process took nearly one year and resulted in a first draft of a decree, but it was not voted in due to budgetary austerity.

In the beginning of 2007 a new decree on housing and care was drawn up by the office of the Flemish minister of Health, Welfare and the Family. Because of federal elections for the Parliament in June 2007 and the functional adaptations made at the Flemish level, the succession of the new design remains uncertain (see endnote 11 for an update).

Due to the protocol agreement between the federal state and the Regions/Communities, an extra budget was created to replace 'normal' beds into nursing beds. The objective of the first protocol in 1997 was to limit the increase of the number of beds in the residential sector but at the same time it allowed the creation of the much-needed nursing beds. The second (2003) and the third agreement (2005) again allowed for normal beds in residential homes to be replaced

with nursing beds. A part of the budget can also be spent in enlarging the supply in home care (via alternative caring arrangements). In this way, the communities can themselves choose how to delineate their policy.

What have we learned on the ground?

Table 6.3 shows that there is still a huge gap between the programme figures and the realisations within the field: some of the services reach only half or even less of the norm: this applies to day care centres, short-stay, local service centres and service flats (considering the existing housing units). There is also a gap within the residential sector. In other words, the government is not managing to meet its own standards. With respect to family aid, the Flemish government decided in 2000 to increase the number of subsidised hours by 4 per cent. Currently there is only a 2 per cent increase per year.

Table 6.3 — Expansion of the number of residential and nursing beds and other accommodation and services between 2000 and 2007 and realisation of the target number (in %)

Services	Realised on 1 Jan 2000	Percentage value of target number	Realised on 1 Jan 2007	Percentage value of target number
Residential and nursing homes				
Number of beds				
Existing, incl. those under investigation	58,476	89%	63,382	79%
Existing and planned	67,118	102%	73,580	92%
Service flats				
Number of housing units				
Existing, incl. those under investigation	9,829	34%	12,872	40%
Existing and planned	17,728	61%	19,717	61%
Day Care centres				
Number of accommodation units	680	29%	1,335	50%
Short-stay centres				
Number of beds	237	10%	744	28%
Sitting services for the elderly				
Number of services	42	70%	47	78%
Service centres				
Regional	53	88%	50	83%
Local	127	23%	155	27%
Family aid				
Number of hours	13,364,589	82%	15,190,237	83%

SOURCE: Vanderleyden (2004); IVA Zorg en Gezondheid

In addition, the shortage differs according to the place of residence (province) (Geerts & Breda, 2007: 162). In the provinces of East and West Flanders the supply of residences is high. In Limburg the real number of beds in rest homes is far below the programme figure and this also applies to the number of service flats. In Flemish Brabant the situation is also far from satisfactory. However, regarding family aid, Limburg scores better than Flemish Brabant.

From a time perspective, it is clear that there is progress within a number of services (day care, short stay, etc.). Also notable is that within the residential sector, the percentage reflecting the relation between the real number and the programme figure is decreasing instead of increasing (79% in 2007 versus 89% in 2000). This may be explained by the fact that the ageing of the population is progressing quicker than was foreseen by the population projections; as a result the ratio of the existing beds to the standard is decreasing. We have to keep in mind that the programme figures are calculated on the basis of the population size of the fifth year following the year of admission.

As to the expenses today, the residential sector still absorbs the greatest part of the budget. Analysing the expenses of the (federal) Institute for Health and Invalidity, we observe that in 1999 Flanders spent 57.5 per cent of the total budget for the lump sum payments in rest homes, nursing homes, day care and home care [14] to the residential sector. Wallonia scores higher with 62.8 per cent, and in the Brussels-Capital Region it is even 82.6 per cent. In 2005 the share increased to 62.4 per cent in Flanders, 66.4 per cent in Wallonia and decreased slightly in the Brussels-Capital Region to 81.4 per cent. Of course this is partly due to the maturing of the system wherein rest home beds are transformed into (more expensive) nursing home beds.

6. The position of Flanders in Europe

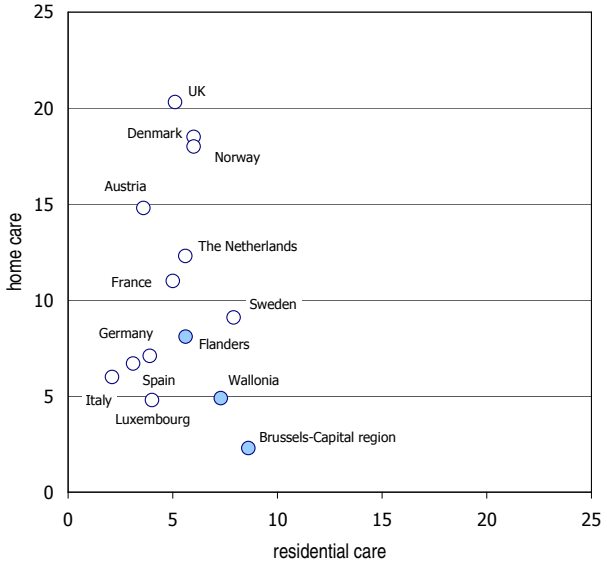
Although this chapter focuses on the situation in Flanders, the question concerning the position of Flanders within Europe may be raised. What is the share of the population aged 65 and over receiving home help at the one hand and residential care on the other? [15]

Flanders is on par with the average with respect to residential care. Compared to other countries, Flanders has a rather low score in home care (8.1%), although Wallonia (4.9%) and the Brussels-Capital Region (2.3%) have even lower scores as can be seen in figure 6.6. It should be mentioned here however that in the case of Flanders, Wallonia and the Brussels-Capital Region, the figures relate to home nursing only.

Of all the countries under study, the United Kingdom has the highest score, indicating a large supply in home care services; next are Denmark and Norway who have also a relatively extensive network of residential homes. Denmark is one of the Scandinavian countries where elderly care is mostly a state matter. This applies also to Sweden; however, during the nineties the state did realise more and more that families themselves are responsible for the care as well. Countries in the South of Europe like Spain (3.1%) and Italy (2.1%) have a low score in residential care and in home care (Spain: 6.7%; Italy: 6%).

Figure 6.6 — Percentage of elderly (65 years and over) in home care by percentage of elderly in residential care, per country

SOURCE: OECD, 2005 (Austria, Germany, Luxembourg, Norway, Sweden, UK); Pommer *et al.,* 2007 (France, Denmark, The Netherlands); Comas-Herrera & Wittenberg, 2003 (Italy, Spain); Pacolet et al., 2004 (Flanders, Wallonia, Brussels-Capital Region)



7. Concluding remarks

Elderly care policy in Flanders is characterised by a series of initiatives. Homes for the elderly, service flats and service centres, together with a broad range of support services and a number of benefits have been constructed and developed. Choices among care options and a tailor-made supply are supposed to contribute to better quality of life. Indeed consumer choice can improve the satisfaction of older people and increase the degree of independent living, even in cases of dependency on long-term care.

Family members still today provide the bulk of assistance to older people living at home. Governments must be aware of the importance of informal care and act properly by giving support to family members. The existing help patterns between the generations do not release the State from its responsibility towards elderly people. Results from the DIALOG project (Schoenmaeckers *et al.*, 2006: 60) indicate that citizens agree on the statement that children should take care of their aged parents, especially in case of need. But at the same time, citizens realise the limits of informal care. It is the responsibility of the government to provide the necessary services and institutions, which means home care facilities as well as residential care. The promotion of home care in Flanders since the 1980s is undeniable, although it is not a matter of 'one *or* the other', but as to financing, a great part of the budget still goes to the residential sector. More investments in innovation and technical progress may be recommended (for example, more advanced ICT-applications in home care as well as in residential care) in order to reduce the gaps in the existing care system and to improve the quality of life of elderly people.

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Endnotes Chapter Six:

1 Taking 60 as the age limit may be subject for debate. The choice here is made to be consistent with Flemish legislation, which defines 'elderly' as people aged 60 or over. However, with the 'Flemish Parliament Act on Home Care and Residential Care' ('*woonzorgdecreet')* of 2008 (see endnote 11) the age limit of 60 has been increased to 65.

2 Another is a financial dependency ratio: total amount spent on pensions versus labour income.

3 In the case of Denmark, the decline is partially the result of using a less severe measure of disability (only having functional limitations).

4 The extent at which life expectancy might further increase in the future is the subject of much scientific debate. According to a report by the U.S. Census Bureau (2005), the debate can be summarised as follows: "The first (pessimistic view) contends that the practical limits have nearly been attained, while the second (optimistic view) says that old-age mortality will decline at a more accelerated pace in the future. Some researchers believe that the maximum average life expectancy is about 85 years of age and argue that the incremental improvements needed to achieve much higher levels of life expectancy are unlikely… Others believe that recent declines in mortality rates will continue, given the continued steady progress against the diseases of old age, that life expectancy could reach much higher levels in the coming century, and that medical developments will extend life expectancy to 100 years or more …".

5 As a result of five successive revisions to the constitution in 1970, 1980, 1988-1989, 1992-1993 and 2001, the unitary entity of Belgium has been transformed into a federal state of three communities (the Flemish, the French and the German-speaking Community) and three Regions (the Flemish, the Walloon and the Brussels-Capital Region). Each of them has its own parliament and government, except in Flanders where the Community and Region form a single institution. The communities are authorised with respect to so-called personal matters, such as culture, education, child protection, providing assistance for families and relief for immigrants. The federal government has authority for matters such as defence, foreign affairs, justice, finance, social security, some publicly owned enterprises, significant areas of public health and home affairs (including security and asylum).

6 Due to the sharp increase of the expenses in hospitals, the state was forced to economise: acute hospital beds could be replaced by nursing beds in rest homes, in particular reserved for severely disabled elderly people. This meant an important money-saver because the personnel standards in rest homes are lower than in general hospitals. Moreover, elderly people pay a greater share of the total cost in rest homes than in hospitals where the daily in-patient accommodation charge is reimbursed by the federal Institute for Health and Invalidity (Vanderleyden, 2004: 156).

7 Services for family and elderly care provide help to families, elderly and handicapped people in performing the instrumental activities of daily living. In the home care decree of 1998 focusing on all categories of users (and not only the elderly), the term is replaced by 'services for family aid'. To simplify, from now on we will only use the term 'services for family aid'.

8 An investigation in the second half of the nineties shows that the cost per year in home care is equal to € 2,130 on average. This amount differs according to the degree of care: severely handicapped elderly spend more than double in home care compared with those who are still capable of performing a great deal of their daily activities. The degree of care was measured via a dependency scale used in

home care and residential care. Category O = physically completely independent; category A = moderately physically dependent: need help with bathing, and/or dressing, category B = dependent in bathing, dressing and transfer and/or going to the toilet, category C = dependent in bathing, dressing, transfer and/or going to the toilet and additionally dependent as a result of incontinence and/or feeding. About half of the € 2,130 goes on average to co-payment and personal contributions in health care, another half consists of dependency costs, such as the use of family aid, meals-on-wheels, transfer, etc. The dependency cost of severely handicapped people amounts to 60 per cent.

9 Despite processes of individualisation, data from the Netherlands Kinship Panel Study (NKPS) involving respondents between the age of 18 and 80 years, show that substantial amounts of instrumental support are still being exchanged between parents and children (Knijn and Liefbroer, 2006: 103). Although we have evidence that the support by the informal network had somewhat declined in the 1975-2002 period (Vanderleyden, 2003), informal care is still more important than professional care.

10 For the inventory of the realisations on the ground, we've investigated the laws and decrees as coordinates of the realised policy.

11 The legislation will change in reasonable times because today (November 2008), a preliminary draft of the 'Flemish Parliament Act on Home Care and Residential Care' has been approved by the Flemish Government and will soon be discussed in the Parliament. The decree integrates the legislation on home care and residential care.

12 The Flemish Parliament was opposed to the idea of developing this initiative on the federal level, citing a conflict of interest because the initiative was situated on the borderline between the federal level (social security) and the level of the communities (assistance to persons).

13 The creation and development of services by the government was not always inspired by the concern to cover the needs of the population involved; sometimes rationality was at stake. The creation of cleaning services in 1977 made it possible for low-skilled unemployed people to participate in the labour market. In the seventies, with 1973 as a line of demarcation for the slowing growth which would last for a long time, the unemployment rate rose sharply. Through the development of cleaning services work could be offered to low-skilled people, who suffered most from the crisis.

14 This concerns all dependent people who need care, but almost 80 per cent of the total numbers are elderly people.

15 In order to compare some European countries with respect to their share in home care and residential care, the age of 65 is used as a criterion for all countries under study, including Flanders.

Chapter Seven

The Budgetary Sustainability of Population Ageing: Belgian and European Answers

Micheline LAMBRECHT

Contents:

1. Introduction

This chapter deals with two policy experiences, the one of a single country, Belgium, and a multilateral approach as adopted in the European Union. They illustrate how European governments have progressively become aware of population ageing [1], how they have attempted to quantify the effect of this unprecedented phenomenon on public expenditure, and how they initiated the first reforms so as to guarantee the sustainability of the welfare systems with a maximum of equity for all citizens.

This chapter starts with a close look at the federal Belgian 'Ageing policy' (section 2). It then continues with the main features of the European 'Ageing policy', focusing on the impact of 'population ageing' on public expenditure in the EU Member States. With the exception of Belgium, no statistics or indicators are presented for individual Member States; the data in figures and tables are, with the exception of figures 7.2 and 7.4 limited to groups of Member States (EU15, EU10, EU25) (section 3).

The chapter ends with some concluding remarks, including the role that can be expected from the European Union.

2. The Belgian ageing policy at federal level

This paragraph concentrates on the Belgian federal ageing policy, as a great deal of the ageing policy in Belgium is also elaborated on the Community level.

2.1. Overview of the Belgian ageing policy at federal level

In the early eighties, Belgian society became aware of the future ageing of the population. The attention focused mainly on the sustainability of the public pension schemes as less people of working age are supposed to finance the pensions of a still growing amount of older people.

From that sudden awareness, banks and insurance companies started to actively promote their own pension products. Ministers of Pensions (Mr Mainil, Mr Busquin, Mr Dehaene) commissioned the preliminary studies on the financing of public pensions schemes, feeling that ageing was an irreversible phenomenon. International institutions such as the IMF, the OECD and the EU loudly presented their conclusions about the threat to the pension systems, but without too much nuance, essentially intending to tap capital for the private sector.

The successive Belgian Ministers of Pensions and Social Affairs then took various policy measures. These were based on the outcome of simulations carried out with the MALTESE model (see the more technical developments at section 2.2 hereafter). The

most important measures can be summarised as follows:

- 1990 (Ministers Vanderbiest and Detiège): flexible retirement age for male workers aged 60-64;
- 1994 (Minister Dehaene): global management of the various systems of social security;
- 1996 (Ministers Willockx and Colla): reassurance of basic protections within the framework of the first (legal) pension pillar, and compliance to the EU requirement to progressively align women's legal retirement age to 65;
- 2001(Minister Vandenbroucke): setting up of an 'Ageing fund' to face the future financing of pensions, a commitment to reduce public debt, and the creation of a 'Study Committee on Ageing' (see above), responsible for the monitoring of the socio-economic effects of 'population ageing', of which the outcomes are presented in annual reports;
- 2003 (Minister Vandenbroucke): reinforcement and democratisation of the second pension pillar (pensions funds);
- 2004-2005 (Minister Demotte): creation of a Belgian Health Care Knowledge Centre (KCE) with a view to maximising the efficiency in utilisation financial resources for health care [2];
- Finally, in 2006 the Federal Government took various measures within the framework of a 'Generations Pact', such as the provision of financial incentives for working longer, incl. the possibility to continue working after the legal retirement age, the provision of financial incentives efforts enabling new career schemes, support for the smallest pensions (for the self-employed, for women with career breaks, for part-time workers or older pensioners), and the provision of higher fiscal reductions on pension savings, as support for the third pillar.

So, step by step, Belgium developed a federal 'Ageing policy', mainly focused around two axes: fiscal sustainability and social sustainability.

Specific measures to guarantee fiscal sustainability are:

- incentives to work more, also in the new work schemes, and longer;
- global management of social security;
- limited welfare adjustments of the existing pensions;
- reduction of public debt and setting up of an ageing fund;
- analysis and control of health expenditure.

The measures that are intended to guarantee social sustainability are intertwined with the existence and development of a three-pillar pension system. They rely more particularly on:

- the consolidation of the first pillar, which is the main support for the lowest pensions;
- the development of a more generalised and guaranteed second pillar; and
- the provision of fiscal incentives inside the third pillar.

2.2. The Belgian Federal Planning Bureau and the Study Committee on Ageing: two actors at federal level

The objective of this section is to present two major 'actors' dealing with the issue of the economic and social consequences of an ageing population, and laying the foundations for the policy-making process.

In October 1959 a cell called Programming Bureau was installed within the Ministry of Economic Affairs. One of its mandates was the planning of public expenditure. The Programming Bureau was re-named the Planning Bureau by the Act of 15 July 1970. The Planning Bureau was placed under the joint authority of the Prime Minister and the Minister of Economic Affairs. In the following twenty-odd years the Planning Bureau made several attempts to elaborate five-year plans. This work was achieved in collaboration with the social partners (enterprises and trade unions) and the regional economic councils. The role and structure of the Planning Bureau were reviewed by the Act of 21 December 1994 in order to cope with new challenges such as environmental concerns and to take into account new regional structures (Belgium had become a federal state after several consecutive revisions of the country's constitution in the 1970s and 1980s). Since then the Planning Bureau has been known as the *Federal Planning Bureau* (FPB).

Currently, the FPB carries out economic and social analyses, mainly forecasts with sophisticated mathematical tools. It thus provides short-term economic forecasts for 1-2 years used for the public budget, medium-term economic forecasts for 5-8 years, and long-term forecasts of demography and age-related expenditure for up to 50 years. Most of these forecasts are applications of the MALTESE system of models (see further below).

In line with those long-term forecasts, the FPB was entrusted with the Secretariat of the *Study Committee on Ageing*, which was set up by the Act of 5 September 2001. In this role the FPB prepares on an annual basis simulations and national reports, which are

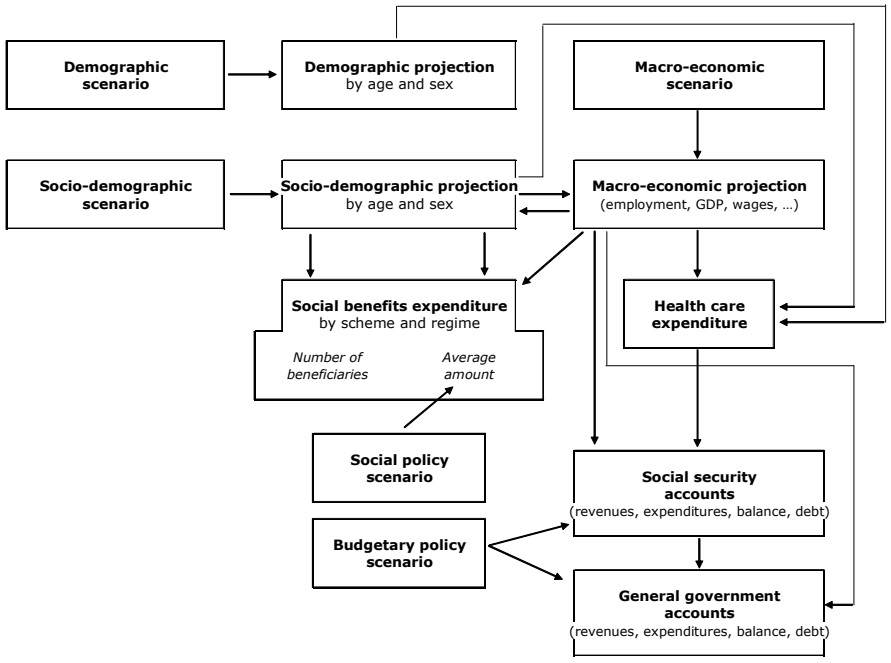
published by the High Council of Finance.

Finally, the FPB acts as the Belgian representative in the *Working Group on Ageing Populations and Sustainability* inside the Economic Policy Committee of the European Union.

2.3. The FPB MALTESE System of Models as an analytical instrument

This section describes the instrument used by the FPB to analyse the evolutions of the age-related expenditure and to test various political scenarios. The diagram of the MALTESE [3] system of models illustrates the complexity of the approach. As is shown in diagram 7.1, MALTESE combines in fact the outcomes of several independent models, each with their own scenario.

Diagram 7.1 — The FPB MALTESE System of Models



The starting point in the model is the demographic scenario. A socio-demographic scenario breaks down the population into various groups which can be contributors to

or beneficiaries of the welfare system. The numbers of beneficiaries combined with average amounts of various social benefits as well as hypotheses for a social policy scenario determine the social expenditure. A macroeconomic scenario determines the evolution of productivity, which is equal to GDP growth and supports revenues, as well as the level of employment. Demography and the growth rate of GDP influence the health expenditure. Finally, a budgetary policy taking into consideration the long-term evolution of the interest rate and its relation to public debt contributes to the elaboration of the general government accounts.

3. The European ageing policy

3.1. Overview of the European ageing policy

As of the Lisbon Summit in 2000, the European governments recognised the necessity of taking measures to face population ageing. The focus was placed on the *employment rates*. Men and women, women only, and older workers should reach the employment rate of 70 per cent, 60 per cent and 50 per cent respectively by 2010. Governments should strive for a decrease in early retirement and encourage long-life learning.

In view of tackling the challenge of financing the pensions, the '*Three-pronged strategy for pensions*' was defined at the Stockholm Summit in 2001. It defined three ways to be followed by the Member States: the reaffirmation of a global higher employment rate, lower public debts, and pension reforms.

The Laeken Summit in 2001, under the Belgian Presidency emphasised the necessity of pension reforms. The question of the adequacy of pensions to meet people's needs was addressed, as well as the fiscal sustainability of the pensions and the modernisation of their management.

3.2. The Working Group on Ageing Populations and Sustainability

As of December 1999 the Economic Policy Committee (EPC), which answers to and advises the European Ministers of Economy and Finance, created a new working group around the issue of 'population ageing'. The 'Working Group on Ageing Populations and Sustainability' (commonly referred to as AWG, or Ageing Working Group) saw its mission redefined in February 2007.

It is composed of Delegates from the Member States (representatives of ministries of finances, planning bureaus, central banks, etc.), the Commission services (DG-ECFIN), observers from the OECD (to avoid double work on the issue) and the European Central

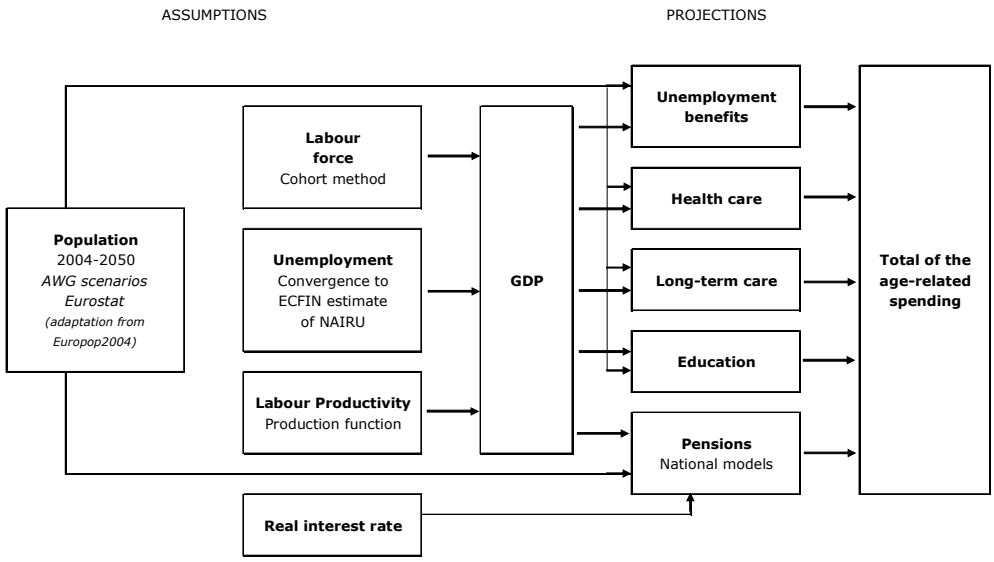
Bank. It cooperates with Eurostat (which is the Statistical Institute of the European Communities), the national institutes of statistics and, if relevant, the International Monetary Fund (IMF), the World Bank and other EU Committees, in particular the Social Protection Committee. It receives its mission from the EPC and regularly reports to it. Since its foundation the President of the AWG is the Belgian Plan Commissioner, Head of the FPB.

The core business of the AWG is threefold: to carry out long-term age-related budgetary projections; to contribute to assessing the long-term sustainability of public finances, notably through long-term projections, appropriate indicators and peer reviews of the new major pension reforms; and finally to analyse, on request of the EPC, the various long-term consequences of ageing on fiscal sustainability and macroeconomic aggregates.

3.3. The impact of ageing on public expenditure in the EU Member States

The general scheme of the successive calculations is given in diagram 7.2 and is analogous to the one developed for the Belgian projections of the budgetary cost of ageing (diagram 7.1).

Diagram 7.2 — General scheme of the 2005 EU projection of age-related expenditure



The following sections describe the different elements of this diagram. They provide an overview of the changes that are expected in the main variables from the present to 2050. The presentation has been limited to the changes that correspond to the baseline projection, i.e., the projection that is the result of the 'most likely' scenario.

3.3.1. Expected evolution in demographic, socio-economic and economic variables

- ***Population***

The baseline projection of the Europop2004 exercise of Eurostat was adapted by this institute for the AWG to introduce convergence in the evolutions of the fertility and the life expectancies by country and to include the last observed migration values. Table 7.1 gives the values for the main demographic parameters as observed in 2004 and as expected for 2050 corresponding to the Eurostat/AWG Baseline projection.

Table 7.1 — The main demographic parameters of the Eurostat/AWG baseline population projection

	2004	2050
Fertility (TFR)		
Belgium	1.6	1.7
EU15	1.5	1.6
EU10	1.2	1.6
Life Expectancy at birth (years) - Men		
Belgium	75.5	82.1
EU15	76.4	82.1
EU10	70.1	78.7
Life Expectancy at birth (years) - Women		
Belgium	81.6	87.5
EU15	82.2	87.0
EU10	78.2	84.1
Net migration (thousands)		
Belgium	24	19
EU15	1.347	778
EU10	-3	101

SOURCE: Eurostat/AWG Baseline projection, 2004

In 2004, the new European Member States (EU10) experienced extremely low levels of fertility, on average a TFR (Total Fertility Rate, or mean number of children per woman) of no more than 1.2. According to the convergence scenario, in the long run the EU10 (countries that joined the EU in 2004) are expected to align their total fertility rate to the one expected for the EU15 European (pre-2004) members; an average of 1.6 children in 2050. This is a significant increase with respect to the current level, but it is still quite below the replacement level.

The life expectancy at birth of the EU10 Member States would remain lower (by about 3 years) to that of the EU15, in spite of the fact that it is expected to increase substantially (+12% for men and +8% for women). These are greater relative increases than those expected for the EU15 Member States (+7% and +6%, respectively). The annual net positive migration is expected to decrease in the EU15, while the EU10 countries would evolve from countries with a net *e*migration to countries with a net *im*migration.

Table 7.2 presents the population numbers in Belgium and in the other EU countries in 2004 and 2050 by broad age categories; the numbers in 2050 are those corresponding to the baseline projection.

Table 7.2 — Population in 2004 and 2050 by broad groups, Belgium and EU (in millions, top; and in percentages, bottom)

	Total		Ages 0-14		Ages 15-64		Ages 65+	
	2004	2050	2004	2050	2004	2050	2004	2050
Belgium	10.4	10.8	1.8	1.6	6.8	6.3	1.8	3.0
	100.0%	*100.0%*	*17.3%*	*14.8%*	*65.4%*	*58.3%*	*17.3%*	*27.8%*
EU15	382.7	388.3	62.4	52.7	255.1	221.3	65.2	114.2
	100.0%	*100.0%*	*16.3%*	*13.6%*	*66.7%*	*57.0%*	*17.0%*	*29.4%*
EU10	74.1	65.5	12.4	8.6	51.7	37.8	10.1	19.1
	100.0%	*100.0%*	*16.7%*	*13.1%*	*69.8%*	*57.7%*	*13.6%*	*29.2%*
EU25	456.8	453.8	74.8	60.4	306.8	259.1	75.3	133.3
	100.0%	*100.0%*	*16.4%*	*13.3%*	*67.2%*	*57.1%*	*16.5%*	*29.4%*

SOURCE: Eurostat/AWG Baseline projection, 2004

Between 2004 and 2050, the total population of the EU15 countries is expected to increase slightly (a mere 1.5%), while the population of the EU10 is expected to decrease by close to 12 per cent.

More impressive still is the change of the age structure of the populations. Over this period, the share of the young people in the population would decrease from 16 to 14 per cent in the EU15, from 17 to 13 per cent in the EU10. The part of the elderly in the population is expected to increase considerably, by 12 to 16 percentage points, from 17 to 29 per cent in the EU15 and from 14 to 29 per cent in the EU10.

The changes in the age composition have a direct impact on the old-age dependency ratio, or the number of people aged 65 or more over the number of people aged 15-64.

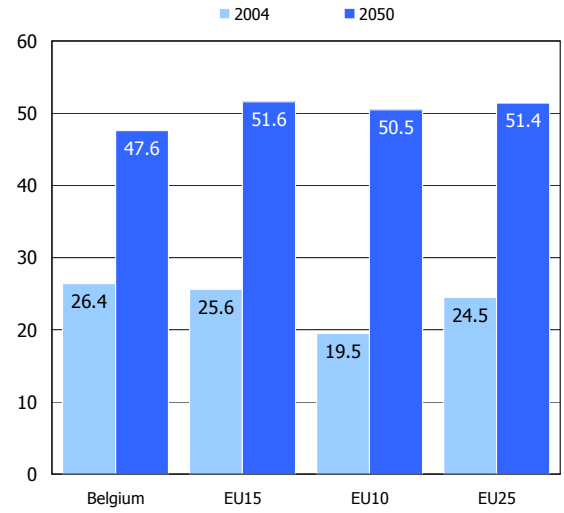
As can be observed from figure 7.1, for all EU Member States as a whole (EU25), during the next decades the strict demographic old-age dependency ratio will about double, from 25 older people per 100 at working age in 2004 to 51 in 2050 [4]. The highest increase is observed for the EU10 countries, where the ratio will be multiplied by 2.6.

In 2004, compared to the other EU Member States, the old-age dependency ratio in the new EU Member States was still relatively low due to net *em*igration and lower life expectancies (19.5 vs. 25.6). Those conditions will change rapidly in the future (in 2050, 50.5 vs. 51.6), with net *im*migration and faster increasing life expectancies.

Figure 7.1 — Old-Age Dependency Ratio *, Belgium and groups of EU Member States. Comparison between 2004 and 2050

* = 100 x [(65+)/(15-64)]

SOURCE: Eurostat/AWG Baseline projection, 2004



- ***Labour force***

Participation rates are projected with the use of the cohort methodology developed by the OECD. This method takes into consideration life profiles of the participation rates

by sex, which are derived from observation of the cohorts from 1998 to 2003. This method also defines the probability of entering or leaving the labour market (starting from the 1997–2003 observations).

Participation rates among women can be expected to further increase in the future for two reasons. Women steadily reach a higher educational level, which promotes holding a well-paid job, and fertility is expected to remain quite low in the future.

Healthy ageing and chances of living longer encourage the older workers — both men and women — to remain longer in the labour force, increasing participation rates at the highest working ages. Also, recent pension reforms on the exit age keep older people at work for longer.

Figure 7.2 presents the impact of the recent pension reforms on the labour exit age.

Figure 7.2 — Impact of recent pension reforms on the labour exit age: Increase in years, by sex, for a selected group of EU Member States [5]

SOURCE: EPC/Commission Report on Ageing (2006a)

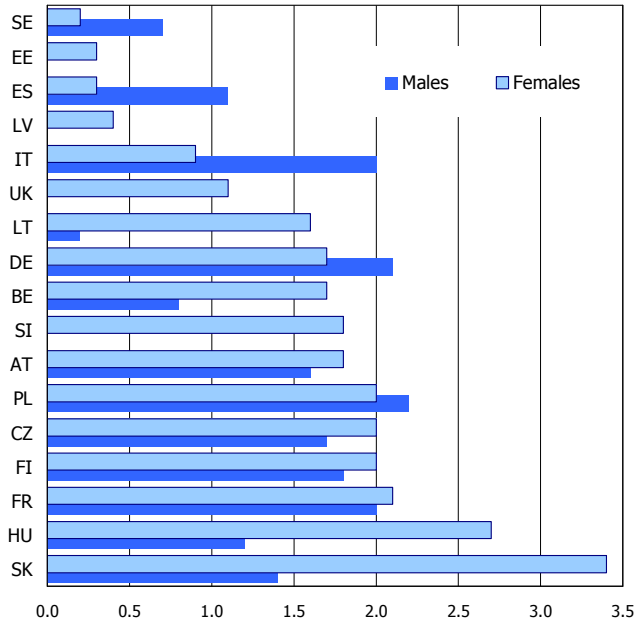


Table 7.3 gives the participation rates in 2003 and their increase until 2050. It underlines the lower participation rates of young and older people in the EU10 countries. The participation rates of people aged 55 to 64 is expected to increase significantly, by 17.7 percentage points in the whole EU25.

Projections of the size and structure of the labour force are obtained by combining

projections of the activity rates with the projected working age population described in the section relative to 'population'. Even with the increase of the participation rates the labour force is expected to decrease due to the global reduction of the working age population and to its ageing, which increases the share of older workers (aged 55–64) in the total labour force whose participation rate is lower than that of younger age groups.

Table 7.3 — Participation rates (in %) in 2003 and 2050
(expected increase in percentage point differences in italics at bottom)

	Situation 2003				Expected situation 2050			
	All age groups	15-24	25-54	55-64	All age groups	15-24	25-54	55-64
Belgium	65.0	35.2	82.3	28.9	70.0	36.9	88.6	44.9
					5.0	*1.7*	*6.3*	*16.0*
EU15	70.4	48.2	83.5	44.2	76.1	49.6	88.6	62.0
					5.7	*1.4*	*5.1*	*17.8*
EU10	65.4	36.2	83.1	34.5	71.8	37.9	89.3	52.8
					6.4	*1.7*	*6.2*	*18.3*
EU25	69.6	45.8	83.4	42.7	75.5	48.0	88.7	60.4
					5.9	*2.2*	*5.3*	*17.7*

Source: EPC/Commission Report on Ageing (2006a)

- ***Unemployment and employment***

The definition for unemployment corresponds to the one used in the Labour Force Surveys; it can diverge from the official national ones which can exclude some categories such as the older unemployed.

Due to the shrinking of the labour force, by 2008 unemployment rates are expected to converge to their minimal structural levels, or NAIRU [6] (at the time of writing, the EU15 average for 2007 was estimated at 7%), and then to remain constant [7]. Countries with relatively high unemployment may reach their NAIRU after 2008; for some EU10 countries the process may even take 20 years. Belgium is expected to reach 6.5 per cent in 2013.

The employment projections result from the evolution of the labour force and the timing of its confrontation with those minimal structural rates of unemployment. The employment projections are given in terms of people. The baseline scenario keeps the other employment parameters constant. These parameters are the total hours worked

as well as various distributions: between public or private wage-earners and self-employed, between full-time and part-time workers.

Do these perspectives of employment allow the Lisbon targets to be met? The Lisbon targets have already been presented in section 3.1: men and women, women alone and older workers are expected to reach employment rates of 70 per cent, 60 per cent and 50 per cent respectively in the year 2010. Denmark, the Netherlands, Sweden and the United Kingdom already met those objectives in 2004. The EU25 area could meet them in 2020. Yet, several countries will most likely not be able to meet those objectives, even by 2050 (Belgium, France, Hungary, Italy, Luxemburg, Malta and Poland).

- ***Economic dependency ratios***

The *old age dependency ratio* was previously defined in Figure 7.1. Being a *strict demographic* indicator of the age composition of the population, it links the population aged 65 and more to the population of working age, defined as the people aged 15 to 64.

Yet, not all people aged 15-64 are employed. Taking employment into account as well presents us with two so-called economic dependency ratios. The *economic old age dependency ratio* reports the non-employed aged 65 and more to the employed population aged 15 to 64. The *economic total dependency ratio* also takes into consideration children aged 0 to 14, and reports the total number of non-employed compared to employed people. Table 7.4 compares those three dependency ratios.

Table 7.4 — Demographic and economic dependency ratios, Belgium and groups of EU Member States, 2003, 2025, and 2050

	Demographic old-age dependency ratio = [(65+) / (15-64)]			Economic old-age dependency ratio = [(non employed 65+) / (tot. employed 15-64)]			Economic total dependency ratio = [(tot. non employed) / (tot. employed 15-64)]		
	2003	2025	2050	2003	2025	2050	2003	2025	2050
Belgium	26	36	47	43	55	71	156	150	164
EU15	25	36	52	38	49	70	136	125	147
EU10	19	33	50	34	45	73	132	126	145
EU25	24	25	51	37	48	70	136	125	147

Source: EPC/Commission Report on Ageing (2005)

The economic total dependency ratio in Belgium will be relatively much more important in 2050 than in the whole EU25 area, due mainly to the importance of the non-employed aged between 15 and 64, especially at the end of the working age. Participation rates of older workers are especially low in Belgium, even if they have increased in recent years under the impact of several policy measures.

- ***Labour productivity and GDP***

A production function approach has been used to explicitly link the growth of GDP to labour productivity and employment, in view of underlining the role of the evolution of the population.

The classical production function explains the GDP growth by two main production factors: labour and capital, and by a third one, called the total factor productivity (TFP). The TFP explains the part of the GDP growth not brought about by an increase of labour and capital and embodies the technical progress.

From there it is possible to explain the GDP growth by the combination of employment and the labour productivity, given that the growth in labour productivity itself largely depends on the evolution of capital intensity, i.e., the capital labour ratio. An increase of that ratio implies more equipment per worker, enabling him/her to produce a larger output. The technical progress has an important influence as well on the labour factor as on the capital factor.

In association with the Output Gap Working Group, hypotheses have been built up for the future evolution in the long run, as well in the EU15 as in the EU10 countries, of the TFP, the capital deepening (ratio of the investment to GDP), the capital/labour ratio (or capital stock per worker) and finally the labour productivity (ratio of GDP to employment, or production per worker). Table 7.5 derives the GDP growth results from the expected evolutions of labour productivity and employment.

At present, there is considerable difference in the rate of annual growth in labour productivity between the EU15 and the EU10 countries due to a catching-up effect in the new acceded countries (for the period 2004-2010, the annual growth in labour productivity is estimated at 1.3 and 3.6 per cent respectively for these two groups of countries). Due to a convergence of the TFP in the long-run, from 2030 onwards, the annual growth in labour productivity is estimated to become 1.7 per cent for the EU15 and 1.9 per cent for the EU10 countries.

As mentioned before, because of the reduction of the working age population (15-64 years) and despite the increase of some participation rates, there will be a shrinking of employment in the long run. Hence, the GDP annual growth [8] resulting from the combination of labour productivity and employment is expected to fall dramatically in

the EU25 area (from 2.4 presently to 1.2 in 2050), and even more specifically in the EU10 area (from the present high level of 4.5 to 0.9), as illustrated in table 7.5.

Table 7.5 — Annual growth (in %) of GDP and its components, Belgium and groups of EU Member States, by period

	GDP			Labour productivity			Employment		
	2004-10	2011-30	2031-50	2004-10	2011-30	2031-50	2004-10	2011-30	2031-50
Belgium	2.4	1.8	1.5	1.5	1.8	1.7	0.9	0.0	-0.2
EU15	2.2	1.8	1.3	1.3	1.8	1.7	0.9	-0.1	-0.4
EU10	4.5	3.0	0.9	3.6	3.1	1.9	0.9	-0.1	-1.0
EU25	2.4	1.9	1.2	1.5	2.0	1.7	0.9	-0.1	-0.5

SOURCE: EPC/Commission Report on Ageing (2005, 2006a)

- ***Real interest rate***

The long-run real interest rate determinant for the calculation of future pensions especially in the case of compulsory private funded schemes has been fixed, in agreement with the OECD and the European Central Bank, at 4 per cent.

3.3.2. Current and future expenditure

All those hypotheses having been defined concerning the population, the labour force, unemployment and employment, labour productivity and potential growth and the real interest rate, it is now possible to calculate the different age-related expenditure (see general scheme at beginning of section 3.3, diagram 7.2).

- ***Unemployment benefits***

The unemployment benefits result from a combination of three elements:

- a *constant ratio between the average unemployment benefit per head and the GDP per person employed*, equal to 14.4, as observed during the period 1998-2002;
- the *ratio between the unemployed and employed people*, as calculated; and
- the *GDP per worker*.

Because of smaller numbers of people at working age, unemployment is expected to decrease, along with its associated benefits. Table 7.6 shows the evolution of the unemployment benefits in percentage of GDP.

Table 7.6 — Total of unemployment benefits, as a percentage of GDP, Belgium and groups of EU Member States, selected years

	2002	2010	2030	2050	Change 2002-2050
Belgium	2.30	2.03	1.77	1.76	*-0.54*
EU15	1.04	0.80	0.68	0.68	*-0.37*
EU10	0.33	0.35	0.18	0.18	*-0.15*
EU25	1.01	0.79	0.61	0.61	*-0.40*

Source: EPC/Commission Report on Ageing (2006a)

Unemployment benefits in the EU25 countries would slightly decrease from 1.0 per cent of GDP in 2002 to 0.6 per cent in 2050. During the entire period, Belgium remains at a high level of unemployment benefits due to a favourable legislation, which allows, for example, people without employment to receive the benefits irrespective of the number of years being unemployed. As a result, their share in GDP remains relatively high, 2.3 per cent in 2002 and 1.8 per cent in 2050.

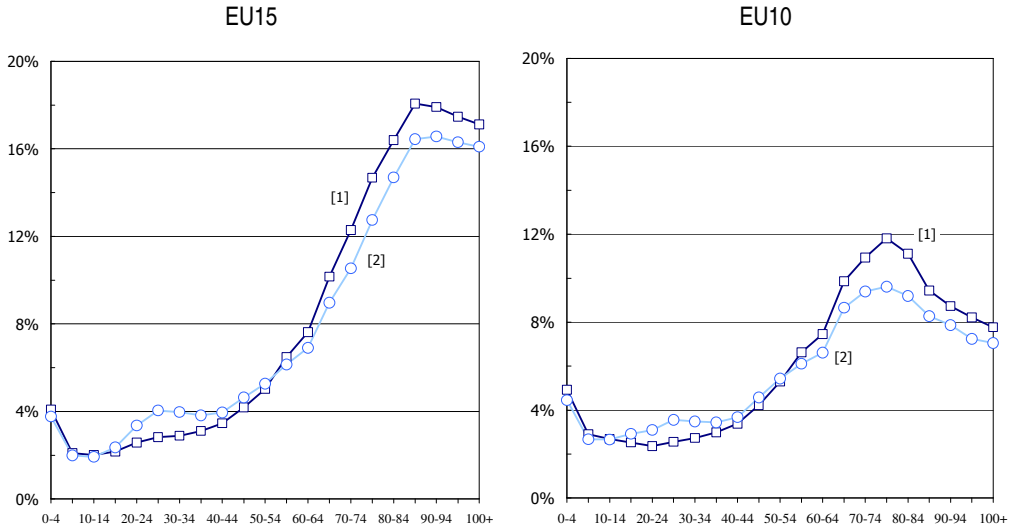
- ***Health care expenditure***

The projection of health care expenditure concerns 'acute' health care, and excludes long term care handled in the following section. It combines different elements:

- the evolution of *the population;*
- the importance of *health care expenditure relating to each age;*
- the *link between health care expenditure and growth* (GDP per head), with an elasticity of 1.1 at the beginning of the period and a move towards 1 at the end of the period;
- a higher health care expenditure at the end of life (*death-related costs*).

Figure 7.3 shows the health care expenditure profiles by 5-year age group for the EU15 and the EU10 countries. By and large, both groups of countries show a similar age pattern. In the EU10 countries the health care expenditure above age 70 is lower.

Figure 7.3 — Age-related health care expenditure profiles in the EU15 and the EU10, measured as percentage of GDP per capita, by sex



Key: [1] male; [2] female

SOURCE: EPC/Commission Report on Ageing (2006a)

Table 7.7 — Health care expenditure, expressed as a percentage of GDP, for Belgium and groups of EU Member States for selected years and expected change in percentage points from 2004 to 2050

	2004	2010	2030	2050	Change 2004-2050
Belgium	6.2	6.4	7.1	7.6	*1.4*
EU15	6.4	6.5	7.5	8.1	*1.6*
EU10	4.9	5.2	5.8	6.2	*1.3*
EU25	6.4	6.6	7.4	7.9	*1.6*

SOURCE: EPC/Commission Report on Ageing (2006a)

Table 7.7 shows the evolution of the health care expenditure as a percentage of GDP in the baseline scenario. For all countries, health care expenditure is expected to increase

from 6.4 per cent of GDP in 2004 to 7.9 per cent in 2050 — an increase of 1.6 percentage points of GDP. According to this scenario (which is based on a constant age profile: see figure 7.3) health care expenditure in the EU10 countries will remain below the EU average, from 4.9 per cent of GDP in 2004 to 6.2 per cent in 2050. In fact, by 2050 the difference in health care expenditure — expressed as percentage of GDP — could even be greater than in 2002.

- ***Long-term care expenditure***

The baseline projection of long-term care expenditure combines the following elements:

- the evolution of the *population;*
- the level of *disability*, assuming that gains in healthy life expectancy are half the gains in total life expectancy;
- the *link between health expenditure and growth* (GDP per head), fixed at an elasticity of 1.

The long-term care age profiles have quite another aspect then the health care profile. Nearly flat until the age of 60, this last profile then increases, particularly strongly after 75.

A distinction was made between formal care in institutions which would concern 130 per cent more people, and formal care at home which would concern 110 per cent more people in the EU25 area between 2004 and 2050.

As can be seen from table 7.8 long-term care expenditure would rise from 0.9 per cent of GDP in 2004 to 1.5 per cent in 2050, representing an increase in GDP by 0.6 percentage points.

Table 7.8 — Long-term care expenditure, expressed as a percentage of GDP, for Belgium and groups of EU Member States for selected years and expected change in percentage points from 2004 to 2050

	2004	2010	2030	2050	Change 2004-2050
Belgium	0.9	0.9	1.3	1.9	*1.0*
EU15	0.9	0.9	1.1	1.5	*0.6*
EU10	0.2	0.3	0.3	0.5	*0.3*
EU25	0.9	0.9	1.1	1.5	*0.6*

SOURCE: EPC/Commission Report on Ageing (2006a)

- ***Education expenditure***

The AWG scenario combines different elements, some of which held constant as observed in 2002:

- the evolution of the *population;*
- the growing *school participation rates*, considered to be complementary to activity rates;
- constant *pupil-teacher ratios* determining the staff, and consequently *staff expenditure;*
- *working and capital costs*, and *transfers* (allowances and grants), in constant proportion to staff expenditure;
- the evolution of *GDP per worker, used to index-link* all expenditure to welfare, so as to reflect the real wage or other expenditure increases.

Table 7.9 shows the evolution of the education expenditure as a percentage of GDP. Due to the decreasing number of children, education expenditure will decrease slightly over the 2004-2050 period in the EU25 area. It would fall from 4.6 per cent of GDP in 2004 to 4.0 per cent in 2050 — a reduction in GDP of 0.6 percentage points.

Table 7.9 — Expenditure in education, for Belgium and groups of EU Member States, expressed as a percentage of GDP for selected years

	2002	2010	2030	2050	Change 2004-2050
Belgium	5.6	5.2	5.0	5.0	*-0.6*
EU15	4.6	4.2	4.0	4.0	*-0.6*
EU10	4.7	3.8	3.2	3.3	*-1.4*
EU25	4.6	4.2	3.9	4.0	*-0.6*

SOURCE: EPC/Commission Report on Ageing (2006a)

- ***Public pension expenditure***

The pension expenditure taken into consideration in this exercise refers to the pensions paid by the governments, forming the first pillar. Privately funded schemes, the second pillar, and private savings (the third pillar) are not taken into consideration.

Contrary to the expenditure reviewed previously, simulations for public pension expenditure were not conducted by the European Commission on the basis of a commonly agreed methodology. Instead, each country has run its own model to take into consideration the specific rules of its legislation.

The case of Belgium illustrates the various schemes that may be considered for inclusion. They concern old-age pensions (for wage earners, self-employed, civil servants or beneficiaries of an elderly guaranteed income), early retirement pensions and disability benefits. Table 7.10 indicates that pensions represent a large share of annual wealth. Also, this share would strongly increase. From 2004 to 2050, public expenditure on pensions will increase from 10.4 per cent of GDP to 15.5 per cent, which is 5.1 percentage points more of GDP over the period.

Similarly, figure 7.4 illustrates the projected changes in public pension expenditure in percentage points of GDP, over the period 2004-2050.

The projected changes in public spending on pensions range from a decrease of 5.9 percentage points of GDP in Poland to an increase of 12.9 percentage points in Cyprus. Some newly acceded countries have thoroughly reformed their pension system, giving more space to privately funded schemes. Other countries, like Sweden and Italy, have introduced mechanisms that link the pension benefits to wage contributions and the effective career.

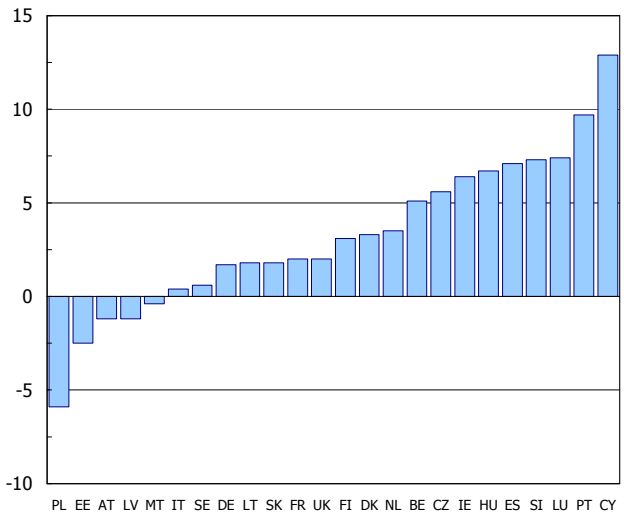
Table 7.10 — Public pension expenditure related to retirement in Belgium, expressed as a percentage of GDP, for selected years; and expected change from 2004 to 2050 in percentage points from 2004 to 2050

	2004	2010	2030	2050	Change 2004-2050
Old-age pension	9.2	9.8	13.5	14.5	*5.3*
wage earners	5.2	5.7	8.1	8.7	*3.5*
self-employed	0.7	0.8	1.1	1.1	*0.3*
public sector	3.2	3.3	4.2	4.6	*1.4*
elderly guranteed income	0.1	0.1	0.1	0.1	*0.0*
Early retirement schemes	0.4	0.5	0.5	0.4	*0.0*
Disability schemes (private sector only)	0.8	0.8	0.7	0.7	*-0.1*
Total	10.4	11.1	14.7	15.5	*5.1*

SOURCE: EPC/Commission Report on Ageing (2006a)

Figure 7.4 — Projected changes in public pension expenditure by EU Member State, in percentage point difference of GDP from 2004 to 2050

SOURCE: DG-ECFIN, European Commission (2006a) [9]



To analyse the factors driving pension expenditure, public pension expenditure growth in percentage of GDP has been split up into four main ratios:

- the *old-age dependency ratio* (see definition above);
- *inverse* of the *employment rate* for those at working age (i.e., the complement of the unemployment rate, see definition above);
- the *take-up ratio*, i.e., the number of pensioners over the total number of people aged 65 and over; and
- a *benefit factor*, i.e., a factor which captures the changes in the average pension relative to the GDP per employed person.

The role of those four factors can be expressed as follows:

$$\frac{\text{Pension Expenditures}}{\text{GDP}} = \frac{\text{Pop. aged >= 65}}{\text{Pop. (15-64)}} \times \frac{\text{Pop. (15-64)}}{\text{Pop. Employed}} \times \frac{\text{Pensioners}}{\text{Pop. aged >= 65}} \times \frac{\text{Pension Exp./ Pensions}}{\text{GDP/ Pop. Employed}}$$

Table 7.11 gives the magnitude of the relative importance of each factor in the evolution of public pension expenditure relative to GDP for Belgium and groups of EU member countries in 2005 and 2050. The changes that are expected in the ratios between those two years (for the pension expenditure as a whole and for its components) are expressed in percentage point differences.

The old-age dependency ratio (OADR) will increase the most in the new Member States (by +9.9 percentage points) and the employment ratio will also decrease there the most (by -1.7 percentage points). Yet thanks to the pensions reforms the growth of public pension expenditure over the period would be limited there to 0.3 percentage points of GDP.

The evolution of public pension expenditure will be far less favourable in the EU15 zone (+2.3 percentage points of GDP). In Belgium, the OADR should increase by 7.7 percentage points but at the end of the period public pension expenditure growth would gain 5.1 percentage points of GDP. Both illustrate the necessity of more reforms to face the challenge of financing future pensions.

Table 7.11 — The public pension expenditure growth in per cent of GDP, Belgium and groups of EU Member States; and percentage point differences of its four components from 2005 to 2050

	Pension expenditures, as percentage of GDP (percentage point difference in italics at bottom)		Expected changes from 2005 to 2050 in the various pension factors (in percentage point difference)				
	2005	2050	Old-age Dependency ratio	Inverse of Employment rate	Take-up ratio	Pensions Replacement rate	Interaction Effect (residual)
Belgium	10.4	15.5					
		5.1	*7.7*	*-1.5*	*-0.4*	*-0.6*	*-0.1*
EU15	10.5	12.8					
		2.3	*8.2*	*-1.0*	*-1.7*	*-2.8*	*-0.4*
EU10	11.5	11.8					
		0.3	*9.9*	*-1.7*	*-3.8*	*-3.5*	*-0.6*
EU25	10.6	12.9					
		2.3	*8.6*	*-1.1*	*-2.1*	*-2.7*	*-0.4*

SOURCE: EPC/Commission Report on Ageing (2006a)

3.3.3. The budgetary cost of ageing

Finally, by adding together the development of all age-related expenditure calculated in section 3.3.2. we get the *budgetary cost of ageing,* which is *the INCREASE in percentage points of GDP of TOTAL age-related expenditure*.

Table 7.12 details the evolution for Belgium. The impact of ageing would be the most important between 2004 and 2030 (+4.5 percentage points of GDP). After 2030, the influence of the important 'baby boom' generation will gradually disappear. Between 2030 and 2050, the age-related expenditure will still increase but only by +1.8 percentage points of GDP.

The impact of pension expenditure is the most important (5.1 percentage points of GDP over the 2004-2050 period). Over the same period, health and long-term care will accrue their weight by 2.4 percentage points of GDP. Education and unemployment benefits would only register a reduction of 1.2 percentage points of GDP.

Globally, the budgetary cost of ageing in Belgium will attain 6.3 percentage point of GDP over the 2004-2050 period.

Table 7.12 — Evolution of age-related expenditure (in % of GDP) and budgetary cost of ageing (in percentage point difference) in Belgium

					Changes (percentage point diff.)	
	2004	2010	2030	2050	2004-2030	2004-2050
Pensions	10.4	10.5	14.7	15.5	*4.3*	*5.1*
Health care	6.2	6.4	7.1	7.6	*0.9*	*1.4*
Long-term care	0.9	0.9	1.3	1.8	*0.4*	*1.0*
Education	5.6	5.2	5.0	5.0	*-0.6*	*-0.7*
Unemployment	2.3	2.0	1.8	1.8	*-0.5*	*-0.5*
Total	25.4	25.1	29.9	31.7		
Budgetary Cost of Ageing					*4.5*	*6.3*

SOURCE: EPC/Commission Report on Ageing (2006b)

Finally, table 7.13 gives the budgetary cost of ageing caused by age-related expenditure in the different European areas, comparing it to Belgium.

Table 7.13 — Expected change in age-related expenditure by type and budgetary cost of ageing, over the 2004-2050 period, in percentage points of GDP, in Belgium and groups of EU Member States

	Pensions	Health care	Long-term care	Education	Unemploy-ment	Budgetary cost of ageing
Belgium	5.1	1.4	1.0	-0.7	-0.5	6.3
EU15	2.3	1.6	0.7	-0.6	-0.2	3.7
EU10	0.3	1.3	0.2	-1.3	-0.2	0.2
EU25	2.2	1.6	0.6	-0.6	-0.3	3.4

SOURCE: EPC/Commission Report on Ageing (2006b)

The exercises presented above are based on a no-policy-change scenario.

In this framework, the budgetary cost of ageing could be relatively low for the EU10 countries (0.2 percentage points of GDP over the 2004-2050 period). The increase in

health care expenditure would carry the most weight (1.3 percentage points of GDP), however this increase would be compensated by a similar reduction in education expenditure as the result of low fertility.

In the EU15 countries, pensions, health care and long-term care expenditure will increase by 2.3, 1.6 and 0.7 percentage points difference, respectively. As a result the budgetary cost of ageing over the 2004-2050 period in the EU15 would reach 3.7 percentage points of GDP.

By and large, in Europe, the budgetary cost of ageing already seems to be benefiting from the positive impact of all the reforms previously introduced. However, there is still work to be done, in the whole area and in some countries in particular, as is the case for Belgium.

By and large, in Europe, the budgetary cost of ageing already seems to be benefiting from the positive impact of all the reforms previously introduced. However, there is still work left to be done, in the whole area and in some countries in particular. The latter is certainly true for Belgium.

3. Concluding remarks

This general increase of life expectancy is an unprecedented occurrence in human history. It offers new perspectives but also generates challenges.

Having been combined in most Western countries with a long-lasting low fertility rate, this evolution generates concerns, notably about how to continue to finance expenditure specifically linked to older people, namely pensions, health and care expenditure and so on. The recent and so far short-lived experience of the EU Member States has been described here to illustrate the problems that can be encountered and possible solutions to them. This can constitute an instructive example for others who are bound to experience the same evolution sooner or later.

The role of a supranational organisation such as the European Union can be underlined as the definition of common goals and working methods to face a common challenge, as well as mutual aid, which have largely contributed to the timely launch of necessary and deep reforms in its Member States.

> ***The Increase of Life Expectancy as Initiated in the Twentieth Century: a Revolution Calling For Societal Reforms.*** In the European countries and all over the world, since ageing will sooner or later become a universal phenomenon, policy-makers and society should realise that the increase of life expectancy is a profound structural change not [10]

only with opportunities, such as a longer healthy life, but also entailing burdens, such as an increasing dependency in the oldest age groups.

As a consequence, the course of life should be thoroughly adjusted to a larger mix of education, work and leisure. New concepts should be introduced, such as life-long learning (even for the eldest) and longer but lighter professional careers to combine more adequately and less heavily work, family, self-development and social activities, and this for all ages.

> ***How to Face the Challenge of Financing Ageing. The Case of the European Countries.*** In most EU countries *there is a window of opportunity to prepare the ageing peak*. Most of the 'baby-boom' generations (i.e. the aged generations born in the two decades after WWII) will reach retirement age in the period 2015-2030. Employment will continue to grow until 2017. In this respect, there would still be time to adopt the necessary new life-styles. However policy-makers should also realise that time is needed to get people used to the changes.

In other words, there is an *urgent need for citizens to become fully aware of the challenges of ageing*.

Besides *necessary societal reforms*, the governments should pursue the reforms to *guarantee the financing of old age-related expenditure*. An adequate economic, financial and social policy should be founded on the following axes:

- guaranteeing positive and solid growth, notably by developing a good structure of economic activities and by supporting research and education;
- promoting employment, through an adequate policy respecting people of all ages;
- pursuing strict public finance policies by reforming the sectors linked to ageing, and avoiding all unnecessary expenditures;
- aiming social interventions at the most needy.

> ***The Role of the European Union.*** So far, at international level the measures that should lead to adopting new ways of life are limited. However, *the European Union does encourage Member States to adjust their economic and budgetary policies*. Several instruments have been developed for this:

- the *Lisbon Strategy*: aiming to enhance employment and GDP growth;
- *Budgetary Surveillance*: based on the long-term budgetary projections, and assessment of the sustainability of public finances within the framework of the Stability and Growth Pact;

- the *Open Method of Co-ordination*: by peer review of policies, such as the new pension reforms and research of the best practices.

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Endnotes Chapter Seven:

1 See introductory chapter by R. Schoenmaeckers.

2 On its website (http://kce.fgov.be) the KCE is presented as follows: "The KCE is a semi-governmental institution which produces analyses and studies in the different research domains in which decisions must be taken; collecting and disseminating objective information from registered data, literature and current practice; and developing high level scientific expertise in its research domains".

3 MALTESE stands for: Model for Analysis of Long Term Evolution of Social Expenditure.

4 Changes in various dependency ratios are further discussed in section 3.3.1.

5 The abbreviations used correspond to those agreed upon by the European institutions: PL (Poland), EE (Estonia), AT (Austria), LV (Latvia), MT (Malta), IT (Italy), SE (Sweden), DE (Germany), LT (Lithuania), SK (Slovakia), FR (France), UK (United Kingdom), FI (Finland), DK (Denmark), NL (Netherlands), BE (Belgium), CZ (Czech Republic), IE (Ireland), HU (Hungary), ES (Spain), SI (Slovenia), LU (Luxembourg), PT (Portugal), CY (Cyprus). Data for GR (Greece) were not available.

6 NAIRU (Non-Accelerating Inflation Rate of Unemployment) corresponds to the lowest possible unemployment rate compatible with a non-inflationary environment. The NAIRU estimates used by the Commission are those agreed by the Output Gap Working Group of the Economic Policy Committee.

7 These values refer to the 2006 AWG exercise. A new exercise will be published in 2009.

8 Long term economic projections are elaborated in real terms.

9 Cf. footnote nº 5.

10 As emphasised by the Madrid International Plan of Action on Ageing in 2002; cf. Report of the Second World Assembly on Ageing, Madrid, 8-12 April 2002.

Chapter Eight

Population Ageing in Europe: Lessons Drawn from EU Projects

Jolanta PEREK-BIALAS

Contents:

1. Introduction

'Population ageing' has become a common research item in Europe, not only among population scientists, but also among social policy scientists. Quite often these days research on social policy starts by referring to 'population ageing'; it appears to be the key issue, the basis of the analysis which is to follow. Demographers may not like it, but the concept of 'population ageing' has become the main research issue for sociologists, psychologists, economists, social science researchers; and (of course) also for gerontologists, geriatricians and medical science researchers.

This chapter focuses on the way that 'population ageing' has become a major topic for the research agenda of the European Commission. This will be done by presenting an inventory of recent and current research projects on the issue carried out with financial assistance from the European Union.

The inventory should shed light on the following specific questions:

a) In what way is the EU interested in European population ageing research? What are the specific projects that are related to population ageing?

b) What have we been able to learn from these projects?

c) What are we (still) missing? And what are the (policy) recommendations for future research?

The chapter ends with some recommendations for the future research agenda and for policy-makers.

Before tackling the European research agenda on 'population ageing', however, let us start by presenting a (very) short overview of the demographic development that is at the bottom of its interest, i.e. the growing number of older people.

2. The background

'Population ageing' refers to the end result of changes in fertility and mortality that lead to an older population age structure. In short, the process refers to the growing numbers of older people — commonly defined as those aged 60 or over — in the population. To some demographers (see for example Schoenmaeckers in the first chapter) the process may be seen as the last leg of the 'demographic transition' (for more explanation, see for example Chenais, 1986). Regardless whether one shares this point of view, there is a growing agreement among demographers and social scientists

that 'population ageing' will be the most important demographic development of the 21st century (Lutz, Sanderson and Scherbov, 2004).

'Population ageing' appears to be a universal phenomenon. It would, however, be wrong to conclude that it occurs in all countries at an identical pace. The diversity across countries (and continents) is already demonstrated in the first chapter by Schoenmaeckers. But also inside the European area one can observe important differences between countries. It is not the purpose here to discuss in detail the differences in demographic regime that exist between the European countries. We only want to draw attention to the most salient differences with respect to the proportions of older people in the EU Member States and the differences in the observed and expected evolution of these proportions. Here we are not really interested in the experience of a single country. In most instances it seems sufficient to underline the differences that exist between the 15 'old' and the 10 'new' EU Member States; by 'new' we refer of course to those eastern European countries that joined the EU on 1 May 2004. The differences between these two groups of countries in the proportion of older people are indicative of different demographic regimes in the past. And although the changes are similar in all Member States — low levels of fertility and increases in life expectancy — to a large extent these differences will persist for the next couple of decades. Policy-makers need to be aware that the EU Member States are not, in spite of their similarities, a homogeneous set of countries.

2.1. More older people

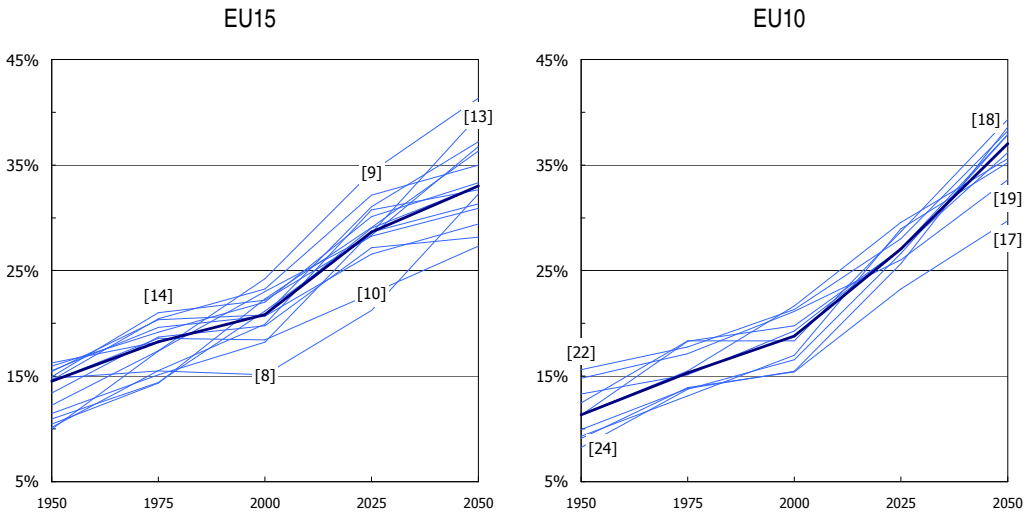
The major differences between Member States with respect to the evolution of the proportions of older people are captured in figures 8.1 and 8.2.

Figure 8.1 shows the percentage of people aged 60 and over and of age 80 and over, respectively. For each set, the data are shown for the 'old' EU (EU15) and the 'new' EU (EU10) Member States. At individual country level, only some 'outliers' have been identified. The major differences that exist between the two groups of Member States are captured by the thick line in the graphs, which corresponds to the median value between the countries in each group.

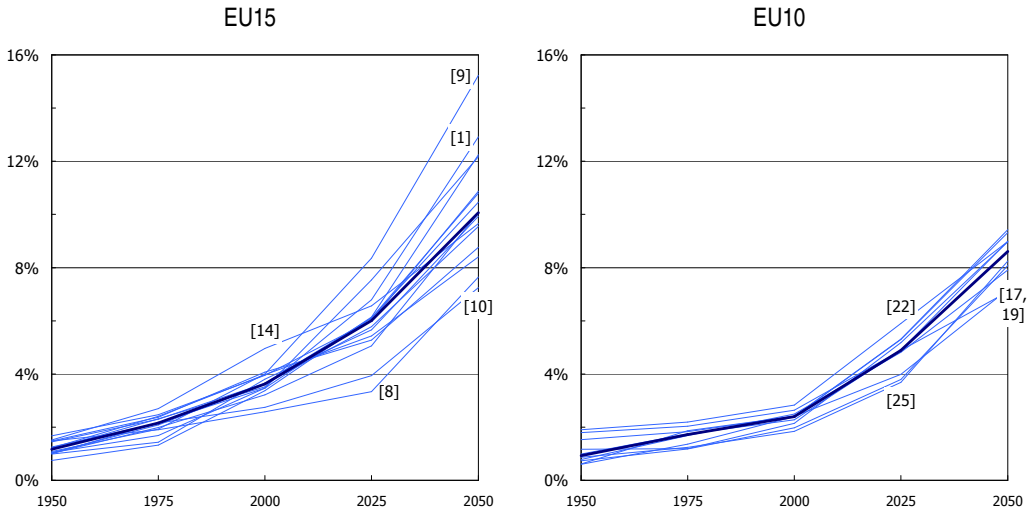
It is clear that, by and large, the percentage values are higher for the 'old' member countries; this is true for the proportions of people aged 60 or more and of the proportions aged 80 or more (the latter also called as the 'oldest old'). This suggests that 'population ageing' is a more recent phenomenon for the 'new' Member States than for the 'old' Member States. However, the situation is changing rapidly.

Figure 8.1 — Evolution of the proportion of people aged 60 and over and of age 80 and over in the Member States of the EU, 1950–2050

A. Percentage people aged 60 and over



B. Percentage people aged 80 and over



Key (limited to the countries identified in the graphs):
[1] Austria, [8] Ireland, [9] Italy, [10] Luxembourg, [13] Spain, [14] Sweden, [17] Cyprus, [18] Czech Republic, [19] Estonia, [22] Latvia, [24] Poland, [25] Slovakia

SOURCE: *UN World Population Prospects. The 2004 Revision*

The graphs show that by 2050 the share of older people will be greater in the EU10 than in the EU15 countries; by that time, a full 37 per cent (median value) of the population in the EU10 countries will be aged 60 or more compared to 'only' 33 per cent in the EU15 countries. As can be observed from the graphs most of the increase in the proportions will be occurring between 2000 and 2050. The explanation is that the fertility decline that is associated with the 'second demographic transition' (van de Kaa, 1987) has started later in the Eastern European countries than in the Western European countries, and that the decline has occurred in a relatively shorter period.

However, the greatest differences between the EU15 and EU10 countries are found for the proportions aged 80 or more. As shown in the chapter by Schoenmaeckers, the proportions aged 60 or more are especially sensitive to fertility decline and in all countries fertility is very low (less than 2 children) [1]. At a higher age, the proportions become more sensitive to mortality. Indeed, the smaller proportions of people aged 80 or more that are observed for the EU10 countries are the result of the fact that life expectancy in these countries is, on average, about 5 years lower than in the EU15 countries, 74 years as opposed to 79 years (2005–2010, both sexes combined) (UN, 2005) [2]. But, as can be derived from the steeper slope in the graphs after 2000, the 'new' Member States are expected to 'catch up' in the near future; by 2050, the difference in life expectancy will be reduced to less than four years, 80.1 years as opposed to 73.7 years (median value, both sexes combined; UN, 2005).

Finally, from figure 8.1 one can observe that also within each group of countries there are important differences between countries with respect to the evolution of the proportions of older people. For example, by 2050 both Italy and Spain are expected to have the highest proportion of people aged 60 or more in their population. However, at around 2000 the proportion for Spain was still below the median value. The steep rise for Spain can be explained by a relatively late fertility decline in this country (later than in Italy and much later than in, for example, Sweden, which showed the highest proportion of older people at around 1975).

By 2050, Italy will experience the highest levels for both the proportions of people aged 60 and over *and* aged 80 and over. This is the result of very low fertility (1.38 children per woman) and of relatively high life expectancy (81 years) (both measures referring to the situation in 2005–2010; UN, 2005).

One specific question that is raised in the context of 'population ageing' is to what extent the increase in life expectancy implies an extra number of years in good health.

2.2. Extra years in good health

So far, researchers do not seem to agree on the answer to this question. Some, such as for example Robine *et al.* (1992), have a pessimistic point of view; they tend to believe that the higher longevity implies more years in bad health. Others, like for instance Schoenmaeckers (2005), referring to the work of Lutz and Scherbov (2003), share a more optimistic view: longer life expectancy must not necessarily imply more years in bad health. The difference is important. If Schoenmaeckers, Lutz and Scherbov (and others) are right, an older population structure should not immediately be associated with an increase in medical expenses. However, as will be shown below, 'population ageing' does have an important bearing on the quality of life, and the quality of life is closely correlated with the individual health status. As a result, many European projects related to the issue of 'population ageing' are identified as 'health'-related research. The discussion has at least the merit to indicate that the demographic indicator of 'life expectancy' is a crude indicator for measuring the quality of life at old age.

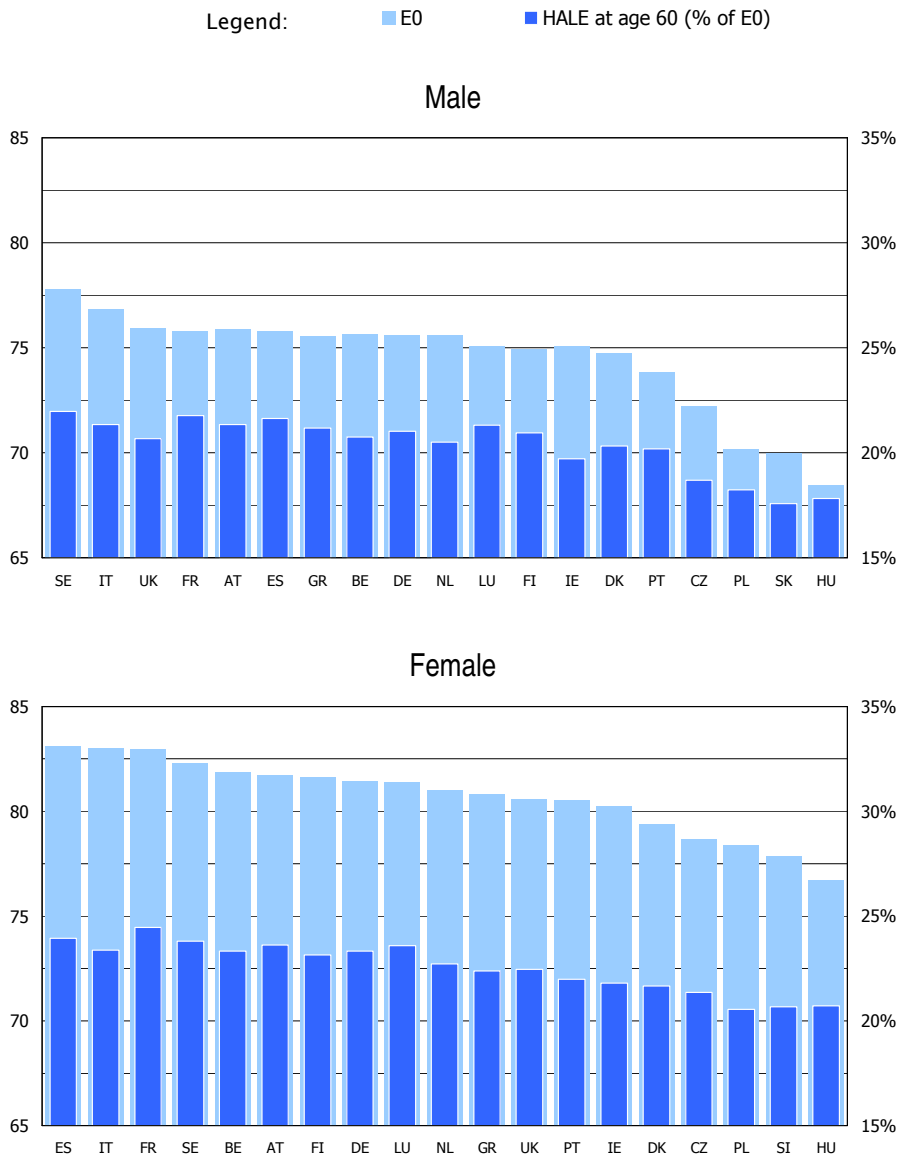
Healthy life expectancy needs to be taken into account when assessing the quality of life in analyses related to the issue of 'population ageing' (Mollenkopf and Walker, 2007 [3]). In order to compare healthy life expectancies between countries there is the need to develop measures for health-adjusted life expectancy, such as the one presented in table A1 in annex, and further used in figure 8.2.

Figure 8.2 shows the life expectancy at birth at around 2002 and the HALE values at age 60 expressed as a percentage of total life expectancy. The countries are ranked by decreasing level of life expectancy; ranking is done separately for each sex.

Even this simple presentation is indicative of the fact that, although there certainly is a close association, in relative terms, the extra amount of life spent in good health is not constant with respect to the level of life expectancy. For males, the percentage of HALE at age 60 with respect to life expectancy at birth varies from 17.6 to 21.0 per cent; for females it varies from 20.5 to 24.5 percent. Not only are the percentage values difference between the sexes, so is the range: the range between minimum and maximum is about one percentage point greater for men than for women.

But the most important observation is that there is no direct relationship between the level of life expectancy and the relative value of HALE. For males, for example, with a HALE percentage value of 21 per cent, Finland ranks relatively high (about 0.2 percentage points above the median), but only occupies 12th position with respect to life expectancy, 75 years or nearly three years less than Sweden (77.8 years).

Figure 8.2 — Life expectancy (E0, in years), left scale, and Health-adjusted life expectancy (HALE) at age 60, right scale, expressed in percentage of E0, selection of EU Member States, situation around 2002



SOURCE: Table A1 in annex (for HALE values) and *UN World Population Prospects. The 2004 Revision* (for E0)

Similar observations can be made for women. Moreover, figure 8.2 shows that the ranking is different by sex — for both life expectancy as for the HALE values.

3. The European Union research agenda on 'population ageing'. An inventory on recent and on-going projects

From the above it is clear that in the coming decades the age composition of the European populations is to change dramatically: the proportion of older people (those aged 60 and more) will increase from about 20 per cent in 2000 to no less than 35 per cent by 2050 — a multiplication by three-quarters. As some demographers have already indicated, 'population ageing' will be the major demographic phenomenon of the 21st century and the change in age composition is bound to have major socio-economic consequences.

It is therefore no surprise that the European Commission has included 'population ageing' in its research agenda where it has become one of the major research themes. Indeed, as is shown in the database 'CORDIS' [www.cordis.europa.eu], over 300 EU projects so far can be identified as related to the issue. All past and future framework programmes include themes or areas that can be linked to research on 'population ageing'. In the 5th Framework Programme there were two relevant Thematic Programmes: 1) "*Quality of life and management of living resources'* with Key Action: The ageing population and disabilities; and 2) '*Improving human research potential and the socio-economic knowledge base'* with Key Action: Improving human research potential and the socio-economic knowledge base. In the 6th Framework Programme the thematic areas were as follows: life sciences, genomics and biotechnology for health, citizens and governance in a knowledge-based society (with cross-cutting activities for research for policy support in which population ageing issues could be analysed [4]). Finally, the major themes of the current 7th Framework Programme are 1) Major trends in society and their implications; and 2) The impact of demographic changes in Europe (within the overall subject of Demographic Changes.

Most likely, the European Commission's interest in 'population ageing' will not disappear in the near future. But before discussing future themes and projects, let us have a look at past and present activities already financed by the European Commission.

Table A2 in annex gives an overview of projects that are related to 'population ageing' financed under the 5th and 6th Framework Programmes [5]. The table includes a short

description for each project and gives, where possible, the name of the project co-ordinator and the website address.

4. Conclusions

Taking into account the many studies on the subject that have recently been financed, there is no doubt that the process of 'population ageing' is considered as a main topic for the European research agenda. The European projects cover a wide range of aspects such as: health, care, work, retirement, gender, education, technology, immigration. From here one may conclude that we must have learned a lot on the subject; on the other hand, many of the studies point to the fact that there is still much more to learn.

One thing should be clear, however, namely the fact that in order to better understand the effects that population ageing may have on our societies, there is the need for much international co-operation. This was one of the conclusions of the 'Triple-Dose' Conference that was held in Kraków, Poland in 2006 [6]. As Schoenmaeckers points out in his study for the Council of Europe (2005: 94), this conclusion is not new. However, it is worth reiteration. In the case of 'population ageing', the phenomenon, its consequences and the challenges that it entails, will never be fully understood without effective international co-operation. One particular issue (also mentioned by Schoenmaeckers) is the need for an international database and the sharing of existing statistical information. At this moment, there already exist two data sets financed from the European budget that to a certain extent meet with these demands.

The first one is the *European Social Survey* [7]. The ESS covers a variety of socio-economic issues. The data set is well documented and is available free of charge. The second one (included in table A2), is the *Survey of Health, Ageing and Retirement in Europe*, better known by its acronym SHARE [8]. SHARE is, as its name suggests, more specific in scope than the ESS. The SHARE data set is the result of a project funded under the 5th and 6th Framework Programmes.

One cannot question the fact that during the last years much progress has been made in our understanding of 'population ageing', more particularly from projects undertaken under the umbrella of the EU Framework Programmes. However, much more needs to be done, and the identification and development of future research should best be based on past experiences.

It is for instance clear that there is much overlap between many projects already realised. In this respect there is the need for some 'cross-cutting' analysis — a kind of

'executive summary' — of obtained results. A comparison of results would be a great asset for policy-makers. It is also important that results be clearly disseminated to policy-makers and the general public through 'accessible' publications, web pages and conferences and that these results are discussed at workshops that should be organised as 'meeting places' for academics and policy-makers. It is a fact that all too often the results are discussed at workshops where the only participants are researchers. Very often these workshops are an integral part of the project implemented under the umbrella of one of the Framework Programmes. However, the key issue here should be 'shared responsibility': researchers have the responsibility to present their findings in a clear language, avoiding 'academic jargon'. On the other hand, policy-makers have the duty to identify the (technical and political) obstacles for implementing the suggested solutions.

With these objectives in mind, we would suggest the following recommendations:

- **A more efficient dissemination of research results.** It needs to be recognised that the issue of clear dissemination is largely undervalued in many projects. The issue is particularly worrisome for researchers from Central and Eastern European countries, for whom the latest publications are not always easily accessible (in spite of financial support from the European Commission). Events such as, for example, the "First Forum on Europe's Demographic Future", held at the end of October 2006, and organised by the DG Employment [9] should happen at more regular time intervals and as such become an integral part of the research agenda.

- **The elimination of barriers for the implementation of recommendations based on research findings**. One specific barrier is the fact that policy-makers are not inclined to take long-time perspectives into account. 'Population ageing' is a clear example. For about 50 years now, demographers point at the emergence of older population structures as a 'logical' result associated with the demographic transition (see, for example, the article by Frank Notestein of 1953). Researchers themselves are part of the problem to the extent that communication with policymakers is not their main priority; what counts is an exchange of ideas with colleagues in the research community. On the other hand, it needs to be recognised that very often policy-makers are rather short-sighted in looking for solutions (the next elections appear to be their natural horizon). Clearly, one and the other bring us back to the earlier point, namely efficient dissemination of results.

- **Promoting the idea of shared responsibilities.** The need for shared responsibilities has already been outlined above. It is repeated here because it is a key recommendation. The idea has more than just a practical dimension. Shared

responsibility also means that everyone — policy-makers and researchers alike — should feel responsible for making progress to ensure a better quality of life for Europe's population.

The idea is not entirely new. It can also be found in documents produced by the European Commission, such as the report by Kok (2004), which focuses on the joint responsibility of different stakeholders in human capital investment. The concept of sharing costs and responsibilities for increased investment in human resources by all actors — public authorities, individuals and employers — is expected to foster the implementation of new measures to develop a widespread culture of business investment in training, accessible for all, regardless of age, and encourage individuals to participate in lifelong learning [10].

Its implementation cannot be taken for granted. One of the reports of the European Forum on Population Ageing Research [11] contains the very sincere but rather pessimistic message that "*getting national funders to work together at the European level was considered problematic, and barriers to European collaboration included a competitive rather than collaborative research environment, problems with apportioning funds appropriately, evaluating cross-disciplinary research, and cultural and linguistic barriers*" [12].

Not surprisingly, the Commission itself already has some ideas about how future research in the area of 'population ageing' should best be organised.

The Commission expects that research should aim to providing further understanding of the interactions between current demographic and societal trends at the European and international level. For example, what are the implications of trends such as ageing, low fertility and migration for the European welfare systems; and what would be the best policy measures for meeting these challenges? One and the other is already part of Area 1 of the 7th Framework Programme on 'Demographic Changes' (see also Vittorino, 2007a, 2007b). We can only hope that the results of newly funded projects will be helpful for all of us and will help in identifying the right direction towards a better quality of life.

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Annex

Table A1 — Health-Adjusted Life Expectancy (HALE), at birth and at age 60, by sex, 2002- estimates for OECD countries

	HALE at birth			HALE at age 60		Expected number of healthy years over entire life span			
						Number of years		% of life expectancy	
	Both sexes	Male	Female	Male	Female	Male	Female	Male	Female
Australia	72.6	70.9	74.3	16.9	19.5	7.0	8.7	9.0	10.4
Austria	71.4	69.3	73.5	16.2	19.3	7.1	8.6	9.3	10.5
Belgium	71.1	68.9	73.3	15.7	19.1	6.3	8.2	8.3	10.1
Canada	72.0	70.1	74.0	16.1	19.3	7.1	8.3	9.2	10.0
Czech Republic	68.4	65.9	70.9	13.5	16.8	6.6	8.1	9.1	10.3
Denmark	69.8	68.6	71.1	15.2	17.2	6.3	8.4	8.4	10.5
Finland	71.1	68.7	73.5	15.7	18.9	6.1	8.0	8.1	9.9
France	72.0	69.3	74.7	16.5	20.3	6.6	8.8	8.7	10.6
Germany	71.8	69.6	74.0	15.9	19.0	5.9	7.6	7.8	9.3
Greece	71.0	69.1	72.9	16.0	18.1	6.7	8.1	8.9	10.0
Hungary	64.9	61.5	68.2	12.2	15.9	6.9	8.6	10.0	11.2
Iceland	72.8	72.1	73.6	17.5	18.7	6.3	8.2	8.1	10.0
Ireland	69.8	68.1	71.5	14.8	17.5	6.3	8.2	8.5	10.3
Italy	72.7	70.7	74.7	16.4	19.4	6.0	7.8	7.8	9.5
Japan	75.0	72.3	77.7	17.5	21.7	6.1	7.5	7.8	8.8
Luxembourg	71.5	69.3	73.7	16.0	19.2	6.4	8.0	8.4	9.8
Mexico	65.5	63.4	67.6	14.5	16.3	8.4	9.3	11.6	12.1
Netherlands	71.2	69.7	72.6	15.5	18.4	6.3	8.5	8.3	10.4
New Zealand	70.8	69.5	72.2	16.0	18.2	7.2	9.0	9.3	11.1
Norway	72.0	70.4	73.6	16.2	18.9	5.9	8.1	7.8	9.9
Poland	65.8	63.1	68.5	12.8	16.1	7.5	10.2	10.6	13.0
Portugal	69.2	66.7	71.7	14.9	17.7	6.9	8.8	9.4	10.9
Rep. of Korea	67.8	64.8	70.8	13.2	17.1	6.9	8.6	9.7	10.8
Slovak Republic	66.2	63.0	69.4	12.3	16.1	6.7	8.9	9.6	11.4
Spain	72.6	69.9	75.3	16.4	19.9	6.2	7.7	8.2	9.3
Sweden	73.3	71.9	74.8	17.1	19.6	6.2	7.9	7.9	9.5
Switzerland	73.2	71.1	75.3	17.1	20.4	6.6	8.1	8.5	9.7
Turkey	62.0	61.2	62.8	12.8	14.2	6.7	9.3	9.8	12.9
United Kingdom	70.6	69.1	72.1	15.7	18.1	6.7	8.4	8.8	10.4
United States	69.3	67.2	71.3	15.3	17.9	7.4	8.5	9.9	10.7

SOURCE: *WHO World Health Report 2003*: Annex Table 4

NOTE: Healthy life expectancy, or health-adjusted life expectancy (HALE), aims to summarise the number of years to be lived in what might be termed the equivalent of "full health". To calculate HALE, WHO weights the years of ill-health according to severity and substracts them from overall life expectancy to give the equivalent years of healthy life

Table A2 — List of selected projects related to 'population ageing' under the 5th and 6th EU Framework Programmes

Title of the project (acronym when available) and EU project identification number	Project co-ordinator, website and contact person; list of project partners when available
European forum on population ageing research management QLK6-CT-2001-30116	
The project seeks to develop synergies between the key action on ageing and national and international research programmes; to improve research communication; to promote cooperation in ageing research; to stimulate new interdisciplinary research; and to promote a dialogue between science and citizens in this field. The end results should give clearer research priorities, closer collaboration between research programmes and a more efficient and effective approach to ageing research in Europe.	DEPARTMENT OF SOCIOLOGICAL STUDIES, UNIVERSITY OF SHEFFIELD (United Kingdom) www.ageingresearch.group.shef.ac.uk Dr Anne MALLABAND
The impact of population ageing on health care expenditure and long term care costs QLK6-CT-2001-30084	
The project partners claimed that at present our knowledge regarding the impact of population ageing on the costs of health care and long-term care is limited and the issue is subject to conflicting arguments. As there is no one source of information on this issue, nor is there any systematic review of the literature in this area, so their project aimed to provide European policy-makers with this necessary and relevant information, so that they will be better equipped to address the implications of ageing in the EU.	DEPARTMENT OF HEALTH, LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE (United Kingdom) Dr Bryan PEARCE

Ageing populations - policy lessons from the east — Acronym: APPLE

QLK6-CT-2002-30201

How will pensions be financed? Who will care for older people? How can older people pursue active, inclusive lives? A workshop was organised in which experts from the economically dynamic Asian countries presented the policy challenges and solutions sought in their own countries. A dissemination strategy could ensure that relevant policy lessons are available to researchers and policy-makers in the EC and its Member States.

SCHOOL OF SOCIAL SCIENCE, DEPARTMENT OF SOCIAL POLICY AND SOCIAL WORK, UNIVERSITY OF BIRMINGHAM (United Kingdom)
www.socialresearch.bham.ac.uk

Ms Jean HAMMERSLEY

Site for training in ageing and gerontological education

QLK6-CT-1999-51267

Erotological research related to improving the quality of life and better functioning of the elderly - applied to social policy, ethics and society; biomedical research; assessment and rehabilitation; care in practice and variations in quality of life.

SHEFFIELD INSTITUTE FOR STUDIES ON AGEING, UNIVERSITY OF SHEFFIELD (United Kingdom)
www.shef.ac.uk/sisa/international

Dr Anne MALLABAND

Ageing well: European study of adult well being — Acronym: ESAW

QLK6-CT-2001-00280

A European Study of Adult Well-Being (ESAW) would produce a European Socio-Cultural Model for Ageing Well, which estimates the direct causal contribution of five key components (physical health and functional status, mental efficacy, life activity, material security and social support) with personal characteristics and culture to the outcome variable ageing well. The research would yield an integrated dataset from six national samples of 2000-2400 adults aged between 50 and 90. The findings informed domestic and international policy development, and guide the delivery of professional care and services to older people across Europe.

CENTRE FOR SOCIAL POLICY RESEARCH AND DEVELOPMENT, UNIVERSITY OF WALES - BANGOR (United Kingdom)
www.bangor.ac.uk/esaw

Mr Paul STOREY

Participants: UNIVERSITEIT VAN AMSTERDAM, UNIVERSITY OF VIENNA, LUND UNIVERSITY, CENTRE UNIVERSITAIRE DE LUXEMBOURG, ITALIAN NATIONAL RESEARCH CENTER ON AGING

Enabling autonomy, participation, and well-being in old age: the home environment as a determinant for healthy ageing — Acronym: ENABLE-AGE

QLK6-CT-2001-00334

This interdisciplinary project considers subjective and objective person-environment relationships as important determinants to healthy ageing, in an EU perspective. The main aim was to examine the home environment as a determinant for autonomy, participation, and well being in old age, in a longitudinal perspective. The seven project objectives focus person-environment transactions among very old adults in five different countries. A macro level update on housing policies was performed, and integrated with the knowledge generated by a survey (N=2,000) and an in-depth study (N=200), a revised and optimised standard methodology for housing issues as related to functional health be provided, furthering the provision of evidence-based policy recommendations in order to maintain autonomy, participation, and well-being in old adults in the EU.

DEPARTMENT OF CLINICAL NEUROSCIENCE, DIVISION OF OCCUPATIONAL THERAPY, LUND UNIVERSITY (Sweden)
www.enableage.arb.lu.se/pub.html

Prof. Susanne Iwarsson

Participants: THE UNIVERSITY OF LIVERPOOL, THE GERMAN CENTRE FOR RESEARCH ON AGEING AT THE UNIVERSITY OF HEIDELBERG, THE MANCHESTER METROPOLITAN UNIVERSITY, INSTITUTE OF SOCIOLOGY - HUNGARIAN ACADEMY OF SCIENCES, MEDICAL ACADEMY OF LATVIA

Minority elderly care

QLK6-CT-2000-00779

Europe's minority elderly in the next decade will be a larger share of the elderly giving rise to 'urgency' in research and developments. Policymakers face the dilemma of how best to meet their needs. The project provided empirical evidence on the 'best fit' in managing health and social care to minority elderly. It should adopt three foci using quantitative and qualitative methods adopting a process perspective. The project tried to assess expectations and needs met from minority elderly perspective; assess actual delivery by mainstream providers and minority voluntary organisations. In turn it examined anecdotal presumptions held by the three groupings like 'they will return home';

PRIAE - POLICY RESEARCH INSTITUTE ON AGEING AND ETHNICITY, LEEDS (United Kingdom)
www.priae.org/projects/mec.htm

Lord Herman OUSELEY

Participants: STAKES NATIONAL RESEARCH AND DEVELOPMENT CENTRE FOR WELFARE AND HEALTH, ASSOCIATION NATIONALE DES COMMUNAUTES EDUCATIVES, STICHTING VOOR TOEGEPASTE GERONTOLOGIE V.U. , PLAN EXCEL SOCIEDAD LIMITADA, INTERNATIONAL INSTITUTE FOR EMPIRICAL SOCIOECONOMICS

'families look after their own'. This represents a first comparative research examining diverse minority elderly including displaced population in 8 countries.

European challenge for healthy ageing — Acronym: ECHA

QLK6-CT-2001-00128

Frailty is emerging as a major characteristic of elderly people. It is characterised by an impending disability and high risk of morbidity and mortality. The relative impact of environment and genetics on frailty is presently unknown. This question was addressed by assuming that frailty is low in centenarians' children and by comparing couples of cousins 60-80 years old born from discordant sib pairs as for age of death (one centenarian and his/her sib died at relatively young age) with couples of cousins born from concordant sib pairs (both sibs dead at ages which do not differ more than 5 years). In these samples the unbalance of genetic transmission of alleles of genes related to the stress response was assessed and compared with measures of frailty (motor and cognitive disabilities) expressed as "frailty index". This approach should help defining risk profiles of healthy/unhealthy ageing in the population.

DIPARTIMENTO DI BIOLOGIA CELLULARE, UNIVERSITA DEGLI STUDI DELLA CALABRIA (Italy)

Prof. Giovanni LATORRE

Participants: UNIVERSITY OF BOLOGNA, CENTRE REGIONAL DE LUTTE CONTRE LE CANCER DE MONTPELLIER, UNIVERSITY OF SOUTHERN DENMARK, UNIVERSITY OF ODENSE, MAX-PLANCK GESELLSCHAFT ZUR FOERDERUNG DER WISSENSCHAFTEN E.V.

Demographic uncertainty and the sustainability of social welfare systems — Acronym: DEMWEL

QLK6-CT-2002-02500

The project focused on the sustainability of welfare systems in EU countries in the face of ageing and demographic uncertainty. The main innovation was to bring new quantifications of demographic uncertainty into economic and social analysis of the effects of population ageing. The main tools are general equilibrium models with overlapping-generations structure. They compared the welfare systems in

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participating countries and looked for systems and rules that performed well under uncertainty. The project also attempted to improve current policy instruments, and design new, to better cope with demographic uncertainty, and evaluate their performance with model simulations. Guidelines for future development for both economic and demographic models were also created.

ET DE REFLEXION SUR L'ECONOMIE MONDIALE, FUNDACION DE ESTUDOS DE ECONOMIA APLICADA, NATIONAL INSTITUTE OF ECONOMIC AND SOCIAL RESEARCH (UK), BUREAU FEDERAL DU PLAN, THE RESEARCH INSTITUTE OF THE FINNISH ECONOMY, CPB NETHERLANDS BUREAU FOR ECONOMICS POLICY ANALYSIS, CENTRE FOR ECONOMIC AND BUSINESS RESEARCH

Population, ageing and labour markets

HPSE-CT-2001-60016

The economic policy debate has concentrated so far mainly on the sustainability and the appropriate design of social security systems. However, ageing will have important effects on the composition of labour supply whose effect have not yet been studied in depth. The aim of the exploratory workshop was to explore how ageing may affect income inequality and unemployment, and what the proper policy should be concerning e.g. subsidies to youth employment or seniority pay rules. The workshop provided evidence on the quantitative importance of changes in the composition of the work force and would indicate directions for future research.

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Participants: CENTRE D'ETUDES PROSPECTIVES ET D' INFORMATIONS INTERNATIONALES/ CLUB D'INFORMATION ET DE REFLEXION SUR L'ECONOMIE MONDIALE

Ageism: Demographic changes and universal ethical principles — Acronym: GIORDANO SIMONA

QLK6-CT-2001-50971

Methods of rationing healthcare increasingly appeal to age or life expectancy. The morality of such methods is controversial. This research identified an ethical framework for the provision of publicly financed healthcare goods/services and ensured coherence with respect for fundamental ethical values and rights of each age group.

INSTITUTE OF MEDICINE, LAW AND BIOETHICS, UNIVERSITY OF MANCHESTER (United Kingdom)

Mr Neil Ferguson

Consulting the users: information needs of older disabled people — Acronym: CONSULTING THE USERS

QLK6-CT-2002-30472

The INFOPARK project was undertaken to identify the information, health & social care needs of older people with Parkinson's disease in 7 European countries. The objective was to evaluate the applicability of the findings of projects to reflect the needs of other older disabled people (i.e. those not suffering from Parkinson' s disease) in European countries not involved in the original project and to determine the appropriateness of the 3 educational packages for older disabled people, their informal carers & health & social care professionals. This was done through expert round table meetings, where 'expert' refers to the disabled people and their informal carers. In addition collaboration with European user/patient organisations would promote the establishment of self-management/expert patient groups on a European basis. It explored new ways of establishing efficient and acceptable user/ professional partnerships.

DEPARTMENT OF GERIATRIC MEDICINE, COLLEGE OF MEDICINE, UNIVERSITY OF WALES (United Kingdom)

Dr Michael GRANT

Extending quality life in old age - the state of the art — Acronym: EQUAL

QLK6-CT-2001-30168

This exploratory project was designed to assess the state-of-the art knowledge concerning the social and economic determinants of quality of life in old age. It intended to review the scientific literature in selected Member States in order to compare and exchange information on the factors, which extend or limit quality life. This included research on the views of older people themselves on the quality of their lives. The project delivered brief reports on relevant research in six Member States together with an overview. The results were presented during a

DEPARTMENT OF SOCIOLOGICAL STUDIES, UNIVERSITY OF SHEFFIELD (United Kingdom)
http://www.shef.ac.uk

Prof. Alan WALKER

workshop for scientists and policy-makers. European added value would be gained from the pooling and dissemination of existing knowledge across the Member States.

Looking to a positive future - quality of life of older people with intellectual disabilities — Acronym: MERCURIUS

QLK6-CT-2001-30243

Due to the continuous improvement in healthcare the average life expectancy of people with intellectual disabilities is steadily rising. This creates new needs in relation to training of personnel, housing facilities and the role and needs of caregivers. In order to anticipate on these needs comprehensive research has to be undertaken. To enhance the efficiency of such research all stakeholders can best define the topics. It was therefore proposed to organise an EU-wide conference in which experts participate representing research institutions, the care sector and people with disabilities. A comprehensive overview was made of the new demands that care systems in the EU would have to face.

EUROPEAN ASSOCIATION OF SERVICE PROVIDERS FOR PERSONS WITH DISABILITIES (Belgium)
http://www.easpd.eu

Mr Luk ZELDERLOO

Health ageing and education — Acronym: HEAD

QLK6-CT-2001-30006

It was designed to bring together researchers and experts in the subject of promoting the education of older people, specifically those from less educated backgrounds. Educational inequalities between the generation, between those in the same generation of older people and between older people in the different Member States are growing ever larger with consequences for well being, health and social exclusion. The meeting was designed to look at the evidence for the health value of education when undertaken later in life, focusing on those of low educational achievement who are now in retirement. Ways of

DEPARTMENT OF PUBLIC AND ADMINISTRATIVE HEALTH, NATIONAL SCHOOL OF PUBLIC HEALTH (Greece)
http://www.e-bug.eu/ebug.nsf/Greece?OpenForm

Prof. Jenny KOUREA-KREMASTINOU

Participants: C.M.T. PROOPTIKI (PERSPECTIVE) LTD

developing educational interventions with this least privileged group of older people were examined in terms of European experiences. Using an adapted form of a health promotion intervention, designed originally to develop young people's life resources, was a way of approaching this group of older people.

The prerequisites of the elderly for living at home: criteria for dwellings, surroundings, and facilities — Acronym: ELDERATHOME

QLK6-CT-2000-00405

The purpose of the project was to improve the conditions of living at home of the elderly with focus on the prerequisites of living at home in existing dwelling stock, rather than ideal newly built environments. The objectives were:
1. Clarification of the present situation both in terms of supply and demand.
2. Developing sets of criteria that cover the preconditions of the elderly for living at home with regard to the dwelling, its surroundings and facilities providing services and infrastructure.
3. Testing and improving sets of criteria, after work in empirical cases.
4. Suggesting dissemination plans for authorities, builders, service organisations, etc...

DEPARTMENT OF HOME ECONOMICS, WORK EFFICIENCY INSTITUTE (Finland)
http://www.tts.fi/uk/projects/elderathome

Dr Tarmo LUOMA, Dr Pirkko Kasanen

Participants: WAGENINGEN UNIVERSITY, TECHNICAL RESEARCH CENTRE OF FINLAND, DANISH BUILDING AND URBAN RESEARCH, PRO A SOLUTIONS SL

Keys for quality performance management of the care of older persons in Europe — Acronym: CAREKEYS

QLK6-CT-2002-02525

CareKeys develops, validates and disseminates methods and performance indicators for evaluation of quality, cost-effectiveness and equity of the care of older people. Special focus is on linking the client preferences and quality of life objectives to the professional and managerial objectives of high quality care, and on establishing a clear validity to the indicators and models to be developed. The practical objective

POLICY AND SERVICES FOR AGEING PEOPLE, STAKES NATIONAL RESEARCH AND DEVELOPMENT CENTRE FOR WELFARE AND HEALTH (Finland)
http://www.stakes.fi/EN/Tutkimus/index.htm

Prof. Vappu TAIPALE

was to provide a reliable, easy-to-use Toolkit with key quality indicators for practical care management. CareKeys will support European regions in developing and maintaining good quality, integrated care for older Europeans by means of Social and Health Economic research, Best Practice Modelling and user trials. The main result was a Handbook on the CareKeys Quality Management Model (client quality, professional quality, management quality). The methodology should be documented for further IT-development.

Participants: THE UNIVERSITY OF LIVERPOOL, OTTO-FRIEDRICH-UNIVERSITAET BAMBERG, STOCKHOLM COUNTY COUNCIL, UNIVERSITY OF TARTU, CITY OF HELSINKI

A multi-disciplinary approach to healthy ageing and its determinants in 11 European countries — Acronym: HALE

QLK6-CT-2000-00211

Changes in and determinants of healthy ageing in terms of mortality and morbidity outcomes as well as in terms of physical, psychological, cognitive, and social functioning in 11 European countries were studied. Changes in bio local risk factors with age were studied and related to long-term cardiovascular and all-cause mortality. Dietary variables were related to self-perceived health, psychological and cognitive functioning and all cause mortality. In addition, the integration of the diverse indicators of healthy ageing were investigated. For this purpose, existing databases of three longitudinal studies were used. This project provided valuable information to support health promotion activities of the EU and the WHO.

NATIONAL INSTITUTE OF PUBLIC HEALTH AND ENVIRONMENT (Netherlands)

Dr Gijs ELZINGA

Participants: UNIVERSITA DEGLI STUDI DI PERUGIA, UNIVERSIDAD COMPLUTENSE DE MADRID, GHENT UNIVERSITY, UNIVERSITY OF CRETE, UNIVERSITY OF KUOPIO, UNIVERSITA DEGLI STUDI DI PADOVA, WAGENINGEN UNIVERSITY, UNIVERSITE LOUIS PASTEUR, STRASBOURG 1, CENTRE HOSPITALIER DE VALENCE, NATIONAL PUBLIC HEALTH INSTITUTE, ISTITUTO SUPERIORE DI SANITA, BISPEBJERG HOSPITAL, INSTITUTO NACIONAL DE SAUDE DR RICARDO JORGE, WARSAW, AGRICULTURAL UNIVERSITY, ASSOCIAZIONE PER LA RICERCA CARDIOLOGICA

Network for integrated European population studies

HPSE-CT-1999-00005

The main objective of the Network for Integrated European Population Studies was to bring

CENTRUM VOOR BEVOLKINGS- EN GEZINSSTUDIE (Belgium)

together national population institutes in Europe, in order to form an all-European platform aiming at promoting a dialogue on policy relevant interactive domains of population and family dynamics and socio-economic processes. Three major issues were addressed: 1) gender relations, family building and patterns of work; 2) ageing, intergenerational solidarity and age specific vulnerabilities; 3) demographic and cultural specific and integration of migrants.
The project should lay grounds for future research by devising comparative methodologies and survey instruments for policy-oriented research in the three domains studied.

http://aps.vlaanderen.be/cbgs/content/79.html

Prof. Thérèse JACOBS

Participants: CHARLES UNIVERSITY PRAGUE, UNIVERSITY OF LATVIA, AUSTRIAN ACADEMY OF SCIENCES, BUNDESINSTITUT FÜR BEVÖLKERUNGSFORSCHUNG, NETHERLANDS INTERDISCIPLINARY DEMOGRAPHIC INSTITUTE, THE FAMILY FEDERATION OF FINLAND, ESTONIAN INTERUNIVERSITY POPULATION RESEARCH CENTRE, DEMOGRAPHIC RESEARCH INSTITUTE AT THE HCSO, WARSAW SCHOOL OF ECONOMICS

Population policy acceptance study - the viewpoint of citizens and policy actors regarding the management of population related change — Acronym: DIALOG

HPSE-CT-2002-00153

Population Policy Acceptance Study built on the analysis of data from 13 national surveys on practices, attitudes and opinions concerning demographic changes, fertility behaviour, intergenerational exchange of resources and services, and population related policies. The study analysed values and attitudes affecting fertility decisions, perception of advantages and disadvantages of having children, meaning of family and parenthood, aspirations in life, opinions and attitudes towards population policy issues and measures, and the role of government. It set out to achieve data harmonisation and utilisation of quantitative and qualitative empirical data in 13 European countries - some EU Member States and some associated states - in view of comparative and interdisciplinary research on acceptance of the existing population policies as they relate to family dynamics and population ageing and expectations of citizens.

BUNDESINSTITUT FÜR BEVÖLKERUNGSFORSCHUNG (Germany)
http://www.bib-demographie.de/ppa/Main.htm

Prof. Charlotte HÖHN

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Care for the aged at risk of marginalisation — Acronym: CARMA

QLK6-CT-2002-02341

CARMA pooled the resources of academic research institutions, social service providers and educational institutions to analyse current social care services for the aged from a multitude of angles: among others, with longitudinal studies on coping skills of the aged, a comparative study of care arrangements, and a comprehensive literature review. All those findings were discussed and developed further in conferences with the partners and external experts, and were integrated into Guidelines and Protocols for Policy-makers, Social Service Providers, and Private Networks.

INSTITUT FUER SOZIALFORSCHUNG, COMPASS, SOZIAL- UND GESUNDHEITSVEREIN (Austria)

Mrs Gerlinde STESSEL

Participants: UNIVERSITY OF TARTU, KATHOLIEKE HOGESCHOOL KEMPEN, ESTONIAN GERONTOLOGY AND GERIARTRIC ASSOCIATION, COO.S.S. MARCHE ARI COOPERATIVA SOCIALE MARCHIGIANA DI SERVIZI E SANITARI ONLUS, SOCIAL SCIENCE RESEARCH CENTER BERLIN, SOUTH AND EAST BELFAST HEALTH AND SOCIAL SERVICES TRUST

Cross-national determinants of quality of life and health services for the elderly — Acronym: CLESA

QLK6-CT-2000-00664

Because of the aging of the population, and the expected increase in health care demands, epidemiological data to be used to establish priority areas for interventions were most needed. This project contributed to increase the knowledge of the predictors (socio-demographic, behavioural, psychological factors and chronic conditions) of major health outcomes, such as decline in functional status, institutionalisation, and mortality. It allowed the comparison of health services in six different countries in relation to the abovementioned health predictors and outcomes. The results should become instruments that contribute to a better quality of life for the aged people, allowing also the countries to better allocate their resources for health care.

CENTRO PER LO STUDIO DELL'INVECCHIAMENTO, NATIONAL RESEARCH COUNCIL OF ITALY (Italy)
http://www.unipd.it

Prof. Gaetano CREPALDI and Dr Stefania Maggi

Participants: KAROLINSKA INSTITUTE, UNIVERSITY OF TAMPERE, UNIVERSIDAD AUTONOMA DE MADRID, KAPLAN MEDICAL CENTER, JAGIELLONIAN UNIVERSITY, INSTITUTE OF EXPERIMENTAL AND CLINICAL MEDICINE

Advanced multidisciplinary analysis of new data on ageing — Acronym: AMANDA

QLK6-CT-2002-02426

New multidisciplinary and cross-nationally comparable micro data were being collected on the medical, psychological, and socio-economic aspects of ageing. This project brought together scientists from many disciplines that used advanced econometric and statistical methods to analyse these micro data. The aim of the analyses was to obtain a better understanding of the complex interactions between economic, health, psychological and social factors determining the quality of life of the elderly, and of the behavioural responses ("feedback effects") of elderly individuals to public policy concerning for example pension and health care system design. They develop cross-nationally comparable indicators for key concepts relevant to EU-policy such as disability status, retirement incentives, savings adequacy, and well being of the elderly. They linked these indicators to Member States and Union policies.

MANNHEIM RESEARCH INSTITUTE FOR THE ECONOMICS OF AGING , UNIVERSITAET MANNHEIM (Germany)
http://www.amanda-project.org

Dr Susan-Annette STORM

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Research training network on health, ageing and retirement — Acronym: REVISER

HPRN-CT-2002-00330

In most developed countries people not only live longer but also live longer in better health. Recent research in bio-demography suggests that this trend might continue albeit at a slower pace. It is therefore necessary to move beyond a simple "chronological" view of the ageing process and to take full account of the biodynamic aspects. The aim of the project was to explore existing, and develop new, measures to describe the health status of an ageing population, further to feed these findings into projections of future pension and health expenditure. The project

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http://ceps.be/Projects.php

Dr Daniel Gros

Participants: FUNDACION DE ESTUDOS DE ECONOMIA APLICADA, CPB NETHERLANDS BUREAU FOR ECONOMICS POLICY ANALYSIS, UNIVERSITÉ DE PARIS IX - DAUPHINE, GERMAN INSTITUTE FOR ECONOMIC RESEARCH, THE RESEARCH INSTITUTE OF THE FINNISH ECONOMY

formulated policy conclusions addressing the ageing issue and threw new light on key long-term social and financial policy topics for the European Union and its Member States. The sensitivity of demographic, health expenditure and retirement benefits projections to alternative health statistics was carefully examined.
By incorporating a number of biodynamic and health factors into the demographic projections it should provide the European and national decision-takers with new tools of analysis and new arguments in policy debates.

Old age and autonomy: the role of service systems and intergenerational solidarity — Acronym: OASIS

QLK6-CT-1999-02182

The main objective was to provide a knowledge base of how we may support autonomy in old age to enhance quality of life of elders and their family caregivers. Variations in family solidarity and welfare regimes in interaction as impacting quality of life were studied, to give recommendations on sustainable service systems for the future. A comparative cross-cultural, cross-generational approach will be used. Cross-sectional (survey) of 3 cohorts (75+, 50-60, 20-30) and longitudinal in-depth interviews (a year apart) with 25-40 dyads of 'elders at risk' and their caregivers were performed.

UNIVERSITY OF HAIFA (Israel)
http://oasis.haifa.ac.il/publications.htm

Prof. Ariela Lowenstein

Participants: THE UNIVERSITY OF THE BASQUE COUNTRY, NORWEGIAN SOCIAL RESEARCH, UNIVERSITY OF KEELE, DEUTSCHES ZENTRUM FUER ALTERSFRAGEN, JDC ESHEL - THE ASSOCIATION FOR PLANNING AND DEVELOPMENT OF SERVICES FOR THE AGED IN ISRAEL

Socio-economic and occupational effects on the health inequality of the older workforce — Acronym: SOCIOLD

QLK6-CT-2002-02292

The proposed interdisciplinary research provided detailed evidence on the association between socio-economic factors and physical and mental health and sense of well being of the older workforce (above the age of 50) and highlight the direction of causation of this relationship. A

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CENTRE FOR EUROPEAN LABOUR MARKET RESEARCH , UNIVERSITY OF ABERDEEN (United Kingdom)
http://www.abdn.ac.uk/sociold/
Dr Alastair ALEXANDER

number of issues were investigated relating to differences between sexes with respect to the effects of socio-economic/and occupational status on the physical and mental health status at the later stages of working life. The size of the impact of the socio-economic and occupational differences in physical and mental health is crucial, not only for our understanding of the development of age-related diseases and disability, but also how these may be avoided by controlling contributory socio-economic factors.

Participants: NATIONAL AND KAPODISTRIAN UNIVERSITY OF ATHENS, THE RESEARCH INSTITUTE OF THE FINNISH ECONOMY, UNIVERSITÉ PANTHEON-ASSAS - PARIS II, UNIVERSITY OF MACEDONIA, UNIVERSITY OF MACEDONIA, FOUNDATION FOR ECONOMIC RESEARCH OF THE UNIVERSITY OF AMSTERDAM

Ageing, health and retirement in Europe — Acronym: AGIR

QLK6-CT-2001-00517

Recent biometric research, based mainly on US data suggests that people live longer in better health. This project should first document to what extent this trend exists in Europe. A comparison of data from existing national socio-economic panels established what happened over the last 10-15 years. A search of archives of health insurance companies and national health services should yield data spanning 40-50 years, thus allowing making more solid longer term projections for the health of the elderly. These projections should be used to asses the sustainability of social security system based on a detailed analysis of the influence of better health on the demand for health care and retirement decisions. Future elderly may demand less health care than anticipated because they are healthier, and they might also be able and willing to work longer, thus reducing the burden on pension systems.

CENTRE FOR EUROPEAN POLICY STUDIES (Belgium)
http://ceps.be/Projects.php

Dr Daniel GROS

Participants: CENTRE D'ETUDES PROSPECTIVES ET D' INFORMATIONS INTERNATIONALES/CLUB D'INFORMATION ET DE REFLEXION SUR L'ECONOMIE MONDIALE, GERMAN INSTITUTE FOR ECONOMIC RESEARCH, FUNDACION DE ESTUDOS DE ECONOMIA APLICADA, NATIONAL INSTITUTE OF ECONOMIC AND SOCIAL RESEARCH, BUREAU FEDERAL DU PLAN, THE RESEARCH INSTITUTE OF THE FINNISH ECONOMY, CPB NETHERLANDS BUREAU FOR ECONOMICS POLICY ANALYSIS, UNIVERSITÉ DE PARIS IX - DAUPHINE,

Providing integrated health and social care for older people – issues, problems and solutions — Acronym: PROCARE

QLK6-CT-2002-00227

By comparing and evaluating different modes of care delivery, PROCARE identified factors and actors that constitute an integrated care system with enhanced outcomes for all actors involved. Thus, performance and quality indicators for use in evidence-based policy making, planning, quality assurance and controlling of social and health services were developed, based on interviews with clients and their carers, and focus group discussions with all stakeholders involved. The dissemination of good practice by involving professionals and various organisations from 9 EU Member States promoted the development of a European understanding of integrated care, and shared views of definitions and approaches.

DEPARTMENT AGEING, CARE POLICIES AND SOCIAL SERVICES, EUROPEAN CENTRE FOR SOCIAL WELFARE POLICY AND RESEARCH (Austria)

http://www.euro.centre.org/detail.php?xml_id=532

Prof. Bernd MARIN

Participants: THE DANISH NATIONAL INSTITUTE OF SOCIAL RESEARCH, STAKES NATIONAL RESEARCH AND DEVELOPMENT CENTRE FOR WELFARE AND HEALTH, NATIONAL CENTRE FOR SOCIAL RESEARCH, STICHTING VERWEY-JONKER INSTITUUT, STUDIO COME SRL, EMME & ERRE S.P.A., UNIVERSITY OF KENT AT CANTERBURY, UNION NATIONALE INTERFÉDÉRALE DES OEUVRES ET ORGANISMES PRIVÉS SANITAIRES ET SOCIAUX, FORSCHUNGSGESELLSCHAFT FUER GERONTOLOGIE E.V., UNIVERSITÉ PIERRE MENDÈS FRANCE – GRENOBLE 2 SCIENCES SOCIALES,

Research action for improving elderly workers safety, productivity, efficiency and competence towards the new working environment — Acronym: RESPECT

QLK6-CT-2000-00038

The overall aim of RESPECT was the promotion of the health, working ability and well-being of ageing workers. The Consortium first developed reliable assessment criteria; strategies and tools to evaluate existing and emerging methods measuring the impact on work-life, health and efficiency of elderly workers. A number of field pilots as well as laboratory studies were realised, to develop new working methods, to improve the

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http://respect.iccs.ntua.gr/index.html

Dr Ing Hilke WUEDERMANN

Participants: FINNISH INSTITUTE OF

productivity, safety and work satisfaction of elderly workers (those aged 45 or over) with all types of jobs and to promote their integration into the labour market. Finally RESPECT proposed policies for improving the older workers' position in the labour market.

OCCUPATIONAL HEALTH, FINNAIR OYJ, DAIMLERCHRYSLER AG, IAS – INSTITUT FUER ARBEITS- UND SOZIALHYGIENE STIFTUNG, Institute of Communication and Computer Systems, TRANSEUROPEAN CONSULTING UNIT OF THESSALONIKI S.A., DEUTSCHE BANK AG, CENTRE NATIONAL DE LA RECHERCHE SCIENTIFIQUE, THERAPEUTIRIO XRONION PATHISEON ATTIKIS, UNIVERSITAET BASEL, CIVIL AVIATION ADMINISTRATION, FINLAND

Mapping existing research and identifying knowledge gaps concerning the situation of older women in Europe — Acronym: MERI

QLK6-CT-2002-30372

Recent approaches aimed at compiling information on the living conditions of older women led to the conclusion that they are neglected as an own target group in research, although almost every fifth person in Europe is a woman aged 50 or more. In addition, there is clear evidence in the work of NGOs that certain groups of older women are disadvantaged in different social aspects, e.g. as regards the quality of medical treatment or isolation in old age. So the project aimed to increase the knowledge about the living conditions and problems of older women, to improve the empirical basis for work of scientists, NGOs and for government tasks at social policy level aimed at older women, to stimulate and set the agenda for future research on women and ageing, as well as to raise public awareness of their situation.

INSTITUT FUER SOZIALE INFRASTRUKTUR GBR, Frankfurt Am Main (Germany)
http://www.own-europe.org/meri/

Dr Karin STIEHR

Participants: CENTRO DE ESTUDOS PARA A INTERVECAO SOCIAL, EUROPEAN CENTRE FOR SOCIAL WELFARE POLICY AND RESEARCH (Austria), UNIVERSITY OF SHEFFIELD, NATIONAL SCHOOL OF PUBLIC HEALTH, DE SENECTUTE, NEDERLANDS INSTITUUT VOOR ZORG EN WELZIJN, SVERIGES PENSIONAERSFOERBUND, VRIJE UNIVERSITEIT BRUSSEL, STAKES NATIONAL RESEARCH AND DEVELOPMENT CENTRE FOR WELFARE AND HEALTH, ASOCIACION MULTIDISCIPLINAR DE GERONTOLOGIA, ASSOCIAZIONE GENERAZIONI

Future elderly living conditions in Europe — Acronym: **FELICIE**

QLK6-CT-2002-02310

The project was focused on a 2000-2030 forecast in a well balanced selection of nine European countries of the population aged 75+, classified by sex, age, marital status, together

UNITE DE RECHERCHES COMPARAISONS INTERNATIONALES, INSTITUT NATIONAL D'ETUDES DEMOGRAPHIQUES (France)
http://www.felicie.org/

with health, family and socio-economic conditions. It resulted in a quantification of living arrangements and an estimate of the future demand for nursing homes, both formal and informal core data on elderly-specific needs. Demography provided a hard-core data basis and a highly efficient birth cohort approach. It should reveal large gender imbalances, important changes in the availability of potential support to the elderly and marked geographical contrasts. Comparable numerical results lead to propositions for the adaptation of family and elderly policies, and to a debate with policy-makers and civil society at national and European levels.

Dr Patrick FESTY

Participants: LONDON SCHOOL OF ECONOMICS AND POLITICAL SCIENCE, UNIVERSITY OF FLORENCE, LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE, NETHERLANDS INTERDISCIPLINARY DEMOGRAPHIC INSTITUTE, UNIVERSITE CATHOLIQUE DE LOUVAIN, FONDATION NATIONALE DE GERONTOLOGIE, CHARLES UNIVERSITY PRAGUE, MAX-PLANCK-GESELLSCHAFT ZUR FOERDERUNG DER WISSENSCHAFTEN E.V., UNIVERSITY OF HELSINKI, UNIVERSIDADE NOVA DE LISBOA

The dynamics of income, health and inequality over the life cycle — Acronym: ECUITY III

QLK6-CT-2002-02297

Research has reported persistent significant socio-economic inequalities in health and inequities in the use of health care and identified the elderly among the most disadvantaged groups. Causal relationships to help policy-making can be found by following the elderly in the European community Household Panel as they lose health, move out of work and start enjoying a widely varying level of social protection, offered by the different pension and transfer schemes. Special attention should be given to the transmission of inequalities in health to old age, and the inequitable treatment of elderly by the health care systems, which in some Member States may be due to changes in insurance coverage related to taking up pension.

DEPARTMENT OF HEALTH CARE POLICY AND MANAGEMENT, ERASMUS UNIVERSITEIT ROTTERDAM (Netherlands)
http://www2.eur.nl/ecuity/ecuityiii.htm

Dr Josée VAN EIJNDHOVEN

Participants: ECONOMIC AND SOCIAL RESEARCH INSTITUTE, UNIVERSITY OF BRISTOL, UNIVERSITÀ DEGLI STUDI DI ROMA TOR VERGATA, UNIVERSITY OF YORK, UNIVERSITY OF BERGEN, INSTITUTE FOR THE STUDY OF LABOR GMBH, STAKES NATIONAL RESEARCH AND DEVELOPMENT CENTRE FOR WELFARE AND HEALTH, UNIVERSITY OF SOUTHERN DENMARK - UNIVERSITY OF ODENSE, UNIVERSITAT DE BARCELONA, UNIVERSITAIRE FACULTEITEN SINT-IGNATIUS ANTWERPEN VZW, UNIVERSITY OF MACEDONIA, UNIVERSITY OF BERNE, UNIVERSITE DE LA MEDITERRANEE D'AIX-

MARSEILLE II, TINBERGEN INSTITUTE

The measurement of quality of life in older adults and its relationship to healthy ageing — Acronym: WHOQOL-OLD

QLK6-CT-2000-00320

The first main aim of the research was to develop a reliable and valid measure of quality of life in older adults through the adaptation of the World Health Organization's so-called WHOQOL. The second main aim was to include the Older Adults WHOQOL in a cross-cultural study of healthy ageing, which should help to identify which factors are important within cultures and which are important in all cultures in their contribution to healthy ageing.

DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF EDINBURGH (United Kingdom)
http://www.feast.org/?project&ID=189

Dr Robert SMAILES

Participants: UNIVERSITY OF BATH, UNIVERSITY OF UMEAA, WORLD HEALTH ORGANIZATION, INSTITUT NATIONAL DE LA SANTE ET DE LA RECHERCHE MEDICALE, BEN GURION UNIVERSITY OF THE NEGEV, UNIVERSITAET LEIPZIG, REMOTE DATA ENTRY SYSTEM SL, FREDERIKSBORG GENERAL HOSPITAL, PRAGUE PSYCHIATRIC CENTER, NATIONAL INSTITUT FOR MEDICAL REHABILITATION, MHS COLLEGE, UNIVERSITY OF VICTORIA, THE UNIVERSITY OF MELBOURNE, HEALTH RESEARCH ASSOCIATES, INC., SCIENCE UNIVERSITY OF TOKYO, SUN YAT SEN UNIVERSITY OF MEDICAL SCIENCES, NATIONAL INSTITUTE OF EXPERIMENTAL AND CLINICAL MEDICINE

The aged in home care project — Acronym: THE AD HOC PROJECT

QLK6-CT-2000-00002

Despite Home Care (HC) is among the fastest growing segments in the health care sector, there is no information about the characteristics of Services, patients and outcomes nor shared knowledge regarding the best models of care. This Project aimed to define the characteristics of Home Care patients and Services in 11 European countries. Baseline characteristics of both patients and Services and year follow-up data were collected by trained personnel and centrally

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Dr Giuseppe MOBILIA

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scored in a database, the Community Care Data Centre.

UNIVERSITE DE PARIS V 'RENÉ DESCARTES', INSTITUTE FUER GESUNDHEITSANALYSEN UND SOZIALE KONZEPTE E.V., NATIONAL UNIVERSITY HOSPITAL (ICELAND), KAROLINSKA INSTITUTE, UNIVERSITY OF KENT AT CANTERBURY

Services for supporting family carers of elderly people in Europe: characteristics, coverage and usage — Acronym: EUROFAMCARE

QLK6-CT-2002-02647

EUROFAMCARE provided a European review of the situation of family carers of elderly people in relation to the existence, familiarity, availability, use and acceptability of supporting services. Six countries and the WHO Europe formed a trans-European core group. National Background Reports from 23 European countries were integrated into a Pan-European Background Report showing the state of family carers and support services in 2003/2004. National Surveys in the six core group countries analyzed 6,000 family care situations in different regional sites. EUROFAMCARE pushed a change management process at various policy levels to promote social policies towards family carers of the elderly.

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http://www.uke.uni-hamburg.de/extern/eurofamcare/

Dr Hanneli DÖHNER

Participants: UNIVERSITAET BREMEN, MEDICAL ACADEMY - BIALYSTOK, NATIONAL SCHOOL OF PUBLIC HEALTH, ISTITUTO NAZIONALE RIPOSA E CURA ANZIANI "VITTORIO EMANUEL II", LINKOEPING UNIVERSITY, UNIVERSITY OF SHEFFIELD, MARTIN HAMBLIN GFK, AGE - THE EUROPEAN OLDER PEOPLE'S PLATFORM

Life quality of senior citizens in relation to mobility conditions — Acronym: SIZE

QLK6-CT-2002-02399

Maintaining the mobility of the elderly is a central element of integration in society. Often it looks as if experts know too little about elderly citizens: Senior citizens want to lead an autonomous and independent life as far as possible. The focus of SIZE was on the present mobility situation, the problems, needs and wishes of different groups of senior citizens, and parallel on experts' view on all this. With the help of qualitative and quantitative survey

INSTITUTE OF SOCIOLOGY - FACULTY OF SOCIAL SCIENCES AND ECONOMICS, UNIVERSITY OF VIENNA (Austria)
http://www.size-project.at/

Dr Anton AMANN

Participants: UNIVERSITA DEGLI STUDI DI ROMA TRE, LUND UNIVERSITY, FACTUM OHG, UNIVERSITY OF ERLANGEN-NUREMBERG,

instruments, and multidisciplinary discussions, based on the survey results, policy-makers, politicians and the industry discussed the results of SIZE together with senior citizens representatives and the SIZE consortium. The final product was a list of problem types and respective solution types to mobility and transport problems of senior citizens.

UNIVERSITY COLLEGE CORK, NATIONAL UNIVERSITY OF IRELAND, CORK, TRANSPORT RESEARCH CENTRE, UNIVERSITAT DE VALENCIA, ASSOCIATION OF ABSOLVENTS OF CRACOW POLITECHNIC, ASOCIACION DE AMAS DE CASA TYRIUS, ASSOCIAZIONE ABITARE E ANZIANI AEA, PRO SKANE, STADTSENIORENRAT DER STADT NUEMBERG

Ageing, Health Status and Determinants of Health Expenditure — Acronym: AHEAD

FP6-POLICIES- 502641

CEPS is leading a consortium of 18 partners in a project examining the future evolution of health expenditure in the (enlarged) European Union. This project will refine existing estimates of the links between reported states of health and use of medical services. As well as looking at the effects of ageing on health care the research will take account of the link between health expenditure and fertility rates and the demands on health services made by non-native populations. Particular attention is paid to costs of care near death. A study will be made of factors other than demand (such as methods of financial control) which may influence health spending. An important aspect of the research is that the work is carried out so as to be able to provide not only the familiar projections and scenarios but also standard deviations and confidence limits for predictions of key variables such as healthy life expectancy and demand-driven expenditure levels. These will allow policy-makers to judge not only possible outcomes but also the risks surrounding them and to assess their implications.

CENTRE FOR EUROPEAN POLICY STUDIES (Belgium)
http://ceps.be/Projects.php

Dr Daniel GROS and other partners

The Second Demographic Transition in Europe

HPCF-CT-2000-00167-01 and -02

The proposed series of two conferences tried to achieve a number of goals: - Documenting demographic changes in the realms of family and fertility since the 1960's and especially in the 1990's - Understanding the driving forces behind these changes and disentangling the relevance of economic, cultural and social factors affecting fertility and family behaviour - Assessing whether these driving forces are similar in Western, Eastern and Southern Europe - Evaluating whether the changes, like the movement to unprecedented low fertility levels during the 1990's, are of temporary or permanent nature - Evaluating the role of medical innovations, effective contraception and perception on fertility and sexuality - Understanding the interrelationships between changes in family and fertility on the one hand and changes in other demographic processes (migration and mortality) on the other hand - Charting the individual and social implications of demographic changes (e.g. with regard to social cohesion, social exclusion, public policy) - Investigating the possibilities of public policies to accommodate or influence these developments.

http://www.esf.org and
http://calenda.revues.org/nouvelle818.html

Dr Josip HENDEKOVIC

Socio-economic determinants of healthy aging: from description to explanation

QLK6-CT-1999-02161

This project aimed to describe socioeconomic differences in health expectancy among the elderly in 11 European countries, and to contribute to the explanation of these differences. The study was performed on the basis of survey data on the prevalence of disability, diseases and risk factors, mortality data by cause of death, and data from longitudinal studies of disability and mortality.

FACULTY OF MEDICINE AND HEALTH SCIENCES, DEPARTMENT OF PUBLIC HEALTH, ERASMUS UNIVERSITEIT ROTTERDAM (Netherlands)
http://www2.eur.nl/fgg/mgz/mgzprojects/

Dr H. VAN DER MOLEN

Participants: UNIVERSIDAD COMPLUTENSE DE

Life expectancy with and without disability should be calculated, and differences between socioeconomic groups would be analysed using decomposition techniques and multistate life tables. The study leads to a better understanding of how socioeconomic factors promote healthy ageing, which is important for the development of policies leading to a compression of morbidity.

MADRID, GENT UNIVERSITY, SCIENTIFIC INSTITUTE OF PUBLIC HEALTH (Belgium), INSEE - INSTITUT NATIONAL DE LA STATISTIQUE ET DES ETUDES ECONOMIQUE, UNIVERSITA DEGLI STUDI DI PADOVA, STOCKHOLM UNIVERSITET, FAFO INSTITUTE FOR APPLIED SOCIAL SCIENCE, AUSTRIAN ACADEMY OF SCIENCES, VRIJE UNIVERSITEIT AMSTERDAM - VERENIGING VOOR CHRISTELIJK WETENSCHAPPELIJK ONDERWIJS, LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE, REGIONE PIEMONTE AZIENDA SANITARIA LOCALE, STOCKHOLM UNIVERSITET, CENTRE REGIONAL DE LUTTE CONTRE LE CANCER DE MONTPELLIER, STATISTICS DENMARK, NATIONAL INSTITUTE OF PUBLIC HEALTH, UNIVERSITY OF HELSINKI, UNIVERSITY OF HELSINKI, ERASMUS UNIVERSITEIT ROTTERDAM, AYUNTAMIENTO DE BARCELONA, STATISTICS NORWAY, OFFICE FOR NATIONAL STATISTICS (UK), KARL-FRANZENS-UNIVERSITAET GRAZ

The care and management of services for older people in Europe network

QLK6-CT-2000-00584

This network of research and service-delivery organisations examined how services for older people can be better managed by exploring the efficiency, quality and user-acceptability of different modes of health and social care services for older people. The network:
1. Focused on the efficiency of integration between three interfaces of care: Primary care (at home) and acute hospitals; acute hospitals and long/short stay residential homes; residential homes and primary care.
2. Determined factors that inhibit and promote effective integration.
3. Examined the coordination of services within primary care and between primary care and social services.

EUROPEAN HEALTH MANAGEMENT ASSOCIATION (Ireland)
http://www.ehma.org/projects/

Dr Philip BERMAN and 38 partners

4. Explored the whole-systems planning & policy implications and established a website & database, organised workshops, published findings, encouraged pilot projects.

Supporting Independently Living Citizens — Acronym: SILC

IST-2000-27524

The SILC project aimed at developing an innovative and intelligent alarm system to increase the safety and independence of elderly and disabled citizens. In contrast to existing alarm phones, SILC was equipped with a range of biometric sensors which can be programmed individually to trigger an alarm call automatically when a critical situation is detected. In order to increase the benefit to the user beyond the alarm function several additional utilities - like a cordless phone, environmental control functionality, and personal digital assistant-like functions - combined with an intuitive user interface will be integrated to facilitate safe and independent living at home. In general, SILC fostered and facilitate senior citizens' capacity to stay longer in their own household.

FORTEC/ RESEARCH GROUP FOR REHABILITATION TECHNOLOGY, INSTITUTE OF INDUSTRIAL ELECTRONICS AND MATERIAL SCIENCE (Austria)
http://www.is.tuwien.ac.at/fortec/silcweb/SILC.htm

Dr Wolfgang ZAGLER

Participants: CHCVITAE, S.A., KNOWSLEY METROPOLITAN BOROUGH COUNCIL, REGIONE DEL VENETO, CLOUDWORLD LIMITED, JOANNEUM RESEARCH FORSCHUNGSGESELLSCHAFT MBH, CARDIONETICS LIMITED, AJUNTAMENT DE CALLUS, TECWINGS INDUSTRIALISIERUNG UND ELEKTRONIKPRODUKTION GMBH, JOHANNITER-UNFALL-HILFE IN OESTERREICH, STADT WIEN

Web accessibility initiative: ageing education and harmonisation

IST-SSA- 035015

Accessibility Harmonisation include activities to better understand the needs of the ageing community in the context of existing Web accessibility guidelines; to work with the ageing community to obtain more direct contribution into the World Wide Web Consortium (W3C)/The Web Accessibility Initiative (WAI) work; to revise existing and develop new educational materials to better reflect the needs of the ageing community; and to pursue standards coordination to promote adoption and

GEIE ERCIM (France)
http://www.w3.org/WAI/WAI-AGE

Dr Judy BREWER

implementation of a common set of guidelines.

Collaborative working environment for ageing workforce

FP6-IST- 035064

This project aims to contribute to the definition and development of a renewed European social model for one category of disadvantaged population; the ageing workforce, which is increasingly excluded from the labour market. Overall, the aim is to support the revised Lisbon strategy. Most EU countries should shift their paradigm, and learn from practices in other parts of the world, such as India, where the ageing workforce and expert retirees are considered a "national treasure" . However, Indian companies have not yet reached the EU level of innovative ICT practices, and more specifically CWE (Common Weakness Enumeration), to best capitalise this knowledge and use it to improve the quality of life of the active retirees who travel a lot around the country. Thus, by both exchanging experiences and bridging the gap between user communities' practices through the innovative use of the most advanced ICT tools in the work process, an important part of the European ageing workforce should be able to remain happily active in the labour market.

DISTANCE EXPERT (France)
http://www.distance-expert.eu/

Dr Nicole TURBE-SUETENS

Participants: HANDELSHOEJSKOLEN I KOEBENHAVN, TECH MAHINDRA LIMITED, AGEPROOF CV, NETCIPIA UK LTD, MAHINDRA & MAHINDRA LIMITED, KURSVERKSAMHETEN VID LUNDS UNIVERSITET

Bridging the micro-macro gap in population forecasting — Acronym: MIC/MAC

FP6-POLICIES- 6637

The provision of high quality and sustainable health care services and pension systems require an instrument to monitor and forecast demographic change. The aim of this proposal is to develop that instrument. The methodology consists of a macro-model MAC that models demographic changes at the population level and a micro-model MIC that models demographic events at the individual level. Mac extends the

NIDI, KONINKLIJKE NEDERLANDS AKADEMIE VAN WETENSCHAPPEN, NEDERLANDS INTERDISCIPLINAIR DEMOGRAFISCH INSTITUUT (Netherlands)
http://www.nidi.knaw.nl/nl

Dr Nicole VAN DER GAAG

Participants: INSTITUT NATIONAL D'ÉTUDES DÉMOGRAPHIQUES, UNIVERSITÀ

cohort-component model to a multistate model that considers transitions in life other than birth and death. The transitions determine the distribution of cohort members among functional states. The output of MAC consists of cohort biographies. The aggregate level of MAC is adequate for most regular demographic projections. MIC addresses demographic events and other life transitions at the individual level. It is a micro-simulation model that produces individual biographies. That level is required to project very detailed population categories and to assess the potential impact of policy interventions on the occurrence and timing of demographic events in life. They will be used to address policy questions such as the provision of health care services in an ageing population with morbidity expanding or compressing, or the provision of pensions in an ageing population with age at retirement declining or increasing. User-friendly software will be developed, including a library of algorithms (objects) that are applied in the models. Hands-on training will be provided to forecasters from around Europe. The project is expected to produce a self-sustained European network on ageing.

COMMERCIALE "LUIGI BOCCONI", ERASMUS MEDICAL CENTRE, ROTTERDAM, MAX PLANCK SOCIETY REPRESENTED BY MAX PLANCK INSTITUTE FOR DEMOGRAPHIC RESEARCH, INTERNATIONAL INSTITUTE FOR APPLIED SYSTEMS ANALYSIS, UNIVERSITY OF ROSTOCK, OESTERREICHISCHE AKADEMIE DER WISSENSCHAFTEN

Needs for Female Immigrants and their Integration in Ageing Societies — Acronym: FEMAGE

F6-POLICIES- 22355

The overreaching objectives are to generate knowledge about obstacles and needs for opportunity enhancement for economic and social integration and emancipation of women immigrants in a life-course perspective, identify requirements for integrative interaction between immigrants and national population in the host country, build this knowledge into a platform for the policy deliberations among key policy stakeholders, and elaborate recommendations on needs for immigrants and support policies and

BUNDESINSTITUT FÜR BEVÖLKERUNGSFORSCHUNG (Germany)
http: //www.bib-demographie.de/projekte/index_projekte.html

Prof. Charlotte HÖHN

Participants: MAGYAR KOZPONTI STATISZTIKAI HIVATAL NEPESSEGTUDOMANYI KUTATO INTEZET, POPULATION AND SOCIAL POLICY CONSULTANTS, INTERNATIONAL

services for their integration in view of population ageing in Europe.

ORGANIZATION FOR MIGRATION, MASARYKOVA UNIVERZITA V BRNE, ZNANSTVENORAZISKOVALNI CENTER SLOVENSKE AKADEMIJE ZNANOSTI IN UMETNOSTI, OESTERREICHISCHE AKADEMIE DER WISSENSCHAFTEN, VÄESTÖLIITTO RY THE FAMILY FEDERATION OF FINLAND, ESTONIAN INTERUNIVERSITY POPULATION RESEARCH CENTRE

Ambient Lighting Assistance for an Ageing Population — Acronym: ALADIN

FP6-IST- 045148

The overall aim is to extend knowledge about the impact of lighting on the well-being and health of older people and translate this into a cost-effective open solution. Adaptive lighting can contribute considerably to sound sleep and a regular sleep-wake cycle, which are essential to preserve and enhance people's health and well-being. This will assist older adults in living at home autonomously for a longer time and contribute to their quality of life.

FACHHOCHSCHULE VORARLBERG GMBH (Germany)
http://www.ambient-lighting.eu
Dr Guido KEMPTER

Participants: BECKER KLAUS, APOLLIS - INSTITUT FUER SOZIALFORSCHUNG UND DEMOSKOPIE OHG, UNIVERSITATEA POLITEHNICA DIN BUCURESTI, LUDWIG-MAXIMILIANS-UNIVERSITÄT MÜNCHEN, BARTENBACH LICHTLABOR GMBH, BUDAPESTI MUSZAKI ES GAZDASAGTUDOMANYI EGYETEM

Survey of Health, Ageing and Retirement in Europe: Integrating Activities to Access the Time Dimension and to Enlarge the Cross-national Dimension — Acronym: SHARE

1) 5FP: QLK6-CT-2001-00360

2) FP6-INFRASTRUCTURE- 26193

SHARE is a multidisciplinary and cross-national panel database of micro data on health, socio-economic status and social and family networks of more than 30,000 individuals aged 50 or over. Eleven countries have contributed data to the 2004 SHARE baseline study. Further data have been collected in 2005-06 in Israel. Two 'new' EU Member States - the Czech Republic and Poland - as well as Ireland joined SHARE in 2006 and

MANNHEIM RESEARCH INSTITUTE FOR THE ECONOMICS OF AGING (MEA), UNIVERSITAET MANNHEIM (Germany)
http://www.share-project.org

Prof. Axel BÖRSCH-SUPAN

Participants: UNIVERSITY OF SOUTHERN DENMARK, INSTITUT DE RECHERCHES ET DE DOCUMENTATION EN ECONOMIE DE LA

participated in the second wave of data collection in 2006-07. At present the survey's third wave of data collection, SHARELIFE in 2008-09, will collect detailed retrospective life-histories in sixteen countries, with Slovenia joining in as a new Member.

The multidisciplinary nature of the data (freely available to the research and public policy community) will provide new insights in the complex interactions between factors determining the quality of life of the elderly. These interactions, along with pertinent methodological findings, were detailed in a series of reports emanating from the project, laying the foundation for a longitudinal SHARE in all EU-countries.

The project will create a key infrastructure that will enable researchers to analyse the Europe-wide ageing process; to better understand adaptive behaviour in response to population ageing and its induced policy changes; and to develop cross-nationally comparable indicators for key concepts relevant to EU policy.

SANTÉ, PARIS, UNIVERSITA DEGLI STUDI DI PADOVA, TILBURG UNIVERSITY, UNIWERSYTET WARSZAWSKI, UPPSALA UNIVERSITET, UNIVERSITE DE LAUSANNE, KINGS COLLEGE LONDON, UNIVERSITY OF DUESSELDORF, ENVIRONNEMENT, SANTE ET SOCIETE, ERASMUS UNIVERSITY MEDICAL CENTER, DEPARTMENT OF PUBLIC HEALTH, UNIVERSITA CA' FOSCARI DI VENEZIA, EUROPEAN UNIVERSITY INSTITUTE, UNIVERSITEIT ANTWERPEN, PANTEION UNIVERSITY OF SOCIAL AND POLITICAL SCIENCES, CENTRO DE ESTUDIOS MONETARIOS Y FINANCIEROS, JOHANNES KEPLER UNIVERSITAET LINZ, UNIVERSITE DE LIEGE, ECONOMICS INSTITUTE, ACADEMY OF SCIENCES OF THE CZECH REPUBLIC

Work harder and have more babies? A political-economic analysis of the care economy: old-age provision

FP6-MOBILITY- 28345

The object of the research project is the crisis of the welfare state focused on old-age provisions. Population ageing puts into question to be able to maintain adequate and sustainable pensions. The political commitment to enhanced labour market participation of women at the European level seems to engender a contradictory imperative at the individual level: to work harder in order to secure (private) provision for one's old age and, simultaneously, to have more children who will be able to sustain the public pension schemes once they are grown up. The aim is to make a contribution to a new economic theory

INSTITUT FÜR POLITIKWISSENSCHAFT, WESTFÄLISCHE WILHELMS-UNIVERSITÄT MÜNSTER (Germany)

http://www.uni-muenster.de

Prof. Klaus SCHUBERT

framework, including a comprehensive gender analysis of welfare state reform.

The social impacts of ICT and their limited reach to potentially- excluded communities. Measuring the problem and undertaking initiatives for its effective mitigation — Acronym: ICT FOR ALL

FP6-POLICIES- 22436

ICT embedded in a rapidly expanding set of devices, of all scales and potential uses and facilitated by state of the art communication protocols (broadband, 3G, etc.) is reshaping contemporary life and unleashing an amazing, even to comprehend, potential. The target communities of this project, namely immigrants, disabled, unemployed and ageing, have yet to be fully reached by the welcome effects of these, very often barrier removing, technologies. However both the size of the communities, the existing technology opportunities as well as the quest for social cohesion renders it important to drastically improve the uptake of modern ICT within these particular communities. ICT for ALL seeks to set a measuring framework of the interaction of these communities with ICT and in particular with the more revolutionary elements of the term, i.e., broadband Internet, 3G, digital TV and ambient intelligence. A framework that will comprise indicators describing in fine detail the current uptake (monitoring indicators) of ICT of all these communities, in a relative manner, against the respective uptake in the rest of the society.

ASM - CENTRUM BADAN I ANALIZ RYNKU SP. Z.O.O. (Poland)
http://www.asm-poland.com.pl

Dr Maria GORECZNA
Participants: BUDAPESTI CORVINUS EGYETEM, INSIGHT SOCIAL RESEARCH LTD, ISTITUTO COOPERATIVO PER L'INNOVAZIONE SOCIETA COOPERATIVA, EUROPEAN PROFILES ANONYMI ETAIREIA

Major Ageing and Gender Issues in Europe — Acronym: MAGGIE

FP6-CITIZENS- 28571

The project identifies and analyses indicators of quality of life among the population aged 65+ to reveal gender gaps and their factors. It focuses on changes due to renewal of cohorts. Consideration is taken of cohorts now old

U13 - UNITÉ COMPARAISONS INTERNATIONALES, INSTITUT NATIONAL D'ETUDES DEMOGRAPHIQUES (France)
http://www.ined.fr

(broken into age groups, given the heterogeneity of conditions at older ages) and of those who will reach old age in the next 25 years (considering the situation of people aged 40+ in 2005), for a prognosis of trends in gender differentials and an evaluation of actions likely to reduce these gaps. Quality of life is measured on health conditions, economic resources, family situation and social integration. On each, objective indicators of living conditions are confronted with perceptions by the people of their own situation. It is argued that the main factors of gender gaps in well being are to be found in the life course of individuals – in particular in the way they conciliated their professional career with their family life – and in the way they have experienced some more recent key events like retirement, widowhood, health deterioration or institutionalisation. Statistical analysis of individual-level data, based on event-history methods, will show the impact of these factors. It is also argued that gender gaps in quality of life are shaped by the socio cultural context (welfare regimes, economic circumstances, normative climate).	Dr Joelle GAYMU Participants: UNIVERSITE CATHOLIQUE DE LOUVAIN, LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE, NETHERLANDS INTERDISCIPLINARY DEMOGRAPHIC INSTITUTE, UNIVERSITÄT ROSTOCK, NIVERSITA DEGLI STUDI DI FIRENZE, HELSINGIN YLIOPISTO, ESCOLA NACIONAL DE SAUDE PUBLICA – UNIVERSIDADE NOVA DE LISBOA, DEMOGRAPHIC RESEARCH INSTITUTE HUNGARY, FONDATION NATIONALE DE GERONTOLOGIE

Source: EU COMMISSION, CORDIS SEARCH PROJECTS (2007) [13] and information on the website of the projects.

Acknowledgements:

Many thanks to Ronald Schoenmaeckers for proposing this paper and for offering comments, suggestions and producing figures with demographic data; also to Lieve Vanderleyden as co-editor; to Piotr Szukalski for reviewing the first draft of the paper; and to Jasper Tilbury for language editing of the first draft.

Endnotes Chapter Eight:

1 For the years 2005-2010 the median TFR-value between all EU countries is 1.4 children per woman, with minimum and maximum values being 1.49 and 1.95 children, respectively (UN, 2005)

2 As a matter of fact, the increase in life expectancy that the industrialised countries have experienced in the 20th century is mainly the result of a lowering of mortality after age 60; see, for example, Schoenmaeckers (2004).

3 Both authors also worked on the European project entitled *Old Age and Autonomy: The Role of Service Systems and Intergenerational Family Solidarity* (acronym OASIS). OASIS was carried out under the 5th EU Framework programme. Its goal was to come to a better understanding of the interplay between family culture, intergenerational relations, and service systems, and their impact on elders' autonomy and quality of life. For more information, see: http://oasis.haifa.ac.il.

4 In fact, projects financed under the 6th Framework Programme related to 'population ageing' are connected to the following activity areas of this framework: information society technologies (6 projects), citizens and governance (1 project), research infrastructures (1 project), life-science, genomics and biotechnology for health (3 projects), research for policy support (4 projects), specifics of SME activities (3 projects), joint research centre (1 project), and Marie Curie Fellowships (Mobility) (1 project).

5 The DG Research and Development prepared some publications summarising the results of projects financed under the 5th and 6th Framework Programmes; see for instance *Key Action, Improving the Socio-Economic Knowledge Base*, Synopses of Key Action Projects Funded as a Result of the Three Calls for Proposals (1999-2002), European Commission, Directorate-General for Research; Citizen and Governance in a Knowledge-based Society, 2003; European Union-Supported Research in Social Sciences and Humanities 1998-2005, European Commission, 2006; Social Sciences and Humanities in FP6, Projects' Synopses, All Calls – July 2006, European Commission.

6 Tripl-E Dose Conference (Education-Employment-Europe), organised by the Jagiellonian University (Cracow) and National Contact Point of the European projects of the Institute of Fundamental Technological Research of the Polish Academy of Science (Warsaw), Kraków, Poland, 21-22 September 2006. The Conference Proceedings are available at the Tripl-E Dose website: http://www.kpk.gov.pl/triple.

7 www.europeansocialsurvey.org

8 *Survey of Health, Ageing and Retirement in Europe: Integrating Activities to Access the Time Dimension and to Enlarge the Cross-national Dimension.*

9 *First Forum on Europe's Demographic Future*, held at the end of October 2006, European Commission, DG Employment, Social Affairs & Equal Opportunities, http://ec.europa.eu/employment_social/emplweb/events/event_en.cfm?id=625.

10 Another example of shared responsibilities in the field of lifelong learning is the initiative of FREREF — *European Summer University for Lifelong Learning*, which is annually organised in various parts of Europe with the objective of discussing topics such as, for example, *Integration into Working Life: Tensions between education, training and employment* (Luxembourg, 2007), http://conf.emacs.uni.lu/freref/2007/site/.

11 http://www.ageingresearch.group.shef.ac.uk and the *Report of the Second Meeting of the European Forum on Population Ageing Research*, European Forum on Population Ageing Research, Brussels, 2004

[12] Report of the Second Meeting of the European Forum on Population Ageing Research, European Forum on Population Ageing Research, Brussels, 2004: 4.

[13] http://cordis.europa.eu/fp6/projects.htm.

Chapter Nine

Features and Challenges of Population Ageing: The European Perspective

Asghar ZAIDI and Alexandre SIDORENKO

Contents:

1. Introduction

The phenomenon of population ageing could be referred to as the spirit of the time: in various countries people are thinking about the longevity gains and how best to meet the challenge of longer lives. Our views on this issue, as you will see from this chapter, bear a very optimistic tone: population ageing is to be an achievement of our societies and not a potential disaster waiting to happen.

In this chapter, we begin by sketching out the issue of population ageing and its possible implications. We then go on to discuss public policies that are required to deal with the challenges posed by population ageing. A European perspective is adopted in this chapter as Europe as a region was the first to face the challenges of population ageing and to pave the ways to address them. We briefly describe how individual countries as well as the European Union and the United Nations Economic Commission for Europe (UNECE) are steering strategies to deal with these challenges. At the outset, simple messages are outlined that would summarise the contents of this chapter:

- Population ageing could be considered as a series of demanding challenges and, simultaneously, it could be embraced as new opportunities for a society depending upon how well society prepares for it. If preparations were adequate and timely, they would actually turn challenges into opportunities and promote a greater extent of social cohesion across generations. However, it could also become a hazard if society fails to take into account all the challenges and act in advance.
- Another message that could come from this chapter is that it is not just the public policies that need to be reformed to account for ageing issues; in fact the private sector and civil society are among the key players in adapting to the new situation and in coming up with innovative solutions.

We recognise that Europe extends beyond the twenty-seven countries of the European Union and includes, along with others, several countries with economies in transition. These countries are a home of several hundred of millions of people and an arena of an extensive and intensive demographic transition to an ageing society. The demographic situation in some of these countries could be characterised as critical as the ongoing process of demographic transition has been aggravated by an extensive emigration of economically active population causing the phenomenon of accelerated ageing. On top of it, the processes of political, economic and social transition remain unfulfilled in many of these countries (World Bank, 2007), which make the adjustment to population ageing a daunting task. The ageing situation in the countries of the former Soviet Union deserves special attention. Meanwhile, we believe that this chapter

could be a source of information for developing indigenous responses to challenges and opportunities – and as of now mostly challenges – of ageing in the transitional countries of Eastern Europe and the former Soviet Union.

It should be noted that the international community, including European countries, is not left empty-handed in their efforts to address the challenges and opportunities of ageing of their populations, and that the recent years have seen significant advances on the arena of international policy development. The most notable progress was achieved by the convening by the United Nations in April 2002 of the Second World Assembly on Ageing in Madrid, Spain. The Assembly developed and adopted the Madrid International Plan of Action on Ageing (MIPAA) [1] – a broad policy framework to respond to the opportunities and challenges of population ageing in the twenty-first century. MIPAA offers coherent recommendations towards how individual countries should design and monitor their policy actions on ageing. Simultaneously, MIPAA outlines priorities for international collaborations across countries.

In September 2002, UNECE at the Ministerial Conference on Ageing in Berlin, Germany, adopted a Regional Implementation Strategy (UNECE RIS) [2]. UNECE RIS contains ten commitments with concrete objectives and measures for policy actions in Europe and other countries of the vast UNECE region. The first five-year review of the MIPAA in the European region has been concluded with the Ministerial Conference in León, Spain, which took place from 6 to 8 November 2007. The Conference in León analysed the achievements and obstacles in implementing MIPAA and UNECE RIS and outlined future perspectives for policy action on ageing in the region [3]. Thus, undoubtedly, international policy documents on ageing under the auspices of the UN have been playing a significant role in the efforts to understand in greater depth the challenges associated with population ageing and to better prepare to meet them.

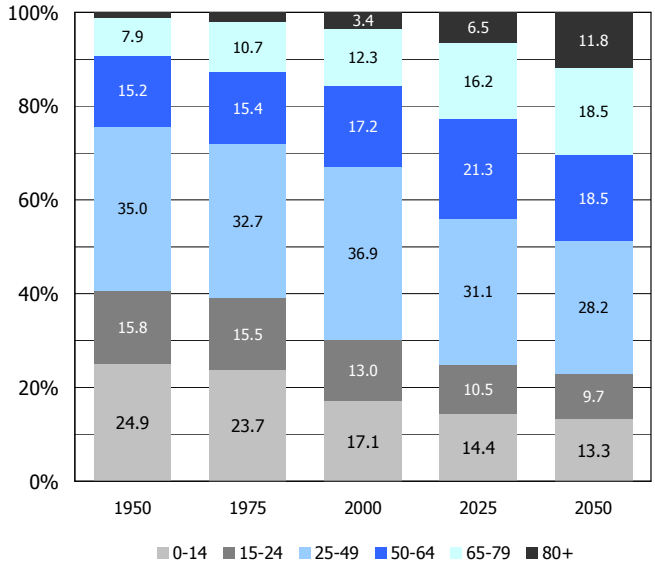
2. Features of population ageing phenomenon in European countries

Figure 9.1 shows the data for the European Union 25 member countries. It illustrates how population shares of different age groups (in the age brackets 0-14, 15-24, 25-49, 50-64, 65-79 and 80+) have changed in the last 50 years and will continue to change in the future 50 years. The youngest age group (0-24) are in the lowest part of the bar diagram and the oldest age group (80+) are at the top. The data covers the period from 1950 to 2050. Thus, these hundred years of data show how population structure is changing in the European Union countries. The last two bars at the top (representing the age groups 65-79 and 80+) illustrate how quickly the share of those two age groups is increasing: from 10% in 1950 it will rise to be close to 33% in 2050.

Therefore, the context of the population ageing phenomenon in Europe is a rising share of older people accompanied by a shrinking population overall.

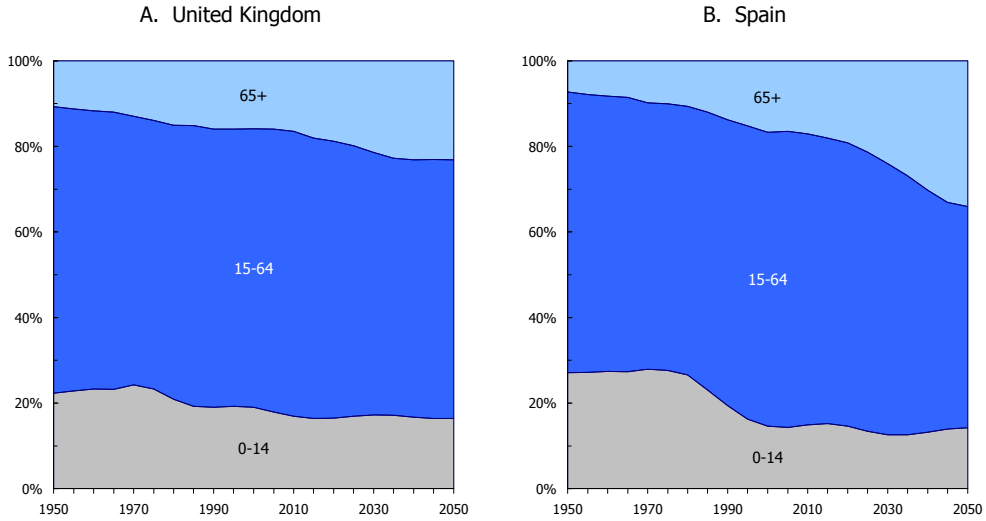
Figure 9.1 — Rising share of the elderly population in EU-25, 1950-2050

SOURCE: *UN World Population Prospects. The 2002 Revision*; and Eurostat 2004 Demographic Projections (Baseline scenario)



The process of population ageing in Europe is not uniform. Let us compare this process across two individual countries: Spain and the United Kingdom. Spain will be absorbing a much quicker rise in the share of older people than most of the other European countries (and the UK is presented as a contrasting example here). As seen in figure 9.2, from 2000 onwards the share of older people in the total population is increasing at a much faster rate for Spain than it is for Britain. Thus while all European societies are ageing, some societies are ageing faster than others, so the challenges of an ageing population manifest quicker for some countries than for others. Another notable phenomenon obvious from this figure is the shrinking of the age group 15-64. This shows that as Europe moves into the future a smaller fraction of its population will form the working age group. This shrinking working population is one of the main challenges that Europe will have to deal with in the future and this poses a serious challenge for European economies to continue to grow and to be competitive.

Figure 9.2 — Changes in the age structure (by broad age groups) in Spain and the United Kingdom, 1950-2050



SOURCE: Adaptation from Marin & Zaidi (2007)

So, what are the main factors behind the ageing of European societies? Three obvious factors can be identified:

1. Ageing of the baby-boom generation (people born from 1945 through 1965) as they reach an average "retirement age" of 65+ in 2010 and beyond;
2. Much lower fertility following the baby boom period; and
3. Rising life expectancy at older ages (a critical factor that is likely to continue).

The first factor that is quite easy to understand is the ageing of the baby boom generation: this generation was born 1945 and 10-20 years after that. Thus, there will be a large number of people who will be retiring from the early 2000s onwards in the next couple of decades. The main predicament has been that this phenomenon of the high baby boom did not continue and, instead, it was followed – at least in Europe – by a much lower fertility rate. Meanwhile, this can also be regarded as a success of societal development: society offered much more choices to women, and women had much better control over when to have children, how many children to have in the family, or even not to have children at all. Thanks to an empowerment of women in society, they are now offered different opportunities beyond staying at home and

taking care of family and children. Women can expect to get much better and more equal opportunities in the future and thus they are more likely to be more often active in the labour market. Among the consequences, however, have been either a lower number of births per women or the postponement of births to a later age.

However, the most successful phenomenon that we often associate with population ageing is the rise in life expectancy, particularly at older ages. Those who make it to the age of 60 to 65 have much higher chances of surviving until much later in life. To illustrate this, two graphs are presented which give a comparison of life expectancy at 65 years for men and women in some EU and North American countries as well as Japan.

The first graph (figure 9.3) presents the situation for men: on average men live 16-20 years after they have reached the average retirement age of 65. It should be noted that the life expectancy gains at older ages amounted to 3-4 years over a period of 40 years in the majority of developed countries (Japan observed even higher gains: 6 years). Equally important is that the phenomenon of population ageing is not just restricted to one or two countries, it is an issue observed in almost all countries of Europe. Moreover, the rise in life expectancy is prominent across the globe in all developed countries, as well as in many developing and transition countries and we refer our readers to other chapters of this book, where this issue is discussed at length.

Figure 9.4 clearly illustrates the fact that women live longer than men: 19-22 years at the age of 65. Thus the longevity gains in recent decades have been even more substantial for women, and this phenomenon is quite similar across countries (once again the exception is Japan, where life expectancy gains for women have been as much as 8 years).

Europe has been at the forefront of many innovative policies that were introduced in the past century to provide resources and services for older people. It was in Europe that the first retirement income systems were introduced: such a system was introduced first in Germany, then in the UK and then in other countries. Europe also had innovative ideas towards providing long-term care for older people: the institutionalised long-term care for older people is first observed in Europe. There is now no reason to expect, when European countries face the challenges of population ageing to a greater extent, that they will not live up to these challenges and provide adequate and timely solutions.

Figure 9.3 — Life expectancy at age 65 for men in 1960 and 2000, elected group of countries

SOURCE: Author's manipulation on UN data on life expectancy

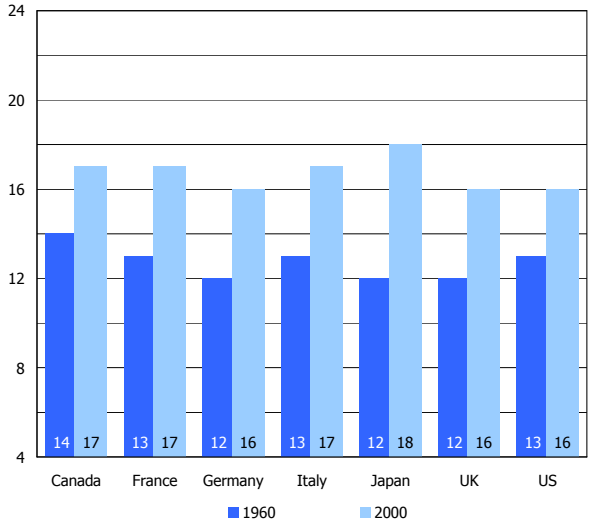
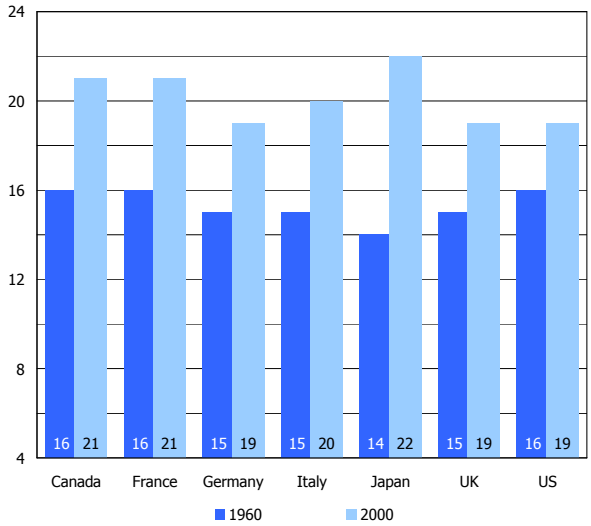


Figure 9.4 — Life expectancy at age 65 for women in 1960 and 2000, elected group of countries

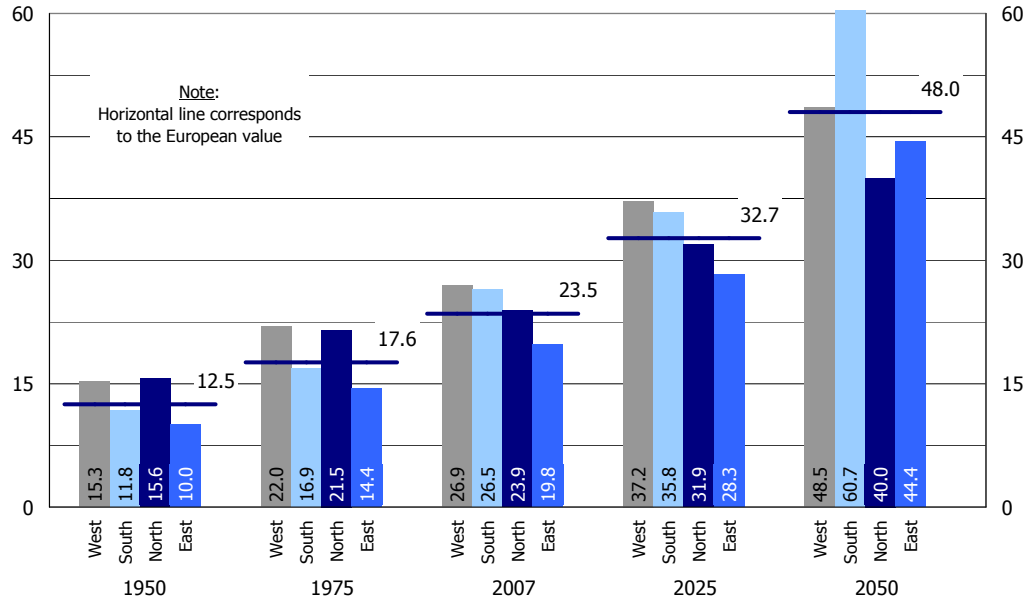
SOURCE: Author's manipulation on UN data on life expectancy



The population ageing has been a success and a sign of progress for European societies but it also raises concerns in particular for pensions and long-term care. For example, pensions will have to be provided for a much longer duration of retirement. Moreover, as Europeans are living longer and not every year gained in life would necessarily be spent in absolute good health, one could expect that a lot more resources will be required in providing health and care services to the future

population of older people. This is all very well understood, but what is often missed out in such debates is the social cohesion challenge: Europe in less than 50 years will become a society in which 1 out of 3 people would be aged 65+, so European countries will be facing a serious challenge to find new ways to balance interactions across the generations. Social coherence between the younger and older generations will be at the heart of solutions to population ageing challenges, and it is not just public policies but also civil society and the media that will be required to play an active role in finding social cohesion across generations. The ageing societies of Europe have to find a way in which they can continue to provide support to older people but at the same time not consider them as a burden for future development.

Figure 9.5 — Old-age dependency rate in Europe by region, 1950-2050

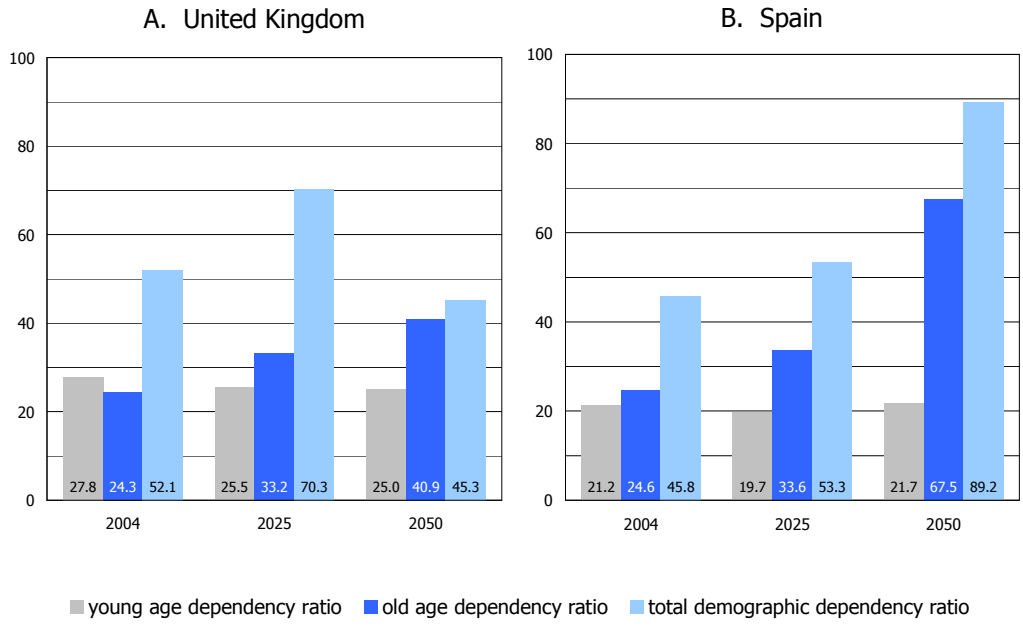


Source: *UN World Population Ageing 2007*

The above illustrations are quite useful for depicting the major features of population ageing in Europe. However, they do not say much about the implications of ageing for society and its members. An indicator that does point to such implications is an old-age dependency ratio indicator as it shows the number of people above the age of 65 as a proportion of working age people (15-64 years old). In a typical *pay-as-you-go* (PAYG) pension system, the working age population put money in a pot and then the

money from the same pot is used to pay for the pensioners of that time. So, changes in the old-age dependency ratio tells us that, in the future, there will be less people contributing to that PAYG pot and more people who will be receiving from it. In most European countries, the old-age dependency ratio has risen to an extent that now about five people contributing for one pensioner, and by 2050, that proportion would become roughly 2:1 (see figure 9.5 above).

Figure 9.6 — Various dependency ratios for Spain and the United Kingdom



SOURCE: Marin & Zaidi (2007)

At this point, we are comparing dependency ratios in different European countries, using again data for the UK and Spain (figure 9.6). In recent times, both the total and the old age dependency ratios have been rising in both countries, although the rise is observed to be more significant in Spain than in Britain. This implies that the speed of ageing is much faster in Spain. The third-bar in the graph (which is the total demographic dependency ratio) is showing that in the UK the dependency ratio between 2004 and 2025 will rise at a faster rate than it will in Spain. However, for Spain, the total dependency ratio will continue rising between 2025 and 2050, whereas a reversal of this trend is expected in Britain. Moreover, by 2050, the old age

dependency ratio in Spain will reach a much higher level than that in the UK. Therefore, Spain will face the challenge of ageing and the issues arising out of population ageing to a higher degree than the UK and many other European countries and for a longer time period.

3. How to adjust to the challenges associated with population ageing?

Five different areas of public policies are selected here for their importance in preparing for ageing societies of the future:

1. Pension policy
2. Health and long-term care policy
3. Employment policy
4. Migration and integration policy
5. Infrastructure development

The scope of this chapter would not allow us to go into many details of each of these policy areas; the objective here is to raise awareness about different issues within each area. It would therefore appear to be useful to outline the overall approaches that countries will need to adopt to come up with the right kind of policies. Most of these approaches are conceptually elaborated and practically detailed in the MIPAA and the UNECE Regional Implementation Strategy:

- The ageing-related policies will have to be transversal so that they could become a part of the overall developmental strategy in making Europe a high growing and competitive region; the importance of 'mainstreaming ageing' will have to be emphasised;
- The policies are to be pursued so as to benefit from a 'full potential' of older people and make our societies fit for people of all ages; thus the concept of 'active ageing' will have to be at the centre of all future policy strategies; and
- Involvement of key stakeholders, including the private sector and civil society, will be a key to success in designing and pursuing a comprehensive strategy to adjust to ageing societies.

Thus, the first approach envisages that policies on ageing have to become a part of an overall strategy of socio-economic development in which Europe seeks to become a region of high growth and a high degree of competitiveness while simultaneously to promote an improvement in quality of life for people of all ages. Another approach

calls for mobilising resources in order to obtain the full potential of people of all ages. Rejecting the views of an ageing work force or of older people as a burden and as a non-productive segment of our societies, this approach aims to find innovative ways to mobilise the skills and knowledge of older people that they have accumulated during active lives for the progress of society. Active ageing is the concept that has been promoted strongly in Europe; it envisages that individuals while ageing could continue to contribute to society's well-being as well as their own.

In addition, the future policies for ageing societies should involve all the key stakeholders of the given society. The task of adjusting to ageing should not be the challenge for public policies alone; it should also be faced by the private sector and civil society, including the research community. The private sector enterprises and the civil society will have to come up with innovative ways in which they could provide for a society in which a greater number of older people are living alongside younger people.

3.1. Pension policy challenges

A broad consensus idea is that societies will have to continue to provide adequate pensions so as to maintain decent living standards for older members of society. Indeed, provision of adequate resources to pensioners has always been the major and universal objective of the pension policy. If a pension policy failed that objective, it would have to be reformed and new ways found to provide resources to reach that objective. It has been shown (Zaidi & Grech, 2007) that recent pension reforms in European countries are overly concerned about fiscal sustainability. Specifically, countries are troubled by the proportion of GDP that is going towards pension provisions and its predicted rise.

One of the possible adjustments of pension schemes to ensure fiscal sustainability is to reduce the pension benefits of the forthcoming cohorts of retirees. Meanwhile, countries with such reforms will face challenges again in the future when a greater number of older people will face the risk of falling into poverty; thus, these reforms raise concerns about social sustainability. Nonetheless, pensions systems should not get overly generous, i.e. generous to an extent that they become unsustainable and will not have enough resources to continue honouring the pensions promise made during the contribution stage. It should be noted that in most of the countries that are adjusting their pension schemes, policy changes have not taken the form of large-scale cutbacks in benefits or the dismantling of public programmes [4]. Most of the reforms included parametric changes, such as an increase in the age of retirement (entitlement) and/or indexing the amount of benefits following the increase in life expectancy.

Another common challenge that the pension policy would be facing is to continue to modernise its operational and functioning capability to cover most of the groups that are likely to be at risk of being in low pensions or without any social security coverage at all. There is a need to ensure pension entitlements for those people who are not normally covered by the formal systems, for instance women who take time off from their formal working careers to care for their family members. In other words, the pension system will have to come up with ways to take into account groups that provide non-quantifiable informal services to society in order to include members of these groups into the pension system. Sweden, for instance, established ways to provide pension credits to women who take time off from work to take care of their own children or their elderly parents.

Another challenge that the pension policy of the future will be facing is to ensure intergenerational fairness. If a society promises too much generosity in pension benefits to the current generation of workers, it runs the risk that future generations of workers will have to pay the bill of this generosity. Thus, the pension policy will have to be devised in a manner that it is fair *across* generations. In the context of many European countries, the private sector will have to play a significant role in providing for pensions through offering innovative financial products, which should be available for individuals to save in order to then benefit from those savings in their retirement.

3.2. Long-term care policy challenges

Longer lives are often associated with the increased probability of chronic disease and disability. There is, however, a well grounded hope that most of these formerly inevitable negative consequences of longevity are preventable. Preventive measures should include improving awareness in pursuing lifestyles that would result in improvements in health and functional status of people in later life. The purpose of these awareness-raising efforts is to persuade individuals to realise that a healthy lifestyle during all stages of their life will provide them not just additional years in life but also good health in those additional years. Making appropriate changes in daily life is a challenge for individuals, yet society as a whole has to make these healthy choices a public goal.

Meanwhile, affordable long-term care has to be made available for frail older people. As for public policies and private sector provisions, ageing societies will have to facilitate the supply of formal as well as informal care mechanisms so as to respond to the long-term care needs of the 'oldest old'. One important consideration is that public policies will have to ensure that informal care provisions continue to play a significant role in the future, thus public policies need to provide incentives to

individual family members so that they would be able and willing to take care of their own older family members.

What is also very important is the coordination of all actors involved in the provision of long-term care. Here, a partnership between public and private sectors as well as between different layers of the government is desirable, so as to come up with solutions in which more affordable and good quality long-term care will be provided in the future as a continuum of various formal and informal provisions. The private sector has always been the leader in coming up with innovative ideas, and it should see a clear motive to come up with innovations that will help meet additional demands of social and health care services that can be provided at home, at day care centres or in formal institutions.

3.3. Employment policy challenges

The phenomenon linked with demographic ageing is the decline in the working age population. This phenomenon implies that in the future an overall decline in the population will be manifested in a smaller share of the working age population. The best way to ease the transition towards a smaller population would be, obviously, to encourage people to work for longer and remove the barriers that prevent them from doing so. As mentioned above, pension policies have already been making changes to improve incentives for longer working careers, by raising the statutory pension age, restricting pathways to early retirement and eliminating mandatory retirement. It is important to refer here to the potential of employment for women, not just in part-time but also full-time employment. Policies to encourage women into the workplace, through better provisions for child care and parental leave will help redress the balance between work and family for women.

The employment potential of other groups, which often suffer from low employment, should be utilised. For example, policies towards greater employment amongst people with disabilities should be pursued with a greater persistence. One should also keep in mind the importance of formalising the employment status of the migrant population, which would also contribute to the labour force capacity of their new homelands.

In countries where early-retirement pathways have been heavily used, notably in Europe, a number of reforms have already taken place to discourage formal early retirement (e.g. Austria, Belgium, and France). In addition, measures have been introduced to tighten qualifying conditions for other pathways, such as disability benefits (e.g. Denmark, the Netherlands, and the United Kingdom) and unemployment benefits (e.g. Austria, Finland, and the Netherlands). A higher pension eligibility age

for men and women has also been introduced in several countries (e.g. Denmark, Germany, Italy, and the United Kingdom). However, caution is necessary in interpreting these trends. Country experience shows that, unless reform is comprehensive, there is a risk of substitution between early-retirement pathways. For instance, the phasing out of formal early retirement schemes in Belgium and France has been offset by a rise in the number of older unemployed exempt from active job search. Disability benefits remain a major early-retirement pathway in many OECD countries. Consequently, the effective retirement age is still well below official retirement age in many OECD countries.

One critical aspect in improving employment for older workers is their employers' views on whether the productivity of older workers is aligned with the rising labour costs of older workers. Empirical studies show that the hiring rate of older workers is lower in those countries where the relative labour costs of hiring older workers are higher. This phenomenon partly reflects the negative employer attitudes that labour costs rise with age faster than productivity. Such an attitude leads to employers pushing their older workers to find an appropriate pathway towards retirement. If public policies towards improving older workers' employment must work, it is essential that employers remove these negative perceptions and facilitate a better working environment in which older workers continue to improve their productivity. At the same time, rigid salary structures in which pay rises with seniority alone should also be replaced with more flexible ones, in which wage rises are associated with productivity gains and performance. Thus, employers and trade unions also have the responsibility to find ways to restrict rising labour costs with age.

What would also be required are sectoral changes by which more and more people could be found working in the sectors that provide for older people. More people should be trained to work in the health and social care provision sectors. This is an important infrastructural development that societies will have to go through so as to prepare to meet the challenge of an ageing population in the future. One other promising way to deal with this challenge of a shrinking population is to increase the output of society by raising the productivity of the working age population. Society has to adopt the life course approach and think where more people could get into employment and where more people could work more productively.

3.4. Migration policy challenges

Ageing societies will consider importing younger workers from younger societies as it will ease labour shortages, though it would not stop the ageing of societies because the numbers required would be too vast. Furthermore, here lies one of the major

challenges for the European countries: the integration of these migrant workers into the workforce as well as into society overall. Referring again to the example of Spain, this country has been able to attract migrants (more than anticipated!) while reasonably successfully integrating them into the labour force. Europe as a region, including Central Asian countries and Eastern European countries, has a great potential to benefit from migration within the region. Caution is necessary here, though. In addition to the inevitable brain drain, those societies that export young workers are also ageing and the emigration would exacerbate challenges in some countries while offering solutions to other countries. One of the authors of this chapter was told by an official in one of the countries of the former Soviet Union: "We are rejuvenating Western Europe while accelerating our own ageing". Indeed, in some of the Eastern European countries almost one out of every two people who are in the productive phase of their working life has either already left for Western Europe or they are planning to leave. So, some of the older European countries can deal with the challenge of population ageing by importing younger workers from the younger countries, but such a solution will generate more problems for the countries that are exporting those younger migrants with possible repercussions for the entire Eurasian region.

At the same time, the migration policy challenges should not be viewed too negatively: if the whole region of Eurasia is seen as part of the global village, then one can assume that some of the people who do not have employment opportunities in their own countries will be able to find employment opportunities elsewhere and bring back resources to their own country, and over the longer term this could contribute to the development of their own country. There is, however, a danger of over-reliance of some of the transitional countries with heavy emigration on the remittances as a source of increasing their GNP instead of facilitating national development, including establishing conditions for decent work at home. A viable solution to this dilemma is perspective planning, with evidence-based integration of population ageing into national development strategies. Equally important is that these challenges of inter-related transitional processes in the mega-region of Eurasia should be addressed through cooperation across all countries of the region — beyond the twenty-seven members of the European Union.

3.5. Infrastructure development challenges

Infrastructural development is often an overlooked dimension of ageing societies: while societies continue to gain the absolute and relative number of older people, institutional development lags significantly behind emerging challenges and

opportunities. In other words, population ageing and societal infrastructure development for adapting to demographic transition do not match each other. A stronger institutional and physical infrastructure development will assure a greater social cohesion across older and younger generations. Moreover, both institutional and physical infrastructures are an essential component of the national capacity to deal with population and individual ageing.

An institutional infrastructure is itself a multi-dimensional notion: it includes various governmental agencies and national committees on ageing. A specifically designated focal point on ageing within the government at the central, provincial and local levels is particularly important for providing the necessary political and administrative weight to the ageing agenda. In addition to government entities, national infrastructure on ageing includes other essential stakeholders such as non-governmental organisations of and for older people, academia and the private sector. All these stakeholders have an important role in designing, implementing and monitoring national policy actions on ageing. Cooperation between and mutual reinforcement of national stakeholders is a central prerequisite for putting into practice various plans and programmes of action, which otherwise are destined to fill up the shelves of libraries and archives.

4. Conclusions

Population ageing is a well recognised and thoroughly investigated phenomenon. The essence of it is a rising share of older people and a falling share of younger people in society. This is not a disaster waiting to happen; in fact it may offer new opportunities for people of different ages to live together and for an ageing society to continue to prosper. The core message of this chapter is that population ageing can lead to a disaster or it can become an opportunity but it all depends on how well ageing societies prepare to adjust for it. The task of adjustment to ageing was formulated as the central purpose of the Madrid International Plan of Action on Ageing. The Madrid Plan of Action determines that the success of the adjustment efforts will be measured in terms of social development, the improvement in quality of life of older people, and the sustainability of the various formal and informal systems that support the quality of life throughout the life course.

The analyses included in this chapter go through different policy domains and discuss various ideas about how public policies in European countries ought to change in the future. The population ageing phenomenon is offering a new setting in which societies have to realise and benefit from the full potential of older people. A new social coherence will have to be found in a society in which younger and older people live well and productively with each other. And the phenomenon of population ageing is

not just a challenge for public policies but also for all major stakeholders to work together for the future.

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Endnotes Chapter Nine:

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2 Ageing Populations. Opportunities and Challenges for Europe and North America. United Nations Economic Commission for Europe. United Nations, New York and Geneva, 2003.

3 The Conference adopted the Ministerial Declaration "A Society for All Ages: Challenges and Opportunities".

4 Major developments in the area of ageing since the Second World Assembly on Ageing. Report of the Secretary-General (E/CN.5/2007/7).

Chapter Ten

What have we learned?

Ronald C. SCHOENMAECKERS and Lieve VANDERLEYDEN

Contents:

1. Introduction

The present chapter is a 'summary' of the various contributions in this publication. It may also serve as a 'guide' for the reader. The chapter is a reflection of the two editors on the nine chapters. Its content has not been discussed with the authors of the other chapters. It is possible that they would have preferred other findings of their work to be underlined. In other words, the *Concluding remarks* and especially the *afterthoughts regarding the role of the international community* are the sole responsibility of the authors of this chapter.

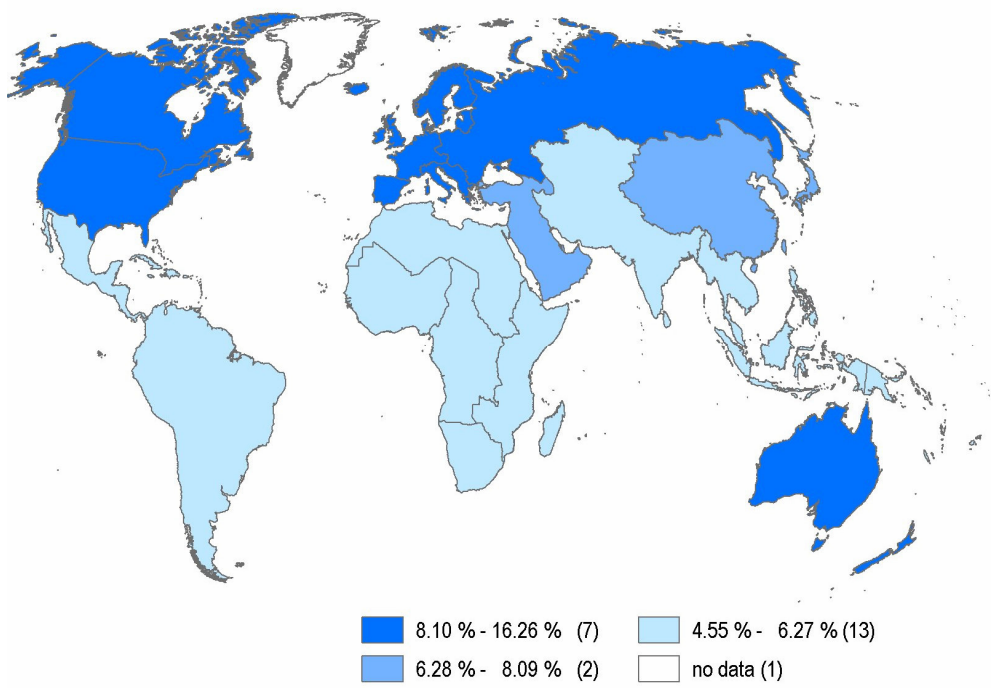
2. A truly global phenomenon

Before starting to comment on the various contributions, let us once more take a look at the increase in the number of people aged 60 or more in the world. The statistics are presented in figure 10.1, which consists of three panels. Panel A shows the situation in 1950; panel B the situation in 2000; and panel C the (prospective) situation in 2050. Each panel shows a map of the world in which the sub-regions are shaded according to the proportion of elderly people; the lightly shaded areas indicate low proportions; the darkly shaded ones high proportions [1].

A comparison between the three panels indicates that the number of elderly is increasing rapidly throughout the world: panel C has many more darkly shaded areas than panel A. In 1950 there was not one single sub-region with a proportion of people aged 60 or over exceeding 25 per cent (in fact, there was not one single sub-region with percentages above the 8.10%-16.26% bracket). By 2000 there was one single sub-region where one quarter of the population was above age 60 (Southern Europe). By 2050, according to the UN population forecast (UN, 2005), there could be no less than 12 sub-regions (55% out of a total of 22) with one quarter of the population aged 60 or over. These 12 sub-regions include the entire industrialised world but also Eastern Asia (in which China is included), South-Eastern Asia, the Caribbean and South America. The only continent showing proportions below 25 per cent is Africa. However, a closer look at the different panels indicates that also here within the next decades the number of sub-regions with high proportions of elderly is likely to increase rapidly. The highest increase is likely to occur in Northern Africa. In this sub-region, between 2000 and 2050, the percentage of elderly will triple, from 7.0 per cent to 21.6 per cent (by 2050, in Tunisia, 28.8% of the population will be aged 60 or over).

The dramatic increase in the proportions of elderly in the world is perhaps even clearer when considering the development at the level of individual countries.

Figure 10.1a — Proportion of population aged 60 and over by sub-region, situation around 1950 (map A)

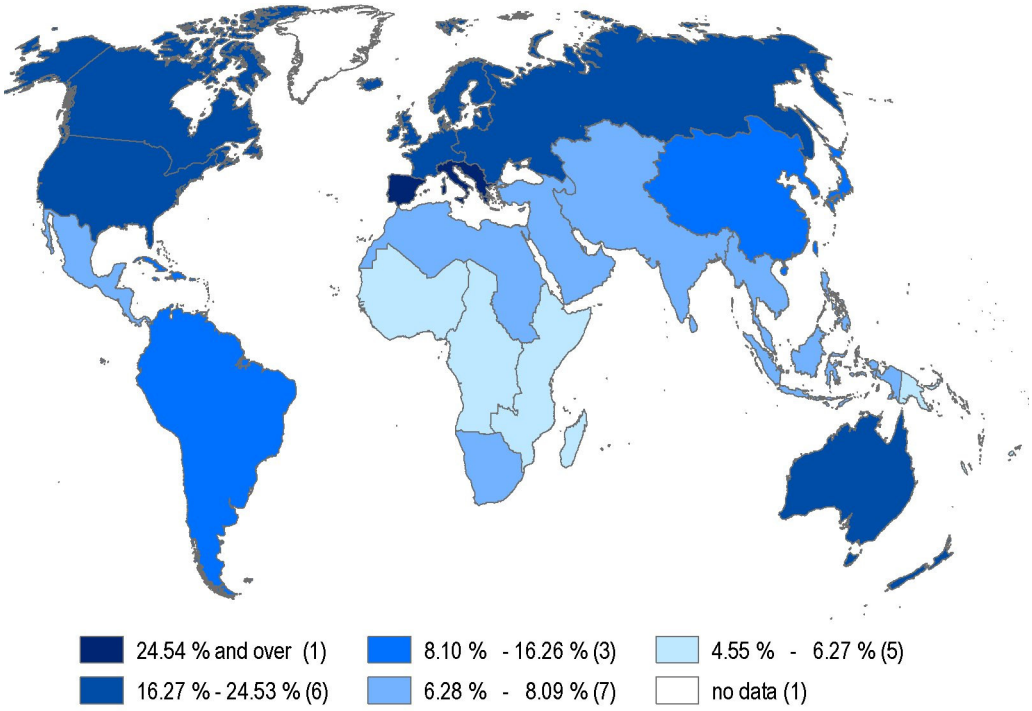


SOURCE: UN (2005), *World Population Prospects. The 2004 Revision*

In 1950 the median value for the proportion of people aged 60 or over that could be observed for 168 countries [2] was 6.5 per cent (UN, 2005). At that time, only 4 countries (2% of the total) experienced a share of older people exceeding 15 per cent of their total population: Latvia (15.61%), United Kingdom (15.52%), Austria (15.43%) and Belgium (15.96%). By 2050 there will be no less than 114 countries (67%) where the share of elderly will exceed 15 per cent. In fact, in 32 countries (19%), the share of elderly will be equal to or exceed one third of the population. The highest proportions of elderly will be found in Japan (41.67%) and in Italy (41.35%); both countries currently experience very high levels of life expectancy (more than 80 years, both sexes combined) and both show very low fertility levels (a TFR below 1.4 children) [3].

By 2050 the median value across countries for the proportion of people aged 60 or over will be 22.4 per cent (more than triple the value observed in 1950).

Figure 10.1b — Proportion of population aged 60 and over by sub-region, situation around 2000 (map B)

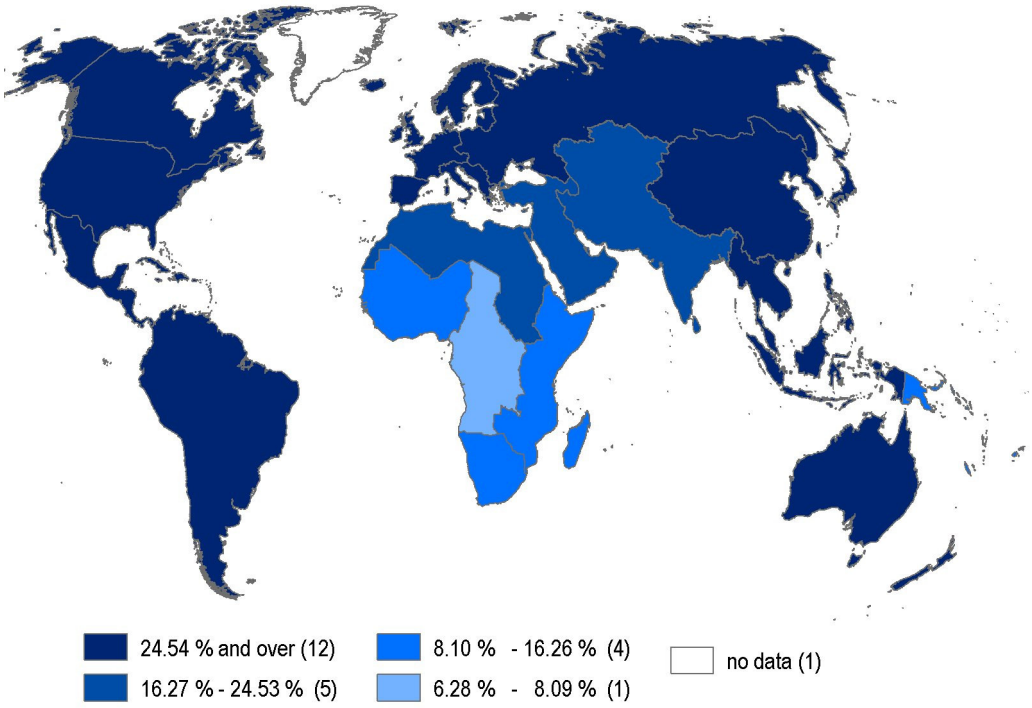


SOURCE: UN (2005), *World Population Prospects. The 2004 Revision*

Clearly, these few observations do not leave any margin for error: 'population ageing' — the changes in the age composition that result in an older age structure — is a truly global phenomenon.

However, the scattered patterns in the various shades in figure 10.1 point to the fact that the increase in the proportion of elderly in the world is far from evenly distributed between continents and countries. Already in 1950 (map A) in most industrialised countries — Northern America, Europe, Australia — the proportion of elderly constituted an important share of the total population, with levels roughly between 8 and 16 per cent [4]. By 2000 (map B), many Asian and Latin American countries show the levels reached by the American and European countries in the 1950s (which in most cases implied a doubling or more of the proportion of elderly in a time span of 50 years).

Figure 10.1c — Proportion of population aged 60 and over by sub-region, situation around 2050 (map C)



SOURCE: UN (2005), *World Population Prospects. The 2004 Revision*

By 2050 (map C), most countries in the world will have populations with over one quarter of its members being aged 60 or over. The notable exception will be the sub-Saharan African countries. But also in these countries, the percentages will be much higher than those recorded in the 1950s and at around 2000: here too, the increase in the proportions of elderly has taken off.

So much for the statistics. But how are we to interpret these changes? And, more importantly, what are the societal implications of 'population ageing'? How will it affect the lives of individuals? And how are governments reacting to this new 'demographic reality'? These are the subjects handled in the various chapters.

3. The various chapters: what have they told us?

As is shown in ***Chapter 1*** by ***Ronald Schoenmaeckers*** (and as is illustrated again in figure 10.1 above) the highest proportions of elderly (people aged 60 and over) are currently observed in the Western European countries, more particularly the former group of 15 EU Member States. As argued by Schoenmaeckers, the explanation is that precisely these countries are most advanced in what is known as the 'demographic transition'; in fact, the EU15 countries would have reached what could be considered to be the 'last stage' of the transition [5]. By contrast, other countries, more particularly the sub-Saharan countries, are only showing the first signs of the transition. The direct implication is, as illustrated by the simulation exercises in Chapter 1, that the main 'motor' of 'population ageing' is in the EU15 Member States the changes in mortality, more specifically the increase in life expectancy, whereas — at least for the next decades — in the sub-Saharan countries the main 'motor' of 'population ageing' is clearly linked to fertility decline.

- ***The attention given to 'population ageing' by European policy makers***

The relatively high proportions of elderly that European countries have been experiencing since the second half of the 20th Century (of roughly 17%, about double of the World average), combined with the prospect of even higher levels at the start of the 21st Century — as the result of increasing life expectancy and persisting low fertility, associated with the 'second demographic transition' (see, for example, Lesthaeghe & Surkyn, 2007) *and* the fact that the baby-boomers of the 1950s would reach retirement age by 2010 — explains why 'population ageing' and its socio-economic consequences have been high on the European political agenda for some decades already.

There is the fear that the shift in the age composition, more particularly the increasing numbers aged 65 or more on the one hand, and the declining numbers at working age (20-64) on the other hand, which together are captured by the changes in the *dependency rate*, could have far-reaching economic consequences. One particular fear is that the existing *pay-as-you-go* (PAYG) pension system in which the working age population pays for the pensions of the retirees, would become unsustainable. This problem is treated in ***Chapter 9*** by ***Asghar Zaidi*** *and* ***Alexandre Sidorenko***. As possible solutions to 'redress' the *economic dependency rate* they mention to fully using the 'potential of employment of women' and also creating 'greater employment amongst people with disabilities'. Another major challenge would be to discourage early-retirement policies (which have become rather 'popular' in European societies) and to increase the age at retirement (in most countries fixed at age 65). Part of the challenge

would be abolishing the common views that older workers are non-productive; on the contrary, one of the objectives should be finding innovative ways to mobilise and use the skills and knowledge of older people.

In discussing the necessary pension reforms, Zaidi and Sidorenko underline the importance for *intergenerational fairness*: "If a society promises too much generosity in pension benefits to the current generation of workers, it runs the risk that the future generations of workers will have to pay the bill of this generosity". In the margin hereof one may add that the need for intergenerational solidarity (cf. the title of the 'Green paper' published in 2005 by the European Commission, cited in Chapter 1 by Schoenmaeckers) must be regarded as a cornerstone of future policies; it is only regrettable that the concept — and the problem of turning it into a 'concrete' idea in the minds of citizens — has not received more attention among researchers (see also the comments on Chapter 8 by Jolanta Perek-Bialas further below).

The need for ensuring fiscal sustainability for the payment of pensions is also handled in ***Chapter 7*** by ***Micheline Lambrecht***. In this contribution the author focuses on some specific reforms that have been taken in Belgium to meet the impact of 'population ageing' on public expenditures. The first reforms date from the early eighties [6]. Belgium was one of the first countries to establish a specific committee with the mandate to 'monitor' the 'ageing' process: the *Study Committee on Ageing* of which the secretariat was entrusted to the Federal Planning Bureau (FPB). The activities of the *Study Committee on Ageing* and of the FPB are carried out in close collaboration with *Working Group on Ageing Populations and Sustainability* inside the Economic Policy Committee of the European Union. As part of these activities the FPB developed the *MALTESE System of Models* as an analytical instrument. In accordance with the guidelines adopted at European level (cf. the 'Lisbon strategy'), the Belgian authorities strive for higher employment rate, lower public debts, and the need for pension reforms.

Specific attention is given to the impact of 'population ageing' on health care expenditures. Based on the age-related health care expenditure profiles as observed in the EU15 and the EU10 Member States (see figure 7.10), and taking into account the demographic forecast corresponding to the baseline scenario prepared by Eurostat, EU Member States may expect an increase of health care expenditures by 1.5 percentage points of GDP — from 6.4 per cent in 2004 to 7.9 per cent in 2050 [7].

Next to the sustainability of the payment of pensions the (increase) of health expenditures is certainly one of the important topics that need our attention in discussing the socio-economic consequences of 'population ageing'. It is also a fact that many European countries have experienced increases in health expenditures

during the last decades, both in absolute terms or as percentage points in GDP. However, not all researchers are convinced that the sole cause of the increases is an older age composition. Kieffer (2004) has made the observation that the observed age-related pattern closely resembles a death-related pattern. In other words, the expenditures would not be 'age-driven', but 'death-driven'. Other researchers also point to the fact that health expenditures are also largely dependent on other factors, such as the price policies of pharmaceuticals and the use and prescription of drugs (see the discussion in Schoenmaeckers, 2005).

It is clear that the relation between health expenditures and 'population ageing' is so far not perfectly understood. It is not even clear to what extent the 'extra' years as the result of increased life expectancy are years in 'good health' or in 'bad health'; some researchers tend to a more 'optimistic' view, while others to a more 'pessimistic' view (cf. Chapter 8 by Jolanta Perek-Bialas further below).

The discussion of extra years in 'good health' versus 'bad health' is to a great extent also the subject of ***Chapter 6*** by ***Lieve Vanderleyden***. This chapter provides, by way of illustration, more insight in the policies in Belgium, more particularly those adopted by the Government of the Region of Flanders [8]. Personal contacts with fellow colleagues from the global 'South' at conferences and seminars [9] make us believe that many of them envy us the availability of 'retirement homes'; to them, this is an indication that the state 'takes care' of its older citizens. However, surveys such as, for example, LOVO [10] for Flanders and SHARE [11] in an European context, indicate that older people wish to stay in their own homes 'as long as possible', i.e., as long as their physical condition permits them to lead an independent life style. For this reason, the Flemish Government has been early in promoting older people staying in their own homes by means of a variety of services, facilities and care projects. In this context, increasing the capacity for self-reliance has become an important objective of the Flemish policy. The policy has not only the merit of being an answer to the preferences of the citizens, but, as it turned out, for the government it has the additional advantage that home care implies less public spending than residential care.

The main message in Chapter 6 is that it is likely that, although the age at which it may be expected increases, at one stage in their life a number of citizens face the harsh reality that, eventually, they need outside help, to assist them with their 'ordinary' daily activities and/or with physical care. One could say that 'home care' and 'residential care' complete one another; each one would be a response to specific needs.

The impact 'population ageing' may have on health expenditures is a very complex subject. One may even wonder to what extent the increase in health expenditures that

is associated with more preventive medicine, better treatment and the research for more efficient drugs, could be the explanation for the increases in life expectancy as they have been observed for the last century; in some instances these increases were nothing but spectacular [12].

There can be no doubt that 'population ageing' and its socio-economic and societal consequences will remain an object of study for many years to come. And because many European (and other) countries face many, albeit not identical, yet largely similar challenges, there is also the need for an international approach. Both are illustrated in ***Chapter 8*** by ***Jolanta Perek-Bialas*** which provides an overview of projects that have been or are currently being financed by the European Commission. In this chapter Perek-Bialas describes a large number of completed and on-going projects carried out under the umbrella of the so-called 'framework' programmes.

The existence of these framework programmes and the fact that researchers are being given an incentive for international collaboration can only be welcomed by the research community. However, as discussed by Perek-Bialas, the mere availability of comparative analyses is not sufficient. Indeed, more would need to be done to disseminate the results, amongst national and international policy makers and also amongst the general public. One specific objective of these projects should be to disseminate the information and insights and, last but not least, the fact that 'population ageing' is 'here to stay'; or in other words: passing the message that 'population ageing' is probably the most important (demographic) phenomenon that humanity will witness in the 21st Century and that, consequently, there is an urgent need to look for the best possible solutions for the social and financial problems it engenders.

- ***'Population ageing' in the African context***

It is clear that, compared to the situation in Europe, 'population ageing' in Africa has so far not received the same attention from policy makers, either at national or at international level.

However, in spite of these relatively low proportions, 'population ageing' in Africa deserves all our attention. As indicated by Schoenmaeckers in Chapter 1 and again illustrated in figure 10.1, the situation is likely to change rapidly. According to the *Population Prospects* of the Population Division (UN, 2005), by 2050 the percentages of older people may have doubled, coming close to 10 per cent.

But these 'demographics' are not the only arguments why 'population ageing' in Africa deserves the attention of the international community. This is well illustrated in the chapters dealing with the situation in Africa.

In ***Chapter 2 Kuepie*** and ***Yaro*** argue that 'population ageing' will occur in a general context of poverty. Indeed, according to a recent issue of the *Human Development Report* of UNDP (2005), GDP *per capita* in sub-Saharan countries is only a fraction (one fourteenth) of its average value in OECD countries — USD 1,700 vs USD 23,600 in PPP (Purchase Power Parity) equivalent. However, probably even more worrisome is the fact that during the last decades GDP *per capita* actually declined by about 1 per cent per annum. According to the same HD Report, in the period 1990 to 2003 in only 25 per cent of all sub-Saharan African countries was the annual growth rate of GDP per capita higher than 2 per cent (as opposed to 65% of all high-income OECD countries); and in 40 per cent the annual growth rate of GDP per capita was negative (for 35% of all sub-Saharan African countries the growth rate was between 0 and 2%).

What's more, the highest poverty levels are observed for older people; depending on the country [13] the 'poverty rate' of older people would be 5 to 15 percentage points higher than the national average. Very few elderly benefit from a retirement system. In the cities, only about half of the older men who do not work receive a pension; for women, the percentage is only 14 per cent. On the other hand there are indications that those who do benefit from a retirement system have a greater probability of also benefiting from another source of income. Apparently, in Africa too, there would be a 'Matthew effect' at work: those who 'have' can aspire to get (even) more [14].

Kuepie and Yaro also draw attention to the fact that older people in Africa are no longer respected in the same way as in the past; they are, for instance, no longer considered a source of wisdom. Both are the result of the fact that the economic power has changed hands and is now rather in the hands of the well-educated younger generations (in Chapter 4 Busolo and Nhongo also identify the rural-urban migration and the political instability in many African countries as possible sources for the weakening respect for older people).

One implication of this unfortunate situation is that many older people in Africa feel compelled to continue working after 'retirement' age; in Africa, activity rates after age 60 are much higher than in, for example, Belgium. Finally, the authors point at the responsibility of the national governments for developing a much-needed social security system.

In ***Chapter 3***, ***Nana Apt*** projects a similar picture of desolation. She focuses on the situation of women in African society. She reiterates the view already depicted by Kuepie and Yaro, namely that older women often live the last years of their life in very poor conditions. Older women are vulnerable, they live in poverty, cannot benefit from medical care; very often, being widowed or separated, they live in complete social

isolation. Women may live longer than men but because of these hardships this fact can hardly be called a 'blessing'. However, in spite of these poor living conditions society still expects them to take care of the sick and especially of their orphaned grandchildren as the result of the AIDS-epidemic.

Therefore, she argues, an improvement of the living conditions of older women is necessary. However, in spite of the adoption in 2002 of the Madrid International Plan of Action on Ageing (MIPAA) by 159 countries, its implementation in Africa will be extremely difficult. The poor countries in the 'South' will be facing limited resources and the financial assistance of the richer countries in the 'North' is scarce. We will come back to this issue in the next paragraph on concluding remarks.

There is no doubt that in Africa, older people are 'the poorest of the poor'. Older men can still hope to find some solace in the traditional belief that associates wisdom with old age (although the tradition is weakening) but this is not an option for older women. On the contrary, traditional practices may make them particularly vulnerable. For instance, tradition prevents them from holding any property or to remarry as a widow. The situation becomes really severe when they are accused of witchcraft, a situation that is, as illustrated by Apt, not at all that exceptional in rural Africa.

The AIDS epidemic has made older women even more vulnerable. As indicated by Apt, nearly two-thirds of all HIV/AIDS cases in the world are found in Africa. The fight against this deadly disease and the impact it has on older people are investigated in more depth in ***Chapter 4*** by ***Dolline Busolo*** and ***Tavengwa Nhongo*** and ***Chapter 5*** by ***Isabella Aboderin***.

Official statistics are unavailable, but Busolo and Nhongo estimate the number of orphaned children related to the AIDS-epidemic at several million. In most cases — probably up to 60 per cent — by lack of alternatives, these children are being taken care of by their next of kin, usually the grandparents, more specifically their grandmother. While the sacrifice of these older people can only be applauded, it needs also to be realised that they are not well-prepared for this task. The upbringing of their grandchildren represents of course an extra financial burden but most of all in general older people have only little knowledge about the disease and how to protect children from infection; moreover, in the case of sickness they are unable to pay for the extra cost of treatment.

Isabella Aboderin makes a quite critical assessment of the situation. She identifies three causes for the fact that the African countries in general are ill-prepared in their fight against the HIV/AIDS epidemic. The first cause she identifies is the erosion of health systems as a consequence of cuts in public spending that were part of the neo liberal structural adjustment programmes (SAP) in the 1980s and 1990s. In the great

majority of sub-Saharan countries (78%) the budgetary allowances to provide even the most essential public health interventions are much lower than the minimum requirement as estimated by the WHO (USD 34). As second cause she mentions the shortage of health care workers as the result of emigration — a particularly severe handicap in times when there is an ever-increasing need for them. The third and last cause would be that, although lowering under-five mortality and maternal mortality, and the fight against the HIV/AIDS epidemic are all part of the MDGs (Millennium Development Goals) these health-related objectives are not being given the priority attention they deserve. A specific shortage in most policies is that insufficient attention is given to preventive measures such as the counselling of younger people, those aged 15-24, and the high-risk group for infection by the HIV virus.

Finally, Aboderin draws attention to the fact that detection programmes can no longer be limited to those aged 15-45, the so-called 'sexually active'. Those above age 50 also need to be covered by the detection programmes. It has lately become more and more apparent that among these people, too, many are victims of the HIV/AIDS disease.

4. Some concluding remarks

It is obvious that not all topics related to 'population ageing' can be covered in one single publication (or conference). The primary objective of this publication (and of the Conference in 2007) was to indicate that (a) 'population ageing' is, contrary to general opinion, a *global* phenomenon; but (b) that there are clear differences between the countries in 'North' and 'South', both with respect to their specific demographic situation and the socio-economic challenges caused by the changing age structure they are confronting.

One may expect that a global phenomenon requires global action and therefore a coordinated response from the international community. This is, for example, the case for environmental issues, which resulted in international conferences such as the Rio Conference of 1992 and the Rio+10 Conference (or the Johannesburg Summit) in 2002 and ultimately to 'action plans' such as Agenda 21 and the Kyoto Protocol. In the aftermath of the Rio Conference, it is no exaggeration to say that 'sustainable development' has become a household word [15].

The Madrid International Plan of Action on Ageing (MIPAA) adopted in 2002 was certainly a step forward. However, to what extent is the Plan of Action the perfect instrument in preparing the World for an ageing population? It is not the purpose here to provide a detailed critique of the MIPAA. In the next (and final) paragraph we only

attempt to underline the international dimension of the phenomenon and to provide some 'food for thought'.

- ***Afterthoughts regarding the role of the international community***

The MIPAA adopted in 2002 in Madrid was the second Action Plan on Ageing. The first Action Plan dates from 1982 and was adopted in Vienna (VIPAA) [16]. In both instances, the Action Plan focuses on the (special) needs of the elderly and contains guidelines — recommendations — for national governments. It is not our intention to diminish the importance of both Plans of Action. For example, we fully agree with Zaidi and Sidorenko that "[these] international policy documents on ageing [discussed and adopted] under the auspices of the UN have been playing a significant role in the efforts to understand deeper the challenges associated with the population ageing and to prepare better to meet them." Moreover, these Action Plans constitute the basis for international collaborations across countries (see Chapter 9 for more details).

Both are illustrated by current activities. At the time of writing these lines, to meet the demand of many countries at the Léon Conference in 2007 in Spain, organised as a follow-up activity for the Madrid Conference, the Population Activities Unit (PAU) of the United Nations Economic Commission for Europe (UNECE), intends to constitute a Working Group on Ageing to monitor and coordinate the policy actions on ageing undertaken in the UNECE region [17].

Similar initiatives are being undertaken in the Africa region. In November 2007, the United Nations Economic Commission for Africa (UNECA), in collaboration with the Organisation of African Unity, called for a meeting of all African countries in its headquarters in Addis Ababa. The purpose was to identify and discuss the specific challenges related to 'ageing' for the African continent and to look for appropriate measures. The meeting was the basis for a first UNECA Report on the issue (UNECA, 2007).

It is clear that the Addis Ababa meeting was internationally 'driven'. The meeting was part of the search for a regional implementation strategy of the MIPAA. The meeting and the report that ensued from it were the first of its kind for the African continent; it is most likely that in the years to come there will be follow-up activities. It is a clear indication of the fact that the African research community *and* the African policy makers — the meeting was attended by representatives of the African Union — have become fully aware that time is running short and that also African states need to prepare themselves for the challenges related to 'population ageing'.

The initiatives undertaken by UNECE and UNECA are without doubt encouraging. They are instrumental for policy makers in identifying the challenges and for setting

priorities; and international collaboration and the exchange of 'best practices' are a valuable tool in looking for the best possible solutions. However, it should also be realised that, eventually, countries are sovereign in implementing national policies. Supra-national bodies such as the European Commission may restrict autonomy by setting out directives (or guidelines) that Member States are expected to follow [18].

It should also be realised that the Action Plans are not always fully implemented by all individual countries. In some instances this may be because some international guidelines are not fully compatible with national interests. But at times the plan is not implemented simply because countries have other priorities: there are other, more urgent matters that need to be resolved. For example, it may be that a country does not pay sufficient attention to the specific health care needs of elderly because its entire health care system is under equipped and/or understaffed. The whole discussion about the payment of pensions or about keeping economic output level in spite of the dwindling number of people at working age — which translates into changes in the dependency ratio: see chapters by Lambrecht or Vanderleyden — become obsolete in countries where economic outcome is low by all standards. This dilemma became apparent in a comparative analysis on the socio-economic impact of 'population ageing' between for example the affluent Western European countries and the poorer Eastern European countries with economies in transition (cf. Schoenmaeckers, 2005). In the context of such discussion, Klinger (2002) came to the conclusion that "for the transition economies [...] there are [in addition to the issues related to 'population ageing'] the more fundamental issues of economic development and catch-up." In other words, any discussion or programme related to the socio-economic impact of 'population ageing' appears pointless without taking into account the importance of economic development. Affluent countries, such as the Western European countries, must strive to keep, at minimum, the acquired GDP per capita levels constant; and poorer economic countries, such as the Eastern European countries with economies in transition, must in the first place strive to raise the levels of GDP per capita (to come in line with the other European countries). In 2004 ten Eastern European countries have joined the European Union to become full EU Member State; in 2007, two more countries joined the EU. Past experiences with other, earlier, 'new memberships' (Spain, Portugal) permit us to believe that EU membership will give a 'boost' for economic development so that the poorer countries with economies in transition may, to re-cite the words of Klinger, soon "catch up" with the more affluent Western Member States. Unfortunately, the poorer African nations do not have a similar prospect [19].

African nations may be a net beneficiary of international development aid. This can be applauded (which does not imply recognising the fact that all aid would be sufficient or efficient and/or contribute to sustainable development). The main message here is that so far, there are no international programmes geared towards helping the poorer African nations in meeting the challenges related to 'population ageing'. This is all the more astonishing taking into account, as is clearly illustrated in various contributions in this publication, that the needs are huge: many African countries are still being confronted with the devastating effects of the HIV/AIDS epidemic (some of the victims of which are elderly poor); in most countries there is no or hardly any social protection system (whereas for European countries, the sustainability of the existing social protection systems is precisely identified as one of the main challenges related to 'population ageing'); and at the same time, most, if not all, African countries will for many more decades to come continue to be confronted with the difficult issue of high population growth.

The problems are not new. They were identified decades ago. The fact that ageing is a global issue, and that more particularly in sub-Saharan countries there is the urgent need for a social protection system, were for example two of the main conclusions of a CBGS/UNFPA seminar organised in 1998 in Brussels (Cliquet & Nizamuddin, 1999). One of the recommendations of the seminar was the need for an international programme on 'population ageing'. Some of the key issues of such programme were the exchange of 'best practices' and, alongside a 'South-South' dialogue, the existence of a 'North-South' dialogue. It was believed by the participants at the seminar that the demographic process could serve as a 'unifying' factor between countries, and as such contribute to more 'international solidarity' in facing the challenges of 'population ageing' (Vanderleyden & Schoenmaeckers, 1999).

About 10 years on, the situation has not improved. An indication that at international level, 'population ageing' and its socio-economic challenges is not on the list of the priorities of the international donor community, may be the fact that it has not been included in the list of Millennium Development Goals. However, it should be recognised — and the contribution by Schoenmaeckers is a good illustration of this — that a successful implementation of the MDGs (improvement of reproductive health objectives such as a reduction of infant and maternal mortality; an increase of the school attendance by girls; the empowerment of women [20]) will result in a lowering of fertility levels, and hence inevitably lead to a shift in the age composition, i.e., to 'population ageing'. In other words, reproductive health, including family planning and the lowering of fertility on the one hand, and 'population ageing' on the other hand, are but two different sides of the same coin. They therefore merit the same attention in international development programmes.

We can only hope that the reading of the present publication may help us come to a better understanding that 'population ageing' needs a more international approach and therefore needs to be treated in a more egalitarian way as other international 'priorities' such as reproductive health, incl. the combat against the HIV/AIDS epidemic, the empowerment of women, the reduction of poverty…

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Endnotes Chapter Ten:

[1] The sub-regions used have been derived from the geographical classification as used by the UN. In total the maps identify 22 sub-regions: Eastern Africa, Middle Africa, Northern Africa, Southern Africa, Western Africa, Eastern Asia, South-Central Asia, South-Eastern Asia, Western Asia, Eastern Europe, Northern Europe, Southern Europe, Western Europe, Caribbean, Central America, South America, Canada, United States of America (these two constituting together Northern America in the UN classification), Australia and New Zealand, Melanesia, Micronesia, Polynesia.

In the maps, Greenland has not been attributed any data. According to the geographical classification of the UN Greenland is part of Northern America; administratively, however, Greenland is part of Denmark.

The sub-regions are classified according to a total of five categories: 4.55%-6.27%, 6.28%-8.09%, 8.10%-16.26%, 16.27%-24.53%, and 24.54% and over. The delimitations of the categories are the result of an 'EDA' exercise (Tukey, 1977) on the proportions for the year 2000 (map B). The exercise consists of first determining the median value (8.01%) and the minimum (4.55%) and maximum

(24.54%) values. Once this is done, it is easy to calculate the upper and lower hinge: 16.27% [= (Max-Md)/2]; and 6.28% [= (Md-Min)/2].

In all three maps sub-regions are classified according to the same five categories. Note, however, that the two highest ones are not used in map A (1950); and that the lowest category does not appear in map C (2050).

2 Only countries with at least half a million inhabitants by 2050 have been taken into account.

3 The highest life expectancy for the period 2005-2010 is observed in Japan: 82.82 years. Italy follows closely with 80.58 years. Only 12 other countries experience a life expectancy of more than 80 years. In the same period, both countries show very low TFR-values: 1.37 for Japan and 1.38 for Italy. 20 other countries, most of them situated in Eastern or Southern Europe, showed even lower values; the lowest (1.15) being recorded for Ukraine.

4 The figures indicate that also within this group of countries there was much variation in the proportion of elderly.

5 The only other (non-European) country to have reached this stage is Japan. In fact, Japan and Italy, both countries with very high life expectancy and very low fertility, show quite similar proportions of elderly, of about one-fourth of the population (UN, 2005: 2000-2005 estimates).

6 With 18.5%, until the 1980s, Belgium experienced together with Sweden (21.9%), the UK (20.2%) and Denmark (19.5%) the highest proportions of people aged 60 or over.

7 The increase may be as high as 1.7 percentage points for the EU15 Member States and 1.3 percentage points for the EU10 Member States.

8 In the course of the second half of the 20th Century Belgium has become a federal state with three regions: for more details, see endnote 5 in Chapter 6.

9 Personal communication to R. Schoenmaeckers from Indian colleagues during a 'fact-finding' mission organised in 2000 by UNFPA in view of an international programme on 'ageing'.

10 LOVO stands for *LeefsituatieOnderzoek Vlaamse Ouderen* (Survey on Living Conditions of Elderly Persons). LOVO is based on a sample of about 2,500 people aged 55 or over. The interviews were conducted in 2001-2002 and included questions related to various aspects of their daily life. For more details, see: Jacobs *et al.*, 2004.

11 SHARE stands for *Survey on Health, Ageing and Retirement in Europe* — see website http://www.share-project.org/.

12 Between 1950-55 and 2000-05 for all European countries as a whole, life expectancy has increased by no less than 8.2 years or 12.5% (from 65.56 to 73.75 years, both sexes combined); for Western Europe alone the increase was even higher: 11.3 years or 16.8% (from 67.58 to 78.93 years) (UN, 2005).

13 Not all sub-Saharan countries are included in the study. Kuepie and Yaro base their findings on statistics for Benin, Burkina Faso, Côte d'Ivoire, Mali, Niger, Senegal and Togo: see, for example, figures 2.1 and 2.2 and the box in Chapter 2.

[14] The 'Matthew effect' refers to the biblical idea that "the rich get richer and the poor get poorer". In the social sciences it was first introduced by Robert K. Merton (1968) to describe the way that eminent scientists will often receive more credit than a comparatively unknown researcher. In Belgium, the notion was 'popularised' by Herman Deleeck (1983), a specialist in social policies, to refer to the fact that the 'better-off' in society may profit more from social security measures than poorer people.

[15] This international attention does not also imply that all countries implement the action plans adopted at the conferences or even agree with them. In many instances, national interests continue to overshadow those of the international community. For an assessment of the ratification and the implementation of, for example, the Kyoto Protocol, see the website of the United Nations Framework Convention on Climate Change (UNFCCC): http://unfccc.int/essential_background/items/2877.php

[16] VIPAA and MIPAA are available at http://www.un.org/ageing/vienna_intlplanofaction.html.

and http://www.un.org/esa/socdev/ageing/madrid_intlplanaction.html respectively.

[17] A first meeting is scheduled toward the end of 2008 at the UNECE headquarters in Geneva.

The UNECE region comprises a total of 56 countries. Most countries are European countries; other members are the USA, Canada and Israel. Clearly, its 'radius of action' is much wider than the 27 EU Member States.

[18] The amount of 'restriction' is quite relative to the extent that the directives are usually agreed upon by consensus between all Member States.

[19] This publication does not contain a comparison of GDP levels between the affluent Western European countries, the European countries with economies in transition, and the African countries. It may be sufficient to note, however, that, according to the latest Human Development Report (UNDP, 2007) GDP per capita was for the affluent Western European countries 32,153 (median value EU15); 16,879 for the Eastern European countries with economies in transition (median value EU10); and only (average value) 1,998 (or 6 and 12%, respectively) for the sub-Saharan African countries (all estimates in US$ PPP, situation 2005).

[20] The list of the 8 MDGs is as follows: eradicate extreme poverty and hunger achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, ensure environmental sustainability, develop a global partnership for development [see http://www.undp.org/mdg/].

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