AGEING

Thailand, Malaysia, Indonesia and Cambodia

Demographic Transition, Policy and Programmatic Responses

ICOMP International Council on Management of Population Programmes

IPPF International Planned Parenthood Federation
East & South East Asia and Oceania Region

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GLOSSARY OF TERMS

AIDS	Acquired Immunodeficiency Syndrome
ASEAN	Association of Southeast Asian Nations
BAPPENAS	Badan Perencanaan Pembangunan Nasional (National Development Planning Board)
BKKBN	Badan Kependudukan dan Keluarga Berencana Keluarga
BPS	Badan Pusat Statistik
BR1M	Bantuan Rakyat 1 Malaysia (1 Malaysia People's Aid)
CDHS	Cambodian Demographic and Health Survey
CHD	Coronary Heart Disease
DoSW	Department of Social Welfare
EPF	Employees Provident Fund
GDP	Gross Domestic Product
GeM	Gerontologi Malaysia
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICOMP	International Council on Management of Population Programmes
ICPD	International Convention on Population and Development
IG	Institute of Gerontology
IPPF-ESEAOR	International Planned Parenthood Federation-East and South East Asia and Oceania Region
JAMKESMAS	Jaminan Kesehatan Masyarakat (Financed Health Coverage Programmes for the poor and near-poor)
KIS	Indonesia Health Card
KKS	Prosperous Family Saving Card
LLI	Lembaga Lansia Indonesia
LPPKN	Lembaga Penduduk dan Pembangunan Keluarga Negara
MIPAA	Madrid International Plan of Action on Ageing
MOH	Ministry of Health
MOSTI	Ministry of Science, Technology and Innovation
MoSVY	Ministry of Social Affairs and Veteran and Youth Rehabilitation
MPFS	Malaysian Population and Family Survey

GLOSSARY OF TERMS

MPKSM	Majlis Pusat Kebajikan Semenanjung Malaysia (National Advisory and Consultative Council for Older Persons)
MMS	Malaysian Menopause Society
MRA	Mutual Recognition Arrangement
NACCE	National Advisory and Consultative Council for the Elderly
NACSCOM	National Advisory Council for Senior Citizens of Malaysia
NCOP	National Commission for Older Persons
NESDB	National Economic and Social Development Board
NGOs	Non-government Organizations
NIS	National Institute of Statistics
NPA	National Plan of Action
NPE	National Plan on the Elderly
NSSF	National Social Security Fund
NSSS	National Social Security System
OPA	Older Persons Organizations
POPCouncil	Population Council
POSYANDU	Pos Pelayanan Keluarga Berencana - Kesehatan Terpadu (Integrated Health Services Centres)
PRS	Private Retirement Scheme
PUKESMAS	Pusat Kesehatan Masyarakat (Primary Health Care Centre)
SERMRC	South Eastern Region Migrant Resource Centre
SRH	Sexual and Reproductive Health
TASPEN	Tabungan dan Asuransi Pensiun (Retirement Saving for Private Employees, Retirement Saving for Private Employees)
TFR	Total Fertility Rate
U3A	University of the Third Age
UN	United Nations
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
USIAMAS	Persatuan Kebajikan Usiamas Malaysia (Goldenage Welfare Association Malaysia)
WHO	World Health Organization

FOREWORD

The Social Development Agenda was groundbreaking in its quest to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. Its call to "leave no one behind," an imperative for inclusive development, includes the older people whose plight and situations are compelling the nations to take immediate policies and programmatic responses to address their unmet needs.

All countries in the world including Thailand, Malaysia, Indonesia, and Cambodia, are faced with demographic and age structural changes and challenges. The effects of declining total fertility rates and increasing longevity have resulted in a higher proportion of older people. Soon Thailand will become a "super-aged" country in 2030; Malaysia, Indonesia, and Cambodia will become "aged" countries by 2020, 2025 and 2030, respectively. More than the percentage of an ageing population is the sheer number of older people in Indonesia and Thailand with greatest consequences in a variety of areas, including financing, social protection, and health and reproductive health among others. The ageing population will not only change the population structure but will affect profoundly in almost everything. It will also surely cover all policy and programme areas.

Reaching the Global Goals set out by the world leaders will require myriads of interventions. Addressing the needs of the older people is one of the many ways to help realize the 17 goals in particular Goal 3 (Good Health), Goal 4 (Quality Education) and Goal 5 (Gender Equality). Goal 5 is of particular interest given the feminization of ageing and the weak access to information and quality services on sexuality and reproductive health.

It is our pleasure to introduce these case studies as examples of situations of older people, and the wide range of innovative policies and programmes that advanced the issues of the older people. We hope that you will find the case studies useful and inspiring to your work.

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OVERVIEW OF THE SITUATIONS OF AGEING POPULATION IN THAILAND, MALAYSIA, INDONESIA, AND CAMBODIA

Dr. Aurelio Camilo B. Naraval

I. Introduction

1.1 AN AGEING WORLD

World population is becoming older and older each year. In 1995, a year after the declaration of the ICPD, global population was nearly six billion of which 540 million (9%) were aged 60 and over. In 2015, 20 years later, the older population rose by 900 million or equivalent to 67%, or making up 12% of the global population. It is interesting to note that by 2030, for the first time in human history, the percentage of the older population will equal that of the 0-9 year age group at 16% of total population.

Observed across the countries in Asia is the significant shift in population age structure brought by the demographic transition from high to low levels of fertility and mortality, and the state of the art health technology. As a result, population ageing has become one of the three mega demographic trends in most countries along with a rising number of total population and mobility (Arifin & Ananta, 2013). It is no doubt the most significant social transformation of the twenty-first century (United Nations Department of Economics and Social Affairs, Population Division, 2015).

Many of the countries in the region recognized that they are at different stages of this demographic transition, which results in "bulges" at various time periods (bulge at the base, at the young ages, middle and older ages). Demographers and economists are one with their position that the demographic transition contributes to different social and economic benefits and challenges, i.e., labour, financial markets, demand for goods and services, social protection, as well as family structures.

Based on worldwide and regional data, the proportion of older people is growing faster than any other age group, due to two factors—declining fertility and longer life expectancy, which are the results of substantial public health and development efforts. Globally, older persons will comprise one billion of the population by 2020.

In 2050, the number of the elderly worldwide is expected to double at 2 billion. Projected growth of the older population will be felt more in Asia being home to more than half of the world's 900 million older persons in 2015, with 508 million people aged 60 and over. A large proportion of the older people are living in low and middle-income countries (World Health Organization).

1.2 THAILAND, MALAYSIA, INDONESIA, AND CAMBODIA ARE ALSO AGEING.

In the four study countries – Indonesia, Malaysia, Cambodia, and Thailand, the ageing population will increase by 91% (Thailand) to 121% (Cambodia) between 2015 and 2035, the year that older people would have been nearly one billion in Asia. Cambodia is doubling its ageing population in about three decades, far lesser than Japan, New Zealand and Australia, which took these countries 50 years to double their ageing population. Thus, a limited window period is left for Cambodia to prepare.

Among the four countries, ageing is blowing up in high proportions, which is best to be expressed in real numbers. The UN considers a country as ageing if 7% of its population is over 65, while a super-aged country has over 20% of its citizens above that threshold. The three countries, Malaysia, Indonesia, and Cambodia will become an "ageing" country in 2020, 2025 and 2030, respectively. Thailand became an "aged" country in 2000 and will be the only state among the four that will be classified as "super aged" in 2030. It is not just the increased percentage of ageing in the population that is concerning but the sheer number of older people in the countries as exemplified by Indonesia and Thailand at 46 million and 20 million in 2035, respectively.

1.3 CHALLENGES FACING THE FOUR COUNTRIES

When there is a relatively high proportion of the population over 60 years of age, the population will show a bulge in that age group indicating population ageing. This ageing process is an inevitable outcome of a positive demographic trend. However, the increasing burden of illness in older people from non-communicable diseases (mainly from cardiovascular diseases, malignancy, and respiratory diseases) presents a challenge. Population ageing and related burden of illness will have far greater impacts on social security and old-age pensions and health care and will require many changes in social policies and programmes. If not properly understood, these changes could result in policies and programmes that may not be evidence-based and aligned with best practices and the guiding principles (i.e., rights-based approach, equity, gender sensitive) as enunciated in various international conventions and agreements.

Countries in the region have adopted some laws, policies and institutional arrangements to address the needs of ageing people albeit in varying phases, with low and middle-income countries (including the four countries) lagging behind their well-developed counterparts. Of interest is the weak dissemination of information about the benefits accruing from the laws, regulations, policies and programmes for the elderly, and the seeming lack of coordination of various ageing related programmes that are being implemented parallel to each other by different line ministries.

Preparing for the economic and social shifts associated with an ageing population is essential to ensure progress in development, including the achievement of the goals outlined in the 2030 Agenda for Sustainable Development. Population ageing is particularly relevant to the goals of poverty eradication, ensuring healthy lives and well-being at all ages, promoting gender equality and full and productive employment and decent work for all, reducing inequality within and among countries, and making cities and human settlements inclusive, safe, resilient and sustainable.

2. Changing Age Structure in the Four Countries

The shifts in the age structure in the four countries are brought about by several factors mainly the decline in fertility and increase in the survival rates at all ages, particularly in the older people. The speed at which they occur has substantial socio-economic benefits and costs. On the benefit side, the demographic dividend, the growth potential that occurs when the share of the working-age population (15-64) is larger than the non-working age population (0-14 and 65+ years). This period lasts for about three decades. This time can help to facilitate more rapid economic growth. Countries should also prepare to reap the benefits of the second demographic dividend, the wealth accumulation like savings during working life to finance consumption during old age.

2.1 FERTILITY TRENDS

Fertility trends in Thailand, Malaysia, Indonesia, and Cambodia are headed to decline further. In Thailand, the drop in the growth rate of population from over 3% four decades ago to 0.25 percent today was mainly due to the sharp decline in fertility during that period. With the introduction of the National Family Planning Programme in 1970, there had been a rise in Contraceptive Prevalence from 15% (1969) to 80% (1980). There was a confluence of factors including the decline in the number of preferred children and increase in marrying age that led to a Total Fertility Rate (TFR) from 6 to 3 children in 1970 and 1980, respectively. This TFR went down below replacement level at 1.5 in 2015. Also, the rising educational attainment of women and their greater economic participation outside the home; and improvement of survival of infants and young children contributed to increased contraceptive use and delayed in the age of marriage. Indonesia experienced rapid fertility decline in 1970 when the New Era (1966 – 1998) government implemented family planning programme. From 5.6 children per woman, TFR decreased to 2.41 in 2010. With a decentralized government, the National Board of Family Planning (BKKBN) lost its grip at the sub-national levels, which contributed to the plateauing of TFR at 2.6 during 2007-2012. On the other hand, the fertility

rate in Cambodia continuously decreased during the past decade with the intensive promotion of Family Planning and the wider access to contraceptive supplies. Based on the Cambodian Demographic and Health Survey (CDHS), the TFR stood at 2.4 in 2014 as compared with 3.4 in 2005. There are indications that Cambodia will breach the replacement level to 2 children per woman in 2025. Malaysia's decline is dramatic with a TFR of 3 children in 2000 to 2.1 in 2010, which translates to a decrease of 3.6% annually.

There's no precise profile with regards to age structure at the sub-national levels, but it is likely that the data varies from place to place and amongst groups. In Indonesia, the TFR reached below replacement level in some sub-national regions. And the pace of ageing is also different among ethnic groups, provinces, and districts. For example, the old Javanese accounted for 8.9% (Ananta, et. al. 2015) and has the longer life expectancy at birth. Ananta et al. (2015) also revealed that the Chinese Indonesians had an older population as they comprised 11.4% in 2010. Tengku Aizan (Ageing in Southeast and East Asia, 2001) underscored that the elderly population is not a homogenous group. Differences in gender, socio-economic status, social class and education reinforced the varied rates of ageing amongst the major ethnic groups in Malaysia. Perak, Perlis, Melaka and Pulau Pinang are states in Malaysia that are ageing more rapidly than others.

The differentials in status and diverse characteristics of the ageing population are important drivers for the kind of planning necessary to address the current and future needs of this segment of the population. Thus, planners and decision-makers could do better by looking at sub-national trends in guiding their policies and programmes.

2.2 LIFE EXPECTANCY TRENDS

The improvement in the survival rates at all ages particularly in the older years has further contributed to the changing age structure. Investments in health infrastructure, health promotion, diagnostic and treatment, the better policies, and better standard of living have brought about dramatic improvements in people's health and longevity. Infant mortality has declined, and people have been adding more years in their life. The increasing share of the elderly is due to the growth rate of old age population exceeding that of the overall population.

Life expectancy at 60 is the average number of years that a person at that age can be expected to live, assuming that age-specific mortality levels remain constant. Experts' opinion influenced the choice of Life Expectancy at 60 as a better estimate of survival within the adult life course than life expectancy at birth, particularly for low- and middle-income countries. Gleaned from the list below, women in the four countries tend to live longer than men. The years added to men from the three countries range from 15 – 20 years; and 18 – 23 years among women (World Population Prospects, 2015). This differential in the number of years added also brings to the fore that ageing is also becoming the face of women.

Life expectancy also reflects the health conditions, i.e., epidemics and the disasters, in the countries. In Thailand, life expectancy at birth for both males and females increased by 17 and 19 years, respectively, from 1960 to 2015. However, the life expectancy during 1990-2005 went down due to increased mortality associated with the AIDS epidemic. The resumption of improvement in life expectancy since then reflects the success in combating the AIDS epidemic and provision of antiretroviral therapy to those who need of treatment. In Malaysia, the life expectancy for females and males improved from 65.6 years and 61.6 years in 1970 to 77 years and 72 years, respectively in 2010. On the other hand, life expectancy at birth in Indonesia is projected to reach 74.2 for female and 70.4 for the male.

Based on the data from the World Health Organization (2015), life expectancy at birth of the Cambodian people already stood at 73 years (70 years for males and 75 years for females) up from 54 years in 1990. The influence of mortality during the Khmer Rouge period in the late 1970s highlighted by civil war, unrest, widespread disease and related high rates of mortality led to lower life expectancy and resulted to a smaller cohort of surviving individuals that are moving into their elderly years.

3. Social Status of the Older People

3.1 MARITAL STATUS

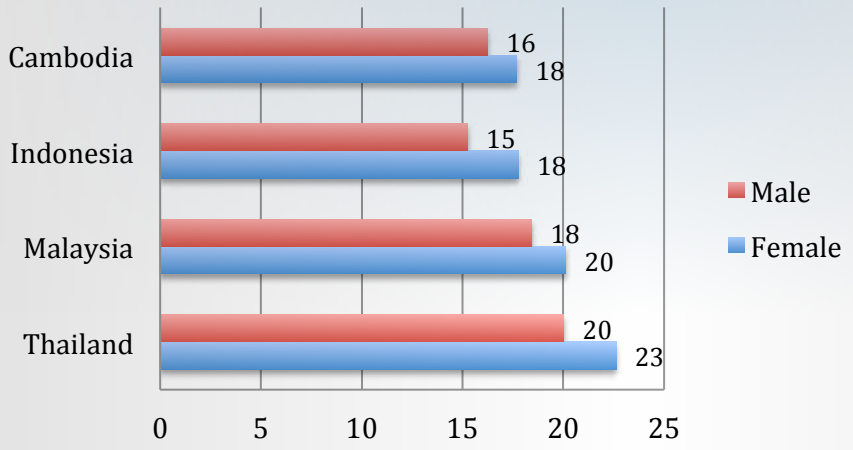
Marital status plays a significant role in understanding the well-being of the older persons and is an indication of living arrangement, social, economic, and psychological support as well as companionship. The marital status of older adults has significant implications for many aspects of their well-being. Spouses are the primary source of material, social and emotional support as well as the providers of personal care during illness. Thus, for the elderly, living with the spouse offers these advantages. It has implications to the cognitive functioning of the elderly, as well. Feng et al. (2014) found that being single and widowhood increased the likelihood of cognitive impairment in late life. It means that marriage has an active role in protecting older persons from cognitive impairment. Marriage provides not only social stability but also psychological stability. Furthermore, marital status affects living arrangement. Older individuals who are single are more likely living alone or living with others, while married older persons reside with their spouses only (living without children), co-reside with a child or grandchild, or co-reside with others. Widowed/divorced elderly are likely to live alone or with a child.

TABLE 1: Percentage distribution of men and women by marital status according to age, 2010

	60-64		65+	
	Men	**Women**	**Men**	**Women**
Indonesia				
Single	0.9	1.5	0.7	1.1
Married	90.6	55.6	80.6	31.3
Widowed	7.0	39.3	17.2	64.7
Divorced	1.5	3.6	1.5	2.9
Malaysia				
Single	4.3	5.1	5.5	5.3
Married	88.9	67.6	79.7	46.7
Widowed	6.2	26.0	14.2	47.1
Divorced	0.7	1.3	0.6	0.9
Thailand				
Single	2.1	4.3	1.6	3.0
Married	87.8	65.3	77.7	45.9
Widowed	8.6	27.8	19.4	49.3
Divorced	0.6	1.0	0.4	0.6
Separated	1.0	1.6	0.9	1.1

Note: Cambodia data not available in the UN 2012 dataset.

Across the four countries studied, only a few of men and women remained single at 60+ across the four countries. Data show a sex diferential and a stark contrast between older men and older women about the percentage of married and widowed. Most men are married at age 60-64 at 90.6, 88.9 and 87.8% in Indonesia, Malaysia, and Thailand, respectively. In comparison, the percentage of married 60-64 years old women in Indonesia (55.6%), Malaysia (67.6%), and Thailand (65.3%) is less than their male couterparts. This data may reflect the difference in life expectancy where women tend to live longer than men. The much larger percentage of married men than women may also indicate a higher likelihood of remarriage among men. On the other hand, the proportion of older women who are widowed increased sharply with age, and at 65+ years about 64.7%, 47.1%, and 49.3% are widowed in Indonesia, Malaysia, and Thailand (UN Data, 2012). The marriage pattern shows that older women were less likely than men to have a partner in their old age. The more there are widowed women means that older women depend on their children and other family members for their care and financial support, as many of them did not have the money. Only a small percentage of older men and women were divorced or separated.



GRAPH 1:
Life Expectancy at 60 Years Old in the Four Countries, 2015

In Cambodia, the proportion of older women who were widowed increased sharply with age. The 2008 census analysis shows that the differential in marital status by sex is more pronounced among the people aged 60 years and above: 86% and 50% of elderly men and women were still married, respectively. About 42% of older women were widowed compared to only 10% widowers among senior men. The differential in the marital status became more pronounced among elderly women than men as they grew older. Among people aged 75 + years old, 75% of men and only 35% of women were still married

3.2 NUMBER OF CHILDREN

It is common for today's older adults to have many children due to the high fertility in the past. Also, Asian tradition encourages people to have many children who could help them do chores on the farm and provide material and other forms of support when their parents become old.

Co-residence with children and support from non-co-resident children mostly depend on the number of children elderly parents have. The mean number of living children among older persons range from 2.4 (Thailand) to 5 (Cambodia).

In 2004, most Cambodian elderly 60-69 years old had at an average of five (5) living children (Knodel, Kim et al. 2005). There are more female children reflecting higher mortality rate among males, including losses due to political violence during the Khmer Rouge period and its aftermath. Thus, the average number of surviving daughters modestly exceeds that of surviving sons.

The steady decline in the mean number of children among the 60-64 to 80+ years age groups from the period of 2007 and 2014 clearly demonstrates the history of fertility decline in Thailand. For example, among 60-64, the average number of living children was at 3.4 and 2.4 from 2007 and 2014, respectively. Among 80+ the mean number of living children was 4.8 in 2007 and 4.4 in 2014. Based on the 2010 Indonesia census, the average number of living children for women aged 55 and above is 3.47 (Badan Pusat Statistik 2010), still reflecting high fertility rate in the past.

Preliminary results from the 2014 Malaysian Population and Family Survey showed that about half of the older adults had 5 or more children, and this ranged from 41% in the urban areas to 60% in the countryside. Only about 6 % of the older persons did not have any children, and these included mainly those who were never married.

With the steady decline of TFR across the four countries, older people of the future predictably will have fewer number of children.

3.3 EDUCATIONAL ATTAINMENT

Level of education is often considered as a significant socio-economic indicator. It also has a significant bearing on the older people's chances of seeking suitable work after formal retirement from employment. Also, it could enable them to be self-employed with the considerable experience gained during regular working life.

Across the four countries studied, there is a general trend of older people progressing from having the basic primary education to a notch higher level of educational attainment. In Malaysia, for example, the proportion of the older adults with no schooling in 2010 has been declining over the years, from 60.5% among those aged 75 years and older to 31.4% among those aged 60-64. On the other hand, older adults with at least secondary education have been rising steadily across the younger age groups from 17.6% among 75 years and over to one-third among 60-64, and this percentage will increase to almost three quarters when those 45-49 years old move into the "older" population. Data from the Badan Pusat Statistik (2010), show that about 53.6% of the elderly in Indonesia has some or completed primary education, and 31.6% had no schooling at all.

There is a clear link between poverty and level of education of older people. Those who became elderly in 2010 were born in the 1950s at a time when World War 2 devastated their respective countries, and when primary education was still recovering from the war. Thus, more of them do not have education and are lingering in poverty. Indonesia, Malaysia, and Cambodia also just had their independence from their colonizers, and they were in difficult economic and political situations. Thus, it is not surprising that majority of them only managed to secure low level of education.

Literacy rate of older men was higher compared to women. In Indonesia, the illiteracy rate among women doubles that of the men, 41.7% versus 21.8%, respectively. Another aspect of vulnerability for the senior citizens in Cambodia is the low level of literacy among older women in rural areas. In the 2008 Cambodian Population Report, about 32.5% (rural) and 56.8% (urban) women 60+ years old were literate. Whereas, 60+ years old men had a literacy rate of 75.1% and 88.2% in the rural and urban areas, respectively.

3.4 LIVING ARRANGEMENTS

The well-being of the elderly, to a large extent, is influenced by their living arrangements. Among the four countries, living with or near an adult child has been the common pattern. As only a small proportion of elders have no living children, only a few of the elderly persons are living alone or with their spouses. However, there has been evident decline in co-residence during the past decades. In Thailand, the percentage of persons 60 years and over who co-reside with an adult child decreased from 77% in 1986 to 57% by 2011. It is interesting to note that the proportion of older people who live alone or with a spouse has increased. Malaysia also has a similar declining trend. In 2004, 72.3% of elderly persons co-resided with an adult child as compared to 63.8% in 2014. Co-residence with children is also the common type of living arrangement among the elderly in Indonesia with 70% of the population aged 55 years and over lived with at least one child (Frakenberg et. al, 2002). In 2007, co-residing with a child was about 66.2 and 61.4 of elderly men and women, respectively. The same trend is also observed in Cambodia, which shows that 80% of Cambodian elders live with at least one child. Interestingly, in a Cambodia study by Zimmer et al., (2002), there is a sharp preference by the elderly to live with a daughter (65.3%) than with the son (32.9%).

Data from Malaysia, Indonesia and Cambodia also show that older women were more likely than older men to live alone.

3.5 ECONOMIC ACTIVITIES

Interestingly, in a some private sector firms, retirement age is compulsory. However, for majority of the working population who are engaged in the agricultural or informal sectors, people continue to work until they are physically able to do so. Thus, the majority of the older population gradually withdraw from employment as they progress to older ages. In Thailand, the percentage of those who worked during the previous week in the age group of 60-64 is at 59% compared to only 26% among 70-74 years old in 2011. Labour force participation rate varies among the elderly age groups. By the time the elderly reached between 60-64 in Indonesia, 7 in 10 are still actively involved

in the labour market. On the other hand, only 35% are still working in the 75-79 age group (Badan Pusat Statistik, 2010). It is entirely different in Malaysia as data indicates that 59.1% of the old age 60-64 are not working anymore.

Up to 55% of Cambodians aged 60+ years are still economically active. Remaining active in the labour market until old age can indicate that working is a necessity since it is likely that the social security services and coverage are limited. Proportions differ starkly across gender with more men (67%) working as compared to women (43%). A survey conducted in 2004 in Malaysia found the same trend with 15.3% of older women aged 55 and over who were working as compared to 37.4% among the older men (Tey and Tengku Aizan, 2014). This differential is likely due to the higher educational level of men, and the dominant cultural practice that men work while the women stay at home. There is also a rural and urban differential among elder people in Cambodia with about 68% from the rural, and 41% from the urban who are still working. Malaysia's elderly are in the services and sales, and as skilled workers in the agricultural sector.

Older women are more vulnerable than men given their lower workforce participationrate; and those whose work, they are concentrated in the informal sector and are receiving less compensation. Owing to the combination of work insecurity, increase in widowhood, and living alone, older women tend to live in more precarious condition than men.

4. Health Status

One of the important aspects in elderly well-being is physical health. Mortality, morbidity and functional limitations escalate steadily with advancing age. As people age, health care demand rises with increasing complexity (WHO 2015).

Noncommunicable diseases affect the elderly group. Hearing loss (26%), visual impairment (44%) and depression (17%) are few conditions that limit meaningful participation and decrease functional participation of older people in the family and community. They too face abuse from their families and community (6%) (WHO, Ageing, and Health).

Measuring health and illness among the elderly is important to understand better their health needs, but it is also a difficult task to undertake. Despite its seemingly superficial character, self-rated health proved to have positive congruence between self and physician's assessment and increase predictive validity of health (Jason Schnittker, 2014). Also, when objective measures are not feasible, self-assessment as a measure of health is helpful. In Thailand, a subjective assessment of health in 2011 showed that 41% of the elderly have "fair" health, 38% "good," and only 4% "very good." Also, during the Indonesian Intercensal Population Survey in 2005, the respondents were asked about their health status. About 39% of the 60+ older persons perceived that they are in good health. There is sex differential on health as evident with a lower percentage of women than men reported they were in good health, 36.4% compared to 41.7%, respectively. The same study found that 74.8% of the elderly fall sick for no longer than one week period. The 2004 Malaysian Population and Family Survey shows that 35% of older adults rated their health as good, 44.5% as fair, and 20% as poor.

An analysis of data in Cambodia reported 25% of 60+ years have been ill or injured, and 44% were reported to have had some forms of disability (NIS 2015). On the other hand, 60% of those admitted to the hospitals for causes related to chronic diseases such as high blood pressure, cardiac conditions, diabetes, and cancers were patients 50 years and over. Although there is a preponderance of chronic illness among the elderly, communicable diseases such as malaria, tuberculosis, HIV and acute respiratory infections remain the country's priority. Even the Health Equity Fund to assist the poor covers only episodes of illness and hospitalization, and does not include chronic conditions. The elderly in Malaysia also suffer from chronic diseases. Citing findings from the National Health and Morbidity Surveys, the Ministry of Health indicates that the disease pattern among older persons has changed from diseases associated with aging to diseases related to lifestyle, that is, hypertension, hypercholesterolemia, diabetes mellitus and chronic obstructive lung diseases. Records of admission to the public hospitals showed that the older persons made up 20.3% of the total admitted in 2010 or about 400,000 older persons.

When it comes to caring for the elderly, data will show that by far the most common person to provide assistance is the daughter. The next most often mentioned are sons, children-in-law, and grandchildren. One-fourth have mentioned spouses. Only a small percentage reported non-relatives, paid caregivers and servants or employees.

5. Feminization of Ageing

Data show that women in the four countries live longer than men. Aside from the phenomenon that men marry younger and suffer from higher mortality across ages, women are more likely to outlive their partners and spend their old age as widows. Thus, there is a predominance of women among the older population, thus the "feminization" of the elderly.. But there is more to feminization than just outnumbering men. The current status of older women is an outcome of generations of discrimination throughout every stage cycle. They are less educated, and many of them do not have work, and therefore they are not covered by the social security system. In most cases, they are dependent on their husband and children for financial support.

Since many of the elderly women are widowed, they are likely to live in poverty and be affected by disability. Note that in one study, older women tend to have a higher probability of difficulty in walking than men, and are more likely to suffer from chronic disabling illness such as arthritis (Choon, Chi'en and Chan 2008) thus limiting their movement. Besides financial and health care needs, older women also need emotional and social support. About a quarter (25%) of older women were "always lonely," and one-third (33%) were "sometimes lonely" in a study in Malaysia (Teh, Tey, and Ng, 2014). In contrast, only about 17% of older men were always lonely, and 29% were "sometimes lonely."

Besides the diseases related to poverty, older women are prone to illness such as osteoporosis and reproductive health related problems like cancers of the ovaries, uterus, etc.. And despite their vulnerabilities, older women's access to healthcare are linked to the persistent societal gender inequalities and inattention to reproductive and sexual health.

6. Policies and Actions

There is a robust body of evidence derived from case studies conducted which shows that Thailand, Indonesia, Malaysia and Cambodia equally recognize the phenomenon of an increasingly ageing population. In response to the challenges that accompany this phenomenon, and guided by the Madrid International Plan of Action on Ageing (2002), the four countries have approved legislations, regulations, and plans of actions for their respective ministries. However, most of the policies are still being carried out in few traditional sectors such as the Ministry of Health, Ministry of Social Affairs, and Ministry of Women's Affairs to name a few. They are seldom found in other ministries such as the Ministry of Finance or Ministry of Labour. To increase collaboration and improve the utilization of resources, Cambodia formed an Inter-Ministry National Committee for the Elderly. Composed of 16 government ministries and organizations under the Honorary Chair, the Prime Minister, and the Executive Chair, the Minister of Social Affairs and Veteran and Youth Rehabilitation, this committee has the broad responsibility to develop national policy promoting the well-being and social welfare of the elderly.

Thailand's commitment to safeguard the welfare of older persons has reached the constitutional level as it provides citizens 60+ years old and those with insufficient resources the rights to use public facilities and receive financial aid from the state as deemed appropriate.

Met with an unprecedented increase in population ageing, the Indonesian Government developed programs under the Director of Social Protection and Welfare of the National Development Planning Board (Bappenas). It also passed two laws: 1) Law No. 13/1998 on "Older Persons Welfare"; and 2) Law No. 39/1999 on "Human Rights". Since then there have been several sets of regulations and programmes specifically enacted to address matters related to older persons in Indonesia. In 2011, Malaysia passed the National Policy for Older Persons and Plan of Action for Older Persons that sought to replace the 1995 policy for the elderly. Cambodia has the National Policy Guidelines (2002), while Thailand passed the "Older Persons Act" in 2003. Also, it approved the 2nd National Plan for Older Persons for 2002-2021 to follow-through with the earlier 1982-2001 version. Broadly, these policies seek to develop a caring society, enhance capacity building, advance health and well-being and address the safety and social security of older adults. Among the key strategies covered are old age protection and social security, alleviation of poverty and employment, health and well-being and promotion of positive attitudes towards ageing. Research and development have also recently been included.

At different ministerial levels, there are several initiatives towards addressing sectoral concerns of the older persons. The Ministries of Health in the four countries came up with their respective policies and guidelines in caring for the elderly. In Thailand, for example, the Ministry of Public Health has been operating elderly health centers at the sub-national level to promote long-term care and "home health care" for older persons with chronic illnesses with support from several thousands of trained volunteers. Hospitals are also required to have a clinic for the elderly people to serve as an express service channel.

Thailand's Ministry of Social Development provides long-term residential homes for older persons who have no shelters or no caregivers. Furthermore, Thailand's Bureau of Mental Health has been implementing a project for elderly mental health. Under this programme, mental health care staff and volunteers conduct home visits to help prevent elderly persons from suffering depression and alleviate their loneliness when their adult children are at work.

At the grassroots level, Indonesia ensures that the Primary Health Care Centers are capacitated to provide promotive, preventive, curative and rehabilitative care for the elderly, or refer them to a higher level of care. An integrated and seamless care from the primary, secondary and tertiary points of care are improving free health care (consultation and treatment) for older persons in Malaysia. This programme attracted 77.3% of the health clinics in 2010 as compared with 41.6% in 2000. Over 22,015 Ministry of Health staffs were trained in post-basic geriatric care to provide support to the elderly.

The older population in the four countries are not just passive receivers of the national programmes, but their respective governments look up to their wisdom and guidance, and encourage their active participation in policy making and programmes implementation ensured through the formal national and sub-national mechanisms. In 1999, Thailand created the National Committee of Senior Citizens, which is an improved version of the National Elderly Council of 1982. Indonesia also established a national commission with similar structures on the regional scale when the Presidential Decree for the National / Regional Commission of Older Persons was signed. Older persons and the civil society organizations are represented in the National Advisory and Consultative Council for the Elderly (NACCE) established in 1996 under Malaysia's Ministry of Women, Family and Community Development. As an example, the Commission of the Elderly successfully lobbied for the universal monthly subsistence allowance scheme in Thailand.

7. Recommendations

GENERAL HEALTH AND SEXUAL AND REPRODUCTIVE HEALTH

1. Strengthen their health care services at the primary, secondary and specialized health care levels for the elderly in the forms of family care, community care centers, nursing homes, and specialized referral hospitals. Service providers including the family and primary caregivers from all levels of care should receive education and skills training on elderly care..

2. Develop comprehensive policies and programmes on the sexual and reproductive health for older persons by investing on research, integrating Sexual and Reproductive Health (SRH) agenda for the elderly in all aspects of their health, and ensuring the training of health care providers on SRH of the elderly. Health service delivery points should likewise invest in providing essential SRH services starting with information and services among peri-menopausal women.

3. Provide the needed training on basic geriatrics care to health care providers through the national regulatory commission or the Mutual Recognition Arrangement (MRA) within the ASEAN which may provide the training courses and/or certification of those who have been trained.

LABOUR PARTICIPATION AND COMMUNITY INVOLVEMENT OF THE OLDER POPULATION

4. Develop national policies that encourage employment of elderly in the different sectors, particularly in the service industry. Such policies should strengthen sustainable income through savings with higher interest rates, and public welfare subsidies for the elderly who are still in the labour force. Integrated into the national policy on employment is the review of mandatory retirement age, which considers factors other than chronological age such as fitness to work, health status and productivity.

5. Strengthen community-based and self-supporting programmes which allow elderly people to use their skills in handicrafts, music, religious traditions, education; and to contribute to the society while earning a living and enjoying a better quality of life. Such senior citizen programmes can provide excellent platform for information dissemination and ensure utilization of both public and private services that cater to the elderly population.

SOCIAL PROTECTION

6. Ensure an affordable, just and financially sustainable social protection system (like a pension scheme) which will extend benefits to all but more especially those who are economically challenged, suffering chronic health issues, or are no longer productive in their old age or are financially incapable; while making way for affordable health and life insurance for the elderly for those who can afford by lifting age limits to insurance plans and encouraging children to invest on their parents' health and life insurance.

RESEARCH AND UTILIZATION OF STUDY RESULTS

7. Conduct periodic household surveys among the elderly to ascertain their socio-economic well-being and their health status; conduct interdisciplinary studies on ageing population with the involvement of gerontologists, public health, economists, demographers, social scientists, etc.; disseminate research/ survey findings widely for purposes of policy making and programming.

8. Improve quality and maximum utilization of population data to be used in developing programmes for the elderly; and disseminate results of research on Gerontology and Geriatrics to policy makers.

COORDINATION AND TECHNICAL SUPPORT TO GOVERNMENTS AND NGOS

9. Increase coordination among line ministries tasked with providing support to the elderly to maximize available resources and to avoid duplication of tasks. Strengthened information regarding the benefits accruing from these laws and programmes to the older population will improve access to health, social protection, labour participation, and community involvement, among others. Non-government organizations, private sectors, and the governments must also enhance their partnership and collaboration thru state-sanctioned or locally organized commissions or groups for the elderly.

10. Strengthen policy and programmatic response to interactive linkages between population dynamics (ageing) and sustainable development through multi-sectoral and interdisciplinary involvement or collaboration among demographers, social scientists, and public health experts.

CASE STUDY

1

POPULATION AGEING IN THAILAND

Dr. Anthony Abeykoon, Ph.D.

Executive Summary

Thailand is currently experiencing extensive ageing of its population. This is a result of the rapid decline in fertility rate from around 6 children per woman before 1970 to 1.5 children in 2015 and rising survival rates at older ages. Changes in the age structure of the population are profound and growth of the elderly population has been rapid. In a couple of years, the number of persons aged 60 years and over will exceed those under 15 years for the first time in Thailand's demographic history.

With regards to the social and economic status among the elderly, significant changes have been observed. Among the elderly, 82% of men are currently married in contrast to only 49% of the elderly women. The proportion of elderly with one or no child is seen to likely increase in the future as a substantial number of younger Thais aged over 40 years are currently unmarried or have only one child. This could create an additional burden on the society as children are traditionally seen as the main providers for material and other support to their elderly parents.

In terms of education, men seem to have an advantage over women as shown by the study that the percentage of women with no education is twice that of men. This is likely to change in the future as the younger cohorts are now more educated. With better education, the likelihood for the elderly to gain suitable employment after post-retirement age is increased.

It has been the cultural practice in Thailand for the elderly to live with an adult child. But this too, seems to be changing. In 2014, nearly 28% of the elderly either lived alone or with their spouse.

Majority of the working population are engaged in agriculture or in the informal sector and they continue to work until they are physically able. In 2014, among the age group 60-64 years, 72% of males and nearly 52% of females continued to be part of the labour force.

With regards to health care, the subjective assessment of the health of elderly indicates that there has been a substantial decline of those with poor or very poor health during the period of 2007 to 2011. Surveys show that the most common person assisting the elderly in activities of daily living is a daughter and that children are the main source of financial support for the elderly. In Thailand, the elderly can avail of free health care in government-run health care facilities. And since 2007, all of Thailand's government hospitals have elderly clinics that serve seniors and have special fast track lanes for the elderly who seek out-patient care.

Pensions for public servants have been given since1902. It is evident that income replacement rates of other pension schemes are not adequate for the private and self-employed workers.

A universal old age pension scheme was started in 2009 with a monthly allowance of 500 Baht. And in 2011, progressive rates have been introduced ranging from 600 to 1000 Baht per month to include the over 60 years of age who are not eligible under the government pension policy.

In 2014, among the age group 60-64 years, about 87% of males were married in comparison to 64% of females. As elderly women outnumber men in older ages, they are more likely to live in poverty and to be affected by disability. Many elderly widows are seen to be disadvantaged as the spouse was then the primary source of financial, social and emotional support. In terms of living arrangements, elderly women are perceived to be at a disadvantage as a higher proportion of women in comparison to men live alone.

Due to changing age structure and disease patterns, older people may be at risk of engaging in unsafe sexual behaviors and consequently be at risk for sexually transmitted infections. Although many women are aware of their reproductive health needs, they do not seem to be aware of their reproductive health rights. To address some of these issues within the adult population, the government of Thailand has enacted the Reproductive Health Law.

With the proportion of elderly population increasing, old-age dependency burden on the working population is seen to increase in the future. Heavier demands on the working age population will come in the form of higher taxes and bigger contributions to maintain a stable level of benefits for the elderly. And although the country has a strong family system, trends in urbanization as well as internal and international migration indicate that in the future, Thailand may face significant problems in terms of caring for its elderly population.

The government of Thailand has, over the years, put in place policies and programmes to address ageing issues concerning the elderly. The Second National Plan on the Elderly (NPE) (2002-2021) provides strategies for long term care for the elderly which cover a wide range of activities among which are: preparing the elderly for quality ageing; promoting the health and well-being of the elderly; encouraging and enabling informal care of the elderly within the family; and the provision of quality health and social services for the elderly both at home and at the community level.

Introduction

Population ageing is an emerging concern in many South-East Asian countries including Thailand. Ageing is a dynamic process determined by the relative size of the younger and older cohorts. The initial size of each cohort depends on the population in childbearing ages and the prevailing fertility rates while the mortality rates determine the number of people of each cohort that survives to old age.

The rapid ageing of the Thai population in recent decades has profound consequences not only on the well-being of the growing elderly population but also on Thailand's economic, social, and cultural wellness.

As the Thai population ages, many changes are brought about including those involving living arrangements. Ageing brings about a change in the sex composition of the Thai population as its women out-live men and thus comprise most of the older population. And as fertility decreased, the participation of Thai women in the labour force has been rising. Women, who traditionally played a key role as providers of family support and care, especially for care for children and the older persons, are now employed outside the home.

While it is important to take note of the social and economic challenges of population ageing, it is just that older persons should benefit equitably from the fruits of development to advance their health and well-being. Chronic and degenerative diseases are more common among older persons, and thus, there is an increased prevalence of non-communicable diseases at older ages.

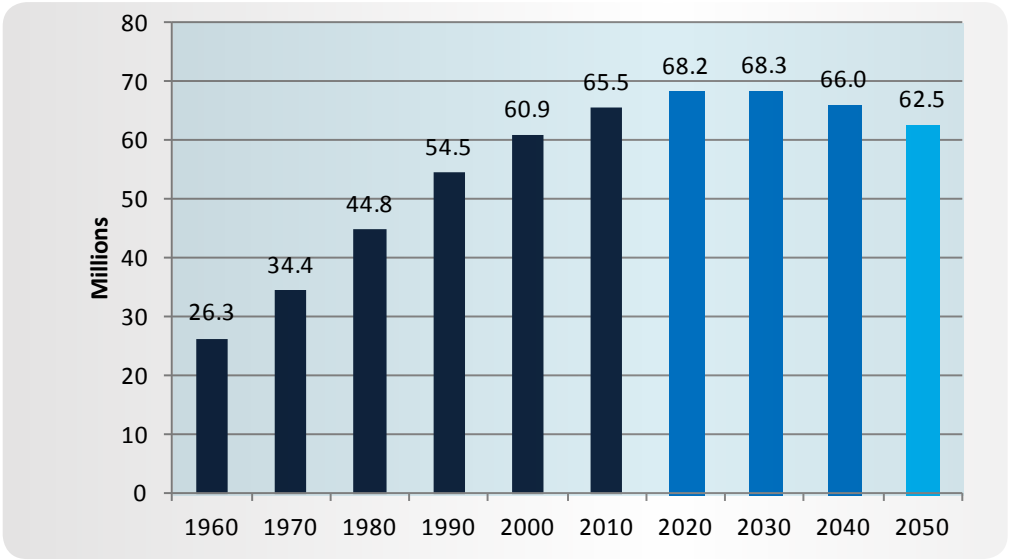
> ***"The rapid ageing of the Thai population in recent decades has profound consequences not only on the well-being of the growing elderly population but also on Thailand's economic, social, and cultural wellness."***

Demography of ageing

During the past five decades, the total population of Thailand increased by two and half fold (Figure 1). Fifty years ago, the Thai population was increasing at an annual rate of over 3%.

Today, the annual rate is about 0.4%. In the next 10 years, the trend is towards a further decline in the growth rate. Population is expected to reach a maximum of nearly 70 million in the next few years (United Nations, 2015). The chief factor contributing to the decline in the population growth rate is the sharp decline in fertility experienced over the past six decades.

FIGURE 1: Growth of population, 1960-2050



Sources: National Statistics Office (NSO); United Nations Population Estimates and Projections (2015). National Economic and Social Development Board (2013).

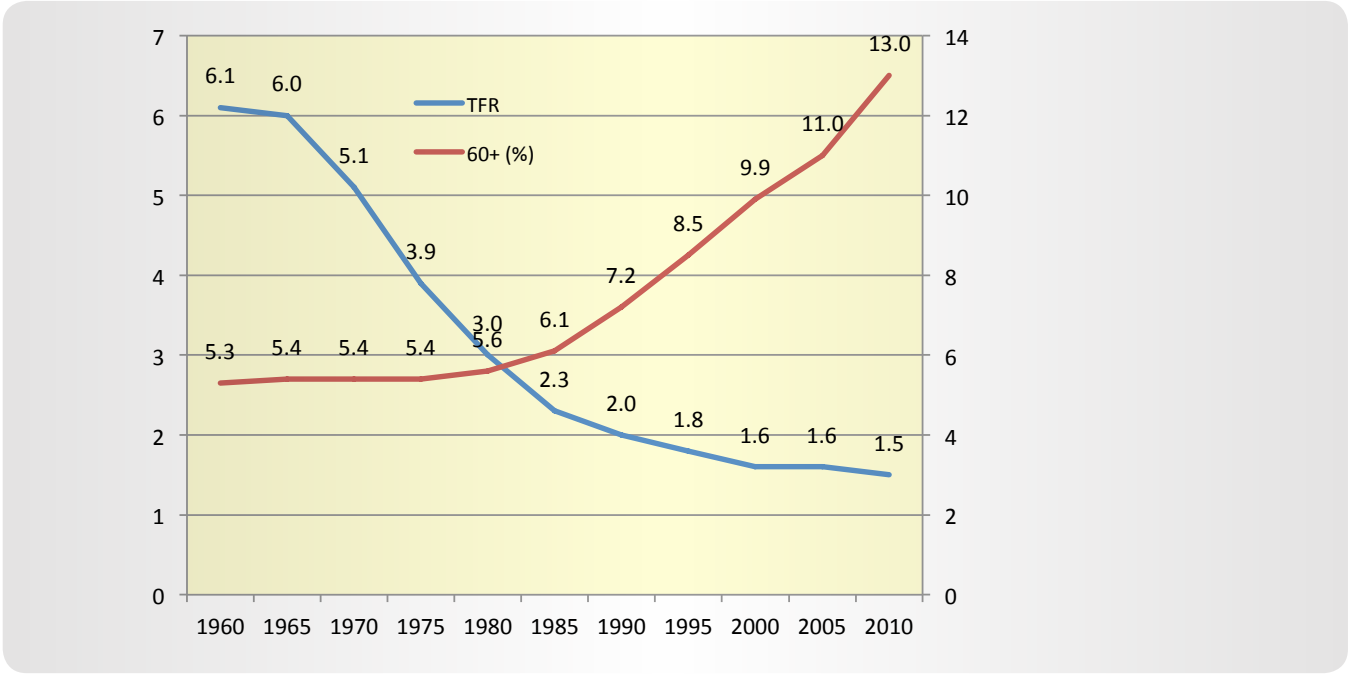
> ***"Thailand's population is expected to reach nearly 70 million in the next few years. 50 years ago, the Thai population was increasing at an annual rate of over 3%. Today, it's down to about 0.4% and expected to decline further in the next 10 years."***

FERTILITY TRENDS

The decline in the growth rate of population from over 3% four decades ago to 0.25% today was mainly due to the sharp decline in fertility during that period. Before 1970, the average fertility rate was 6 children per woman due to low contraceptive use and almost universal marriage.With the initiation of Cabinet of Ministers' Policy on Fertility Control and the National Family Planning Programme to promote voluntary use of contraception in March 1970, the total fertility rate declined from 6 to less than 3 children per woman in the 1980s and to replacement level by early 1990s. In 2015, the total fertility rate was below replacement level at 1.5, comparatively less than Republic of Korea's 1.3 (UNESCAP, 2015). The declining fertility rate contributed to the ageing of the population as seen from Figure 2.

The rapid fertility decline was mainly due to the rise in contraceptive prevalence rate from 15% during the period 1969-70 to 80% in the year 2009. Moreover, the preferred number of children declined from almost four in the 1970s to two in the year 2009. Also, the age at marriage of women increased from 22 years in the 1960s to 24 years during the past decade. The rising educational attainment of women, their greater economic participation outside the home, and the improvement of survival of infants and young children also contributed to the increased contraceptive use and delay in age of marriage.

FIGURE 2: Total fertility rate and population aged 60+, 1960-2010

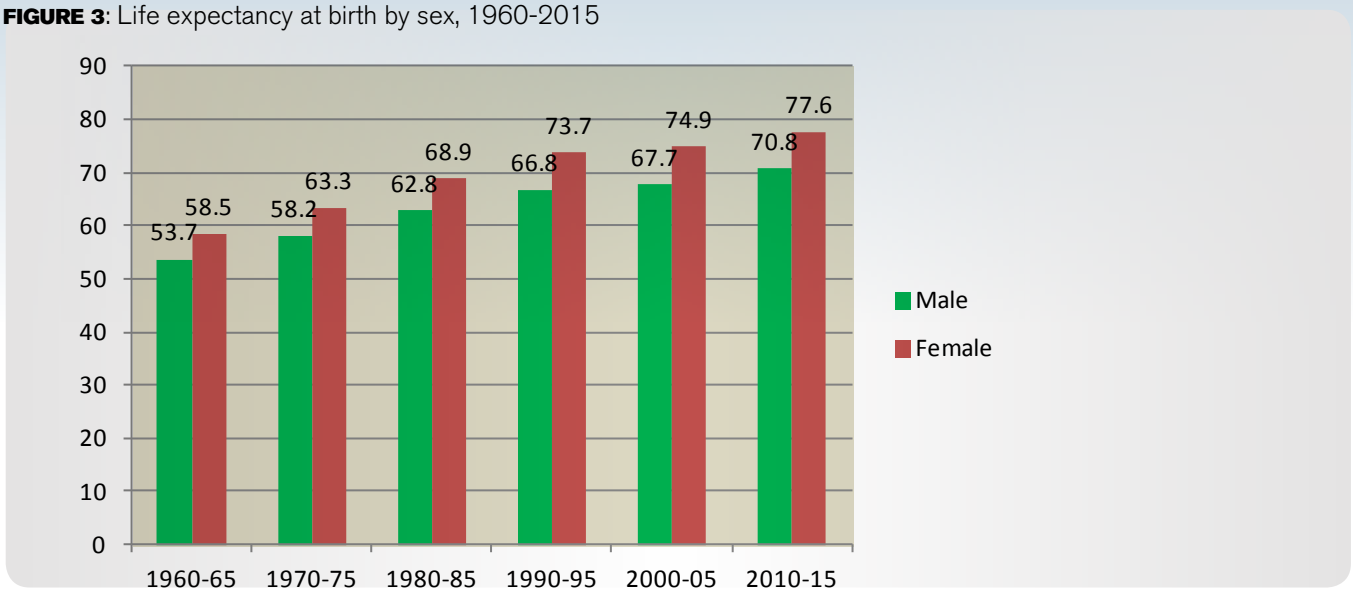


Source: United Nations population estimates (2015).

MORTALITY TRENDS

Improvement in the survival rates at all ages particularly in the older ages contributed to the changing age structure of the Thai population. Life expectancy at birth for both males and females increased by 17 and 19 years respectively from 1960 to 2015 (Figure 3). However, the increased mortality associated with the AIDS epidemic affected the adult population and accounted for the slower increase in life expectancy during the period of 1990-2005. The resumption of improvement in life expectancy since then, reflects the success in combating the AIDS epidemic and the availability and provision of antiretroviral therapy to all who have need of treatment.

FIGURE 3: Life expectancy at birth by sex, 1960-2015



Source: Source: United Nations population estimates (2015).

The rising life expectancy and the faster pace by which it rose since the 1970s can be clearly seen in Table 1. This may be attributed mainly to the decline in non-communicable diseases. Since the late 1980s, the diseases of the circulatory system have become the leading causes of death and cancer has been ranked as the third leading cause of death. The morbidity trends also indicate that hypertension and ischemic heart disease constitute the highest proportion of circulatory system diseases (Country Report, Thailand, 2007).

TABLE 1: Life expectancy at older ages, 1960-2015

Age/Sex	1960-65	1970-75	1980-85	1990-95	2000-05	2010-15
Age 60						
Male	15.4	15.6	16.9	18.1	19.1	20.0
Female	18.1	18.2	19.5	20.6	21.7	22.6
Age 80						
Male	6.1	6.2	6.4	6.5	7.4	7.9
Female	6.7	6.8	7.3	7.4	8.2	8.7

Source: Source: United Nations population estimates (2015).

> ***Life expectancy at birth for both males and females increased by 17 and 19 years respectively from 1960 to 2015.***

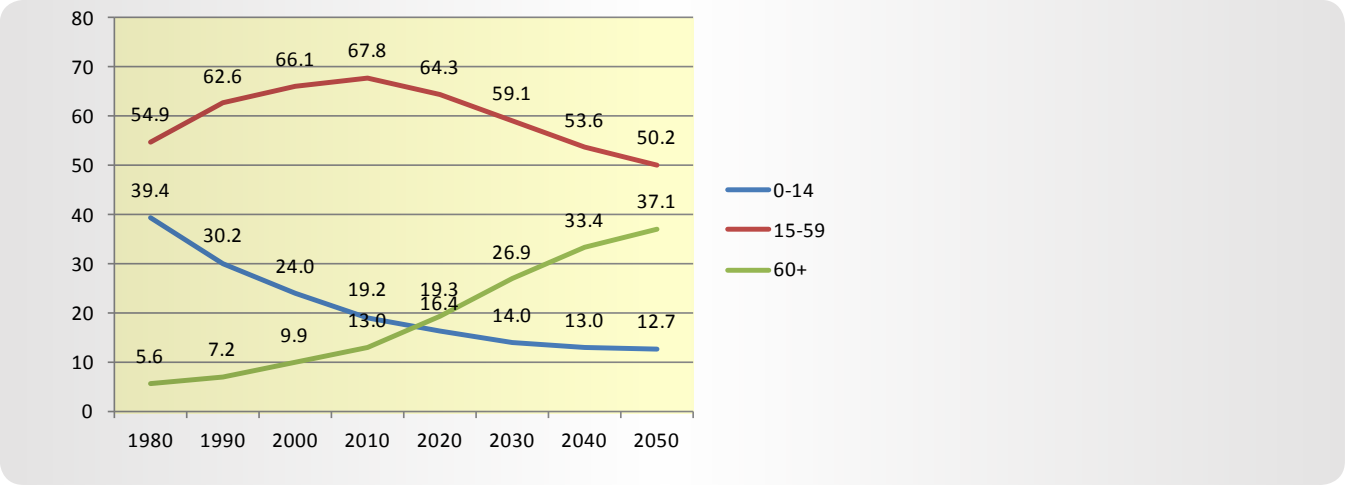
CHANGING AGE STRUCTURE

Changes in fertility and mortality affect not only the elderly but the entire age structure of the population. The speed at which these changes has substantial socio-economic benefits and costs. On the benefit side is the demographic dividend, that is, the growth potential that occurs when the share of the working age population (15-64 years) is larger than the non-working age population (0-14 and 65+ years). This period is projected to last for about three decades. This window of opportunity opened in 1995 and will close around the year 2025. Thailand has only another 10 years to reap the benefits of this demographic dividend. To cite an example, East Asia's 25-40% of per capita Gross Domestic Product (GDP) growth since 1965 has been attributed to have come from the demographic dividend (Palanivel 2016). The country should thus take advantage of this period of demographic dividend.

Thailand should also prepare to reap the benefits of a second demographic dividend, the physical capital accumulation to generate sustainable economic growth. One way to accumulate wealth over a lifetime is through savings. Savings made from income gained during the working period will be a source of income to finance consumption during old age.

The United Nations projects that between the year 2015 and 2020, older persons in Thailand will outnumber those under 15 years of age and this trend will continue to increase to 37.1% by the year 2050 (Figure 4). The proportion of the population who are under 15 years of age will decline from a level of 39.4% in 1980 to nearly 13% in 2050. The net result of the shift in the age structure will be a substantial rise in the median age of the population. Currently, more than half of the population is over 30 years of age but by 2050 this figure is projected t o increase to to 44 years (United Nations, 2015).

FIGURE 4: Percentage of population by major age groups, 1980-2050



Source: United Nations population estimates and projections (2015).

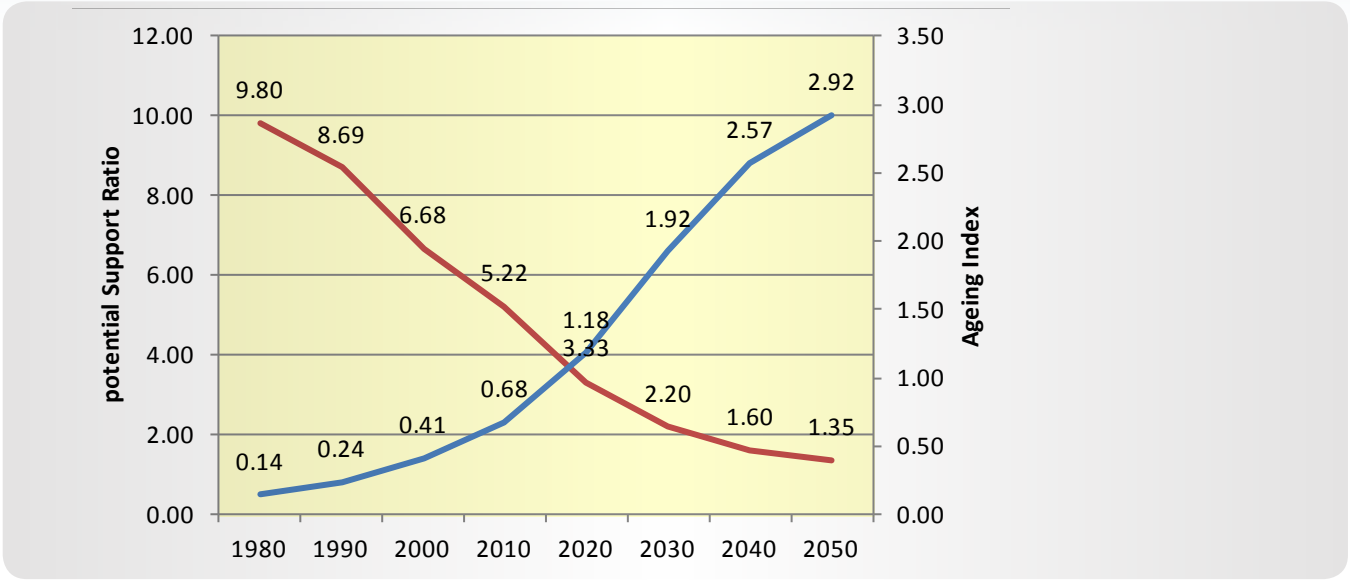
TABLE 2: Proportion of population at old ages, 1990-2050

	Age	1980	2015	2030	2050
Total	60+	5.6	15.8	26.9	37.1
	70+	2.3	10.5	19.5	30.1
	80+	0.6	2.1	3.8	9.9
Male	60+	5.1	14.7	25.1	34.8
	70+	3.3	9.5	17.8	27.7
	80+	0.4	1.8	3.2	8.2
Female	60+	6.1	16.8	28.6	39.3
	70+	4.2	11.4	21.0	32.3
	80+	0.7	2.4	4.4	11.5

Source: United Nations population estimates and projections (2015).

The increasing share of older persons in the Thai population is due to the rapid growth rate of the old age population exceeding that of the overall population. The oldest old, defined as those above age 80 years, are the fastest growing while the growth of those aged 70 years and over is intermediate compared to those aged 60 years and over. For instance, the proportion of those aged 80 years and over is expected to increase by 14.1 fold between the period of 1990 and 2050 as compared to 8.6 fold among those aged 70 years and over and by 5.3 times among those aged 60 years and over (Table 2).

FIGURE 5: Ageing index and potential support ratio, 1980-2050



Source: Computed from United Nations population estimates and projections (2015).

A measure that shows the economic impact of population ageing is the Potential Support Ratio. The term Potential Support Ratio is defined as the ratio of the population aged 15-59 to those aged 60 years and over. This measure shows the support base consisting of persons in ages most likely to be economically active and hence available to support those in older ages. A falling Potential Support Ratio, as illustrated in Figure 5, reflects a decline of support base of adults on whom the elderly can depend on. It is evident that as Ageing Index (60+/0-14) increases, the Potential Support Ratio drastically declines from almost 10 in 1980 to less than two in 2050. This means that there will be fewer productive age persons per capita available to support the elderly in the future. Thus, in response to these demographic changes, more and more young old (aged 60-70 years) will be supporting the old-old (aged 80+ years).

> ***"Changes in fertility and mortality affect not only the elderly but the entire age structure of the population. There will be fewer productive age persons per capita available to support the elderly in the future. Thus, in response to these demographic changes, more and more young old (aged 60-70 years) will be supporting the old-old (aged 80+ years)."***

Social and Economic Profile of the Elderly

In addition to the demographic picture on population ageing, it is also necessary to examine the older persons' social and economic profile for effective planning and implementation of policies and programmes. This section examines the social and economic characteristics of the elderly based primarily on survey data carried out in the years 2007, 2011 and 2014 by the National Statistical Office of Thailand.

MARITAL STATUS

The marital status of elderly citizens has significant implications for many aspects of their well-being. Among the Thais, spouses are the primary source of material, social and emotional support as well as the providers of personal care during illness. Thus, for the elderly, living with the spouse offers these advantages. The marital distribution of a cohort of older persons at a time is determined by the past experiences with marriage, divorce, widowhood, and remarriage as well as by survival chances at different adult ages.

From Table 3, we see that in 2014, only about 4% of elderly over age 60 years were single, a slight increase from the 2007 percentage. However, the proportion of those over age 60 years remaining unmarried in the future will increase as younger cohorts who currently remain single will enter the old age groups.

The overall percentage of the currently married (living together and living apart) elderly in 2014 was about 64% with 75% of the elderly in age group 60-64 years as currently married and a drop to 36% among those over 80 years of age. Majority live with their spouse and only 2.5% live separately. As expected, the percentage widowed increased with age with 16% in the age group 60-64 and 61% among those aged over 80 years. The number of widowed elderly has declined during the period of 2007 to 2014. This is due mainly to the increase in life expectancy. Although the percentage of divorced or separated among the elderly is relatively low, the decline with age may reflect a rising trend over time. In terms of gender, nearly 82% elderly men currently married compared to only about 49% among the elderly women.

TABLE 3: Percent distribution of marital status by age of elderly and gender, 2007 and 2014

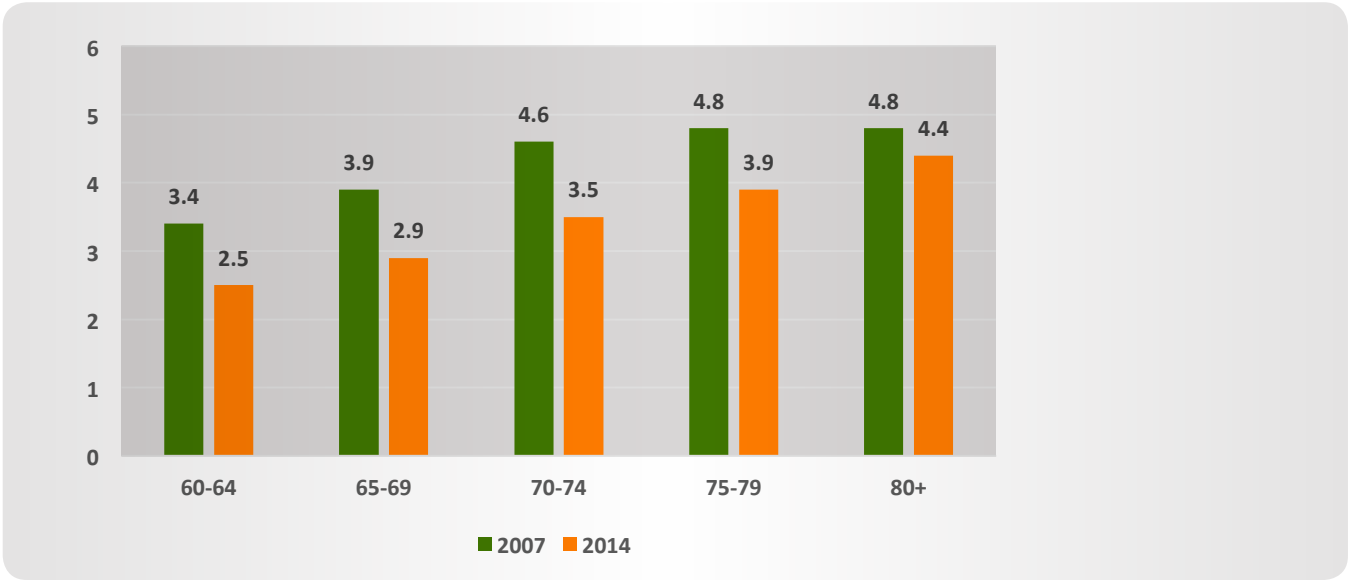
Age and Gender	Single		Married living together		Married Living apart		Widowed		Divorced/ separated		Total
	2007	2014	2007	2014	2007	2014	2007	2014	2007	2014	
Total	2.7	3.9	60.1	61.0	2.4	2.5	32.4	30.2	2.4	2.4	100.0
Age											
60-64	3.0	5.2	72.1	72.0	2.9	3.0	18.7	16.1	3.2	3.6	100.0
65-69	3.2	4.3	65.8	68.6	2.1	2.5	26.4	21.9	2.4	2.7	100.0
70-74	2.1	2.6	55.3	58.0	2.2	2.9	38.2	34.8	2.3	1.7	100.0
75-79	2.5	3.2	47.0	50.8	1.8	1.5	47.0	42.8	1.7	1.7	100.0
80+	2.1	2.2	29.4	34.3	2.1	1.6	65.1	61.3	1.2	0.6	100.0
Gender											100.0
Male	1.5	2.0	79.8	78.9	2.7	2.8	14.3	14.1	1.7	2.2	100.0
Female	3.8	5.4	44.2	46.3	2.1	2.2	46.9	43.4	3.0	2.6	100.0

Source:Knodel et. al., (2008 and 2015)

NUMBER OF LIVING CHILDREN

Children provide material and other forms of support to their elderly parents. Co-residence with children and support from non-co-resident children largely depend on the number of children elderly parents have. The steady decline in the mean number of children among the 60-64 age group to 80+ years age groups and the decline from the period of 2007 and 2014 clearly demonstrate the history of fertility decline in Thailand (Figure 6). In the year 2011, 11% of those in their early 50's were childless (See Knodel et. al., 2013). A projection can be made that in the coming years, the percentage of childless elderly citizens in Thailand will increase.

FIGURE 6: Mean number of living children of elderly by age, 2007 and 2014



Source: Knodel et. al., (2008 and 2015)

LITERACY AND EDUCATIONAL ATTAINMENT

The level of educational attainment of the elderly has an important bearing on their chances of seeking suitable employment after formal retirement. A higher level of education coupled with the considerable work experience could enable the elderly to become entrepreneurs and be self-employed post retirement age. Table 4 shows a progressive shift toward lower levels of educational attainment as the age progresses. For instance, in 2007, among the age group 60-64 years, 9% had no education while among those aged 80 years and over a high 37.3% had no formal education. The expansion of educational facilities in Thailand brought about an improvement in educational attainment. Educational attainments also differ a lot by gender. Overall, men have received more formal education than women. For instance, the percentage of females with no education is twice that of men. Similarly, about 11% of men have had education beyond the lower secondary level as compared to only 5.4% for women. The gender disparity in education is also seen in the 2014 survey. In the age group 70-74 years, the disparity is more than twice in favour of males (Figure 7).

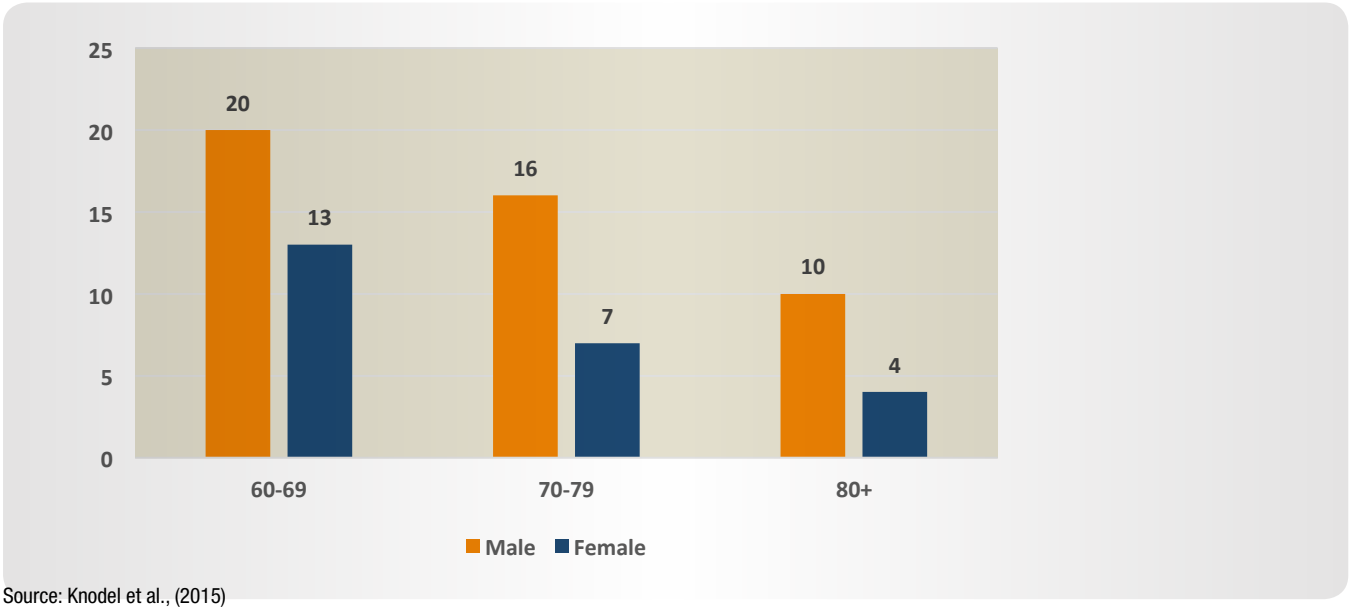
> ***"There has been a progressive shift toward lower levels of educational attainment as the age progresses. Educational attainments also differ a lot by gender. Men have received more formal education than women with the percentage of females with no education twice that of men."***

TABLE 4: Percent distribution of educational attainment by age of elderly and gender, Thailand 2007 and 2011

Age and Gender	None		Less than grade 4		Basic Primary		Lower secondary		→ lower Secondary		Total
	2007	2011	2007	2011	2007	2011	2007	2011	2007	2011	
Total	16.5	11.8	6.8	4.7	68.3	72.7	3.2	3.0	5.2	7.8	100.0
Age											
60-64	9.0	6.4	4.4	2.5	74.5	77.5	4.8	4.0	7.3	9.6	100.0
65-69	12.0	9.7	6.4	4.0	72.8	73.5	3.1	3.6	5.8	9.2	100.0
70-74	17.6	12.8	8.6	6.0	67.5	72.2	2.4	2.1	3.9	7.0	100.0
75-79	20.6	16.8	8.7	8.2	65.0	69.0	2.2	1.7	3.4	4.3	100.0
80+	37.3	26.9	8.4	6.8	49.5	60.7	2.0	1.7	2.8	3.9	100.0
Gender											100.0
Male	9.8	7.1	6.2	3.7	71.8	74.1	5.0	4.4	7.1	10.7	100.0
Female	21.9	15.5	7.2	5.5	65.4	71.5	1.8	1.9	3.6	5.4	100.0

Source:Knodel et al., (2008 and 2013)

FIGURE 7: Percentage of elderly with any secondary education, 2014



Source: Knodel et al., (2015)

LIVING ARRANGEMENTS

The well-being of the elderly is influenced by their living arrangements. In Thailand, as in neighbouring countries, living with or near an adult child is the cultural norm. Since only a small proportion of elders have no living children, for the Thai elderly, co-residence with an adult child is common.However, through the years, there has been a decline in co-residence with the percentage of persons 60 years and over who live in the same household with a child declining from 77% in 1986 to 55% by 2014 (Table 5). During the same period, it is noted that the proportion of older people that live independently of others, either alone or with a spouse, has increased. All these measures taken together indicate that by 2014, about 28% of Thais aged 60 years and over either live alone or with spouse.

TABLE 5: Selected measures of living arrangements of elderly (age 60+), 1986 to 2014

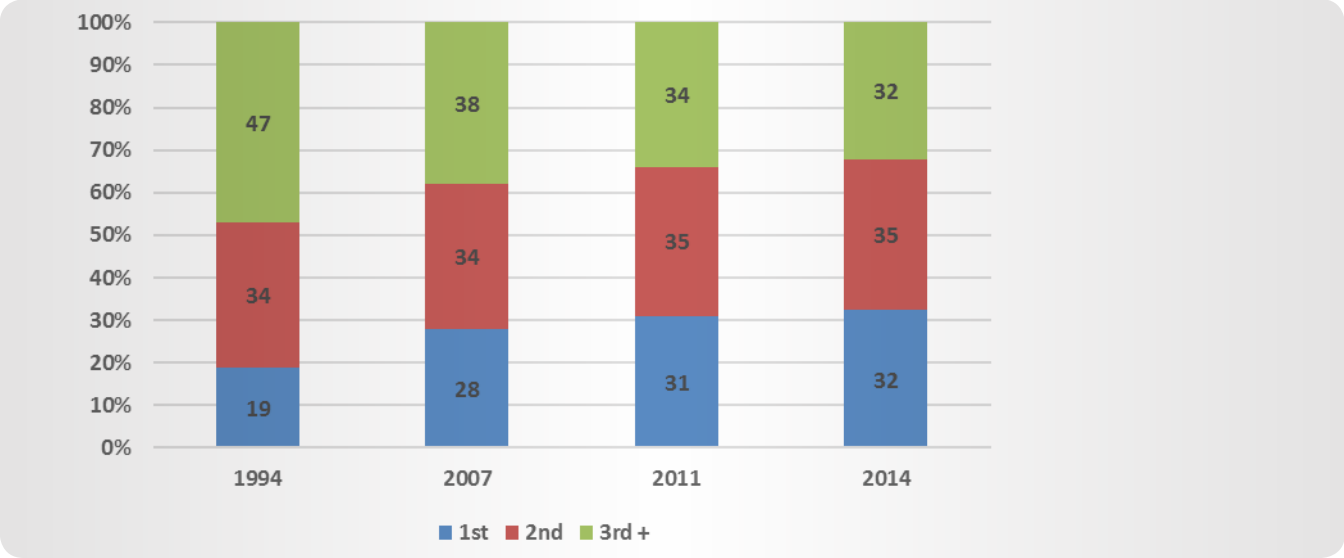
Year	Household size (mean)	% Co-resident with a child	% Living alone	% Living only with spouse
1986	5.04	76.9	4.3	6.7
1994	4.44	72.8	3.6	11.6
2002	n.a	65.7	6.5	14.0
2007	3.75	59.4	7.6	16.3
2011	3.63	56.5	8.6	17.1
2014	3.56	54.7	8.8	19.0

Source:Knodel et. al., (2015)

The trend in declining co-residence with children is now resulting to a shift in generational composition of households of older persons. Figure 8 shows that the percentage of persons of one generation households has increased over time while the percentage in the three or more generation households has decreased. This implies that in the coming decades, one generation households of older persons will predominate among the Thai population.

> ***Co-residence with an adult child is common. However, through the years, the percentage of persons 60 years and over who live in the same household with a child has been declining. In 2014, about 28% of Thais aged 60 years and over either live alone or with spouse.***

FIGURE 8: Percentage distribution of generational composition of households of elderly (age 60+), 1994 to 2014



Source: Knodel et. al., (2015)

ECONOMIC ACTIVITIES

In the formal sector, such as government and some private firms, retirement age is mandatory. However, for majority of the working population who are engaged in agriculture or in the informal sector, people continue to work until they are physically able. Those in the latter group gradually withdraw from employment as they age.

Table 6 illustrates that among the elderly, , the percentage of elderly engaged in economic activities decline with age. In the year 2007, the percentage of elderly

aged 60-64 years who were employed was 54% compared to only 25% for those aged 70-74 years. The same pattern was observed in 2014 but with an increase in the total percentages of elderly who were employed. Overall, men had higher employment rate than women in all ages.

Comparison between the two surveys need to be made with caution as survey data can be affected by the seasonality of work, especially in the agricultural sector where the large majority of the workforce is engaged in seasonal work.

TABLE 6: Percentage of elderly who worked in previous week by age and gender, 2007 and 2014

Age	2007			2014		
	Total	Male	Female	Total	Male	Female
60-64	54	68	42	62	72	52
65-69	40	53	29	46	59	35
70-74	25	36	17	27	36	19
75-79	17	25	11	16	23	11
80+	7	13	4	5	8	3

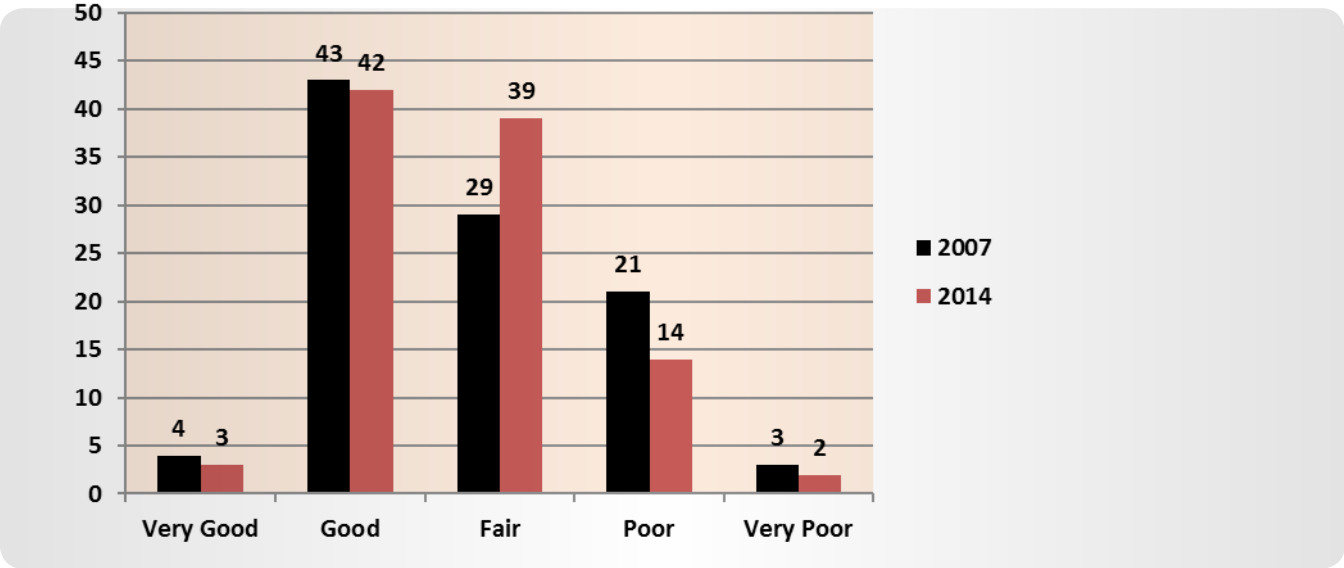
Source: Knodel et. al., (2008 and 2015)

HEALTH STATUS

A very important aspect of elderly well-being is physical health. As mortality and morbidity increases steadily with advancing age, so do functional limitations and their physical and psychological implications. Thus, population ageing creates demand for formal health care services as well as care giving at the family level.

The subjective assessment of health of the elderly on the week before the surveys conducted in 2007 and 2014 is shown in Figure 9. Data reveal that a substantial proportion falls into the middle categories implying that their health is neither very good nor very poor. A decline among those who stated that their health is 'good' in 2007 is seen when compared to the 2014 assessment. And a considerably greater decline is evident among those who indicated that their health was poor in the same period of 2007-2014.

FIGURE 9: Percent distribution of self-assessed health by persons (aged 60+), 2007 and 2014

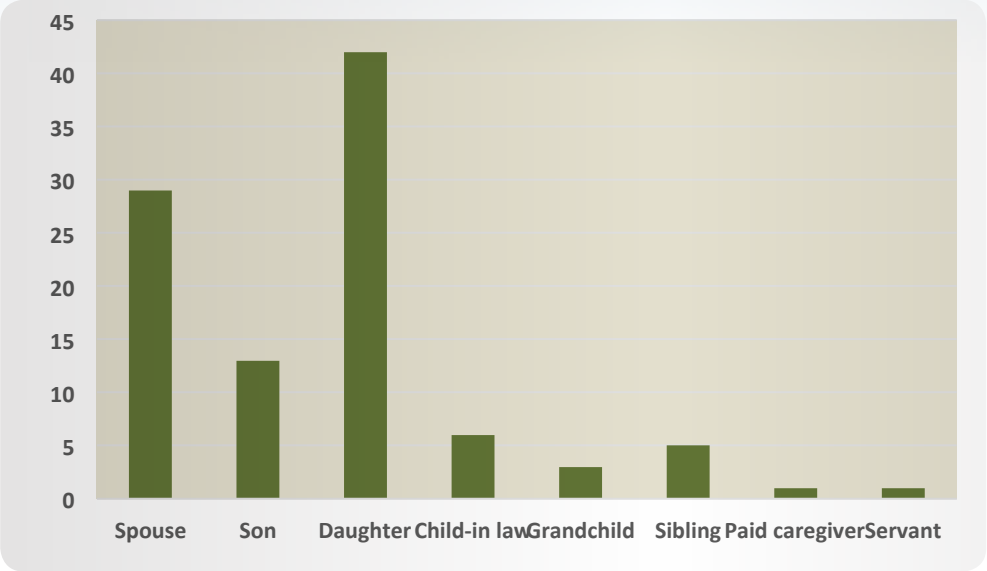


Source:Knodel et. al., (2008 and 2014)

Figure 10 identifies the caregiver who provides personal assistance with regard to activities of daily living to the old persons. By far the most common person to provide this assistance is the daughter. The next most often mentioned is the spouse. Others who provide assistance and care are the sons, children-in-law and siblings.

> ***Surveys conducted in 2007 and 2014 reveal that a substantial proportion falls into the middle categories implying that their health is neither very good nor very poor.***

FIGURE 10: Percentage of elderly (age 60+) who receive assistance with activities of daily living from specified persons, 2014



Source: Knodel et al., (2015)

Social Security of the Elderly

One of the most striking trends in elderly well-being in the more developed countries has been the decline in income poverty among the elderly. In the developing countries of Asia, however, the situation has not improved as these countries only recently began to experience rapid population ageing. Another trend is that, in many developing countries including Thailand, only a small proportion of the elderly in the workforce are engaged in formal employment.

FAMILIAL AND SOCIAL SUPPORT

Table 7 shows the main source of income of older persons as reported in the years 2007, 2011 and 2014. The children are the most common source of income for the elders. This income support from the children however has declined between 2007 and 2014 such that by the year 2014, the Old-Age Allowance has become the main source income for the elders. The government pays the Old-Age Allowance of 600-1,000 Baht per month to those who are 60 years and over on a sliding scale basis: with those who are in the age category 60-69 years receiving 600 Baht per month, those aged 70 to 79 years receive 700 Baht, the 80-89-year-old receive 800 Baht and those 90 years and over get 1,000 Baht per month. Those who have retired from government service are excluded from this Old-Age Allowance; instead the government retirees are entitled to a pension coming from the Government Pension Fund.

TABLE 7: Sources of current income among persons 60 and older, 2007, 2011 and 2014

Percent receiving any income from the following sources	2007	2011	2014
Work	37.8	42.7	38.8
Pension	5.4	7.5	6.3
Old age allowance	24.4	81.4	84.9
Interest/savings/property	31.7	35.7	n.a
Spouse	23.3	21.4	25.2
Children	82.7	78.5	78.9
Relatives	11.0	8.9	10.0
Other	1.5	2.5	1.6

Source:Knodel et. al., (2015)

When the main source of income is disaggregated by age and sex, about 56% among those in their 60s and 17% of those over 70 years, report work as the main source of income (Table 8). Declining working income of those in ages 70 and over appears to be supplemented by income received from their children. When compared to the women, the elderly men gain a higher proportion of income from work. In contrast, the elderly women receive a higher proportion of income derived from the Old Age Allowance, children and relatives.

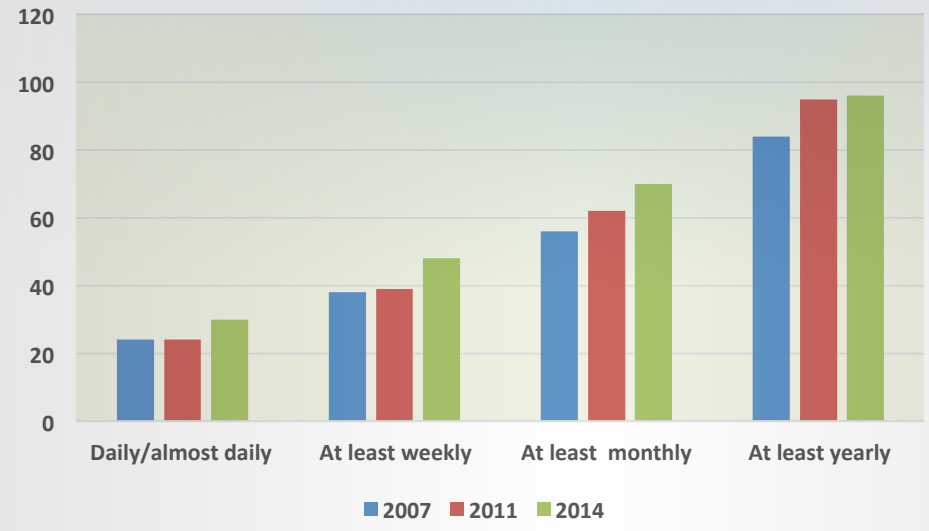
TABLE 8: Sources of income during the previous 12 months by age, gender, persons 60 years and older, 2014

Percent receiving income from the following	Age		Gender	
	60-69	70+	Males	Females
Work	55.6	17.0	49.5	30.0
Pension	7.0	5.5	9.1	4.0
Old age allowance	80.5	90.7	81.9	87.4
Spouse	32.4	15.9	25.7	24.9
Children	73.6	85.7	76.3	80.9
Relatives	8.9	11.4	8.1	11.5
Other	1.9	1.4	1.9	1.4

Source: Knodel et. al., (2015)

Social support by way of visits by children who live away from parental home can enhance the elders' social and emotional well-being. Figure 11 illustrates that among the children who do not co-reside with their parents, nearly one fourth of them visit their parents almost daily. This could be an indication that these children reside near the parental residence. The frequency of visits by children on a monthly or yearly basis have increased between 2007 and 2014. This reflects the improvement of transportation facilities in terms of road networks and mode of transportation.

FIGURE 11: Percentage of parents (aged 60+) and frequency of visits by non-coresident children, 2007, 2011 and 2014



Source:Knodel et. al., (2013 and 2015)

PUBLIC HEALTH CARE

A universal free health care programme for the disadvantaged elderly regardless of age was initiated in Thailand in 1989. In 1992, this free health care was then expanded to cover all elderly. The elderly parents of civil servants' and state enterprise employees' elderly parents have long been entitled to health care benefits. In recognition of the importance of quality of care for the elderly, in 1992, the Ministry of Public Health established the Institute of Geriatric Medicine. The Institute functions as the focal point for the transfer of new knowledge on gerontology to the health care clinics for the elderly.

The first elderly clinic in Thailand's government hospital was started in 1963. By the year 2007, all of Thailand's government hospitals had clinics that cater to elderly patients. Moreover, the government hospitals established priority lanes to fast track the provision of health care for the elderly seeking outpatient health care. In 2005, the Ministry of Public Health initiated the Home Health Care Service to monitor the health of older persons who had been discharged from the hospitals but need continuing health care in the home setting.

For the well-being of elderly, constant and periodic assessment of their current health status, understanding their major health problems, and improving their situation are all necessary. A study among elderly subjects aged 60 years and over done in the Bangkok Metropolitan Area during the period 2003 and 2004 showed that the most frequent chronic diseases were Hypertension (36%), Rheumatism (32%) and Diabetes (18%). The observed high prevalence of chronic diseases calls for further investigation at the national level. Keeping people healthy for as much as possible and giving them the opportunity to do the things they want to should be the key objectives of any strategy aimed at improving the well-being of the elderly (Moriki-Durand, 2005).

> ***"In recognition of the importance of quality of care for the elderly, the Ministry of Public Health established the Institute of Geriatric Medicine. The Institute functions as the focal point for the transfer of new knowledge on gerontology to the health care clinics for the elderly."***

PUBLIC PENSIONS

In 1902, the first government funded pension system in Thailand was initiated for improving the well-being of public servants after their retirement. This pay-as-you-go scheme continued for nearly a century. In the late 1990s, the pension scheme underwent some changes wherein a joint contributory scheme was initiated known as Government Pension Fund for those who joined the public service after 1997. Upon retirement, public servants receive a lump sum pension from the Fund and a monthly pension from the government. As of 2014, there were 1.2 million members of the Government Pension Fund.

As stated earlier, the government also provides an Old-Age Allowance ranging from 600-1000 Baht per month for all the over 60 years of age who are not eligible for any other government pension benefit.

In 1990, the government of Thailand established the Social Security Fund for employees in private enterprises and temporary contract employees in government organizations. Contributions were made jointly by three parties: 3% each from employee and employer and 15% by the government. Self-employed workers could also voluntarily contribute 100 Baht per month. As of 2014, there were 12.7 million members enrolled in this Social Security Fund.

Provident Funds were also setup for employees in both the private sector and state owned enterprises. Employees contribute 2% to 15% of their wages while employers were obliged to contribute no less than employee's contribution. After retirement, employees enrolled in this Provident Funds receive a lump sum payment. As of 2014, 2.7 million workers have become members of the Fund.

In 2011, the Thai Parliament passed the National Savings Fund Act, a voluntary contribution type of pension system with the goal of expanding coverage to include workers in the informal sector. A member upon reaching the age of 60 years, is entitled to receive a lump sum or a pension. This Fund became effective in August 2015.

Thailand's labour force in 2013 numbered 39 million workers, of which 14 million were employed in the formal sector and 25 million were self-employed. There is some concern for the self-employed sector as only 2 million or 5% of the self-employed workers were enrolled in the Savings System. In other words, only about 40% of labour force was covered by old age income security (Wiriyanupong and Wiriyanupong, 2014). Thus, it is important for the government of Thailand to educate people about the importance of saving for old age and to motivate the self-employed to join a retired pension scheme.

Another area of concern with regards the old age pension is the adequacy of the retirement benefits. The government's Fiscal Policy Office recommends that the post-retirement income should not be less than 50-60% of their last drawn salary. Table 9 shows that among the workers in private enterprise and the self-employed sectors, the replacement incomes fall short of the recommendation.

TABLE 9: Income Replacement Rate

Adequacy of Replacement Rate	50-60%
Actual Rate	
Government Officials	50-70%
Workers in Private Enterprises	40%
Self Employed Workers	←40%

Source: From Wiriyanupong and Wiriyanupong, (2014)

The increasing dependency ratio from the 55 in 2015 to 72 in the year 2030 implies that government needs to increase the budget for the elderly welfare. Increasing the welfare budget however, would mean weakening the sustainability of the pension fund if the government revenues are not increased through economic development. Government spending on old-age schemes is expected to increase from 2.2% of Gross Domestic Product (GDP) in the year 2014 to 3.3% in the year 2034. Thus, the government of Thailand needs to address both the adequacy and sustainability of the pension scheme.

Feminization of Ageing

Feminization of the ageing population is an important issue in discussions related to social and economic development. Typically, gender inequalities that disadvantage women relate virtually to all dimensions of well-being whether social, economic or health related. To understand the inter-connection of gender and well-being in older ages, one needs to examine the gender differences in the elderly population.

As elderly women outnumber men, women are more likely to live in poverty and be affected by disability. Many elderly widows have low income and economically disadvantaged. When implementing social policies for an increasingly ageing population, it is important to account gender differences among the elderly.

DEMOGRAPHIC TRENDS

Table 10 demonstrates the gender differences in life expectancy. For instance, the sex ratio in the age group 60-64 in 2010 was 89 males to every hundred females. This is expected to decline by the year 2014 and at a much faster pace in the ages beyond 80 years. As elderly women outnumber and outlive men, they are more likely to live in poverty and disability. Thus, whenever social policies are formulated, it is also important to consider and give attention to gender differences among the elderly.

The married status of the elderly has an important bearing on their well-being especially among the women. Living with the spouse, who is commonly the primary source of material, social and emotional support, is advantageous. As can be seen from Table 11, gender gap is pronounced among the elderly and becomes wider as they grow older. In 2014, among the age group 60-64 years, close to 90% of males were currently married as compared to only 64% for females.

TABLE 10: Sex Ratios of Elderly Population, 2010-2040

Age Group	2010	2020	2030	2040
60-64	0.89	0.87	0.86	0.87
65-69	0.86	0.85	0.84	0.84
70-74	0.81	0.81	0.80	0.79
75-79	0.75	0.75	0.74	0.73
80-84	0.70	0.68	0.66	0.64
85+	0.63	0.57	0.53	0.50

Source: Computed from data of the NESDB (2013).

"As elderly women outnumber and outlive men, they are more likely to live in poverty and disability. Thus whenever social policies are formulated, it is important to consider and give attention to gender differences among the elderly."

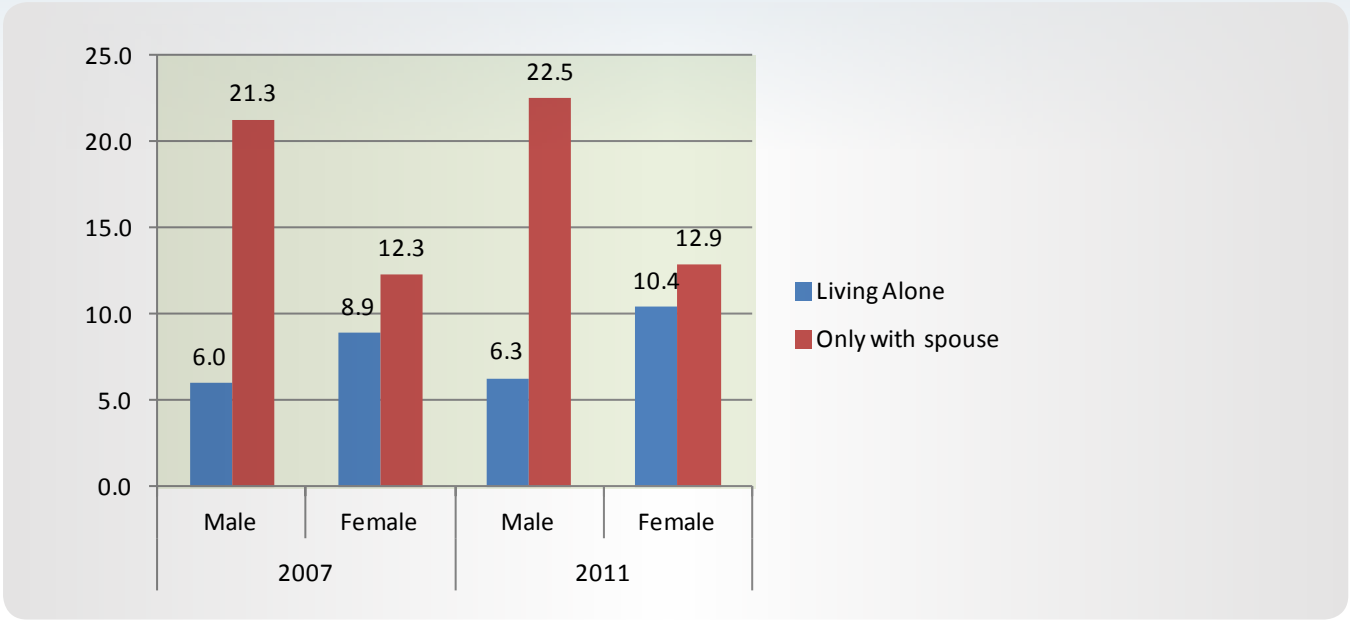
TABLE 11: Proportion of currently married persons aged over 60 years by sex, 2007, 2011 and 2014

Age Group	2007		2011		2014	
	Male	Female	Male	Female	Male	Female
60-64	90	62	89	63	87	64
65-69	86	52	84	56	87	57
70-74	81	39	81	48	81	45
75-79	69	34	78	39	75	35
80+	61	13	64	23	63	18

Source: Knodel et. al., (2008, 2013 and 2015)

Data show that women are disadvantaged when it comes to living arrangements. There were higher percentages of women living alone in the years 2007 and 2011. The number of men living with a spouse is almost double that of women (Figure 12).

FIGURE 12: Percent distribution of persons 60+ by living arrangements and gender, 2007 and 2011



Source:Knodel et al., (2008 and 2013)

With regards to income, men receive a higher income than women. The proportion of men with income over 100,000 Baht is double that of women (Table 12).

TABLE 12: Average annual income of 60 years and older persons by sex, 2014

Income in past year, (% distribution)	Male	Female
Under 10,000 Baht	6.3	9.5
10,000-19,999	11.3	15.3
20,000-29,999	10.5	14.5
30,000-49,999	19.0	22.7
50,000-99,999	28.6	25.5
100,000 and over	24.3	12.5
Total	**100.0**	**100.0**

Source:Knodel et. al., (2015).

It is also evident from Table 13 that females are much more disadvantaged regarding daily living activities when compared to men.

TABLE 13: Percentage of those aged 60 years and over with ADL difficulties by sex, 2014

Activity	Male	Female
Bathing	3.3	4.7
Dressing	3.1	4.0
Using toilet	3.5	5.1
Eating	2.5	3.3
Any ADL difficulty	5.8	8.6

Source:Knodel et. al., (2015).

REPRODUCTIVE HEALTH AND RIGHTS OF ELDERLY WOMEN

Reproductive health services in Thailand cover all age groups. This corresponds to reproductive health concept whereby services are made available for the people in a holistic way. Health services are delivered nationwide through the same network of health personnel and outlets.

The government of Thailand provides public health services and health care facilities to the poor and vulnerable groups under the Universal Health Insurance Scheme. Other ministries also take responsibility for programme implementation in the areas of gender, reproductive health and health rights. The Ministry of Social Development, for instance, addresses the issues of reproductive health rights and gender equality. Non-government Organizations (NGOs) and women's health advocacy groups are involved in improving sexual and reproductive health and rights. Additionally, women parliamentarians have organized themselves to advocate for a law against gender based violence (Ford Foundation, 2006).

In the 1990s, HIV/AIDS became the most important health issue in Thailand. Over the past two decades, the government of Thailand and international donors have worked with NGOs and community based organizations to confront the growing HIV/AIDS problem. In 2000, the Thai government introduced the triple combination antiretroviral therapy. Over the next decade, the government, with the assistance of the Global Fund, expanded the antiretroviral treatment programme and successfully reduced the incidence of AIDS.

With the changes in population age structure and disease patterns, older people may be at the risk for engaging in unsafe sexual behaviors and sexually transmitted infections. The problem can be compounded by the failure of health care workers and policy makers to accept that older women and men have sexual needs.

Although many women are aware of their reproductive health needs, they tend to be unaware of their reproductive health rights. The Reproductive Health Law addresses this issue. However, it still falls short of effectively addressing all the aspects of reproductive rights. Furthermore, Thailand still lacks sustainable capacity to implement recommended measures that address gender, sexuality, reproductive health and rights issues across sectors and among organizations involved.

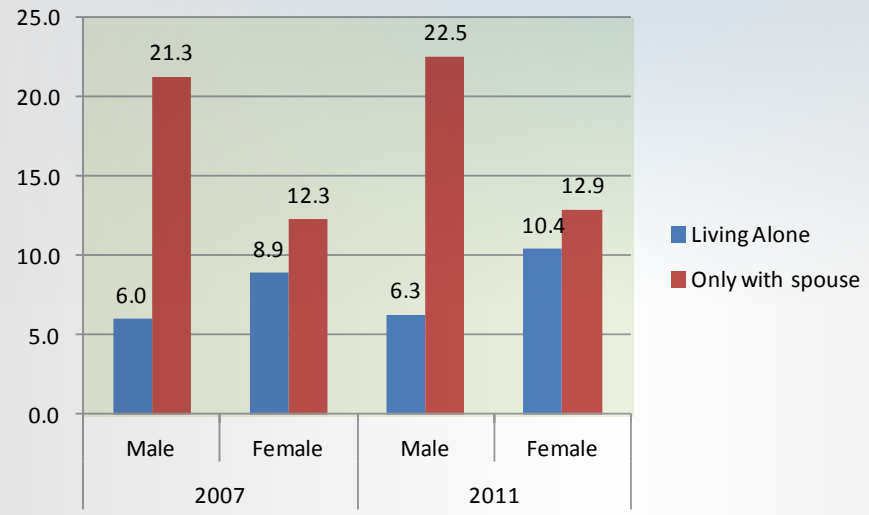
Policy Responses to Implications of Ageing

The economic and social impact of ageing are unlikely to be the same between developed and developing countries such as Thailand. Among the developed countries, the rising life expectancies in the older ages have been accompanied by a shift of support for older generations from family to the State. In Thailand, the family remains as the main source of elderly care and support. However, as life span becomes longer, there may be disruptions in family structure leading to the transfer of support for the elderly from the family to the public systems. It is to be noted that developed countries are financially capable of responding to the challenges posed by population ageing because "they became rich before they became old". Population ageing in Thailand means that to some extent, Thailand became 'old' before the country became 'rich'. Given this situation, it is a challenging task for Thailand to face the social and economic implications of population ageing.

SOCIAL AND ECONOMIC IMPLICATIONS

One important economic implication of the changing population age structure is the decline in the proportion of young persons in the working ages who are expected to provide support for the elderly, and the elderly. For instance, in the year 2010, the age group of 20-30 years numbered 9.0 million as compared to 8.0 million among the age group 50-60 years. In the year 2040, the corresponding numbers will be 7.1 million for the 20-30 years age group and 8.2 million for the age group 50-60 years (NESDB, 2013). This clearly demonstrates that the dependency burden of the Thai working population will increase in the future.

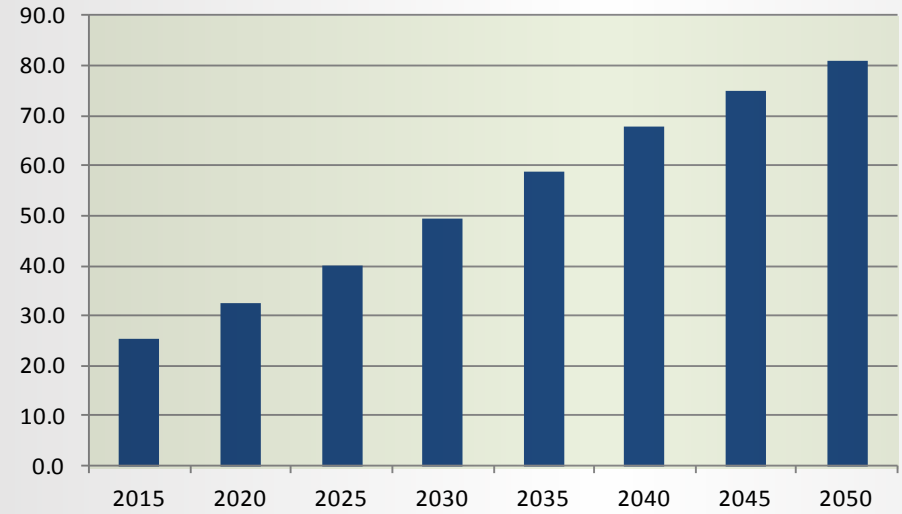
FIGURE 13: Population Dependency Ratios, 1980-2050



Source: Computed from United Nations population estimates and projections (2015).

In 1980, dependency ratio was 82%, which meant that, for every one hundred working citizens, there were 82 dependents. This was mainly due to the high proportion of young persons in the population under age 15 years, which in turn, was the result of a high fertility rate. This dependency ratio gradually declined to about 48% in 2010 because of the decline in fertility rate. However, with the ageing of population, this proportion is projected to increase to nearly 100% in the year 2050 (Figure 13). Thailand should now take full advantage of this currently relatively low dependency ratio before it becomes unfavourable.

FIGURE 14: Old Age Dependency Ratios, 2015-2050



Source: Computed from United Nations population estimates and projections (2015).

Figure 14 illustrates how sharply the old age dependency ratio could increase in the future- whereby the number of potential beneficiaries in health care and pensions will be supported by a relatively smaller number of potential contributors who will by then become economically active, the age group 15-59 years. This will pose heavier demands on the working age population in the form of higher taxes and other contributions to maintain a stable level of benefits to the elderly. With the decrease in the proportion of children under 15 years of age from 17% in the year 2015 to 12% in the year 2050, the income generated

may not be sufficient to offset the increased costs to support the needs of the elderly (United Nations, 2010).

In the ten years from 1999 to 2008, before the global financial crisis, Thailand's GDP grew at an average of 4.7%. With the decline in the population growth rate of about 0.62% per annum during the same period, the per capita income increased at an average annual rate of 4.1%. As population growth rate was kept low during the global crisis, Thailand registered growth rates on per capita income.

FIGURE 14: Percentage of elderly 60 years and over living in households with various household possessions, 2007, 2011 and 2014.

Household Possessions	2007	2011	2014
Television	95.7	98.6	98.1
Refrigetator	87.4	92.5	94.0
Phone	76.0	88.8	92.0
Washing machine	48.0	60.5	71.7
Air conditioner	16.0	18.2	25.2
Car/truck/van	30.9	34.5	42.4

Source: Knodel et al., (2015)

With the rising of per capita incomes, noted to increase was the number of household possessions that the elderly acquired (Table 14). Among the household items that show a significant increase in number are: washing machines, phones, air conditioners and vehicles.

Though labour force participation rate tends to decline with old age, it was not the case with Thailand. Labour participation for those beyond the official retirement age remained high with many retirees continuing to work as self-employed entrepreneurs or engaging in agriculture and continued to work out of necessity. The reason why most of the elderly continued to work was the integrated household economy and the need for all members of the household to make a personal contribution. That Thai elderly stay productive and contribute to the economy is noteworthy. The economic impact of the decreased portion of population in the labour force age group, may be offset to some extent, by more effective utilization of the productive potential of older persons.

The technological progress and changes in economic structure that are taking place in Thailand could be unfavorable to the employment of older workers. This may be especially seen if the work would involve a change in occupation and/or location of work. On the other hand, technical progress may be favorable in improving the health conditions of the elderly workers by reducing the need for heavy manual work.

With the old-old population (age 80+years) increasing at a faster rate in the future, ageing might place greater stress on families at the household level. As the elderly age, the likelihood that they may develop chronic morbidities and disabilities is greater and the probability that they would require more support and care from their family becomes higher.

The rapid economic and social changes may significantly reduce effectiveness of traditional support mechanisms. Caring for the elderly may become stressful in the future as responsibilities will be shared among fewer children. It is to be noted that the children may likely reside or be employed in geographically distant places and may be therefore be unable to personally provide care to their elders. And though the country has the benefit of a strong family system, trends in urbanization, internal and international migration indicate that in the future, Thailand might face significant problems in caring for its elderly population.

POLICIES AND ACTIONS

The Thai Constitution has a provision for the over 60 years of age with insufficient income; who have the right to welfare, public facilities and appropriate aids from the State. The first attempt to address the issues of the elderly in Thailand was in 1982 when the National Elderly Council was established. In 1999, the National Committee of Senior Citizens was constituted to make a commitment to elevate the standard of living of the elderly and protect them from abandonment and violation of their rights. The Older Persons Act was passed in December 2003 and enforced on 1st January 2004. The Act stipulates that the elderly will be entitled to protection, promotion and support in various areas including medical and health services. The First National Plan for Older Persons (1982-2001) addressed health, education, social and income security, social and cultural integration and social welfare. However, the Plan did not specify goals, strategies and actions. The Second National Plan for Older Persons (2002-2021) went beyond the objectives of the first national plan to conform to the goals and objectives of the Madrid International Plan of Action on Ageing adopted in Madrid in 2002. The Madrid International Plan of Action also provides strategies on long term care which cover a wide range of activities including the promotion and support of informal care within the family. The Plan also provides for health and social services both at home and at community institutions.

In 2005, the Ministry of Public Health stipulated that every hospital shall have an elderly persons' clinic to serve as express service channel for the elderly. Certain hospital personnel were especially trained to assist the elderly while they wait to be provided with services.

The National Commission on the Elderly in 2009 successfully initiated and implemented a universal monthly subsistence allowance scheme, from which older persons who have no pension can benefit to maintain their well-being.

The Second National Plan is being successfully implemented and progress has been made in building an ageing friendly society. The government of Thailand plays an active role in coordinating the implementation of activities of public and private sectors and municipalities to achieve the objectives of the Plan (Jitapunkul and Wivatvanit, 2009).

The key domains of the Second National Plan are: 1) the older persons Act of 2003, 2) old age protections and security 3) alleviation of poverty in old age, 4) old persons and emergencies, 5) promotion of positive attitudes toward ageing, 6) employment of older persons, 7) advancing health and wellbeing, 8) providing quality health and long term care, 9) ensuring an enabling and supportive environment, 10) housing and enabling environment, 11) care and support for caregivers, 12) protection of the rights of older persons.

The Ministry of Public Health has been operating elderly health care centres at the sub-national level since 2005 to promote long term care for older persons with chronic illnesses. Thousands of volunteers have been trained to provide health care services at the centres which have been expanded to cover the Provinces.

The Ministry of Social Development launched a home health care policy where an outreach team comprised by a physician, nurse, social worker and physiotherapist do home visitations. This volunteer project is especially helpful to elderly who have no caregivers.

The Department of Social Development and Welfare provides long-term residential homes for older persons who have no shelters or no caregivers. The homes provide health care and rehabilitation services homeless and underprivileged older persons. In addition, there are Elder Care Centres which are run by private and public organizations. These centres provide services including community health care, residential service and health rehabilitation.

The Bureau of Mental Health Technical Development has been implementing a project on elderly mental health care since 2007. Under this programme, mental health care staff and volunteers conduct home visits to help prevent elderly persons from suffering depression and alleviate their loneliness when their adult children are at work.

Thus far, there has been no policy measures towards increasing the fertility rate to near replacement level as an effort to slow down rapid ageing of the Thai population. Recent research had shown that low levels of household gender equity contributed to below replacement fertility in the developed and some developing countries.

It has been demonstrated that greater gender equality at the household level such as greater participation by males in household and childbearing tasks and attitudinal shifts supporting dual earning partnerships would raise the level of fertility (Anderson and Kohler, 2015).

> ***"The rapid economic and social changes may significantly reduce effectiveness of traditional support mechanisms. Caring for the elderly may become stressful in the future as responsibilities will be shared among fewer children. And though the country has the benefit of a strong family system, trends in urbanization, internal and international migration indicate that in the future, Thailand might face significant problems in caring for its elderly population."***

Recommendations

- Assign a central government organization as responsible for elderly matters to avoid duplication of effort and ensure efficient use of resources.
- Develop community based programmes that provide elderly home care by non-family members and local health staff need where family care is insufficient or lacking.
- Employ older persons particularly the young-old as means to reduce poverty and the official retirement age should be raised to keep up with the rising life expectancy at older ages.
- Analysis of data from the censuses and surveys should be encouraged to expand knowledge on ageing and to support periodic policy decisions.
- More health personnel should be trained to specialize in geriatric care and mainstream old age health care.
- As a relatively high proportion of Thai elderly in the age group 60-69 years are in the labour force, it is important to ensure sustainable income by providing opportunities for savings through higher interest rates in addition to the public welfare subsidies that are in place.
- As the tertiary sectors provide majority of employment opportunities for elderly workers and the number of workers who are self-employed increases with age, policies should be formulated to encourage employment of the elderly in the service sectors.
- As living standards depend on the productivity rather than size of labour force, the solutions to problems associated with changing age structure of the population should focus on both demographic and social-economic policies.
- Preponderance of widowed women among the oldest of the elderly has important implications for the kind of care they need in the future. Planning for institutional care focused on the growing number of old widowed women should be a priority.
- As the fertility level in Thailand is well below replacement level, increasing it to at least close to replacement level, increasing it to at least close to replacement level should be prioritized by the government. Improve gender equity at the household level by providing paternity and parental leave at the birth of a child.
- In addition to demographic facts, appropriate policies and programmes in response to population ageing need to be based on solid evidence concerning economic, social and health situation of the older population.
- As only about 40% of the labour force is covered by old age income security savings programmes, it is important for the government to encourage the self-employed to join a retirement pension scheme.
- Promote in-migration from neighbouring countries to cope with the changing demographic scenario--shrinking labour force and lack of caregivers for the elderly.
- Government should act with urgency to capacitate implementing organizations that deal with issues on gender, sexuality and reproductive rights.
- Continue to prepare for the rapid demographic and social change that will inevitably take place among the elderly in the coming decades.

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CASE STUDY

2

POPULATION AGEING IN MALAYSIA

Prof. Tey Nai Peng

Executive Summary

Population ageing is a relatively new phenomenon in Malaysia. The proportion of population aged 60 years and older had been gradually increasing from 5.2% in 1990 to 6.2% in 2000 and 8.0% in 2010. However, the tempo of population ageing will accelerate in the next few decades. Malaysia will be an ageing nation by around 2030 when 14% of the population will be 60 years old and over. By 2050 this will further increase to 24%. Among the older population, the oldest old will be growing at a faster pace. Population ageing is the result of gain in life expectancy and fertility decline to replacement level in 2012. The continuing fertility decline also resulted in labour shortage and erosion of family support for older people.

Population ageing poses serious challenges to the health care and social protection systems, but it also presents an opportunity to tap the vast reservoir of human resources of experienced workers for national development, in the light of a tight labour market. To allow older people to work longer, the Government has raised the retirement age for both public and private sector employees to 60 years old since 2014 from 58 years (public sector) and 55 years (private sector). Still, more efforts are needed to promote active and productive ageing.

The older population is by no means a homogenous group, and their needs differ widely. Older men are more likely to have a surviving spouse than older women, as the incidence of widowhood increased rapidly with advancing age among older women. About two thirds of older adults co-reside with children, while many also receive remittances from children. Many older adults have had no formal education, and are engaged in informal services and agricultural activities. However, with the rising trend in education, the rapidly increasing number of older people with higher education in the next few decades will constitute a pool of skilled human resources.

There are more women than men aged 70 and over in Malaysia, and the gap widens in older age groups. Older women are also much more likely to be widowed than men. The constitution guarantees equal rights for all, but women are discriminated at the work place, and in terms of inheritance. Although women are the main care providers and they take on multiple roles, only less than one fifth of households are headed by women. Compared to older men, older women are in greater need for financial assistance and support. The National Policy for Women focuses more on younger women, especially those in the labour force. Health programmes also focus more on women in the reproductive years, and there is relative neglect of the health care needs of older women.

One of the major challenges in population ageing is the provision of adequate health care services to a rapidly increasing number of older persons with deteriorating health or multiple illnesses. In Malaysia, population ageing has been accompanied by a rise in non-communicable diseases, caused by sedentary lifestyle and food habits. The increasing number of older persons is straining the health care system. Geriatric care in the country is still underdeveloped and available services could not meet the rapidly increasing demand. To meet the health care needs of the rapidly increasing number of older persons, measures are being taken to train more geriatricians and improve geriatric and long term care facilities. There are also efforts to promote healthy living through health education and campaigns to prevent further rise of non-communicable diseases.

Another major challenge in population ageing is the provision of adequate social protection. Older persons generally depend on income from work or savings, as well as financial support from children. The incidence of poverty is higher among older adults than the working age population. Are the existing five pillars of social protection adequate in providing for the needs of the increasing number of older persons? The cash and social assistance under pillar zero is rather limited and many who are in need do not receive it. The Employee Provident Fund (EPF) and Pension (for civil servants) which cover a little less than two thirds of the older adults, are inadequate to meet the financial needs for daily living of the older people, as most people used up their EPF savings within 5 years after retirement. Free and subsidized health care services are provided in government hospitals and clinics to older persons to alleviate their financial burdens amid the escalating health care cost.

Many Non-Government Organizations (NGOs) run by older adults and the community have played an important role in the care and well-being of the elderly, especially with the erosion of family support system which is a consequence of shrinking family size, out-migration of adult children and increased female labour force participation in the modern sector. Government, NGOs and the private sector are forging smart partnerships to cater to the needs of older people, including health care, home care and provision of special privileges to older persons.

The National Policy for the Elderly calls for efforts to enable older people to live independently, with respect and dignity, through self-reliance and continuous participation in society. Various government agencies, such as the Department of Social Welfare and the Ministry of Health have been providing health care and social services to safeguard the welfare of older people.

While Malaysia has taken measures to address issues of population ageing, including the adoption of the National Policy for Older Persons and the National Health Policy, the effectiveness of policies and programmes have yet to be evaluated. With increased funding, Gerontology and geriatric research have proliferated in recent years, and the findings from this research can be used for the formulation, monitoring and evaluation of policies and programmes.

There is a need to promote active and productive ageing from the development perspective, and care and protection from the welfare perspective. Efforts must be made to encourage and facilitate the older persons to participate actively in social and economic activities, as stipulated in the National Policy for Older Persons. Financial and health care needs of the older persons must be provided adequately through improved social protection schemes. Families must be given the needed support to take care of their older members. There is a need to forge a smart partnership between the public and private sector. Efforts must also be stepped up to promote community involvement in the care of older persons, and NGOs must be given the necessary support to play their roles more effectively. In view of the increasing health problems, geriatric health care must be improved, and health education campaigns that promote healthy lifestyle must be given high priority. Research findings can be utilized in formulating, monitoring and evaluation of the policies and programmes.

Introduction

POPULATION AGEING AS AN EMERGING CONCERN IN MALAYSIA

Population ageing is a relatively new phenomenon in Malaysia. The number and proportion of aged 60 years and older increased gradually from 5.2 % in 1990 to 6.2 % in 2000 and 8.0 % in 2010. However, population projections indicate that the tempo of population ageing will accelerate in the next few decades. Malaysia will become an ageing nation by around 2030 when 14 % of the population will be aged 60 and over, and this will increase further to 24 % in 2050. The phrase "getting old before getting rich" is one the most important features of population ageing in developing countries, including Malaysia. Moreover, the shrinking family size and breakdown of the extended family have eroded the traditional care and support for older persons. Social and economic consequences of the rapid increase in the number of older persons have caught the attention of policy makers and researchers.

The age structure of a population is shaped by past trends in fertility, mortality and migration. In Malaysia, population ageing is the result of gain in life expectancy and fertility decline to replacement level in 2012. Malaysia is currently enjoying a demographic dividend, with working age population aged 15-64 years making up 67% of the total population. To sustain economic growth, the nation must take advantage of this window of opportunity, which will last for only a few more decades.

Population ageing and increase in old age dependency pose great challenges to social and economic development, health care, and social protection system. Malaysia still lacks a comprehensive social security scheme for retirees, their dependents and those who are not working. The country is undergoing epidemiological transition, with increasing prevalence of non-communicable diseases. Along with increasing affluence, non-communicable diseases increased the demand for health care services, especially in geriatric care. The 2011-2025 Country Health Plan highlighted that the rapidly ageing population has strained the health care system, because older people use health services far more than younger people (Malaysia, Ministry of Health, 2011). The increasing demand for long term care of older persons poses serious challenges to the capacity of the family and health care providers.

Reproductive health services targeted only those in the reproductive age groups, but neglects those in the older age groups, who have different needs.

At the household and individual levels, many old people and their families are struggling to cope with financial needs and inflation. With urbanization level increasing from 51 % in 1991 to 73 % in 2014, more and more older people are living in cities where cost of living is higher and family and social support systems for elder care are weaker than in the rural areas. Yet, many older adults are being left in the countryside while their children move to the cities. As women are the main care providers within the family, increased female labour force participation has also affected the capacity of the family to take care of the elderly parents.

Recognition of the problems associated with population ageing led to the adoption of the National Policy for the Elderly in 1995, and the revised National Policy for Older Persons in 2010. In addition, the National Health Policy for Older Persons was adopted in 2008. There is an urgent need for strategies and legislations stipulated in the National Policies for Older Persons to be effectively implemented and enforced to protect not just the current older Malaysians but the future of all Malaysians.

A good knowledge of the processes of population ageing, its causes and consequences is essential to assist policy makers define, formulate and evaluate goals and programmes, and to raise public awareness and support for policy changes in line with global changes. Following the adoption of these policies, issues of population ageing have gained increasing attention among researchers, and this led to the proliferation of Gerontology and geriatric research in Malaysia.

> ***"Population projections indicate that the tempo of population ageing will accelerate in the next few decades. Malaysia will become an ageing nation by around 2030 when 14% of the population will be aged 60 and over, and this will increase further to 24% in 2050."***

Demography of ageing in Malaysia

The age structure of Malaysian population underwent significant changes due to falling mortality and fertility rates since the 1950s (Table 1). Median age has been increasing steadily from 17.0 years in 1970 to 26.3 years in 2010, and is projected to increase to 34 years in 2030 and 40 years by 2050. The portion of the population aged 60 and over has increased from 587 thousand or 5.4 % in 1970 to 2.25 million or 8.0 % in 2010, and is projected to increase to 4.9 million or 13.6 % in 2030 and 9.6 million or 23.6 % in 2050. By 2045, population aged 60 and over will equal the number of young people below age 15, each making up 20 % of the total population, and then the old will outnumber the young from then on (Figure 1). The change in the relative size of the young and old population is evidently reflected by the ageing index, which has been rising rapidly from 12.0% in 1970 to 28.7% in 2015 and is projected to reach 60.5% in 2030 and then to 140% in 2050. The age structural shifts also result to increasing old dependency and decreasing young dependency ratio. The old dependency ratio has increased from 9.0% in 1990 to 13.9% in 2015, and is projected to increase to 39.5% in 2050. In contrast, the young dependency ratio has decreased from 90% in 1970 to 64.8% in 1990, 37% in 2015, and it is projected to drop further to 28.3% in 2050. There will also be significant shift in the age structure of the older population. The percentage of those aged 75 and older among the elderly population varied between 18% and 22% for the period 1970-2015, but this will be rising steadily to about 29% by 2040.

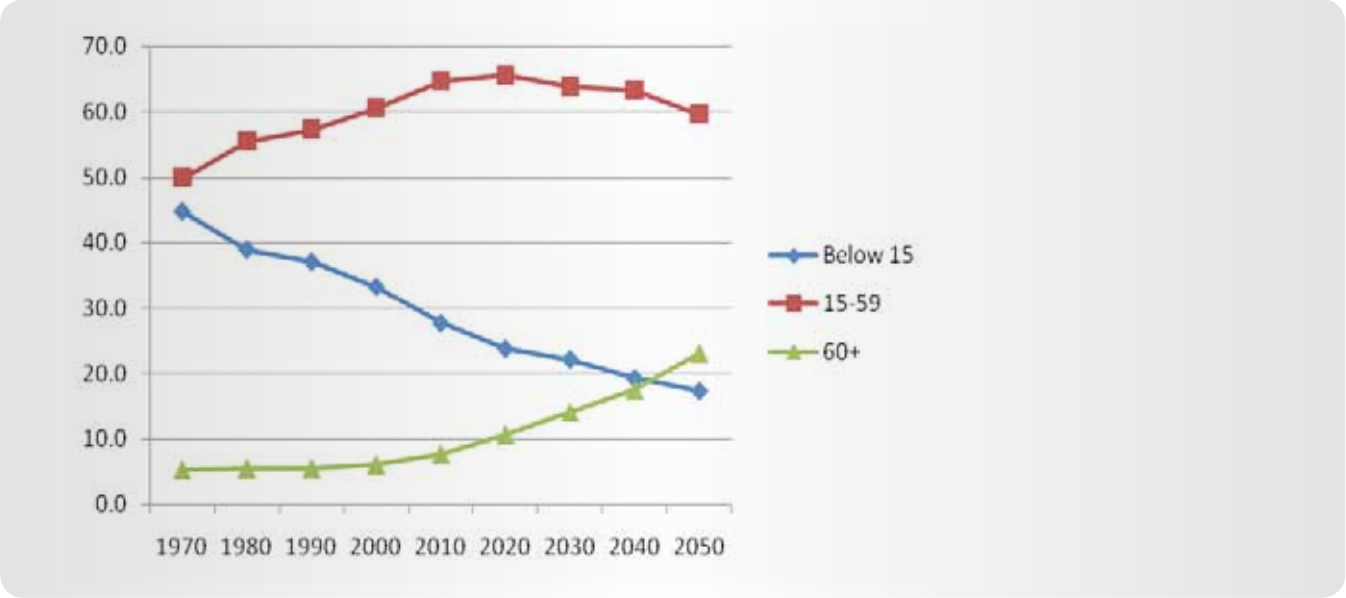
Up until the 1990s, growth rate of the older population followed quite closely that of the total population, growing at about 2-3% per annum. At the turn of the new millennium, the population growth rate has declined rather sharply from 2.4% in 2000 to 1.8% in 2010, and is projected to dip below 1% by 2030. However, the growth rate of older population is projected to increase much more rapidly to a peak of about 4.5% per annum around 2015-2020 before declining to about 3 -3.5% per annum in the succeeding couple of decades.

TABLE 1: Age structural changes and related indicators

	Population (in '000)	Percent (%)									
	Total	Below 15	15-59	60+	75+	60+ (%)	Old DR	Young DR	Ageing Index	75+/ 60+	Median age
1970	10909	4885	5436	587	107	5.4	10.8	89.9	12.0	18.2	17.0
1980	13834	5394	7663	776	140	5.6	10.1	70.4	14.4	18.0	19.6
1990	18211	6756	10428	938	209	5.2	9.0	64.8	13.9	22.3	20.9
2000	23421	7803	14169	1449	273	6.2	10.2	55.1	18.6	18.8	23.8
2010	28120	7822	18518	2249	478	8.0	12.1	42.2	28.7	21.2	26.3
2015	30485	7733	19981	2771	609	9.1	13.9	38.7	35.8	22.0	28.2
2020	32441	7781	21220	3441	733	10.6	16.2	36.7	44.2	21.3	29.9
2030	35966	8088	22982	4896	1175	13.6	21.3	35.2	60.5	24.0	33.0
2040	38558	7537	24725	6295	1792	16.3	25.5	30.5	83.5	28.5	36.0
2050	40725	6871	24261	9593	2721	23.6	39.5	28.3	139.6	28.4	40.0

Sources: Department of Statistics Malaysia, various years, population censuses reports; United Nations (2015).
Notes: Based on 2010 population census, there were 2.18 million Malaysian citizens aged 60 and over out of a total of 26 million, or 8.3%.
Old Dependency Ratio (DR) is defined as the percentage of population aged 60 and over divided by population aged 15-59.
Young dependency ratio (DR) is defined as the percentage of population below 15 years divided by population aged 15-59.
Ageing index is defined as population aged 60 and over divided by population below 15, multiply by 100.

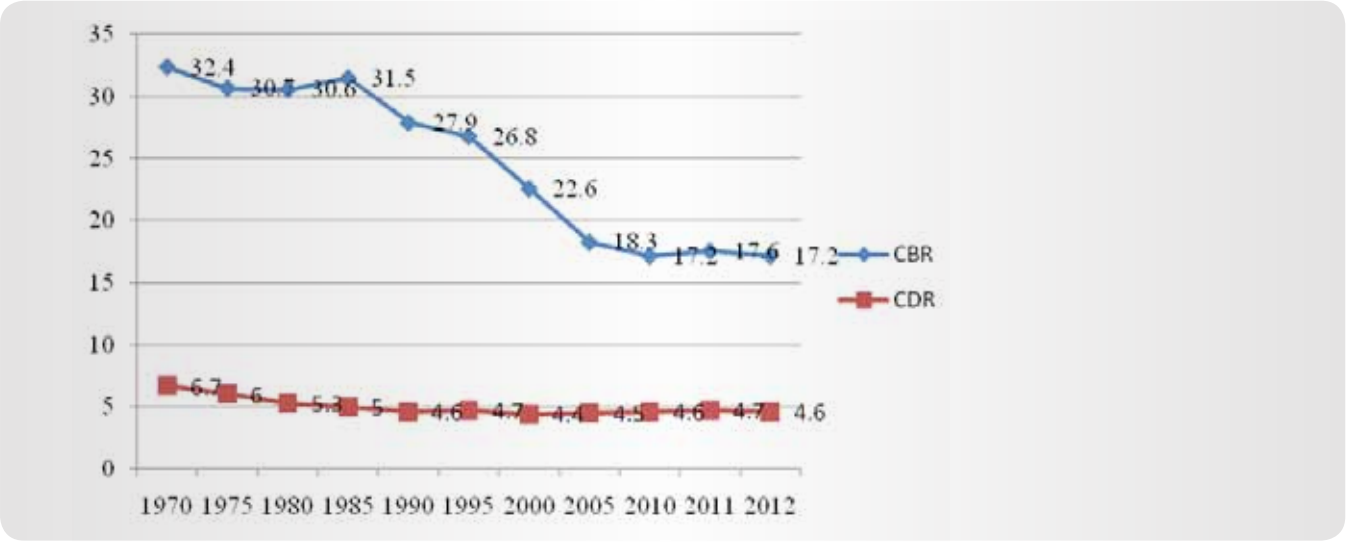
FIGURE 1: Percentage distribution of population by broad age groups.



Demographic transition in Malaysia began soon after the end of World War II, when mortality rate began to fall while fertility rate remained high and even increased in what is known as the post-war baby boom (Stage I of demographic transition). The crude death rate fell from 19.4 per thousand in 1947 to 11.6 in 1955 and to 6.7 in 1970 and stabilized at around 4.5 since 1990 (Hirschman, 1980). While improvement in life expectancy led to the increase in the number and proportion of older persons, fertility decline has contributed to the accelerated pace of population ageing in the more recent years. Between 1980 and 1995, crude birth rate fell from 29 to 23 per thousand population, and then declined more precipitously to 18 per thousand population in 2010 (Figure 2). The total fertility rate (TFR[1]), which measures the number of children a woman would produce in her life time subject to the prevailing childbearing patterns, registered a steeper decline from 3.0 children per woman in 2000 to 2.1 in 2010 (Figure 3). This translates to a decline of 3.6% annually compared to 1.7% per annum between 1970 and 2000. Rapid fertility decline strongly and directly influence on age structural changes and population ageing, as evidenced by the rapid increase in the ageing index shown above.

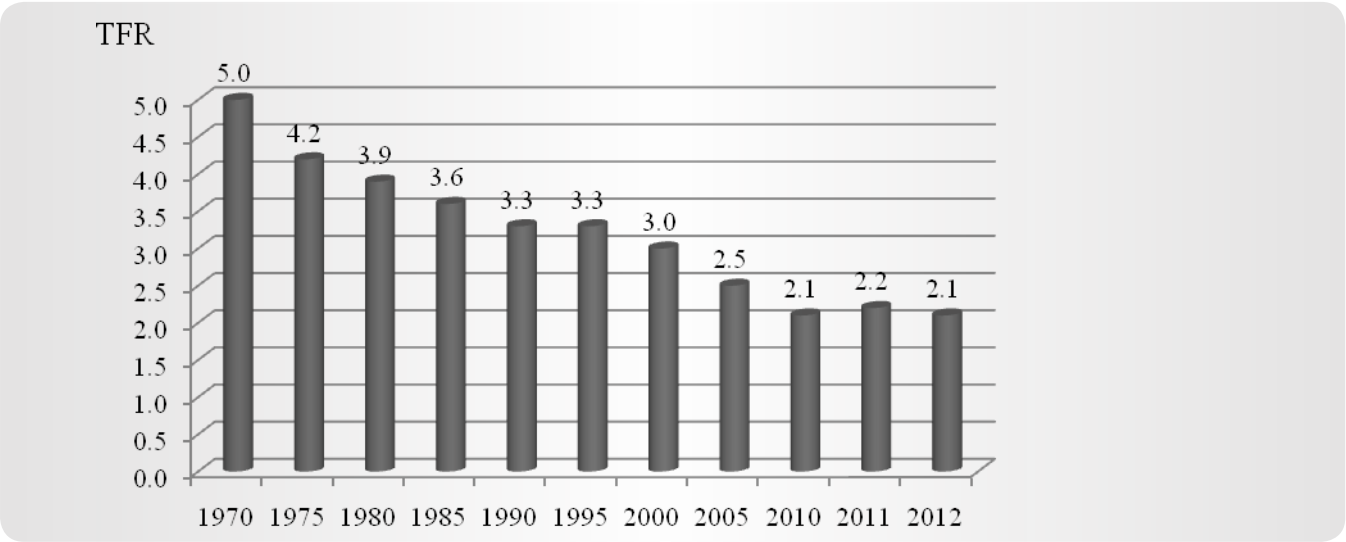
[1]TFR is a more accurate indicator of the declining trend in fertility as it is less affected by changes in the age structure as compared to the crude birth rate)

FIGURE 2: Trends in crude birth rate and crude death rate



Source: Department of Statistics, 2001, 2006, and vital statistics, various years.

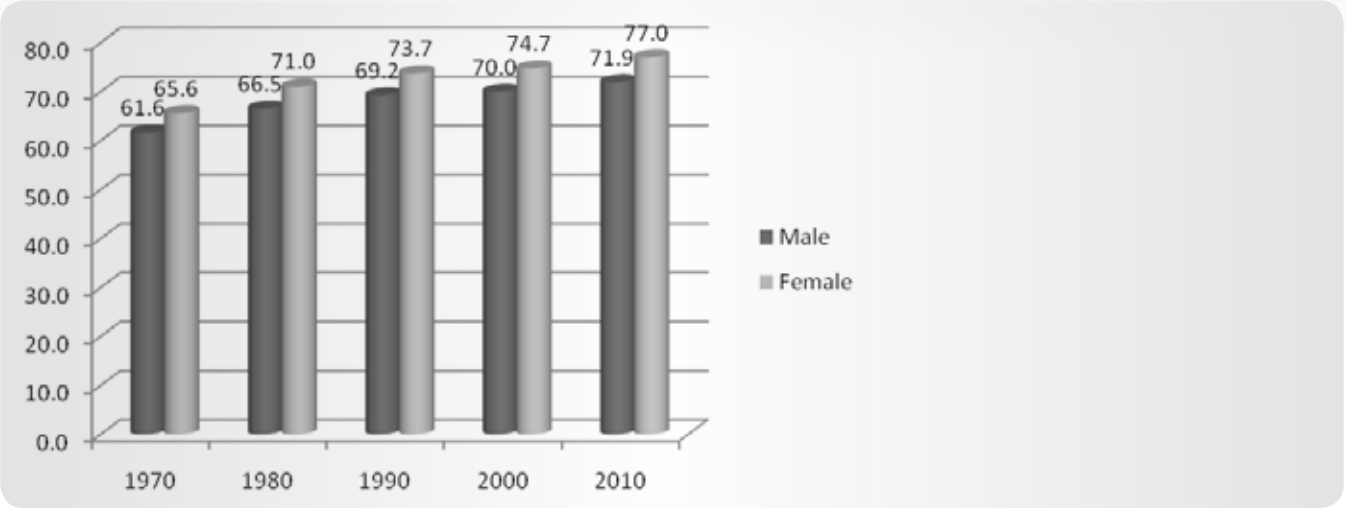
FIGURE 3: Trends in total fertility rate



Sources: Department of Statistics, 2001, 2006 and vital statistics various years

Investments in health infrastructure and better standard of living have brought about dramatic improvement on health status and longevity. Mortality rates registered remarkable declines, resulting in significant gain in life expectancy. For instance, infant mortality rate fell from 39.4 per thousand births in 1970 to 23.8 in 1980, 13.1 in 1990, and 6.3 in 2012. Life expectancy for females and males improved from 65.6 years and 61.6 years in 1970 to 77 years and 72 years respectively in 2010 (Figure 4). In 2010, life expectancy at age 60 for females and males stood at 20.2 years and 17.6 years respectively (Table not shown).

FIGURE 4: Life expectancy for males and female



Sources: Department of Statistics, 2001, 2006 and vital statistics various years

Demographic processes and outcomes are influenced by rapid socio-economic development. Owing to the rapid pace of urbanization, Malaysia is the second most urbanized nation in Southeast Asia, increasing from 25% in 1970 to close to 75% today. Rapid urbanization has been accompanied by fundamental changes in the economy. The proportionate share of workers engaged in agricultural employment has declined from 54% in 1970 to 11% in 2012, while the proportion working in manufacturing and services sector has increased from 9% and 33% to 29% and 54% respectively during the same period. Consequent upon rising education, more and more women are working in the modern sector, and this has eroded the traditional pillar of care for the older people. Following the liberalization of higher education policy and the launching of twining programmes, tertiary enrolment ratio rose from 7% in 1989 to 22% in 1998 and to 36% in 2011. The females have overtaken the males in tertiary education since the late 1980s.

Social and Economic Profiles of the Elderly

MARITAL STATUS, FAMILY AND LIVING ARRANGEMENT

Traditionally, the family has been the main pillar of care and support for older people. In pursuing its policy to encourage family members to take care of their ageing parents, the government has made various provisions such as tax rebate and allowing families with elderly parents to employ domestic helpers from other countries. The importance of the family institution was emphasized in Vision 2020, a long-range development framework adopted in 1992. One of the challenges of Vision 2020 is to establish a "fully caring society and a caring culture, a social system in which society will come before self, in which the welfare of the people will revolve not around the state or the individual but around a strong and resilient family system".

Notwithstanding government policy calling for the strengthening of the family institution, there had

been changes that tend to erode the family's capacity to take care of older members, in the past, marriage used to be almost universal, but there is a trend toward delayed and non-marriage, especially among the better educated women, and less educated men. There is also a trend toward nucleation of the family due to the declining birth rate and out-migration of adult children. Such changes have profound effects on the care being provided by family to their older members.

Information on marital status was available in all the population censuses. However, age at first marriage was not asked and had to be computed using the indirect method. Table 2 shows that about 5% of older men and women aged 60 and over were never married. However, older men were much more likely than older women to be currently married, and this can be explained by the fact that men typically married women 4 to 5 years younger, and women have longer life expectancy than men. The proportion of older women who were widowed increased sharply with age, from 25.8% among those aged 60-64 to 58.5% among those aged 75 and over. The corresponding percentages for men were 6.2 and 21. Only a small percentage of older men and women were divorced or separated. The marriage pattern shows that older women were less likely than men to have a partner in their old age. This means that older women depend on their children and other family members for their care and financial support, as many of them did not have the financial resources.

A previous study shows that the probability of marrying beyond age 30 diminishes sharply with age (Tey, 2007). Hence, with the increase in the proportion of men and women remaining single in their 30s (16.6% for males and 10.8% for females) and 40s (9.9% for males and 6.7% for females) as at 2010, there will be a rise in the proportion of unmarried older adults soon.

TABLE 2: Marital status by gender, 2010

Both sexes	Never married	Married	Widowed	Divorced	Total
35 - 39	13.8	83.7	1.1	1.4	100.0
40 - 44	8.3	88.0	2.1	1.5	100.0
45 - 49	6.0	89.1	3.4	1.5	100.0
50 - 54	5.1	86.6	7.0	1.4	100.0
55 - 59	4.3	84.4	10.2	1.2	100.0
60 - 64	4.7	78.5	15.9	1.0	100.0
65 - 69	5.1	72.2	21.8	0.8	100.0
70 - 74	3.7	63.8	31.8	0.7	100.0
75+	7.1	50.7	41.5	0.7	100.0
Male					
35 - 39	16.6	81.9	0.7	0.8	100.0
40 - 44	9.9	88.1	1.1	0.9	100.0
45 - 49	6.5	91.2	1.5	0.9	100.0
50 - 54	5.1	91.3	2.8	0.8	100.0
55 - 59	4.0	91.3	3.9	0.8	100.0
60 - 64	4.3	88.8	6.2	0.7	100.0
65 - 69	4.9	85.4	9.1	0.6	100.0
70 - 74	3.6	81.9	13.9	0.6	100.0
75+	8.0	70.4	21.0	0.5	100.0
Female					
35 - 39	10.8	85.6	1.6	1.9	100.0
40 - 44	6.7	88.0	3.2	2.1	100.0
45 - 49	5.4	86.9	5.5	2.2	100.0
50 - 54	5.0	81.7	11.4	2.0	100.0
55 - 59	4.5	77.0	16.8	1.6	100.0
60 - 64	5.1	67.9	25.8	1.3	100.0
65 - 69	5.4	58.9	34.7	1.0	100.0
70 - 74	3.9	46.3	48.9	0.9	100.0
75+	6.4	34.3	58.5	0.8	100.0

Source: Department of Statistics, 2012. Population and Housing Census of Malaysia, 2010 -Education and Social Characteristics of the Population

> ***Notwithstanding government policy calling for the strengthening of the family institution, there had been changes that tend to erode the family's capacity to take care of older members.***

Owing to high fertility in the past, it is common for today's older adults to have many children. Preliminary results from the 2014 Malaysian Population and Family Survey showed that about half of the older adults had 5 or more children, and this ranged from 41% in the urban areas to 60% in the rural areas (Table 3). Only about 6% of the older persons did not have any children, and these included mainly those who were never married. However, with continuing fertility decline, the future generations of older adults will have progressively fewer children, and more will be childless, partly due to an increase in non-marriage.

TABLE 3: Number of children for persons aged 60 and over, by stratum, 2014

	Urban	Rural	Malaysia
0	6.6	4.9	5.8
1	5.4	4.2	4.8
2	11.3	5.1	8.5
3	16.9	9.9	13.7
4	18.7	15.8	17.4
5	14.8	15.5	15.1
6	9.1	13.1	10.9
7+	17.3	31.5	23.7
	100.0	100.0	100.0

Source: Author's own computation using data from 2014 MPFS

EDUCATIONAL ATTAINMENT

Data from the 2010 population census report were used to compute the educational level of those aged 45 and over (Table 4). Overall, one quarter to one third of the population in the different age groups did not have educational information and these were excluded from the computation. Table 4 shows that the proportion of the older adults with no schooling has been declining over the years, from 60.5% among those aged 75 years and older to 31.4% among those aged 60-64, and this will be declining further to less than 10% among those who will be entering the "older" age group within the next 10 to 15 years. On the other hand, proportion of older adults with at least secondary education has been rising steadily across the younger age groups, from 17.6% among those aged 75 and over to one third among those age 60-64, and this percentage will rise to almost three quarters when those aged 45-49 move into the "older" population. The proportion of older adults with tertiary education will still be less than 10% in the near future, as rapid expansion of tertiary education following the liberalization of education policy began only in the mid1990s.

Older women have lower educational attainment than their male counterparts, and this will remain so for some time. However, women have overtaken the men in higher education since the 1980 birth cohorts (Tey, 2006). Beyond the next two to three decades, more older women will have higher education as compared to the males.

> ***The proportion of the older adults with no schooling has been declining over the years from 60.5% among those aged 75 years and older to 31.4% among those aged 60-64, and this will be declining further to less than 10% among those who will be entering the "older" age group within the next 10 to 15 years.***

TABLE 4; Educational level by age, 2010

	No schooling	Primary	Secondary	Diploma, certificate	Tertiary (degree)	Total
Both sexes						
45 - 49	8.2	18.3	59.2	8.3	6.1	100.0
50 - 54	11.4	28.5	48.7	6.7	4.7	100.0
55 - 59	14.7	34.2	42.6	4.9	3.6	100.0
60 - 64	31.4	35.3	27.9	3.0	2.3	100.0
65 - 69	39.7	34.8	20.6	2.8	2.0	100.0
70 - 74	51.0	31.8	14.0	1.9	1.4	100.0
75+	60.5	21.9	13.4	2.4	1.8	100.0
Male						
45 - 49	6.5	16.5	60.7	9.0	7.4	100.0
50 - 54	8.5	25.4	52.3	7.6	6.2	100.0
55 - 59	10.0	31.4	47.6	5.9	5.0	100.0
60 - 64	14.9	39.7	37.7	4.1	3.7	100.0
65 - 69	21.7	42.8	28.6	3.7	3.1	100.0
70 - 74	31.9	42.7	20.6	2.7	2.1	100.0
75+	41.1	33.1	20.0	3.2	2.6	100.0
Female						
45 - 49	9.9	20.1	57.7	7.6	4.8	100.0
50 - 54	14.4	31.6	45.0	5.8	3.2	100.0
55 - 59	19.4	37.0	37.6	3.8	2.2	100.0
60 - 64	45.6	31.6	19.6	2.1	1.2	100.0
65 - 69	54.5	28.3	14.1	2.1	1.0	100.0
70 - 74	65.8	23.3	8.8	1.3	0.8	100.0
75+	73.2	14.6	9.1	1.9	1.3	100.0

Source: Department of Statistics, 2012. Population and Housing Census of Malaysia, 2010 -Education and Social Characteristics of the Population (Table 4.1)

ECONOMIC ACTIVITIES

Labour force participation rate of Malaysian women has remained relatively low at around 45-47% since the 1990s. A survey conducted in 2004 found that only 15.3% of the older women aged 55 and over were working as compared to 37.4% among the older men (Tey and Tengku Aizan, 2014). The wide gender differential in labour force participation rate was also evident from the 2010 population census report which showed that 54% of men and 28% of women aged 60–64 were still working. Data from the 2% sample of the 2010 census show that the proportion of older men aged 65-69, 70-74 and 75 and over who were still working was 27%, 20% and 16% respectively, while the corresponding figures for older women was 7%, 5% and 5% respectively. There were about 530 thousand workers aged 60 and over, making up about 4% of the labour force in 2010.

Table 5 shows that workers aged 60–64 were concentrated in service and sales (22%), agriculture (22%), craft and related work (11%), plant and machine operators (12%), and elementary occupations (13.7%). About 8 out of 10 of these older workers were self-employed (Malaysia, Department of Statistics, 2013).

TABLE 5: Economic activities by age, 2010

	0	1	2	3	4	5	6	7	8	9	Total
Both sexes											
50 – 54	37.0	3.8	5.2	5.7	4.8	14.0	7.1	6.1	7.5	8.9	100.0
55 – 59	50.1	2.8	2.9	3.7	3.0	11.4	7.9	5.1	5.8	7.3	100.0
60 – 64	59.1	1.8	1.2	1.9	1.5	9.5	9.4	4.6	5.1	5.9	100.0
Male											
50 – 54	15.1	5.5	6.0	7.6	4.9	18.5	10.1	8.5	11.2	12.7	100.0
55 – 59	31.1	4.2	3.6	4.9	3.4	15.1	11.3	6.9	8.7	10.8	100.0
60 – 64	45.8	2.8	1.8	3.0	2.3	12.0	12.2	5.5	5.9	8.8	100.0
Female											
50 – 54	59.8	2.0	4.4	3.7	4.7	9.4	4.1	3.5	3.5	4.8	100.0
55 – 59	69.8	1.4	2.1	2.5	2.7	7.6	4.3	3.2	2.7	3.6	100.0
60 – 64	72.1	0.9	0.6	0.9	0.6	7.0	6.7	3.7	4.4	3.2	100.0

Source: Department of Statistics, 2013. Population and Housing Census of Malaysia, 2010
Economic Characteristics of the Population (Table 2.1)

0 Not working	1 Managers
2 Professionals	3 Technicians and Associate Professionals
4 Clerical Support Workers	5 Service and Sales Workers
6 Skilled Agricultural, Forestry and Fishery	7 Craft and Related Trade Workers
8 Plant and Machine-Operators	9 Elementary Occupations

HEALTH STATUS

The close association between ageing and deteriorating health had been well established. Population ageing increases the strain on the existing health care system because older people tend to utilize health services far more frequently than younger people as they are more likely to suffer from chronic diseases and multiple illnesses (Rechel et al., 2013; Rowe, 2015). Citing findings from the National Health and Morbidity Surveys, a report of the Ministry of Health (MOH) indicates that disease patterns among older persons changed from diseases associated with ageing to diseases associated with lifestyle such as hypertension, hypercholesterolemia, diabetes mellitus, and chronic obstructive lung disease, and arthritis. Records of public hospitals show that more than 400,000 older persons were admitted or 20.3% of total admissions and the trend is increasing (Ministry of Health Malaysia, 2010). Roziah Omar (2003) reported that "eighty percent of people over 65 in Malaysia have long-term disorders and five percent have disability that requires continuous medical supervision". Health problems specific to old age and poverty include malnutrition, under-nutrition, and chronic diseases such as cardiovascular disease, osteoporosis, diabetes, anemia, cataracts, arthritis and glaucoma, all of which can cause severe stress, anxiety, and even mortality". The study highlighted that "elderly women tend to suffer ailments resulting from history of their reproductive health", and cited menopausal symptoms, cervical and uterine cancers, and thyroid disorders as examples of such diseases and disorders that typically afflict elderly women in Malaysia.

Although research on ageing has proliferated since 2000, there is a dearth of published reports or articles on the health status and morbidity patterns of older adults based on a nationally representative survey. However, a recent article by Teh, Tey and Ng (2014), which analyzed data from the 2004 Malaysian Population and Family Survey found that "the prevalence of the most common non-communicable diseases—arthritis, hypertension, diabetes, asthma, and coronary heart disease (CHD) varied widely across ethnic groups. Older females were more likely than males to have arthritis and hypertension, but

the reverse was true for asthma, diabetes. CHD were most prevalent among Indians, whereas arthritis and hypertension were most prevalent among the Indigenous groups. The Chinese were least likely to report poor health, whereas Indians and Indigenous people were more likely to do so".

In the 2004 Malaysian Population and Family Survey, 35% of older adults rated their health as good, 44.5% as fair and 20% as poor. Older men were somewhat more likely than women to rate their health as good. About eight out of ten older persons had visited the hospital or clinic at least once and about one in five had visited these facilities at least seven times during the 12 months preceding the survey (Table 6). One in five older men and women had been hospitalized during the last 12 months. A little more than one third had high blood pressure, about 16-18% of the older men and women had diabetes and 11% each had coronary heart diseases. Older women were much more likely than older men to suffer from arthritis, but older men were slightly more likely than older women to have asthma (Table 6).

> ***"Eighty percent of people over 65 in Malaysia have long-term disorders and five percent have disability that requires continuous medical supervision."***

TABLE 6: Self rated health, hospital visits, hospitalization, and prevalence of selected illness, among older persons aged 60 and over, 2004

	Male	Female	Both sexes
Self rate health status			
Good	43.9	30.3	35.2
Fair	34.7	50.1	44.5
Poor	21.4	19.6	20..3
Total	100.0	100.0	100.0
Number of visit to hospitals /clinics last 12 months			
None	25.3	17.7	20.4
1	10.2	9.6	9.8
2	11.5	10.2	10.6
3	9.9	11.9	11.2
4	10.2	12.6	11.7
5	3.8	4.5	4.3
6	7.1	10.9	9.5
7+	22.4	22.6	22.5
Total	100.0	100.0	100.0
Warded last 12 months	20.2	21.2	20.8
Had high blood pressure	30.4	39.9	36.4
Had diabetes	16.3	17.7	17.2
Had CHD	10.7	11.2	11.0
Had arthritis	30.1	52.0	44.0
Had asthma	15.3	12.5	13.5

Source: Author's own computation using data from 2004 MPFS

Family Support and Social Security for the Elderly

FAMILY SUPPORT

In keeping with the traditional Asian practice of filial piety, adult children are the main providers of care and financial support to the ageing parents. Basic needs of older persons are provided by co-residing children. However, with rapid social and demographic changes, living arrangements of older adults have changed significantly between 2004 and 2014. Over this period, the proportion of older adults living alone increased from 5.1% to 9.0%. Older women were more likely than older men to live alone (12.4% versus 2.9%). With higher incidence of widowhood among the females, older women were less likely than older men to live with spouse only or with spouse and children while they were more likely to live with children only or with grandchildren and others. Overall, the percentage of older adults co-residing with children declined from 72.3% in 2004 to about 62.5% in 2014 (Table 7). Between 2004 and 2014 while the proportion of older women co-residing with spouse increased from 46% to 51.6%, co-residence with children has declined from 70.4% to 62.5%. The demographic and social trends indicate more and more older adults will be living alone or with spouse only.

TABLE 7: Living arrangement of older men and women aged 60 and over, 2004

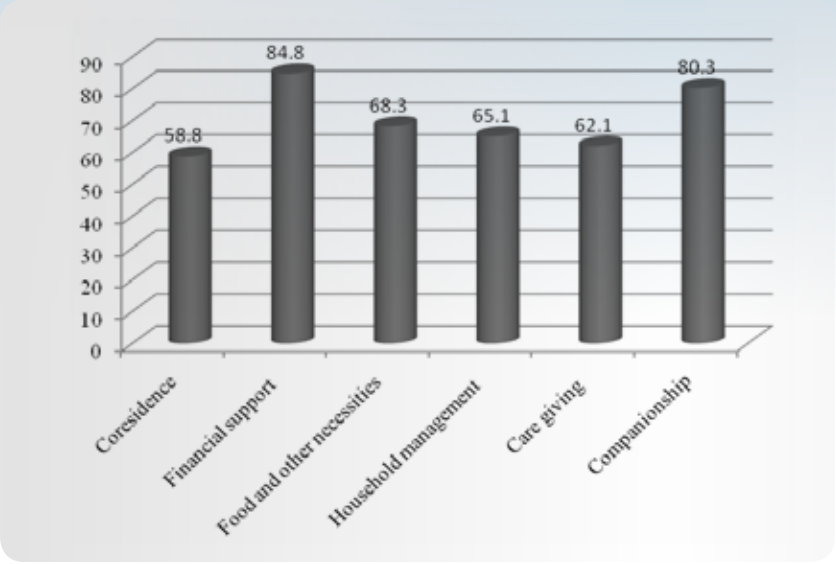
	2004			2014		
	Male	**Female**	**Both sexes**	**Male**	**Female**	**Both sexes**
Stay alone	2.8	7.5	5.1	4.9	12.4	9.0
With spouse only	20.8	15.0	17.9	26.1	16.6	20.9
With spouse and children	64.3	31.0	47.8	54.4	35.0	44.6
With children only	9.8	39.4	24.5	11.3	27.5	19.2
Grand children only/ others	2.3	7.2	4.7	3.3	8.5	6.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

Sources: Author's own computation using data from 2004 and preliminary release of the 2014 MPFS data (personal correspondence with official from the National Population and Family Development Board).

The 2014 Malaysian Population and Family Survey shows that about 85% of older adults received financial support from children through remittances. Close to two thirds of older adults also received other forms of support from children, and these included food and other necessities, care, and house-keeping. About 20% were visited regularly by children living in the vicinity for companionship (Figure 5).

Besides physical care and financial support, children also provide emotional support and are a preferred confidant to their elderly parents. Analyzing data from the 2004 Malaysian Population and Family Survey, Teh, Tey and Ng (2014) found that every other older Malaysian reported that they experienced loneliness, and one in five was always lonely, and nearly half of the older persons mentioned children as their first-choice confidant and 28% as second choice confidant. The oldest-old were most susceptible to loneliness, because many were widowed and had few surviving friends. However, older persons who lived with their children were less likely than those who did not co-reside with children to report being very lonely (16.6% as against 27.9%) (Teh, Tey and Ng, 2014). Older Malaysians who lived with their children have higher life satisfaction than those who did not (H. Kooshiar, 2012).

FIGURE 5: Percentage of older adults by type of support from children



Source: Author's own computation using data from 2014 MPFS

> ***In keeping with the traditional Asian practice of filial piety, adult children are the main providers of care and financial support to the ageing parents. However, demographic and social trends indicate more and more older adults will be living alone or with spouse only.***

An analysis of the sources of income based on a national survey on economic and financial aspects of older Malaysians showed that 73.2% of older Malaysians (67% of males and 79.5% of females) received remittances from their children, whereas 50% received job related income including pensions, and 27% received investment related income. More than half of older Malaysians in this survey had annual household income of less than RM20,000, and 22% reported an income below the poverty level of RM8,292 per year (Tey & Tengku Aizan, 2014). As such, older adults are more likely than the young to be at risk of living in poverty. Older women were more likely than older men to depend on financial support from their spouse and children. Roziah Omar (undated) noted that many elderly are heavily dependent on their children and must cope with the rising medical and other costs of living.

COMMUNITY SUPPORT

Many non-governmental organizations (NGOs) and societies were set up at various levels to complement and supplement the efforts of the government to take care of the wellbeing of older persons. The national umbrella body of these NGOs is the National Advisory Council for Senior Citizens of Malaysia (NACSCOM), which was established in 1990 to advocate for the development of policies, programmes, projects, and services that will enhance the quality of life and well-being of older persons in Malaysia. NACSCOM is composed of 44 senior citizen associations with a total of about 18,000 members and is an appointed member of the National Advisory and Consultative Council on Ageing

The objectives of NACSCOM are:

1. To encourage and support senior citizens and enable them to remain in the mainstream of society, to live their lives to the fullest, and to give them recognition for their contributions to the nation;
2. To recognize, promote, instill and maintain the Asian values of love and respect for elders;
3. To promote better understanding between young and older citizens;
4. To generate community interest, support and participation in organizing programmes and activities with and for senior citizens;

5. To promote opportunities for senior citizens to present their opinions and views on matters concerning their welfare to relevant authorities;
6. To coordinate the work of various senior citizen organizations throughout Malaysia;
7. To encourage and assist the establishment of senior citizen organizations throughout Malaysia; and
8. To raise, collect, manage and disburse funds for the benefit of senior citizens, old folks' homes, welfare services and other projects, subject to the prior approval of the authorities concerned.

Source: http://www.hati.my/senior-citizens/national-council-of-senior-citizens-organisations-malaysia-nascom/

USIAMAS, the Malaysian Golden Age Welfare Association is one of the main organizations for senior citizens, out of about a hundred in the country. The objective of USIAMAS is to contribute to all members of society. Main activities include training the elderly on how to live optimally after retirement, promote noble values and provide Home Help Services. Under Home Help Services, which was launched in June 2005 by the Ministry of Women, Family and Community Development in smart partnership with NGOs, 30 volunteers have been trained to provide services to older persons.

There are 16 licensed nursing homes and 165 old folks' homes in the country and these are regulated separately by the Ministry of Health and the Department of Social Welfare. As of the year 2013, there have been 45 activity centres operating in partnership with the government. Various private care organizations which offer elderly independent living complexes with full support services are emerging.

Neighbourhood associations and community centres have played an important role in promoting inter-generational and social interactions for the well-being of both the young and the old. *Rukun Tetangga* (Community watch) committees were set up by the government to carry out community development programmes and activities. Since 2000, the concept of *Rukun Tetangga* was changed from neighbourhood watch to community outreach to involve more professionals, corporate citizens, government officers and pensioners.

SOCIAL SECURITY SCHEMES

Malaysia's public programmes for age financial protection can be categorized into the World Bank's five-pillar framework, as shown in Table 8. Under zero pillar, the Bantuan Orang Tua (Assistance for Older Persons) programme of the Department of Social Welfare provides a monthly cash allowance of RM300 to older persons from low income families (household income below RM720 per month for Peninsular Malaysia; RM830 for Sarawak and RM960 for Sabah). Coverage of this programme has been quite limited and possibly fraught with targeting issues as many needy older persons did not receive it (Holzmann, 2014). Service provisions through retirement homes and elderly daycare centres under pillar zero are also limited and patchy (Samad and Mansor, 2013). Since 2012, government has also been giving out the 1Malaysia People's Aid (BR1M) of RM950 per annum to low income households (below RM4,000 income per month in 2015). BR1M benefitted about 7 million households/individuals.

Pillar 1 caters to the over 1.2 million civil servants who made up about 13% of the labour force. This pension scheme pays a monthly allowance of up to 60% of a retiree's last drawn salary, based on the length of service, and it is extended to cover widows/widowers of former public sector workers. With a bloated civil service, the pension expenditure may not be fiscally sustainable in the long term.

Pillar 2 provides coverage to two groups - armed forces personnel and private sector employees. This comprehensively defined benefit programme covers members of the armed forces who are not eligible for the conventional defined benefit-type scheme. The Employee Provident Fund (EPF) offers a savings vehicle for private sector employees who can opt for phased withdrawal or lump-sum withdrawal upon retirement. Under this scheme, the employees contribute 11% of their monthly salary while their employers contribute 12%. EPF covers about 52% of the working population, who are mostly employees as only 1% of self-employed persons are participating in this scheme.

Pillar 3 contains voluntary and funded retirement savings provisions that are regulated by the government. The Private Retirement Scheme (PRS), established and implemented in 2012 offers main tax incentives for voluntary participants. However, the take up rate is very low, and covers only about 1% of the labour force (Holzman, 2014).

Pillar 4 encourages strong family support for the elderly by providing a tax relief of up to RM 5,000 to those who provide care for their elderly to cover costs of sending to the day care centre, salary for maids, and daily needs such as disposable diapers and medical expenses. It also provides public health care and housing, and facilitates the continued participation of older workers in the labour force beyond retirement age.

Overall, about 37% of the workers are not covered by any social security scheme. Level of savings among EPF contributors are very low. In 2012, the mean and median accumulated savings for those aged 50-54 years was RM37,965 and RM23,506 respectively. These would yield monthly annuities of onlyRM258 and RM98 respectively, well below the national poverty line of RM820 (Holzmann, 2014). For most contributors, this meagre amount is easily used up within the first three years after retirement.

TABLE 8: Mapping of Pension Programs

	Name of programme/ institution	**Benefit type**	**Financing type**
Pillar 0: Basic benefits through social pension or social assistance	Bantuan orang Tua - assistance for old people (cash benefits, Retirement homes, day-care centres	Basic cash benefit of RM300 per month In kind In kind	General revenue General revenue General revenue
Pillar 1: Mandated, unfunded, defined benefit or contribution schemes	Civil service pension fund SOCSO	Old age disability survivorship. Work injury, disability, survivorship	General revenue Employer contribution Employer and employee contribution
Pillar 2: Mandated, fully funded, occupational or personal schemes	LTAT (Armed forces EPF (private sector)	All benefits Lump sum/phased withdrawal	Employer and employee contribution Employer and employee contribution, Voluntary contribution by self employed
Pillar 3: Voluntary, fully funded occupational or personal scheme	Private retirement scheme	Lump sum (fixed term annuity	Voluntary premium tax incentives
Pillar 4: Access to informal and other formal provision and personal assets	Family, basic health care, public housing	Cash and in kind benefits	Family members, budget financed, budget support

Source: Holzmann, 2014.

PUBLIC HEALTH CARE

Malaysia has almost achieved universal coverage for health care. The health expenditure per capita increased threefold from USD292 in 1995 to USD938 in 2013 (PPP, constant 2011). Increasing demand for health care services led to the mushrooming of private hospitals. The country's population of about 31 million in 2016 is served by 148 public and 141 private hospitals. Over 70% of all admissions (over 2.2 million) are in public hospitals. Older persons make up over 20% of the total admissions and this percentage keep increasing (Tey et al, 2015).

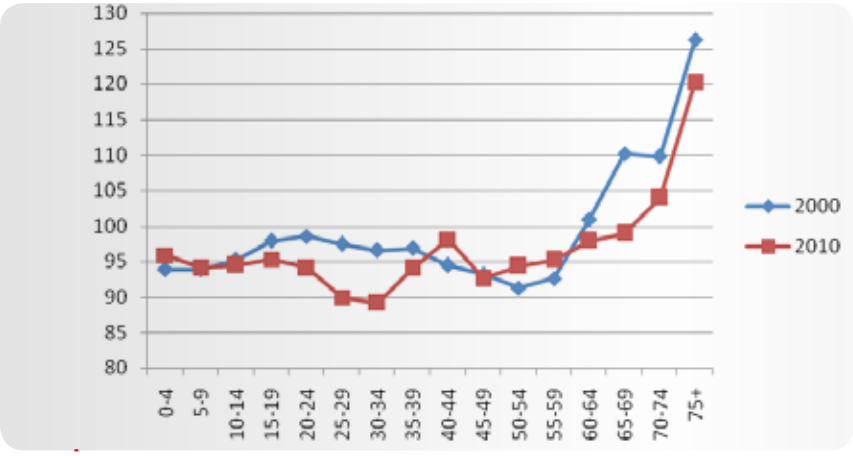
There are only 23 qualified geriatricians in five geriatric units with a combined total number of less than 150 beds, serving a population of over 1.4 million older adults. The infrastructure or continuum of care required in terms of effective primary care networks, community care, homecare services, day care, respite care, and rehabilitation are very much lacking (Tey et al. 2015; Ambigga et al. 2011). Furthermore, community health clinics throughout the country are supported by medical officers who have limited or no training in geriatric medicine. The task of providing the required quality health care services to older people in the immediate future is extremely challenging. This is further compounded by the differential utilization of these services by ethnic groups who vary in terms of cultural practices and religious beliefs which influence their attitudes toward ageing (Tey et al. 2015; Abolfathi Momtaz, Hamid, Ibrahim, Yahaya, & Abdullah, 2012). Additional differences include their capacity to make use of the specialized health services. The use of private health care is often preferred by the more affluent segment of the population due to long waiting times and overcrowding in public hospitals and clinics (Chee, 2008)

FEMINIZATION OF AGEING

The sex composition of a population is a function of sex ratio at birth, age specific mortality rate and migration. The sex ratio at birth in Malaysia is about 106 males per 100 females. However, mortality rates are higher among males as compared to females across the ages. In 2010, the survivorship at age 65 was 85.7% for females against 75.5% for the males. Gender differential in survivorship is reflected by the higher life expectancy of females. At age 65, life expectancy for females and males was 16.2 years and 14.1 years respectively. Hence, while males outnumbered females in all age groups up to age 60/70, there were more females than males at ages 60 and above (in 2000) or 70 and above (in 2010), and the female surplus increased at each successive age group (Figure 6). Older women had been much more likely to be widowed. At age 60 and over, there were almost four times as many widowed older women as men in year 2010 (440,139 as against 120,356).

Between 2000 and 2010 the number of older women aged 60 and over increased from 758,541 to 1,145,924 while the increase in the number of older men was from 693,124 to 1,105,292. Feminization of ageing is more pronounced at ages 70 and over. At ages 75 and over, there were about 120 females per 100 males.

FIGURE 6: Number of females per 100 males by age, 2000 and 2010



Sources: Department of Statistics, Malaysia, 2002, 2011.

> ***"The sex ratio at birth in Malaysia is about 106 males per 100 females. However, mortality rates are higher among males as compared to females across the ages. But at ages 75 and over, there were about 120 females per 100 males."***

RIGHTS AND NEEDS OF OLDER WOMEN

The constitution guarantees equal rights for all citizens. However, women are often discriminated. Based on Ewing (1999), as quoted in Omar (2000) "the current status of a majority of older Malaysian women is the outcome of generations of discrimination, throughout every stage of the life cycle." Although women are the main care providers to the young and the old in the family, they often do not have autonomy and are seldom the decision-makers for major issues in the family. The 2000 Population Census shows that only 18% of the households are headed by women, and women only became household heads after the death of husband.

Older women are much more likely than older men to live in poverty, as many of them were never employed or and have been dependent on their spouse and/or children for financial support. Hence, older women need more financial assistance as compared to older men.

Omar (2003) found that older rural women are prone to illnesses of the reproductive system such cancer of the uterus, besides osteoporosis and poverty related diseases like anemia and under nutrition. Studies on women's health tend to focus on diseases of women in their reproductive years, and there is a lack of research on the health, especially reproductive health, of older women. Omar (2000, 2003) found that older women's health and their access to health care are related to their income, their place of residence, and to the persistent societal gender inequalities in attention to reproductive and sexual health.

Besides financial and health care needs, older women also need emotional and social support. Social isolation, "empty nest syndrome", feelings of loneliness, being neglected, and lack of love may give rise to depression and mental health problems. More women experience loneliness as compared to men. An analysis of the 2004 MPFS by Teh, Tey and Ng (2014) found that a quarter of older women were always lonely and about one third were sometimes lonely, while only about 17% of older men were always lonely and 29% were sometimes lonely.

The National Policy for Women has targeted women in the active working age. There is policy for women to occupy 30% of the decision-making positions in the public and private sector. Health programmes, especially on reproductive health, place great emphasis on women in their reproductive years. In contrast, the social and economic roles, and the health care needs of older women received relatively little attention.

Policy Responses to Implications of Ageing

SOCIAL AND ECONOMIC IMPLICATIONS

Population ageing has wide ranging implications on individuals, family, society and the nation. Older persons deal with deteriorating health conditions and increasing disability as they age. Many older adults grapple with escalating costs of living and health care. The trends towards delayed marriage and childbearing means that an increasing number of retirees will be supporting school-going children. A significant proportion of older persons are feeling lonely, especially if their children have moved out and seldom communicate. Those feelings of loneliness and being neglected had caused depression and other psycho-social and mental health problems to some older persons (Noran N. Hairi, et al., 2011).

Although the family is expected to be the main care provider for older adults, shrinking family size, out-migration of the young, increased female labour force participation and breakup of extended families have eroded the capacity of the family to care for the older persons, especially those who need long term care. Exorbitant costs of medical care for their parents have landed some adult children in financial hardships.

More financial resources are needed for the care of the rapidly increasing number of older persons. For instance, between 2010 and 2013, pensions and gratuities paid out to retired civil servants increased from RM11,515 billion to RM14,854 billion, making up about 7% of the current national expenditure (Malaysia, Central Bank, 2015). The increase of RM3.34 billion in pension payment over the three-year period represents an increase of 8.5% per annum. As more and more civil servants will be retiring, the pension

payment will also be increasing, and this will add to the fiscal deficit. Population ageing is associated with a rise in chronic diseases, and the rapidly increasing number of older people seeking medical treatment has strained the health facilities. Additional budget for the health sector need to be made available.

Although population ageing poses many challenges, it also provides opportunities. The pool of experienced workers can be tapped for national development. Older workers who are healthy and willing to work should be encouraged to continue working. They can act as mentors to younger workers. Increased longevity gives rise to the second demographic dividend, which causes individuals to save more in preparation for old age. This increase in savings can thus contribute to capital accumulation and economic growth.

POLICIES AND ACTIONS

The National Policy for the Elderly was adopted in 1995 "to ensure the social status, dignity and well-being of older persons as members of the family, society and nation by enabling them to optimize their self-potential, have access to all opportunities and have provision for care and protection" (Malaysia, Department of Social Welfare, 1995). The agency which is mainly responsible for this policy is the Department of Social Welfare under Ministry of Women, Family and Community Development.

The objectives of the policy are:

- To enhance the respect for and self-worth of the elderly in family, society and nation.
- To develop the potential of the elderly so that they remain active and productive in national development and to create opportunities for them to continue to live independently.
- To encourage the establishment and the provision of specific facilities to ensure care and protection of the elderly.

Five strategies are stated in the National Policy for the Elderly and they include:

- Respect and Self Esteem – to enable the elderly to live with respect and self-worth, safe and free from oppression and abuse, receive fair and just treatment, enjoy opportunities to realize their optimum potentials and ensure the accessibility to resources for education, culture, spiritual and recreations in the society
- Independence - to ensure the basic needs of the elderly are met; to assist elderly to continue to be of service and contribute to the nation
- Involvement - To enable the elderly to play a role in society and involve themselves actively in the formulation and implementation of policies, form societies or organizations related to their well-being, in accordance with their capabilities and interests
- Care and Protection - to ensure that the elderly enjoy the basic rights of an individual when receiving care and treatment, with respect to their dignity, beliefs and needs; to provide facilities for care and protection within the family and society; and to establish a comprehensive social security system to ensure a stable income and welfare for the elderly, and
- Research and Development – to promote and conduct evidence based research on elderly for program purposes

The National Policy for the Elderly was further translated into a Plan of Action for older person in 1999, with focus on the following:

- Education – to encourage elderly towards continuous learning
- Employment and participation in society - to encourage elderly to continue to participate in the society and contribute to the country
- Recreation – to provide an enabling environment for elderly to carry out recreational activities
- Transportation – to provide public transportation system which is older person friendly
- Housing – to ensure access of older persons to the new development housing area
- Support system of the family – to form a community support system that can assist the family in providing care to older person
- Health and social security – to provide healthcare facilities and comprehensive social security scheme for older person
- Media – to encourage media to play an active role in educating the public towards older persons' issues
- Research and development

A review of the National Policy for the Elderly led to the adoption of a revised National Policy for Older Persons and Plan of Action for Older Persons in 2011. The new policy sought "to develop a caring society, enhance capacity building, advance health and well-being, and address the safety and social security of older adults".

Various social services including long-term care for the needy elderly are provided by the Department of Social Welfare (DoSW) under Ministry of Women, Family and Community Development, including the following:

- Home Help Services – to provide services to elderly who are homeless, who live alone or need help even though they are living with their families. The programme is implemented by DoSW together with the NGOs such as *Majlis Pusat Kebajikan Semenanjung Malaysia (MPKSM), Persatuan Kebajikan USIAMAS, Persatuan Gerontologi Malaysia (GeM*). Volunteers from NGOs are trained to do home visits to assist the elderly in their daily chores such as cleaning the house, paying bills, accessing health care services, and accompanying the elderly for shopping.
- Shelter and care services –Homes are available to provide shelter, care and rehabilitation services to older persons.
- Senior Citizen Activity Centre – 22 day care and activity centres for elderly are available throughout Malaysia. Day care services and other activities including recreation, sports, healthcare, rehabilitation and religious are provided. Training courses are also organized from time to time.
- Senior Citizen Care Unit – to provide transportation to senior citizens who seek treatment or medical examination at the hospital or clinic.

NATIONAL HEALTH POLICY FOR OLDER PERSONS (2008 – 2013)

The development of National Health Policy for Older Persons by the Family Health Development Division, Ministry of Health, aims "*to ensure healthy, active and productive ageing by empowering the older persons, family and community with knowledge, skills, enabling environment; and provide optimal health care services at all levels by all sectors.*"

The policy is based on the following guiding principles and objectives:

Guiding Principles:

- Maintaining Autonomy and Self Reliance
- Recognizing the Distinctive Needs of Older Person
- Training of Supportive Carers
- Promoting Healthy Ageing
- Providing Continuity of Care
- Maintaining the Rights of Older Person to Quality of Life and Death

Objectives:

- To improve the health status of older persons
- To encourage participation in health promoting and disease prevention activities throughout the life course
- To provide age friendly, affordable, equitable, accessible, acceptable, gender sensitive, seamless healthcare services in a holistic manner at all levels
- To advocate and support the development of enabling environment for independent living

The policy is aimed at achieving optimal health for older persons in Malaysia. This is to be achieved through strategies such as health promotion, provision of a continuum of comprehensive health care services, human resource planning and development, information system, research and development, inter-agency and inter-sectoral collaboration and legislation.

Health care for the elderly is the responsibility of the Ministry of Health (MOH) according to the National Health Policy for Older Persons. Free healthcare for the elderly services (no charges for consultations and medications) are integrated at the primary, secondary and tertiary levels. In 2010, 77.3% of all health clinics provided elderly clients with health care services, up from 41.6% in 2000. Over 22,015 MOH staff had been trained in post-basic geriatric care.

Provisions are made to facilitate elderly friendly services in the form of elderly friendly structures, priority in waiting lines, free treatment for pensioners and affordable hospital fees for the low income elderly. Currently there are 10 public hospitals with geriatric wards. Incremental development of geriatric services with priority given to states with a higher proportion of elderly people is being planned.

In keeping with the objective of the National Policy to promote active ageing, the Employment (Part-Time Employees) Regulations 2010 was introduced to enable older persons to work part time in accordance

with to the terms and conditions of the contract of employment under the Labour Law. Government also raised mandatory retirement age to 60 years old in the public and private sector effective July 2014, from 58 years (public sector) and 55 years (private sector).

RESEARCH AND DEVELOPMENT

One of the strategies of the National Policy for the Elderly and the revised National Policy for Older Persons is to promote and conduct evidence-based research on elderly for programme purposes. The Institute of Gerontology (IG) was established in 2002 at University Putra Malaysia to spearhead Gerontology research to support policy that will contribute to the well-being of older Malaysians. The institute also actively promotes lifelong learning for older Malaysians through the establishment of a University of the Third Age (U3A) Malaysia in 2008 to provide affordable learning opportunities for older people in a friendly, supportive and socially enabling environment. In 2011, the Employee Provident Fund provided an endowment fund to set up the Social Security Research Centre at the University of Malaya. The Centre is to carry out research, teaching and dissemination of evidence-based knowledge on social security, including old age financial protection, to enhance understanding on this critical topic towards promotion of economic development and social cohesion in Malaysia.

The year 2012 saw the setting up of a multi-disciplinary research group called the Ageing and Age Associated Disorders Research Group at the University of Malaya, and the Community Rehabilitation and Ageing Research Centre at the National University of Malaysia. In April 2015, IG was upgraded to become the Malaysian Research Institute on Ageing. Government, through the Ministry of Science, Technology and Innovation (MOSTI). and Ministry of Education, had funded many large-scale research projects on the health and socio-economic aspects of ageing (Tey et al., 2015). With funding from the Government, there has been a proliferation of multi-disciplinary research and publication on Gerontology.

GOVERNMENT/NGO ENTITIES IMPLEMENTING PROGRAMS FOR OLDER PERSONS

The National Advisory and Consultative Council for the Elderly (NACCE) was established in 1996 under the Ministry of Women, Family and Community Development to address all issues related to ageing. The Council consists of 34 members from relevant government agencies, NGOs, private sector; with the Department of Social Welfare under the Ministry serving as the secretariat and focal point. The NACCE and formed a technical committee to develop and monitor the implementation and progress of the Plan of Action of Older Persons.

Government health facilities provide age friendly, affordable, equitable, and accessible healthcare services in a holistic manner at all levels. Under the National Health Policy for Older Persons (2008), public primary healthcare facilities provide free healthcare service for older persons. The National Population and Family Development Board provides specialized services for reproductive health among the elderly, including management of menopause and andropause.

Various NGOs such as NACSCOM, USIAMAS and *Majlis Pusat Kebajikan Semenanjung Malaysia (MPKSM),* are represented in the National Advisory and Consultative Council for the Elderly. They have been involved in the formulation of the National Policy for the Elderly and the plan of action as well as in monitoring the implementation of programmes for older persons.

Recommendations

The rapid increase of the number of older people in Malaysia requires urgent actions. It is of utmost importance that the country to develop and implement policies and programmes that cater to the needs of the rapidly increasing number of older persons and population ageing. Research findings pertaining to the elderly should be used effectively to guide policy making, implementation and monitoring of programmes. Below are some recommendations that may be considered and adapted to address the identified problems related to the issue at hand.

1. Encourage healthy and active ageing, and foster community attitudes that see the elderly as potential asset rather than a burden.
2. Facilitate senior citizen's role as grandparents to foster inter-generational relationship and to help in childcare.
3. Encourage older persons to continue to take part in social and economic activities, introduce a system whereby assessment of fitness for work should depend not only on chronological age but also on measured health status and productivity performance. There is also a need to enforce the new mandatory retirement age.
4. Promote family values like those pertaining to care for the elderly and provide the necessary support to families who need to care for their older members..
5. Promote neighbourliness and strengthen community participation in the care of the older people. Forge smart partnership between government, NGOs and the private sector in the community services.
6. Provide more day care centres where the elderly can socialize and take part in community activities. Promote volunteerism among senior citizens
7. Make social protection as a national agenda. Provide more comprehensive social security programmes for the elderly. Ensure that every person subscribes to some form of old age security. Assess what modifications are needed in the EPF to make it a more dependable source of retirement income. Make way for affordable health and life insurance plans,, for the elderly by lifting age limits to insurance, and advocate for children to invest in parents' health insurance.
8. Create a comprehensive system of sexual and reproductive health for older persons, and ensure the inclusion of SRH agenda of older people in health care policies and programmes. Reach out through social media and involve multi stakeholders including the Government, NGOs and faith-based organizations.
9. Improve quality and utilization of population data to plan programmes that cater to the needs of older people. Form a repository and clearing house as data sources. Disseminate research findings to policy makers.
10. Take concrete steps to implement the National Policy for the Elderly (Dasar Warga Tua Negara), gazetted in 1995. Develop a strong national coordinating mechanisms involving the government and civil society organizations.

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CASE STUDY

3

POPULATION AGEING IN INDONESIA

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Executive Summary

An ageing population has emerged in Indonesia. This has become one of the three mega demographic trends in this country along with an increasing total population and population mobility (Arifin and Ananta, 2013). This paper examines the ways by which declining fertility and mortality rates have altered the age-sex structure of Indonesia's population.

Older persons or the elderly are those aged 60 years old and above as stipulated in Law No.13/1998 article 1(2). Ageing population is therefore measured as the percentage of the population aged 60 years and above relative to the total population. Arifin and Ananta (2016) described five important points about the ageing processes in Indonesia. First, percentage of elderly will continue rising, although unlikely as high as in developed countries or Indonesia's neighbour Singapore. Second, given that Indonesia is the fourth most populous country in the world, the total number of the elderly is also large. Third, there is a diversity of ageing population issues at sub-national levels due to geographical diversity within the archipelago. In 2005, there were 20 districts in Indonesia with the elderly accounting for more than 12% of the total population (Arifin and Hogervorst 2015). Fourth, internal migration is not negligible and migration within the country has significant impact on the ageing population at sub-regional levels. Out-migration of younger persons and in-migration among retirees increased the ageing population in some districts. And fifth, ageing population occurs when average per capita income is still relatively low.

In 2010 almost eight in 100 people were aged over 60 years old, an increase from seven in 100 people in 2000. The percentage of elderly population is projected to continue rising to 13.8% in 2030 and 20% by the middle of the 21st century. As in many other countries, feminization of the ageing population in Indonesia is also happening. With regards to marital status, the elderly in Indonesia are mostly married and a higher percentage of them are men. The mean number of children surviving for the women aged 55 and above is 3.47. It is expected that the elderly would co-reside with at least one of their children (61% for women and 66 % for men in 2007).

Meanwhile, the elderly's educational attainment is low due to several reasons, one of which is because they were born and raised during the independent transition period when poverty was rampant and educational facilities were poor. Data show that older persons with no schooling accounted for almost one third in 2010. Together with those who had or completed primary education, they consisted about 85% of the total elderly population. The labour force participation rate of the elderly remained high (65.0 % in 2000 and 51.2 % in 2010) showing how Indonesians aged 60 and above were actively involved in the labour market and therefore labour income was still the major source of financing in later life. Almost seven in ten people worked in the agricultural sector.

The emergence of an ageing population in Indonesia put pressure on the middle age adults particularly those in their 40s and 50s. They are a "*penyet* generation," those who support their elderly parents at the same time as they raise their own children. The *penyet* generation could be in for a crisis, as they have to support both the parents and children. Ageing population impacts all population age groups. Therefore, effective policies for ageing population do not only benefit the elderly but also the working population and their children, and even future generations.

The Government of Indonesia being cognizant of the unprecedented rate of population ageing in the country has taken steps towards slowing it down. The urgency that matter has attracted attention from the National Development Planning Board (Bappenas). However, most of the policies are being carried out by "traditional" sectors such as the Ministry of Health, Ministry of Social Affairs, and Ministry of Manpower. They are rarely found in other ministries such as Ministry of Education, Ministry of Finance, Ministry of Tourism, Ministry of Foreign Affairs, and Ministry of Environment. Some of NGOs such as Yayasan Emong Lansia, Lembaga Lansia Indonesia (LLI), and Senior Club have been actively involved in creating enabling environment for the elderly to age gracefully with dignity. Community based groups like Older Persons Organizations (OPA) have been established in some regions.

National perception of the elderly need for shift from being a "burden" to that of an asset. We recommend the elimination of age discrimination through the abolition or revision of laws that prohibit persons from working because of age. Retirement should be made optional. Every person has the right to work regardless of age.

Along with elimination of retirement age, the practice of seniority in the workplace should be put to an end. In like manner, older employees will not be rewarded or

benefitted simply because of age. Inter-sectoral Active Ageing policies with the "from womb to tomb" approach need to be implemented. Successful Active Ageing policies will make all levels of the population happier. In addition, the growing elderly population can become an important contributor to sustainable development based on the new post 2015 development agenda.

Socialization of issues on ageing population should be enhanced by policy makers, business communities, academicians, NGOs, and people in mass media. And one strategic way to do this is to introduce the issues in the many regional elections in Indonesia.

We should also train professionals on Geriatric care. These professionals should obtain certification with at least an ASEAN recognition, as the ASEAN Community is now also working on Mutual Recognition Arrangement (MRA) in nursing and other professions.

Finally, policies and programmes for ageing population should be backed up with scholarly studies performed by scholars from different disciplines including economists. Furthermore, age disaggregated statistics must be collected and published.

> ***"Along with changing population mobility and an ever-increasing population, ageing population became one of the three mega demographic trends in the future Indonesia."***

Introduction

During the New Order era (1966-1998) and especially since 1970 when the government under Soeharto implemented a stringent family planning programme, Indonesia experienced rapid fertility decline. At that time, the concern among economists, demographers, other social scientists, and policy makers was how to curb high population growth—then seen as an obstacle for economic development. In addition to curbing fertility, mortality had to be improved too. Thus, infant mortality declined and longevity increased. An ageing population emerged in Indonesia.

Along with changing population mobility and an ever-increasing population, ageing population became one of the three mega demographic trends in the future Indonesia, according to Arifin and Ananta (2013), because TFR (total fertility rate) continuously declined and then stabilized at about 2.4, not far from replacement level. TFR even reached below replacement level in some sub-national regions. This emerging trend has far reaching implications for the development of the country.

Ageing population is measured as the percentage of the population aged 60 years and above, relative to the total population. Arifin and Ananta (2016) described five important points about the ageing processes in Indonesia. First, the percentage of the elderly will continue rising, although it is not yet as high as in developed countries or its neighbour Singapore. Second, given that Indonesia is the fourth most populous country in the world, the total number of elderly citizens is also large. Third, there is a diversity of ageing population issues at sub-national levels due to its geographical diversity within the archipelagic nature. In 2005, there were 20 districts with the elderly accounting for more than 12 % of the total population (Arifin and Hogervorst 2015) more than that of its neighbour Singapore. Fourth, internal migration is not negligible and has considerable significance in the ageing population at sub-regional levels. Out-migration of younger persons or 'the young' and retirement in-migration have increased ageing population in some districts. And fifth, population ageing is occurring when average per capita income is still relatively low. The GDP per capita in 2015 is only about 4,000 USD, which is much smaller than that of Singapore's 56,300 USD.

This paper aims to asses and anticipate population dynamics in Indonesia, with focus on the ageing population. It explains the process of population ageing, its future trajectory, and the social-economic profile of the elderly. It also provides policy recommendations to improve the welfare of the elderly and the younger generation. Therefore, this paper provides information to strengthen planning and influence policies for sustainable development.

The following section describes the demography of ageing in Indonesia, beginning with the past and future fertility trends. Other sections will discuss mortality trends and changing age structure, the socio-economic profile of the Indonesian older persons, the social security and feminization of ageing population, and policy responses to implications of ageing.

Demography of Ageing

FERTILITY TREND

By the time the New Order took power, the average number of births per woman as measured by the Total Fertility Rate (TFR) was around 5.6 children (Badan Pusat Statistik 2001). This high fertility rate was considered as an obstacle to economic development, where poverty was high and the GDP per capita was low. Seeking to combat poverty rate and improve the quality of life of the Indonesians, the government committed to decrease fertility rate through its strong commitment on the implementation of its family planning programmes in 1970. Together with a series of development policies, the family planning programme helped reduce total fertility rate within a decade when TFR significantly declined to 4.6 and even further to 3.3 the following decade.

However, at the end of the New Order era, the decline of fertility rate slowed down. Based on the 2010 census, it reached 2.41 (Badan Pusat Statistik 2011a), approaching the replacement level. In the post Soeharto era, Indonesia experienced tremendous social-political transformation, and the process of declining fertility was halted. The National Board of Family Planning (BKKBN) was no longer as strong, losing its grip at the sub-national levels. Different sources of data such as Demographic and Health Surveys showed that the fertility rate was stable at around 2.6 in 2007 and 2012.

The Government of Indonesia and the UNFPA projected that TFR will only reach 2.1 (replacement level) in 2025-2030 (BPS, BKKBN and UNFPA, 2013). It is not so clear, however, why replacement level fertility has become an obsession among policy makers in Indonesia when there is no guarantee that the fertility rate will remain stable. Furthermore, based on the medium variant of the United Nations projection (2015), TFR in Indonesia is projected to reach 2.1 in 2030-2035 and will continue to decline to 1.9 in 2045-2050.

MORTALITY TREND

In the meantime, Indonesians are gaining longevity. Improvement on health services, care and infrastructure, education and other development policies have resulted in better quality of life. Infant and child mortality rates declined significantly. In 40 years, life expectancy at birth increased by almost 25 years—from about 45 in the early 1970s to almost 70 years in 2010 (Badan Pusat Statistik, 2011b). Furthermore, data show that females are living longer than males. Based on latest decennial census, life expectancy at birth reaches 72.2 females and 68.3 for males (Badan Pusat Statistik, 2011b).

It is projected that life expectancy at birth will continue to increase. However the Indonesian government and the UNFPA are not too optimistic about the future trend of Indonesian longevity. Indonesians' life expectancy at birth is only projected to reach 72.5 by 2035 (Bappenas, BPS, UNFPA, 2013), the same as that of the female population in 2010 and compared to the global projection of 74.2 for female and 70.4 for male by 2035. Furthermore, the United Nations (2015) projected that life expectancy at birth will be 76.5 for female and 71.5 for male by 2045-2050.

CHANGING AGE STRUCTURE

Age-sex population structure is an interplay of three main elements of population dynamics: fertility, mortality and migration. Fertility and mortality trends are more predictable and therefore also have more predictable impacts on age-sex population structure. The decline in fertility rate reduces the number and percentage of the young population, while the decline in mortality rate increases the number in each cohort that survives up to the older age groups. On the other hand, migration may affect the age structure in different ways depending on the net effect between in-migration and out-migration for different age

and sex groups, particularly at sub-national levels. At the national level, the effect of migration has not been very significant yet in terms of changing the age structure of Indonesia's population. Yet, as shown in Ananta and Arifin (2014), the importance of international migration seems to have played a growing importance in the latest decade.

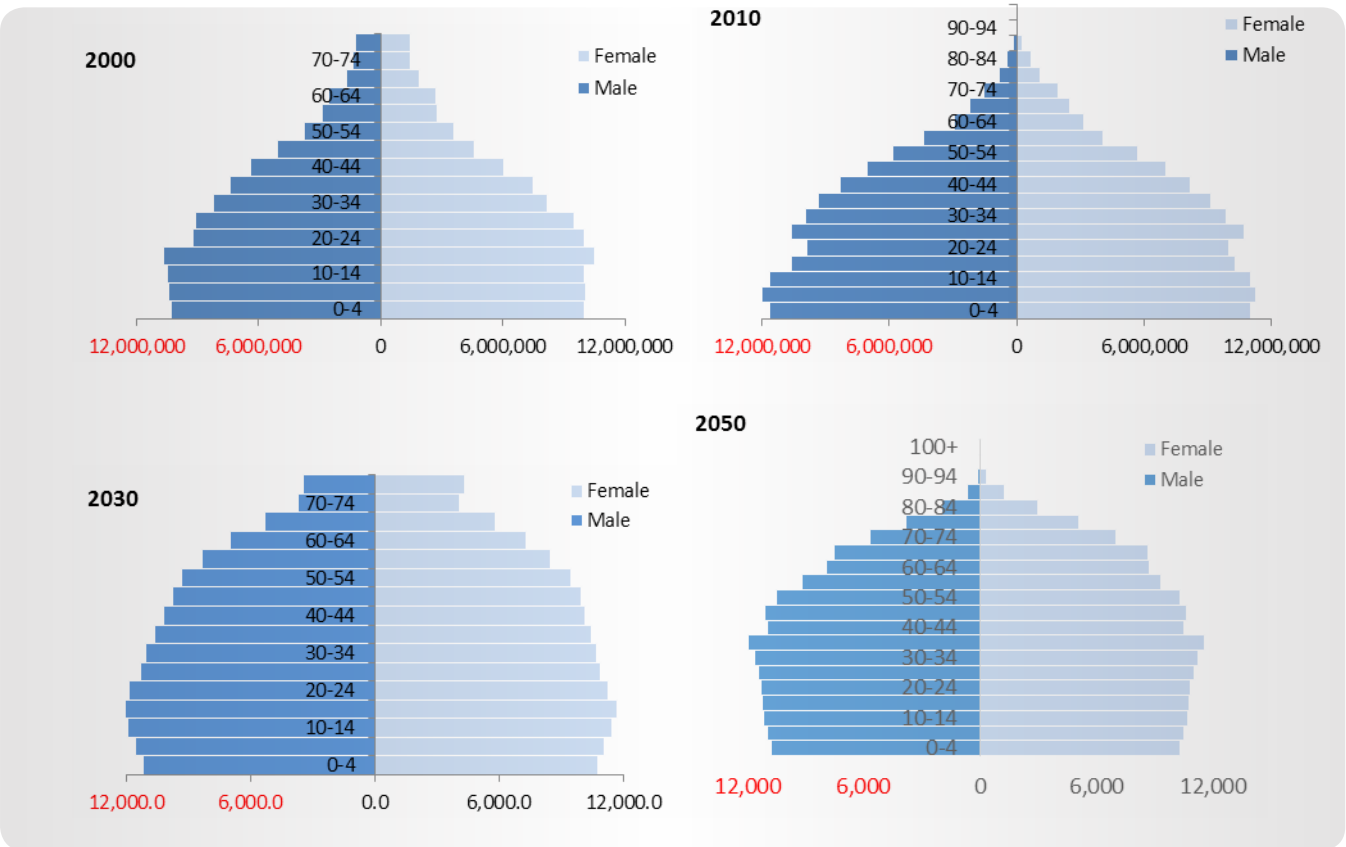
Figure 1 shows the change in structure of Indonesia's population between 2000 and 2010. In 2010, the population of aged 20-24 is relatively skewed in comparison to the immediate older or younger age groups. We may assume that this skewed portion is due to the huge number of overseas migrations from this group. Another different form of the 2010 population pyramid in comparison to the 2000 data is the age grouping. The 2010 data show an improvement by providing more detailed age disaggregation among those aged 60 and above than the earlier data. Meanwhile, the 2000 census only provides the number of population until 75 years and above. Facing the future ageing population, we should continue producing age disaggregated statistics.

As highlighted earlier, fertility rate has been declining and stable in the past decade. However, its impact on the young population has a time lag. Young population aged below 5 is still increasing as the base of pyramid shown in Figure 1 is wider in 2010 than in 2000. Yet, its percentage indicates a slight decline from 9.6% in 2000 to 9.5% in 2010. In addition, the number of young people aged below 15 increased from 61.3 million in 2000 to 68.6 million in 2010. Thus, within this decade, the young population has grown by 1.1% annually. Although the absolute number is increasing, the relative number has declined from 30.4% in 2000 to 28.9% in 2010.

As fertility rate declined and life expectancy at birth improved, the percentage of the elderly has grown, in contrast with the percentage of younger population. In 2010, almost 8 in 10 people were aged over 60 years old, an increase from 7 in 10 people a decade earlier. In 2010, the absolute number of older persons was already very large, having reached 18.0 million, an increase from 14.4 million in 2000.

The percentage of older persons is projected to continue rising in the future. By 2030, based on projections made by the Indonesian government and the UNFPA, the percentage of older population will reach 13.8 %. By the middle of the 21st century, percentage will reach almost 20% as seen in Table 1 (United Nations, 2015).

FIGURE 1. Population Pyramid: Indonesia, 2000, 2010, 2030 and 2050



Source: Years 2000, 2010 and 2030 compiled and drawn from various publications of Badan Pusat Statistik. Year 2050 based on the United Nations (2015) projections.

TABLE 1. Indonesia's Population by Specific Age Groups: 2000-2050

Year	←15	15-59	60+	Growth rate for 60+	←15	15-59	60+
	Number (in million)				Percent		
2000[a]	61.25	125.54	14.44	2.23	30.44	62.38	7.18
2010[b]	68.60	150.99	18.04	4.07	28.87	63.54	7.56
2020[c]	70.71	173.29	27.09	4.13	26.09	63.92	9.99
2030[c]	67.88	187.57	40.96	2.46	22.90	63.28	13.82
2040[d]	66.75	193.31	52.39	1.67	21.36	61.87	16.77
2050[d]	64.47	195.87	61.90	-	20.01	60.78	19.21

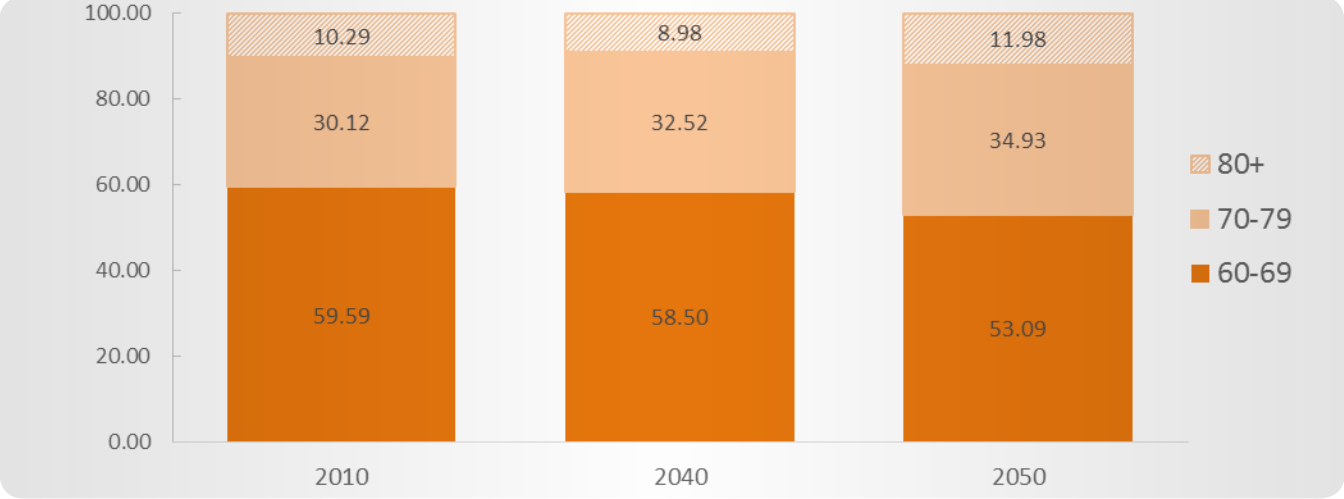
Source: a. Badan Pusat Statistik (2001); b. Online source from Badan Pusat Statistik
c. Badan Pusat Statistik, Bappenas and UNFPA (2013)
d. United Nations (2015).

Indonesia will be home to almost 41.0 million older persons in 2030. This is approximately the sum of population in Malaysia and Singapore in the same year. Yet, in 2010 the elderly in Indonesia were only about 65% of Malaysia's population in the same year. By 2050, the older persons in Indonesia will even be larger and could reach 61.9 million. This will be larger than the sum of population in five ASEAN countries (Malaysia, Singapore, Lao PDR, Timor Leste and Brunei Darussalam) in 2050. In other words, the issue of ageing population in Indonesia is not only about the rising percentage, but also the speed and magnitude. An added concern is the fact that the elderly live within a relatively unfavourable economy.

The need for goods and services among older persons are not uniform. They should be disaggregated into at least three age groups: young old (60-69), middle old (70-79) and the oldest old (80 and over). Milanovi et al. (2013) found that physical fitness (strength, endurance, agility and flexibility) of the young old is significantly different from the middle old.

The young old accounted for 60% which is majority of older persons in 2010 as the average life expectancy dropped to around 70 years old. Meanwhile, the middle age comprised 30% and the oldest age had the smallest percentage. As projected, the oldest old will get larger percentages in the future as seen in Figure 2. Based on the medium variant of the United Nations projection, the portion of the oldest old among older persons will be about 12% in 2050. Henceforth, there will be 7.5 million older persons aged 80 and above who may need long term care and exclusive involvement of care givers. This would be more than three times the total in 2010 which was 1.8 million.

FIGURE 2. Distribution of the older persons by Age: Indonesia, 2010, 2040 and 2050



Note: data in 2020 and 2030 stop at 75 years old and above.
Source: Compiled and drawn based on data from Badan Pusat Statistik (2010) for 2010 and from the UN's projection (United Nations 2015) for 2040 and 2050.

The pace of ageing also vary among ethnic groups (Ananta, Arifin and Bakhtiar, 2008; Ananta et al (2015) and among provinces (Arifin, and Ananta, 2016; Arifin 2012) and among districts (Arifin and Hogervorst, 2015). Yogyakarta province has the highest percentage of older persons (13.0%), followed by the Province of East Java (9.4%) in 2010 (Arifin and Ananta, 2016). This is starkly in contrast to the Province of Papua, where the elderly only accounted for 1.9% (Arifin and Ananta, 2016). Furthermore, among 388 districts that were selected in 2005, there were 20 of them where older persons contributed to more than 12%[1] (Arifin and Hogervorst 2015).

In terms of ethnic differential, Javanese, the most predominant ethnic group, was already entering the transitional population, where the older persons accounted for 8.9% (Ananta et al 2015), just a slight increase from 8.3% in 2000. Javanese had the longest life expectancy at birth among the five largest ethnic groups (Ananta, Arifin and Bakhtiar 2005). Meanwhile, Sundanese, the second largest ethnic group in the country, was younger than the Javanese. The older Sundanese accounted for only 7.3%. Furthermore, Ananta et al (2015) revealed that the Chinese Indonesians had the oldest population as their older persons comprised 11.4% in 2010.

In summary, there is a significant number of older persons in Indonesia and the pace of ageing is expected to accelerate further at least until 2020. The percentage of the oldest old is still growing. The ageing population will bring forth new emerging issues, challenges, and opportunities for Indonesia. Hence, a special concern should be paid to the difference in ethnic composition. Attention should be given to the lower levels of administration such as the district where ageing population is more pronounced. Since the decentralization which officially took place in 2001, decision-making has been shifting to the district level.

Socio and Economic Profile of the Elderly

This section talks about the the socio-economic profile of older persons and how to address their needs for goods and services. It focuses on marital status, number of surviving children, education, living arrangement, health status, and economic status.

MARITAL STATUS

"Population census in 2000 and 2010 shows the marital status of the elderly slightly changed. The percentage of married elderly remained highest, as 6 in 10 older persons in 2010 were married. But this declined as the percentage of the widowed increased. The pattern of marital status among older women is different from their male counterparts. In 2010, the majority were widowed with almost 8 in 10 women aged 75 and above. This raises concern with regards the well-being of these women."

Marital status plays an important role to understand the well-being of the older persons and is an indication of living arrangement, social, economic, and psychological support as well as companionship. In Indonesia, support for the elderly mainly comes from their respective families and thus, information about marital status is vital. Change in marital status impacts many aspects of life. For instance, marital status is associated with cognitive status. As found by Feng et al. (2014), being single and widowhood increased the likelihood of cognitive impartment in late life. It has been found that the relationship between marital status and cognitive impartment was stronger among men than women. In other words, marriage has a positive role in protecting older persons from cognitive impairment. Marriage provides not only social support, but also psychological stability.

Furthermore, marital status affects living arrangement. Single older persons are more likely living alone or living with others, while married older persons can reside with their spouses only (living without children), co-reside with a child or grandchild, or co-reside with others. Widowed / divorced elderly are likely to live alone or with a child.

Based on the two Indonesian population censuses conducted in 2000 and 2010, the marital status of the elderly has slightly changed. Overall, the percentage of married older persons remained the highest, as six in 10 older persons in 2010 were married. However, the percentage seemed to decline and the percentage of the widowed increased (See Table 2).

TABLE 2. Marital Status of Older Persons by Sex: Indonesia, 2000 and 2010

	Year	Single	Married	Divorced	Widowed	Total
Total	2000	3.06	62.18	2.19	32.57	100.0
	2010	1.02	59.80	2.39	36.79	100.0
Male	2000	2.6	85.0	1.3	11.2	100.0
	2010	0.8	84.1	1.5	13.6	100.0
Female	2000	3.5	41.4	3.1	52.1	100.0
	2010	1.2	39.1	3.2	56.5	100.0

Source: Biro Pusat Statistik (1992) and Badan Pusat Statistik (2001) and online source for 2010 (http://sp2010.bps.go.id/index.php/site/tabel?tid=336&wid=0)

In terms of sex differential, data show a stark contrast between older men and older women with regards to the percentage of married and of widowed. Older men were mostly married. Across time, the percentage of married older men declined from 85.0% in 2000 to 84.1% in 2010. In contrast, older women were mainly widowed, with the percentage of widowed increasing from 52.1% in 2000 to 56.5% in 2010. This may reflect the difference in life expectancy where women tend to live longer than men. The much larger percentage of married men than women indicates a higher likelihood of remarriage among men.

With respect to age differential, marriage is universal among men aged 60-64, almost 91% in both 2000 and 2010. Even among the age group 75 years old and over, the married still accounted for at least 71.0%. However, among the older groups, the percentages declined during 2000-2010 and was accompanied by the rising percentages of widowed. Within this period, there had been an increase in the percentage of widowed men especially among those aged 70-74, as well as 75 years and above. At the same time, the percentage of the single or never married older men declined from 2000 to 2010.

TABLE 3. Marital Status by Age and Sex: Indonesia, 2000 and 2010

	Age groups	Single	Married	Divorce	Widowed	Total
Male 2000	60 - 64	1.1	90.7	1.2	7.0	100.0
	65 - 69	1.3	87.7	1.2	9.8	100.0
	70 - 74	1.6	83.1	1.2	14.0	100.0
	75 +	8.2	71.6	1.5	18.6	100.0
Male 2010	60-64	0.9	90.6	1.5	7.0	100.0
	65-69	0.8	87.2	1.5	10.6	100.0
	70-74	0.7	81.1	1.5	16.7	100.0
	75+	0.6	71.0	1.5	26.9	100.0
Female 2000	60 - 64	2.0	53.7	3.4	40.8	100.0
	65 - 69	2.2	45.8	3.1	48.9	100.0
	70 - 74	2.8	30.7	2.9	63.5	100.0
	75 +	8.6	23.3	2.4	65.7	100.0
Female 2010	60-64	1.49	55.59	3.65	39.27	100.00
	65-69	1.22	44.06	3.29	51.43	100.00
	70-74	1.07	30.26	2.93	65.73	100.00
	75+	0.95	18.18	2.51	78.36	100.00

Source: Badan Pusat Statistik (2001) and online source from Badan Pusat Statistik (2010).

The pattern of marital status of women by age group is similar with that of men: the older the age, the smaller the percentage of those who were married. Yet, the magnitude is different where only 5 in 10 older women aged 60-64 were married. Also, 2 or less in 10 women aged 75 and above were married. The pattern of marital status among older women is different from their male counterparts. In 2010, the majority were widowed with almost 8 in 10 women aged 75 and above. This raises questions with regards to the well-being of these women. With whom do these widowed women live? Do they live with their children? Do they enjoy enough financial support?

NUMBER OF LIVING CHILDREN

People get married and have children who will support them in their old age. Way back until the 1970's, the norm was the more children a couple had, the larger the support they could get in their old age since children were providers. More precisely stated, ageing parents expect support from their living children. However, with declining fertility rate, family size is also getting smaller, and number of children on whom older persons could rely on for support during old age is also declining. Moreover, the small number of children may not eventually live with their elderly parents but move to another more modern place where there are better economic opportunities.

However, data from censuses only provided information on children related to fertility, but not as to living arrangement relative to their old parents. Information was limited to women aged below 50. For the 2010 census, there had been information on number of living children for women aged 55 and above, the mean number of which is 3.47 (Badan Pusat Statistik 2010), reflecting the past high fertility rate as mentioned earlier. Other than the population censuses, data on living arrangement between adult children and their elderly parents also need to be gathered.

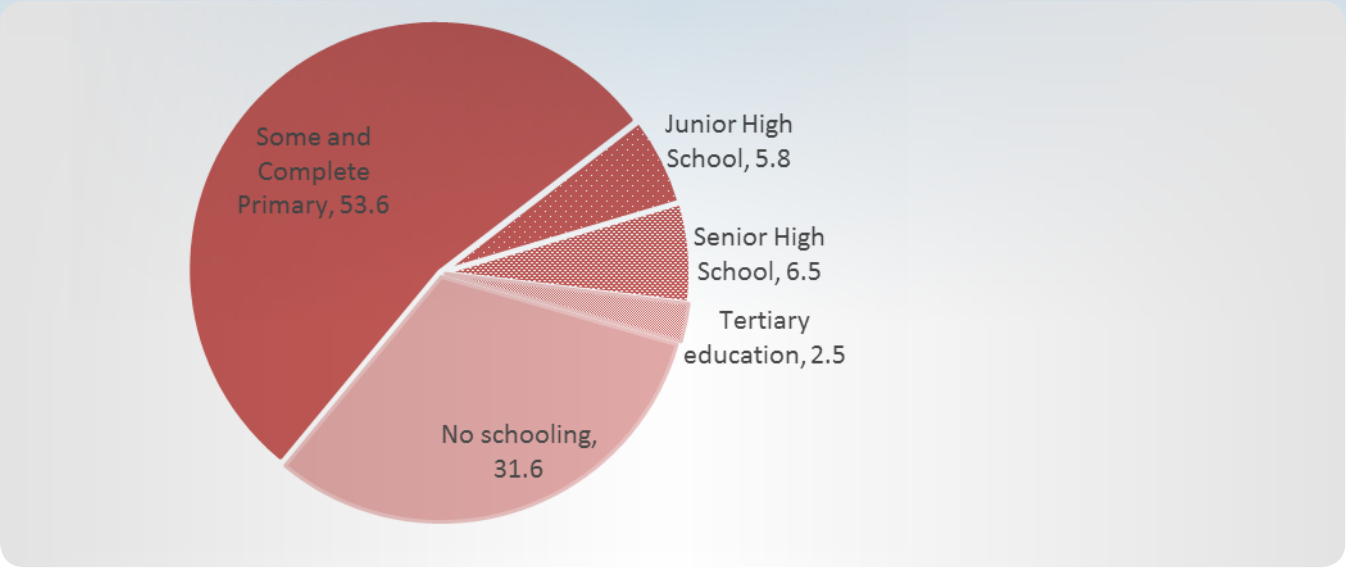
LITERACY AND EDUCATIONAL ATTAINMENT

Educational attainment is often considered as a major socio-economic indicator. The prevalence of poverty among the elderly can be linked to their educational level. Given that the older persons in 2010 were born prior to 1950 when Indonesia just obtained independence from Dutch colonizers, and they grew up during difficult times, both economically and politically, it is inevitable that majority of them only completed a low level of education. More than half of them finished some years or completed primary education. Furthermore, Figure 3 depicts that older persons with no schooling at all accounted for almost one third of their population. Altogether these two groups made up about 85% in contrast to those with tertiary education who only formed 2.5%.

Experience in schooling determines the ability to read and write. Despite the existence of government programmes which aim to improve educational attainment through informal channel of education, illiteracy rate among older persons reached 32.6% among those aged 60 and above in 2010. The illiteracy rate was slightly above the percentage of older persons with no schooling. It is believed that this rate had been declining from the earlier periods, though the 2000 population census publication did not provide the illiteracy rate. Improvement on illiteracy can be observed among different age groups. As seen in Table 4, illiteracy rate of the young old was much smaller than the middle old, and even half of the oldest old, suggesting that the future older persons will have better educational status.

> ***"Illiteracy rate among older persons reached 32.6% among those aged 60 and above in 2010. But illiteracy rate of the young old was much smaller than the middle old, and even half of the oldest old, suggesting that the future older persons will have better educational status."***

FIGURE 3. Educational Attainment of Older Persons: Indonesia, 2010



Source: Drawn from Badan Pusat Statistik (2010)

Furthermore, older women were almost twice more illiterate compared to the men. Illiteracy rate increased with age and the gap between women and men remained. Among women aged 80 and above, there were 6 out of 10 illiterates compared to almost 4 in 10 among men in the same age group.

TABLE 4. Percentage of Illiterate Older Persons by Age and Sex: Indonesia, 2010

Age group	Female	Male	Total
60+	41.73	21.82	32.58
60-69	33.80	16.42	25.48
70-79	49.95	28.28	40.48
80+	59.34	38.11	50.61

Source: Badan Pusat Statistik (2010).

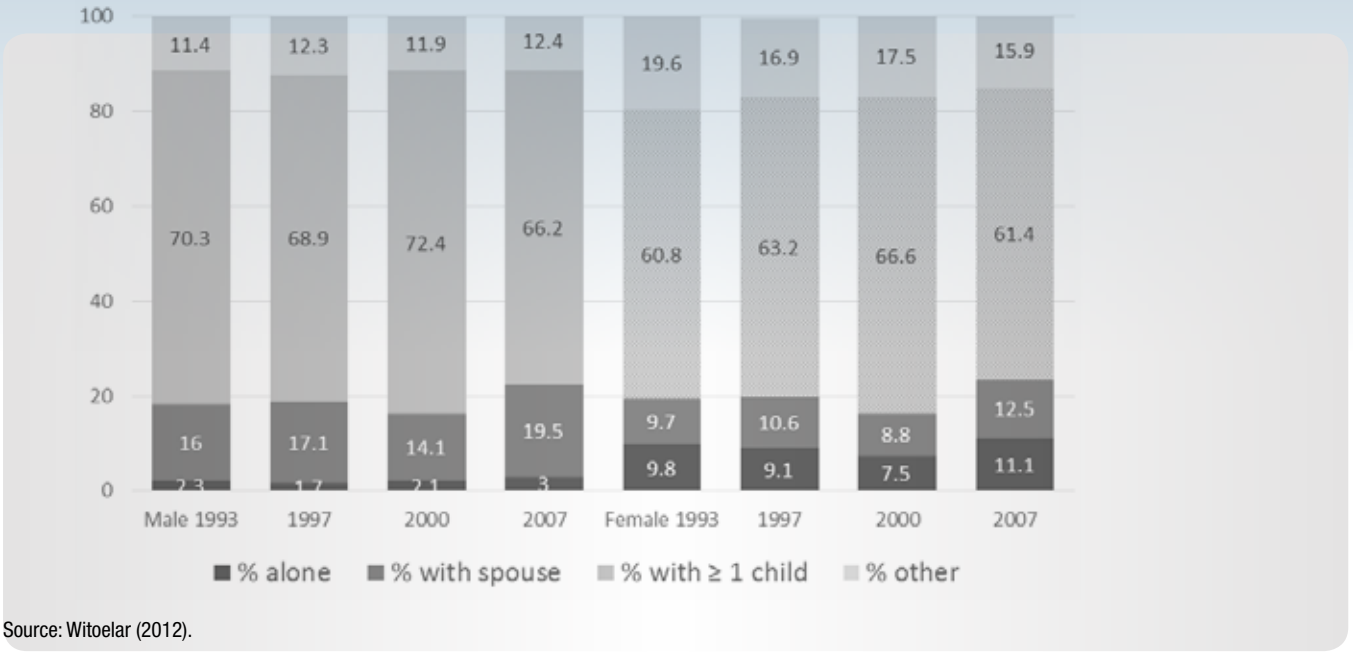
LIVING ARRANGEMENTS

Co-residence with children was the most common type of living arrangement among older persons in Indonesia (Frankernberg, Chan and Ofstedal, 2002; Arifin, 2006, Witoelar, 2012). Frankenberg, Chan and Ofstedal (2002) found that 70% of the population aged 55 years and above lived with at least one child. Later, Witoelar (2012) also found similar numbers as seen in Figure 4. In his assessment of 1993 to 2007, there was no significant change in the type of living arrangement among Indonesian older persons, though there is a declining trend in terms of co-residence with a child.

Living alone is quite uncommon in Indonesia, but most of those who do are women. Not as many older women live with children as compared to men. Less than 5% of men and between 9 and 11% of women lived alone during the observed period (Witoelar, 2012).

FIGURE 4. Trends in Living Arrangement of Population Aged 55 and Above by Sex: Indonesia, 1993, 1997, 2000 and 2007

> ***Around 70% of the population aged 55 years and above lived with at least one child. There seems, however, a declining trend in terms of co-residence with a child.***



Source: Witoelar (2012).

HEALTH STATUS

It is very important to understand whether the gained longevity is reflected in the health status in old ages. It is assumed that as one gets older, the likelihood of experiencing health deterioration is higher. Yet, collecting nationwide information on health status is a challenge itself. Like in other countries, there is still no universal information on health status in Indonesia. Existing censuses or surveys ask different questions about health condition. Surveys generally take the form of self-rated health status, not examinations by health professionals.

The 2005 Intercensal Population survey asked respondents on health status the following question: "[m]enurut Bapak/Ibu, bagaimana keadaan kesehatan Bapak/Ibu? (In your opinion, how is your health?).' Three choices were given, namely: good, not bad, and bad. At the national level, about 39% of the older persons aged 60 and above perceived that they were in good health. Furthermore, a lower percentage of women (36.4%) than men (41.7%) had such perception (Arifin, 2015). In other words, living longer is not yet accompanied with better health, and women are disadvantaged. The consequences of these gender differences on health status is far reaching.

The overall pattern seems to be robust as later statistics show that more than half (52.7%) of older persons had at least one health problem in 2010 (Dewi, Rahardjo and Arifin, 2015). There is no significant difference between older women and men. The health status has been measured as reporting one out of eight health problems, namely, fever, flu, cough, asthma, diarrhoea, headache, toothache, and others. Older persons are more likely to suffer from multiple diseases. Thus, when they visit hospitals or clinics for health tests, they will have a series of screening tests and prescriptions at the same time. Among them, 29.2% had one health problem while 23.5% had at least two.

In addition, the National Social-economic survey provides data on morbidity rate for older persons. The proportion of older persons having health symptoms that cause disruption in their daily activities was 24.8% in 2013, declining from 28.0% in 2011 (Badan Pusat Statistik, 2014). Illnesses could last for a short or long period. Longer sick days indicate worse severity and more expensive treatment. In 2014, surveys showed that almost two thirds (74.8%) of the elderly fall sick within one week. 42.8% fall sick for 1 to 3 days and 32.0% for 4 to 7 days. 15.3% fall sick for 22 to 30 days.

Morbidity rate at longer than a month is also recorded and reported. Self-medication is quite common, but people have been seeking modern medication more than traditional medication. Elderly clients now see private doctors in addition to going to community health centres (puskesmas) to get health checks and medication.

OLDER PERSONS' SEXUAL REPRODUCTIVE HEALTH

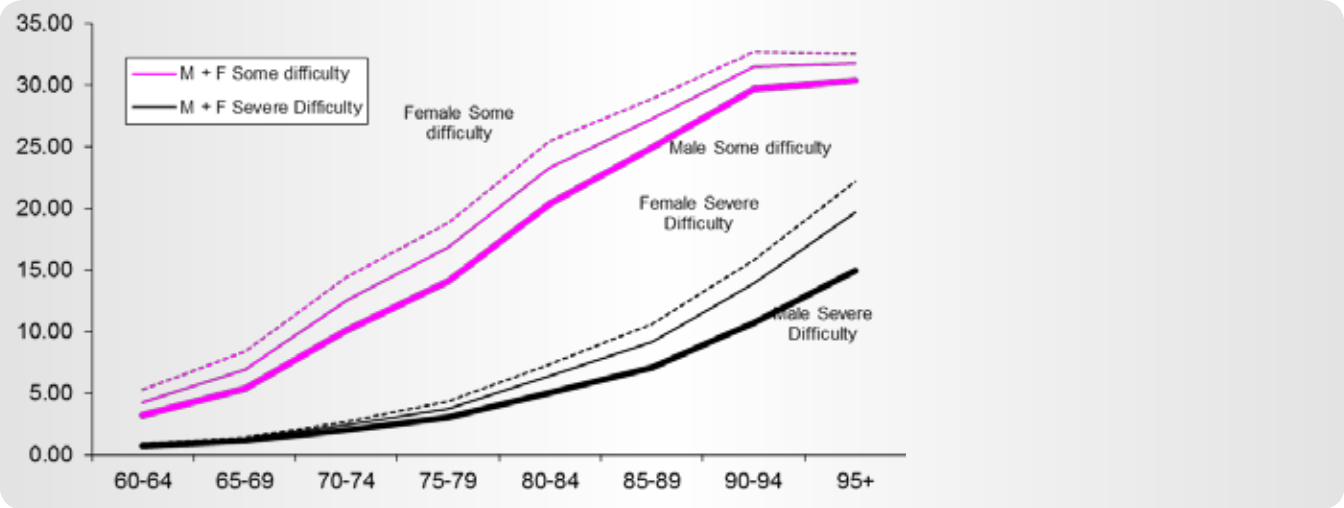
Discussions on sexual reproductive health had been dominated by those involved with reproductive age groups. But sexual reproductive health for those in the older population is equally important as with the young ones. Most importantly, older persons' sexual reproductive health has great consequences on physical health and functional capacity which relates to degree of disability.

Inelmen et al (2012) and DeLamater and Koepsel (2015) found that age-related physical changes do not necessarily lead to a decline in sexual functioning. Good physical and mental health, positive attitude toward sex in later life, and access to a healthy partner are associated with continued sexual activity, and regular sexual expression is associated with good physical and mental health.

It is usually assumed that older adults do not have sexual desires, and older people often find it difficult to discuss this topic with their doctor. But men and women can remain sexually active into their 70s and 80s. Ageing-related physical changes do not necessarily lead to decline in sexual functioning. However, there are many potential barriers concerning sexuality in older age: the lack of a healthy sexual partner, depression, the monotony of a repetitive sexual relationship, a spouse's physical unattractiveness, hormone variability, and illness and/or iatrogenic factors. Adaptive coping strategies can considerably mitigate the impact of such factors, however, and one way to break down barriers and taboos is undoubtedly to ensure that physicians are willing to discuss their patients' sexual history.

Menopause and andropause are unavoidable since they are brought about by hormonal changes that occur with normal ageing. Reduced estrogen production and Vitamin D deficiency may lead to osteoporosis, a medical condition in which bones lose mass and become weaker. Bone mineral density peaks at around age 30 and declines after menopause for women and after 70 years for men (Fransiska et al, 2012). The decrease in bone density among men occurs due to a decrease in testosterone or estradiol levels. As bone strength decreases, the risk of bone fracture increases. Thus, osteoporosis is a major predictor to fractures especially on the hip, spine and wrist. Post-menopausal women are at a higher risk. And fractures may lead to disability that ultimately to the need of long term care.

FIGURE 5. Rate of Difficulty in Walking among Older Persons by Age and Sex: Indonesia, 2010



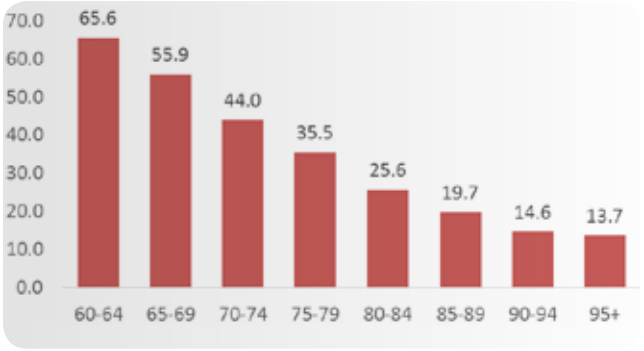
Source: Calculated and drawn from Badan Pusat Statistik (2010).

CASUI's research in 2013 (Rahardjo, 2014) showed that osteoporosis is a common impairment reported by the older persons. A 2010 census provides information on difficulty in walking by age and sex as well as the degree of difficulty. As depicted in Figure 5 walking difficulty among older persons increases with age. Severe difficulty in walking, which may indicate disability, accelerates after the age of 80. Regardless of the degree of difficulty in walking, older women have higher probability of suffering walking difficulty than older men. In addition, Susanti (2010) found that the prevalence of mild disability is higher among older persons, 51% among age 55-64 and 62% among age 65 and above; those with severe disability is also higher for the older age, 7% in age 55-64, 10% in 65-74 and 22% at age 75 and over.

ECONOMIC ACTIVITY AND AVAILABLE OPPORTUNITIES

Global trends as presented in the World Population Ageing (United Nations 2013) indicate that labour force participation rates of older persons in less developed regions have declined. Indonesia followed this trend as the labour force participation rate of older persons in 2000 was 65%, declining to 51.2% in 2010. In addition, the remaining high rate means that older persons aged 60 and above were still actively involved in the labour market and therefore labour income is still the major source of financing in old age.

FIGURE 6. Older Persons' Labor Force Participation Rate by Age: Indonesia, 2010



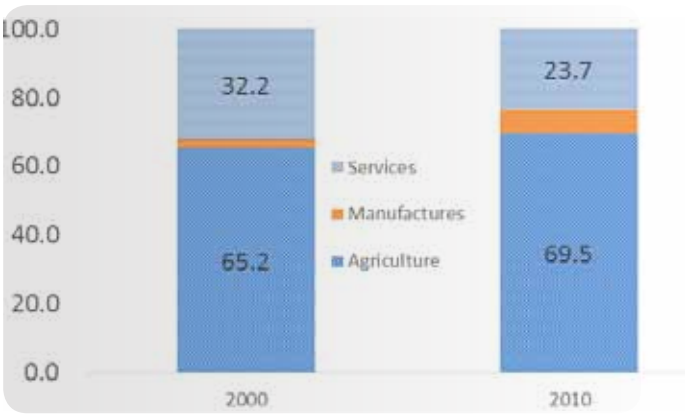
Source: Compiled and drawn from Badan Pusat Statistik (2010).

Furthermore, labour force participation rate varies among age groups. By the time older persons reached between 60 and 64, the labour force participation rate is still high at almost 7 in 10. The rate is still above 50% among those aged 65-69 but getting smaller for the older group (Figure 6) and yet few oldest old remain active in the labour market, with the latter probably based on necessity as social security coverage in Indonesia is still limited. Working in old age could be a mechanism to smoothen their consumption pattern. However, as shown later in this paper, some progress in public transfer or universal social security system has already been going on.

As seen in Figure 7, agriculture remains the most available opportunity for older persons to get actively engaged in the labour market, followed by service sector and manufacturing. In 2000, 65.2% of working older persons were mainly engaged in agriculture sector. The percentage increased to 69.2% in 2010.

If the above trend continues, there is need for technological changes to maintain and improve the agricultural sector. In addition, younger generation must be encouraged to work in agriculture. Although older persons working in manufacturing sector were few, the percentage increased between 2000 and 2010, reducing the percentage of those working in service sector.

FIGURE 7. Main industry of the Older Persons' Job: Indonesia, 2000 and 2010

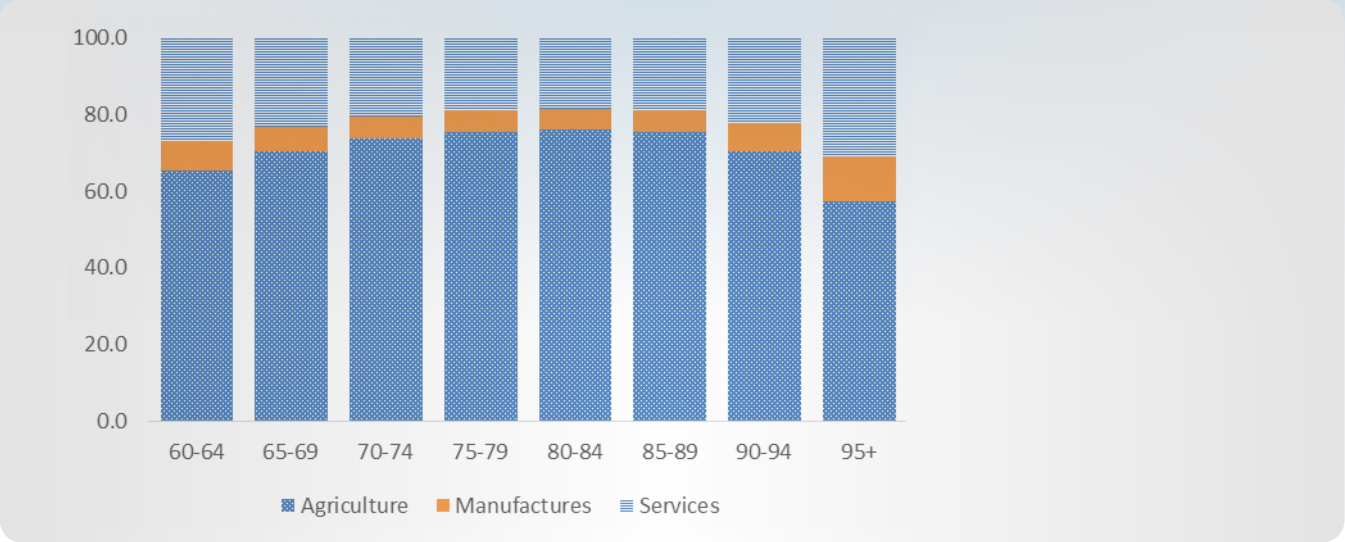


Source : Compiled and drawn from Badan Pusat Statistik (2001, and 2010).

Figure 8 depicts age specific industrial composition in which the percentage of older persons working in agriculture shows a diminishing increase until age 80-84. There is a percentage decline after 85. In all age groups, service sector remains as the second largest opportunity to be economically productive.

> ***"Labour force participation rate of older persons in 2000 was 65%, declining to 51.2% in 2010. The remaining high rate means that older persons aged 60 and above were still actively involved in the labour market and therefore labour income is still the major source of financing in old age."***

FIGURE 8. Older Persons' Main Industry by Age Group: Indonesia, 2010



Source : Compiled and drawn from Badan Pusat Statistik (2010).

Social Security of the Older Persons

Ananta (2012) argued that financing older persons should be seen from a more holistic approach, not simply from the "expenditure" side. He argued for a simultaneous policy package consisting of four policies, not only for the older persons only, but for the whole population. The first policy is the promotion of 'Active Ageing Programmes' using a life-course approach. Having healthy, independent, and productive (financially and otherwise) older persons means much less expenditure on older persons. Moreover, older persons can still contribute to the society.

Active Ageing Programmes include the creation of older persons-friendly public areas, both urban and rural, to reduce the burden of taking care of older persons as well as the young but disabled and fragile persons. Older persons-friendly public areas, including public transportation system and pedestrian routes, reduce the financial burden to take care of disabled and elderly citizens and make way for the latter to make their own contribution to society. Furthermore, older persons-friendly areas could encourage people, regardless of age, to utilize public transportation, walk or ride a bicycle, which is cheaper and healthier. Some progress had been made as more people with wheel chairs are now seen in public areas, along with the provision of priority seats in trains and buses and rising willingness of the younger passengers to allow the older persons take the seats.

Active Ageing Programmes promote harmonious relations within families which provide either or both financial and non-financial support to older persons, and even to younger persons with disability. Programmes include creating living arrangements conducive to the well-being of older persons and making older persons-friendly urban and rural areas. However, the rising mobility of younger generation also implied that children are less likely to stay with or near their parents. Conversely, while the younger generation may be busy at work all day or have migrated to another country, the elderly in the family take care of their grandchildren. In this case, older persons do not receive support from their children, but provide support to their children and grandchildren. The flow of support is more downward or at most balanced. The older persons get the money from farming and pensions. In this case, Active Ageing Community has a direct benefit to the younger persons.

The second policy is the elimination of retirement age and abolition of seniority and juniority system. This will enable older persons to work for while they still can and therefore reduce the burden of supporting their needs. In addition, the elimination of retirement age is also recognition that older persons have the right to work, if they are still able and willing to. This should be done along with the abolition of seniority and juniority systems. People should be hired and paid based on productivity rather than age.

The third policy is the development of market oriented pension and health insurance system, designed particularly for those who have the money. And the fourth policy is for the poor whereby government must create an affordable and sustainable social protection system

for the poor. This social protection system also covers the poor who are disabled and sick, regardless of age.

Currently, health financing in Indonesia follows a three-pillar social security system, discussed below, as described in Silaban (2015). First is the state-funded social assistance/ service. In addition to the benefit for older persons, this assistance/ service also helps the poor regardless of age and those who receive school and micro-business grants from the government. Second is compulsory saving wherein everybody is required to provide fund for their pension. And third is social insurance, where everybody, except the poor, is forced to pay a health premium. Government pays premiums for the poor.

The National Social Security System has two entities: BPJS for Health and BPJS Ketenagakerjaan (for workers), both non-profit entities. The BPJS for health started to provide the universal health insurance in 2014; then coverage for old age, death insurance and work injury coverage in 2015. The system should cover the whole population through both contributory and non-contributory schemes by 2019. It protects employees and residents (also foreigners who have worked at least six months in Indonesia) in a single health care system. The workers' social security provider (BPJS Ketenagakerjaan) also started in 2015. It includes pensions, employment benefits such as care giving for the elderly, workplace accident insurance, and death insurance.

Feminization of Ageing

Feminization of ageing refers to the rising predominance of older women. This has been a global trend (United Nations 2013). This phenomenon is assessed through the ratio between the number of older men and women or sex ratio. Ratio equals 100 means that the number of older men is the same as the number of older women. When it is above 100, men outnumber women, and when it is below 100, women outnumber men. Table 5 shows that the sex ratio of the older persons has been below 100. Older women will continue to outnumber men until 2050. Furthermore, older persons are feminized with age.

Feminization of older persons can have far reaching consequences. It leads to issues related to monetary support since, as described earlier, women are less likely to be employed or to have been previously employed and therefore they are not covered by the social security system. It also leads to issues of long term health care financing and living arrangements since they are susceptible to chronic health issues and functional limitations. Older women tend to have a higher probability to suffer from severe walking difficulty. In addition, women are more likely to suffer from chronic disabling illnesses such as arthritis (Choon, Shi'en and Chan, 2008). Arthritis is the leading cause of physical disability. A lifelong ailment, arthritis is the most frequent health complaint reported by older persons in Indonesia (Sakti and Boldy, 1998). Thus, there is an urgency to prepare for the anticipated long-term care and ensure availability of trained care givers. Traditionally, the care givers had been wives, daughters or grand-daughters. However, care givers within the family are now also actively involved in the labour market and, therefore, face a higher opportunity cost in care giving unless non-family and paid care givers are available. Are the members of the family willing to pay a higher cost to take care of their beloved older persons?

TABLE 5. Sex Ratio of Older Persons by Age: Indonesia, 2000-2050

Age groups	2000	2010	2020	2030	2040	2050
60+	91.23	84.99	91.09	89.95	84.41	81.17
60-64	95.34	93.47	98.64	95.32	93.33	90.78
65-69	87.75	90.13	97.94	91.48	89.40	86.79
70-74	93.15	79.56	88.03	89.84	82.24	81.42
75-79	86.16*	74.18	72.23*	79.01*	73.29	74.07
80-84	-	72.76	-	-	66.45	64.28
85-89	-	71.39	-	-	61.18	53.97
90-94	-	59.79	-	-	46.01	46.11
95+	-	52.65	-	-	41.67	41.67

Source: Calculated from Badan Pusat Statistik (2001 and 2010), Bappenas, BPS and UNFPA (2013).

Policy Responses to Implications of Ageing

GOVERNMENT/NGO ENTITIES IMPLEMENTING PROGRAMMES

The Government of Indonesia being cognizant of the unprecedented rate of population ageing in the country has taken steps towards slowing it down. The urgency of the matter has attracted attention from the National Development Planning Board (Bappenas). However, most of the policies are being carried out by "traditional" sectors such as the Ministry of Health, Ministry of Social Affairs, and Ministry of Manpower. They are rarely found in other ministries such as Ministry of Education, Ministry of Finance, Ministry of Tourism, Ministry of Foreign Affairs, and Ministry of Environment. Community based groups like Older Persons Organizations (OPA) have been established in some regions.

Some NGOs have been actively involved in creating an enabling environment for older persons to age gracefully with dignity. For example, Yayasan Emong Lansia is an NGO established since 1996 which strives for better policies, programmes and facilities in an ageing population. Another example, Lembaga Lansia Indonesia (LLI), was established in 29 May 2000 with the vision "Tua berkualitas, mandiri dan berguna (Quality, independent and useful older persons).

There is also Senior Club, a membership based private club for older persons who have limited mobility and activities located in North Jakarta which conducts activities for the older persons during weekday from Monday to Friday, as well as special programmes on weekend and public holidays. Its motto is **CARE**, which stands for **C***ustomer and member friendly service*, A*im for continuous improvement*, **R***esponsive and Competent staff*, and **E***ffective and efficient care.*

POLICIES AND PROGRAMMES ON OLDER PERSONS

The declaration of Madrid International Plan of Action on Ageing (MIPAA) in 2002, and the WHO document on Active Ageing Framework (2001) are two international policy instruments that guide policies and programmes for the ageing population. MIPAA is an international but voluntary comprehensive plan for all governments and societies in the world to create development for all ages including ageing in their development planning and programmes.

A growing awareness on the importance of the emerging ageing population has led the Indonesian government to have an Older Persons' National Day in May 29, 1996 which has since then been celebrated annually. As described in Sunusi (2014), Indonesia already had policies on older persons as a realization of the Law No. 13/1998 on "Older Persons Welfare" and Law No. 39/1999 on "Human Rights" brought about a set of laws and regulations specifically enacted to address matters related to older persons in Indonesia. Then, the Government produced subsequent ageing related programmes.

In 2003, the National Plan of Action (NPA) for "Older Persons Welfare Guidelines" was established, and then followed by Government regulation no 43/2004 on "Older Person Welfare Improvement Efforts". NPA sought to produce political support for policy makers, NGOs, religious leaders and academic communities to improve the welfare of older persons; informal support through family and community; formal support through improving health services and development in protection system and social security; enforcement of older persons institutions by enhancing inter sectoral cooperation in both national and international levels; and promotion of the roles of older persons in the family, community, nation, and state.

Other government programmes on social protection in which older persons are one of beneficiaries include Social Protection Assistance (Bantuan Perlindungan Sosial), Financed Health Coverage programmes for the poor and near-poor (Jamkesmas), National Programmes for Community Empowerment (Program Nasional Pemberdayaan Masyarakat Mandiri), Credit for Business (Kredit Usaha Rakyat), Indonesia Health Card (KIS), Prosperous Family Saving Card (KKS), Health Care Insurance (BPJS Kesehatan), BPJS Ketenagakerjaan, Retirement Saving for Private Employees, Retirement for Government Officials (Taspen), Integrated Health Services Centres

(Posyandu) for older persons, and community health centre (Puskesmas) for older persons care.

In 2004, the Government also enacted Law No 40/2004 on the National Social Security System (NSSS) and formed "National/ Regional Commission of Older Persons" through Presidential Decree no. 52/ 2004. Commission members were appointed through Presidential Decree no. 93/M/2005 for the period of 2005-2008 and every five years henceforth.

The National Commission for Older Persons (NCOP) is tasked to assist the President in making policies and coordinating efforts to improve social welfare for older persons. Apart from policy making and coordination, the NCOP has other functions such as conducting analysis and research, advocacy, socialization, monitoring, and evaluation.

In 2005, the NCOP conducted research on social-economic conditions of older persons including their health status in 33 provinces to examine the implementation of older persons programmes. To enhance the realization of older persons' welfare programmes at provincial level, Regional Commissions for Older Persons were created based on Permendagri no. 60/2008.

In 2009 the Government issued Law No. 11/2009 on Social Welfare, including those for older persons. Furthermore, in 2013, Law No. 13/2011 on Poverty Eradication was made, to protect and help, among others, the poor older persons.

As described in Kementerian Kesehatan Republik Indonesia (2014), the government programmes on older persons seek to make the elderly citizens happy and useful, focusing on promotive and preventive efforts, with active participation from the older persons themselves. There is inter-sectoral coordination within the programmes prepared by the Regional Commission on Older Persons (KOMDA Lansia) starting with the "pra-lansia" (people aged 45-59) and with Puskesmas (Primary Health Care Centre), a government body at the sub-district (*kecamatan*) level.

Within Puskesmas, services for older persons consist of health care services in puskesmas Santun Lansia (primary health care centres for older persons); referral services at hospitals; promotive, preventive, curative, and rehabilitative efforts at all health care centers; mental health for older persons; home care programmes integrated with the society programmes; enhancing intelligence of older persons; avoidance of degenerative diseases; nutrition for older persons; and health promotion. In 2014, Puskesmas Santun Lansia was already available in 28 provinces.

In addition to government bodies, Indonesia has Posyandu Lansia (integrated service center for older persons) a society based activity (of the older persons, by the older persons, and for the older persons) to promote the quality of life, health, independence and activities of older persons. It prioritizes promotive and preventive efforts in health, without ignoring curative and rehabilitative care. Posyandu Lansia also provides services to address social and religious needs, education, skills development, physical fitness, arts and culture for older persons which must be proactive, polite, of high quality, and helpful to the low-income groups. However, until 2014 Posyandu Lansia was only available in 15 provinces. (Kementerian Kesehatan Republik Indonesia, 2014).

Recommendations

ESTABLISHMENT OF ACTIVE AGEING COMMUNITY

An Active Ageing Community composed of independent, healthy, and productive older persons should be established. As recommended by WHO (2001), this community is inter-sectoral and focuses on six aspects: economic, behavioural, personal, and social determinants, physical environment as well as health and social services. Promoting and implementing active ageing community should be mainstreamed in the sustainable development agenda in Indonesia, in line with the UN declaration on post-2015 development agenda.

One important follow-up in the establishment of Active Ageing Society is the elimination of retirement age. People should be allowed to work if they are able and willing. To deny work for those who are able and willing to work simply because of age is against human rights. So is forcing older persons to work simply to survive.

IMPLEMENTATION OF A LIFE COURSE PERSPECTIVE

Older persons of tomorrow are the young persons of today thus ageing issues do not solely concern the elderly of today. Policies and programmes on ageing should follow a life-course perspective. This perspective starts from the time an embryo is planted, continues until the funeral of the person and even after that. And within it, a supportive inter-generational relationship can be promoted to avoid "inter-generational clash", and must be nurtured to become an asset for sustainable development.

An example of a life-course perspective is the creation of older persons-friendly environment which not only benefit older persons, but also the disabled and fragile young persons. Even healthy persons will enjoy the comfort of older persons-friendly environment.

Promotion of healthy lifestyle is another example of a life-course approach. Fostering good health for all starting from the earliest form of life which is the embryo will result in a healthier, happier, and more productive person through all stages and until old age.

CREATION OF AFFORDABLE, JUST, AND FINANCIALLY SUSTAINABLE SOCIAL PROTECTION SYSTEM

This system is needed especially for those who are not financially independent, suffering long-term health issues, and are no longer productive during their old age. Market oriented insurance can be developed for those who have financial capacity while government assisted programmes should be created to protect those who are financially incapable. Furthermore, adequate pension system must be created, to allow older persons to retire gracefully.

TRAINING OF GERIATRIC PROFESSIONALS THROUGH FORMAL AND NON-FORMAL EDUCATION

With population ageing, Indonesia will need more geriatric professionals trained through both formal and informal education. To guarantee their competencies, they should also be certified, with at least ASEAN recognition. The ASEAN recognition is important as ASEAN Community has been working on Mutual Recognition Arrangement (MRA) in eight professions, including nursing, in ASEAN.

DEVELOPMENT OF DEEPER STUDIES ON AGEING POPULATION

As development work becomes more complicated and challenging, new and more extensive interdisciplinary studies on ageing population should be implemented quickly. Efforts to collect and analyze the data should be prioritized. One of the weaknesses of studies currently being done on the ageing population in Indonesia is the relative scarcity of economists involved. There is also a perceived need to prioritize collection and publication of more detailed statistics on older persons disaggregated by age, for example, 60-64, 65-69, 70-74, 75-79, and 80 and beyond as the issues of older persons vary by age and sex.

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Note

[1] These districts includes Tanah Datar (12.4 %) of West Sumatra; Sragen (12.2 %), Kebumen (12.2 %), Purworejo (14.5 %), Klaten (15.1 %), and Wonogiri (16.3 %) of Central Java; Bantul (12.9 %), Kulon Progo (15.7 %) and Gunung Kidul (17.5 %) of Yogyakarta; Nganjuk (12.7 %), Blitar (13.4 %), Ngawi (13.4 %), Pacitan (14.2 %), Trenggalek (14.5 %), Madiun (14.7 %), Ponorogo (14.9 %), Magetan (14.9 %) of East Java; Tabanan (13.2 %), Bali; Minahasa (12.6 %), North Sulawesi; and Soppeng (12.4 %) in South Sulawesi.

CASE STUDY

4

POPULATION AGEING IN CAMBODIA

Dr. Kannarath Chheng

Executive Summary

Cambodia's demography had been shaped by significant political turmoil. High mortality rate during the Khmer Rouge regime and civil war, and high fertility rate during the post war period made Cambodia population relatively young compared to other countries in the region. People aged 60 years or more comprised 7% of the country's population in 2015. However population ageing had been foreseen to pick up significant speed in the next decade. After a post war baby boom, the fertility rate (TFR) dropped constantly over the past decade from TFR of 3.4 in 2000 to TFR of 2.7 in 2014. Family planning programmes also played a significant role in the decline. Life expectancy at birth dramatically improved from 54 years in 1990 to 73 years in 2013. The proportion of people aged 60 years and above is projected to be 11% in 2030 and reach 18% in 2050.

The probability of losing one's spouse increases as Cambodians age. The proportion of elderly still living with a spouse is significantly higher among men than women (86% vs 50% at age 60 years and above) and the difference becomes more pronounced as age increases (75% vs 35% at age 75 years and above). This reflects higher mortality among men which then leads to the feminization among elderly. The sex ratio among elderly used to be 69 men to 100 women in 2008 and this ratio is projected to increase. Cambodian families tend to be big with 97% of people aged 60 years and above have at least one living child and more than two thirds have at least four living children.

More than half of Cambodians who are 60 years and above are still economically active. The proportion is higher among men compared to women and in rural areas compared to urban areas. Most are unemployed and working on their own farm, gardening or doing petty trade. Most rural elderly do not have real opportunity to enjoy retirement. The main reason that prevents them from pursuing work is poor health. Very few reported to have enough financial support or savings. Traditionally, the most reliable source of support for the elderly is the family which provides basic commodities such as food, clothes, and modest amount of money for social and religious activities.

About a quarter of Cambodians aged 60 years and above were reported to have been ill or injured. Up to 44% were reported to have had some form of disability, and up to 12% had disability with a major impact on their daily activities. Since most of the elderly would still work, illness and disability have major impacts on their livelihood. While healthcare system is preoccupied with pressing concerns such as maternal and child health, healthcare needs of the elderly have not been adequately addressed. There is only one national hospital which has a separate department for elderly care. Financial barriers to healthcare for the elderly does not seem to be different from that of the general population. And financial schemes such as exemptions and health equity funds take down these financial barriers towards elderly access to healthcare. On top of these schemes, the Ministry of Health issued an order to all public healthcare facilities to provide free healthcare to "unsupported" elderly. However, the implementation had not been that systematic and did not cover private healthcare providers from where majority of people received care.

Public pension system is limited in scope and significance. Only those employed in the formal sectors are covered by public pension system and the amount offered is minimal. The community still plays a major role in psychological support for elderly to help them overcome feelings of loneliness.

Population ageing has come to the attention of various stakeholders including the government, media and civil society. There is a well-established government structure responsible for the well-being of elderly. However, its functions and the funding for its purpose remain limited. There is a Department at the Ministry which is tasked to take care of elderly well-being. In addition, the government created an inter-ministerial national committee for elderly. The committee is composed of 16 government ministries and organizations. The committee is under the honorary chairmanship of the Prime Minister and the executive chairmanship of the Minister of Social Affairs and Veteran and Youth Rehabilitation. The main roles of the committee include: development of national policy that promotes the well-being of elderly, organize International Day of Elderly every first day of October, support the Association for Older People and ensure effective management of resources for elderly welfare.

Policies and strategies are clearly spelled out in many national policy papers such as the National Population Policy, Strategic Plan of the Ministry of Social Affairs, Veterans and Youth Rehabilitation, National Social Protection Strategies for the Poor and Vulnerable and National Population Policy 2016-2030.

Introduction

Population ageing is defined as the process whereby age structure has changed from large proportion in young age to large proportion in old ages (Goldstein 2009). The change resulted from two phenomena: increase in life expectancy and decline in fertility, both indicators are welcome from the public health point of view because better health status has led to better longevity. However, this encourageing phenomenon comes with huge challenges to the country, society, family and elderly individuals. Since population usually ages as the economy grows, population ageing is often regarded as an issue of the high income countries and not much of middle and low income countries. This view should not be a cause for complacency for the low income countries. The UN report on world population ageing 1950-2050 (UN 2002), describes population ageing as unprecedented, pervasive, enduring; and although countries are at different stages of population ageing, countries that start the process later would have less time to adjust.

Cambodian population is considered among the "young" in the region (World Bank 2016). This can be explained by the fact that many adults, who should have been elderly by now, died during the genocide regime and war of the 1970s and 1980s; and the post-war baby boom during the late 1980s and 1990s. The country's relatively young population may have little impact on economic growth, but should not preclude Cambodia from the social and public health concern of population ageing. Rapid and consistent economic growth during the last decade coupled with intensive family planning and improved public health services have sharply brought down fertility rate and increased life expectancy. Thus, the number of elderly citizens increases through the years. No viable support system has yet been established. With the migration of more and more young adults who are the main care takers of the elderly society, elderly Cambodians already start to feel the problems that need to be addressed.

"Rapid and consistent economic growth during the last decade coupled with intensive family planning and improved public health services have sharply brought down fertility rate and increased life expectancy. Thus the number of elderly citizens increases through the years. No viable support system has yet been established. With the migration of more and more young adults who are the main care takers of the elderly society, elderly Cambodians already start to feel the problems that need to be addressed."

Demography of Ageing

FERTILITY TRENDS

Fertility is an important component of population dynamics and plays a major role in the population size and structure of a country. Cambodian population structure was severely affected during the reign of the Khmer Rouge (1975 -1979) both in terms of excessive mortality and reduced fertility.

The fertility rate in Cambodia steadily decreased since the past decade as family planning has been intensely promoted and birth spacing methods are already widely accessible. Based on the result of the Cambodian Demographic and Health Survey (CDHS) 2014 (NIS 2015), the total fertility rate (TFR) defined as number of children that a Cambodian woman would bear during her lifetime, now stands at 2.7. TFR in urban areas is 2.1 births per woman, almost one child lower than the rate in rural areas (2.9 births per woman). TFR also vary according to educational levels of women and wealth quintiles (Table 1).

TFR is projected to decline further to reach the replacement level, which is slightly more than 2 children per woman around the year 2025 (NIS 2010). This means that Cambodian population is still expected to grow during the next 10 years.

> ***The fertility rate in Cambodia is steadily decreasing as family planning has been intensely promoted and birth spacing methods are already widely accessible. It is projected to reach the replacement level, which is slightly more than two children per woman around the year 2025. This means that Cambodian population is still expected to grow during the next 10 years.***

TABLE 1. Comparison of TFRs by place of residence, educational levels, wealth quintiles between 2005 and 2014.

Background characteristics	TFR		
	CDHS 2005	CDHS 2010	CDHS 2014
Residence			
Urban	2.8	2.2	2.1
Rural	3.5	3.3	2.9
Education level			
No education	4.3	3.7	3.3
Primary	3.5	3.4	3.1
Secondary and higher	2.6	2.4	2.3
Wealth quintiles			
Lowest	4.9	4.5	3.8
Second	3.9	3.3	2.8
Middle	3.2	3.0	2.8
Fourth	2.9	2.7	2.4
Highest	2.4	2.1	2.2
Total	3.4	3.0	2.7

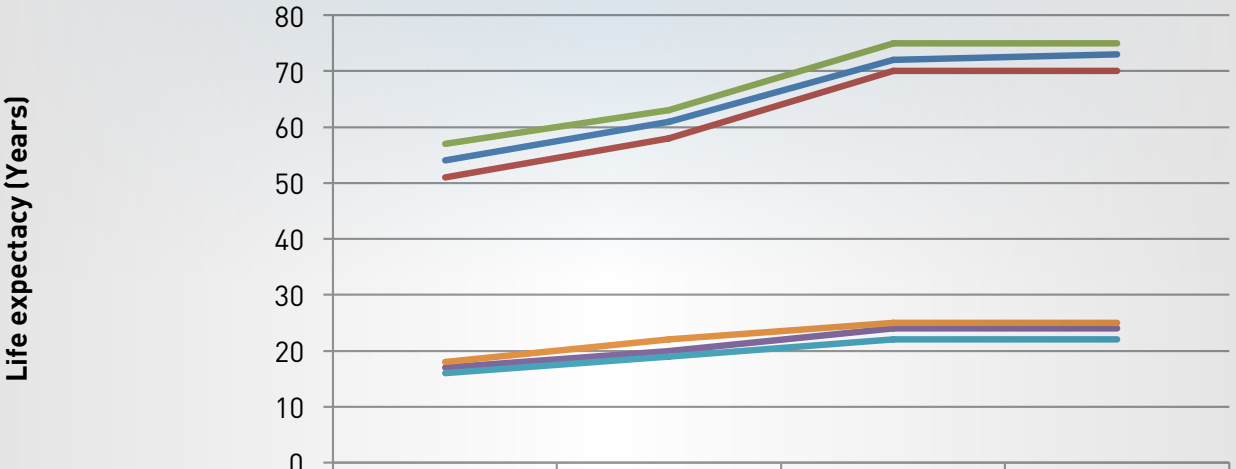
Sources: CDHS 2005 (NIS 2006), CDHS 2010 (NIS 2011) , CDHS 2014 (NIS 2015)

LIFE EXPECTANCY

Life expectancy of Cambodians has remarkably increased in a rate much faster than projected over the last 20 years or so. According to data from the World Health Organization's Global Health Observatory (WHO 2015), life expectancy at birth of the Cambodian people already stood at 73 years (70 years for males and 75 years for females) up from 54 years in 1990 and 61 years in 2000. It was earlier projected that life expectancy at birth would only reach 70 years by the year 2030 (NIS 2012). Although the data sources may need to be reconsidered, a 15-year difference still means that the increase of life expectancy had reached an unprecedented level.

> ***A study in 2015 shows life expectancy at birth of the Cambodian people at 73 years, up from 54 years in 1990 and 61 years in 2000.***

FIGURE 1. Trends of life expectancy at birth and at age 60, Cambodia



	1990	2000	2012	2013
At Birth Both sex	54	61	72	73
At Birth Male	51	58	70	70
At Birth Female	57	63	75	75
At age 60 Both sex	17	20	24	24
At age 60 Male	16	19	22	22
At age 60 Female	18	22	25	25

Source: WHO (WHO 2015)

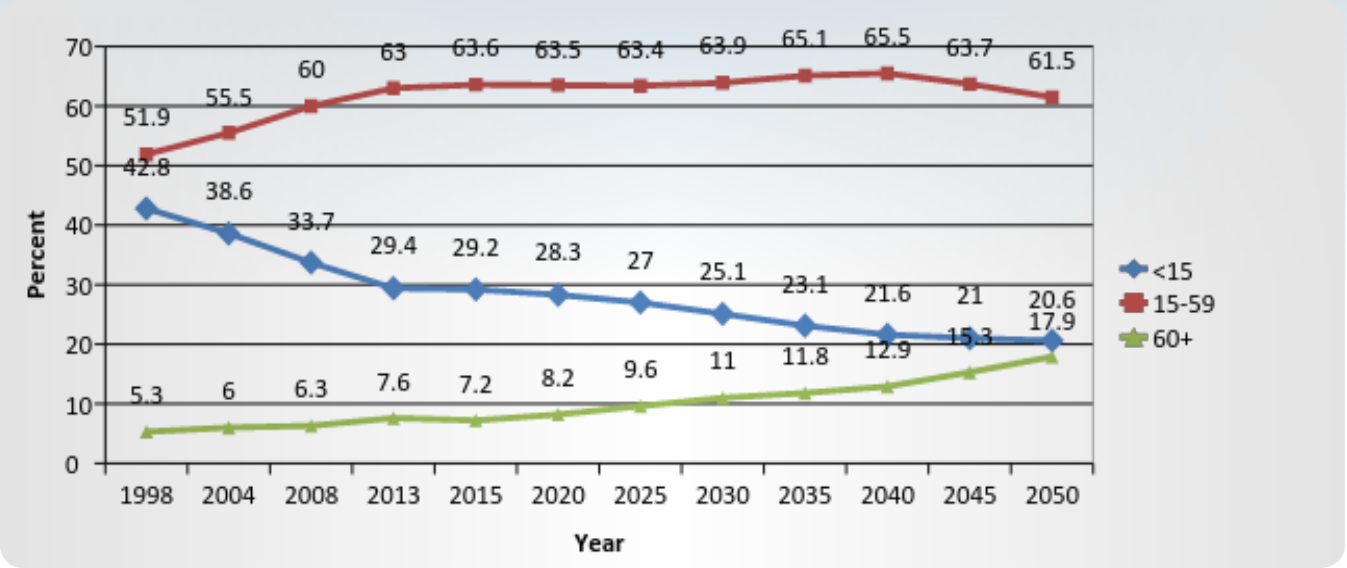
CHANGING AGE STRUCTURE

> ***The proportion of people aged 60 years and above has been increasing rapidly due to the improvement of life expectancy and reduced birth rate over the last decades.***

Cambodian population is still relatively young. NIS 2013 estimated the proportion of people aged 60 years and above to be around 7.6%, which is higher than the previously projected 7.2% by 2015 (NIS 2011). Figure 2 shows the trend of changes in age structure during the past decade and the projected trend over the next three decades. During the last fifteen years or so, there was a sharp drop in the proportion of children below 15 years (42.8% in 1998 to 29.4% in 2013) due to the decline in fertility rate. The drop seems fairly proportional to the increase of the percentage of people aged between 15 and 59 years. However, the increase in percentage of people aged 60 years and above remained modest and disproportional to the drop in percentage of children under 15 years old. The reason for a smaller current percentage of older persons in Cambodia is two-fold: 1) fertility rates have only recently begun to decline and 2) the effect of high mortality levels during the Khmer Rouge period in the late 1970's on the population age structure. The Khmer Rouge period, which was highlighted by civil war, unrest, widespread disease and related high rates of mortality, led to a smaller cohort surviving which now are moving into their elderly years. The war was followed by a Cambodian baby boom in the post war period in the 1980s and early 1990s, resulting in a large cohort now entering middle adult years.

The trend started to change from 2015 onwards. Proportion of people aged 60 years and above has been increasing rapidly due to the improvement of life expectancy and reduced birth rate over the last decades.

FIGURE 2. Changing age structure of the Cambodian population 1998-2050



Data Sources: 1998: Cambodia General Population Census 1998 (actual) (NIS 2002); 2004: Cambodia Inter-Censal Population Survey 2004(estimated) (NIS 2005); 2008: Cambodia General Population Census 2008 (actual) (NIS 2009); 2013: Cambodia Inter-Censal Population Survey 2013 (estimated) (NIS 2013); 2015 – 2050: Cambodia Population Projections (NIS 2011)

POPULATION PROJECTION

Cambodia population stood at around 15.5 million in 2015 (NIS 2011). It is projected to increase around one million every five years till 2025. From 2025 onwards, the growth is projected to slow down to around 600,000 every five years to reach 21 million in 2050, about 1.4 times the 2015 population (Table 2).

Population aged 60 years and above is projected to increase 2.4 times as fast as the total population from 2015 to 2050. In 2050, the population aged 60 years and above is projected to reach 3.8 million, a 3.4 times increase compared to the 2015 population of the same age group. The increase will pick up speed by 2020 and even faster by 2040.

TABLE 2. Population projections 2015-2050

Year	Population			
	All	Male	Female	Age 60+
2015	15,405,157	7,551,944	7,853,213	1,108,961
2020	16,505,156	8,127,496	8,377,660	1,357,833
2025	17,579,212	8,659,399	8,859,873	1,674,124
2030	18,390,683	9,117,812	9,272,871	2,024,171
2035	19,166,551	9,525,894	9,640,657	2,272,892
2040	19,904,952	9,913,161	9,991,791	2,558,771
2045	20,607,225	10,277,581	10,329,644	3,156,216
2050	21,231,982	10,597,975	10,634,007	3,794,409

Source: WHO http://apps.who.int/gho/data/view.main.680?lang=en

Social and Economic Profile of the Elderly

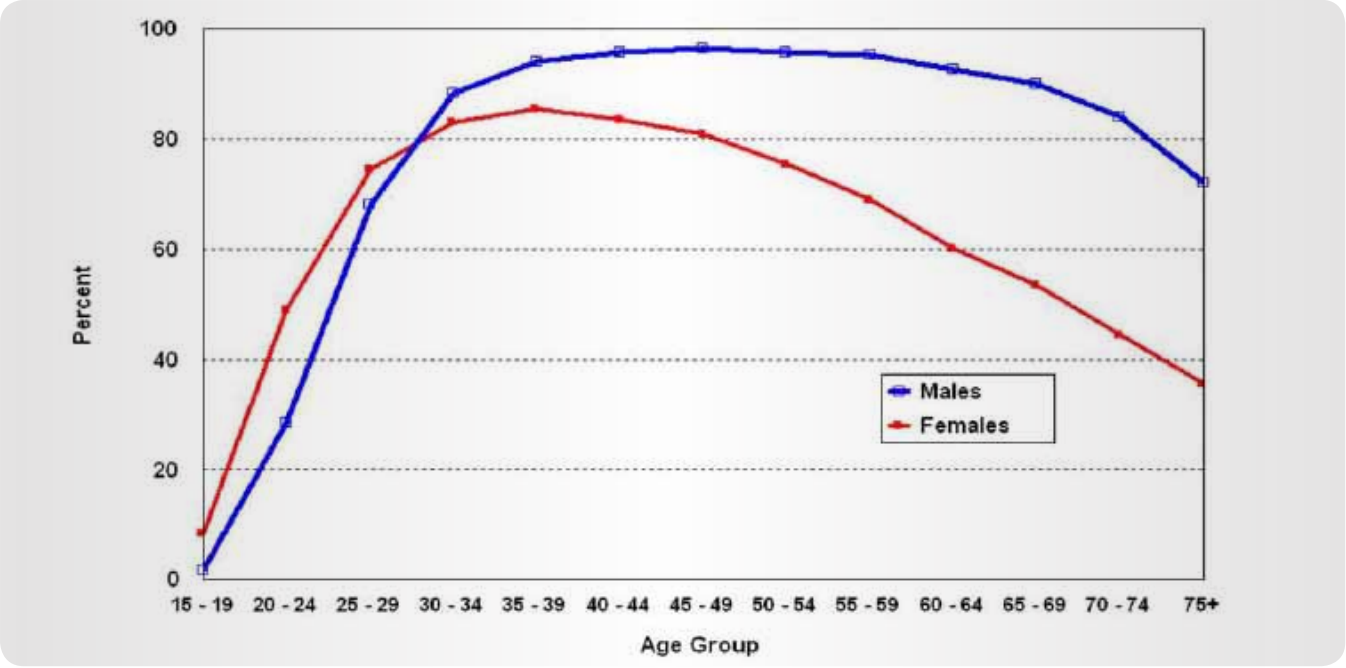
MARITAL STATUS

Likelihood of losing one's spouse increases with age. This contributes to a feeling of increased insecurity for both men and women (NIS 2012). The 2008 Census analysis shows that the differential in marital status by sex is more pronounced among the people aged 60 years and above. Figure 3 shows that 86% of elderly men and 50% of elderly women were still married. About 42% of elderly women were widowed while only 10% of elderly men were widowers. The differentials became more pronounced as subject population became older. Among people aged 75 year and above, 75% of men and only 35% of women were still married.

These differentials reflect marriage and mortality patterns. While a majority of Cambodian men who live to the age of 60 are still married, more than half of the older women live without a spouse. Not having a spouse during old age is a cause for concern for both men and women.

> ***"Majority of Cambodian men who live to the age of 60 are still married; more than half of the older women live without a spouse."***

FIGURE 3. Percentage of currently married people by age and sex, 2008



Source: Report of the 2008 Cambodia population census

NUMBER OF LIVING CHILDREN

Traditionally Cambodian people rely on their children for support in their old age for lack of formal support system. Cambodian tradition encourages people to have many children who could help them do chores in the farm, on the one hand; and to support them when they get old, on the other hand.

In 2004, Knodel J and colleagues conducted a survey on Cambodian elderly from which the following table and description had been adopted (Knodel, Kim et al. 2005).

TABLE 3. Number of living children (own, step and adopted) by sex, location, and age of respondent, elders

	Total	Sex		Location		Age	
		Male	Female	Phnom Penh	Provinces	60-69	70+
Number of children (% distribution)							
none	3.5	1.0	5.3	6.1	3.0	3.8	3.1
1	8.2	5.7	9.9	10.8	7.7	7.0	10.0
2-3	19.9	11.1	25.9	28.2	18.2	17.7	23.2
4-5	29.7	29.6	29.7	28.2	30.0	28.7	31.1
6+	38.7	52.6	29.3	26.8	41.1	42.7	32.6
Total	100	100	100	100	100	100	100
Mean number	4.7	5.6	4.2	4.0	4.9	4.9	4.4
Number of sons (% distribution)							
none	17.1	10.9	21.3	22.1	16.1	15.9	19.0
1	20.7	17.8	22.6	24.9	19.8	17.6	25.1
2	21.1	19.5	22.1	22.1	20.8	19.8	22.8
3+	41.2	51.8	34.0	31.0	43.2	46.7	33.1
Total	100	100	100	100	100	100	100
Mean number	2.2	2.6	1.9	1.8	2.3	2.4	1.9
Number of daughters (% distribution)							
none	12.3	6.1	16.4	16.5	11.4	13.0	11.2
1	19.5	16.6	21.4	22.6	18.9	18.4	21.0
2	22.1	21.9	22.2	24.1	21.7	21.5	23.0
3+	46.1	55.5	39.9	36.8	48.0	47.1	44.8
Total	100	100	100	100	100	100	100
Mean number	2.5	2.9	2.2	2.1	2.6	2.5	2.4

Source: Older persons in Cambodia: A profile from the 2004 survey of elderly, by Knodel J *et al.*

Most Cambodian elders have both living sons and daughters. Reflecting higher mortality rate among males, including losses due to political violence during the Khmer Rouge period and its aftermath, the average number of surviving daughters modestly exceeds that of surviving sons. Differences in the number of living children are indicated according to sex, location and age of elders. Elderly men have larger numbers of surviving children compared to elderly women, reflecting the fact that men are more likely to remarry than women in cases of marital dissolution. Thus men spend more time in reproductive unions and continue having children than do women whose initial marriages ended prematurely. Still only 5% of elderly women are childless and merely one in ten has only one living child. On the average, older elders have less surviving children. This reflects higher mortality among the children of older elders due at least in part to the longer exposure to mortality to which their children would be subjected (given that children of older elders would have been born earlier on average than those of younger elders).

LITERACY AND EDUCATIONAL ATTAINMENT

A high level of illiteracy, particularly among older women in rural areas, is yet another aspect of vulnerability for senior citizens in Cambodia. Older women in rural areas have the lowest level of literacy compared to general population as well as all other elderly, as seen in the tables below.

TABLE 4. Percentage of literate among general population and population aged 60+ by sex and place of residence

Cambodia	Place of Residence	Years	General Population		Population Aged 60+	
			Males	Females	Males	Females
Cambodia	Rural	1998	53.21	41.47	60.70	10.40
	Urban		70.85	62.05	73.23	22.44
	Rural	2008	75.01	64.41	75.17	32.58
	Urban		88.30	82.98	88.20	56.87

Source: Report of the 2008 Cambodia population census

According to Table 4, based on 1998 and 2008 census, literacy among the elderly has been increasing, and the gender gap narrowing especially in the urban areas. In the future, this trend will further increase because there are already more public primary and secondary schools in the communities. Substantial increase in the literacy level of the elderly is necessary for them to acquire a means of livelihood that could lead to a more decent and dignified life.

LIVING ARRANGEMENTS[1]

Many aspects in the well-being of older persons are influenced by their living arrangements. In the Asian context, and specifically in Cambodia, living with an adult child, especially a daughter, is a traditional pattern as this provides mutual benefits. While the elderly gets support and care from their children, they are also of help in taking care of the house, and watching over the young kids, while the kids' parents are busy making a living.

As Table 5 shows, a large majority (80%) of Cambodian elders in private households live with at least one child. Very few of them live alone and only small percentage live only with a spouse. At the same time, elderly women are more likely than men to live alone while elderly men are more likely than women to live only with a spouse. Older elders are also more likely than younger elders to live alone but less likely to live with a spouse only. Women are more likely than men to live with people other than their children or spouse.

It is more common to live with an ever married child than with a single child. This is particularly true for elders who are women or who are 70 years or older. The elderly who live are more likely to live with a daughter than with a son. This tendency, however, is much more pronounced among those who are co-residing with ever married children rather than single children. The last rows of Table 5 show the ratio of elderly who co-reside with a daughter with those who co-reside with a son according to the marital status of the co-resident child. In most cases even when single children are considered, elderly are more likely to be living with a single daughter than a son although the

[1] The data and description in this section is based on the survey of elderly by Knodel and colleagues Knodel, J., et al. (2005). Older persons in Cambodia: A profile from the 2004 survey of elderly. Population Studies Center, University of Michigan, Institute for Social Research.

tendency is modest and elderly men and the elderly who live in Phnom Penh are essentially likely to live with single sons as daughters. However, whenever married children are considered, a very sharp tendency for co-residence with a daughter rather than with a son is evident (Zimmer and Kim 2002). This is true regardless of gender, residence or age of the elderly, although the tendency is somewhat weaker in Phnom Penh than in the provinces.

TABLE 5. Living arrangements, by sex, location, and age, of elders 2004

	Total	Sex		Location		Age	
		Male	Female	Phnom Penh	Provinces	60-69	70+
Living with whom (% distribution)							
Alone	3.3	0.8	5.0	1.4	3.7	2.1	5.0
Spouse only	5.3	7.2	4.1	0.9	6.2	6.5	3.5
Child only	5.3	2.5	7.2	5.2	5.4	5.4	5.2
Others only	7.1	1.2	11.1	7.5	7.0	6.5	7.9
Spouse and child	12.6	24.0	4.9	9.9	13.0	18.0	4.6
Spouse and other	4.7	6.0	3.7	3.3	5.0	4.6	4.6
Child and other	33.8	14.4	47.0	43.7	31.9	25.6	45.8
Spouse, Child and other	27.9	43.9	17.1	28.2	27.8	31.0	23.4
Total	100	100	100	100	100	100	100
Overall co-residence with children:							
% living with							
any child	79.6	84.7	76.1	86.9	78.1	80.0	78.9
any single child	38.6	53.6	28.5	44.1	37.5	50.3	21.5
any ever-married child	58.0	52.1	61.9	69.0	55.8	51.3	67.8
Sex and marital status specific co-residence with children:							
% living with							
Any daughter	65.3	69.4	62.6	70.2	65.4	65.4	65.2
Any son	32.9	45.6	24.3	47.9	29.9	39.4	23.5
Any single daughter	27.6	37.0	21.3	29.4	27.3	35.7	15.9
Any single son	22.3	37.0	12.4	30.3	20.7	31.5	9.0
Any ever-married daughter	47.8	44.1	50.3	53.5	46.6	42.8	55.0
Any ever-married son	13.3	12.6	13.8	23.9	11.2	12.0	15.3
Ratios of co-residence with daughters to sons							
Daughters to sons (a)	1.98	1.52	2.58	1.47	2.19	1.66	2.77
Single daughters to single sons (b)	1.24	1.00	1.72	0.97	1.32	1.13	1.77
Ever-married daughters to ever-married sons (c)	3.59	3.50	3.64	2.24	4.16	3.57	3.59

(a) ratio of the percent co-resident with a daughter to the percent co-resident with a son
(b) ratio of the percent co-resident with a single daughter to the percent co-resident with a single son
(c) ratio of the percent co-resident with an ever married daughter to the percent co-resident with an ever married son

Source: Living arrangement and socio-demographic conditions of older adults, by Zimmer Z et al. 2002

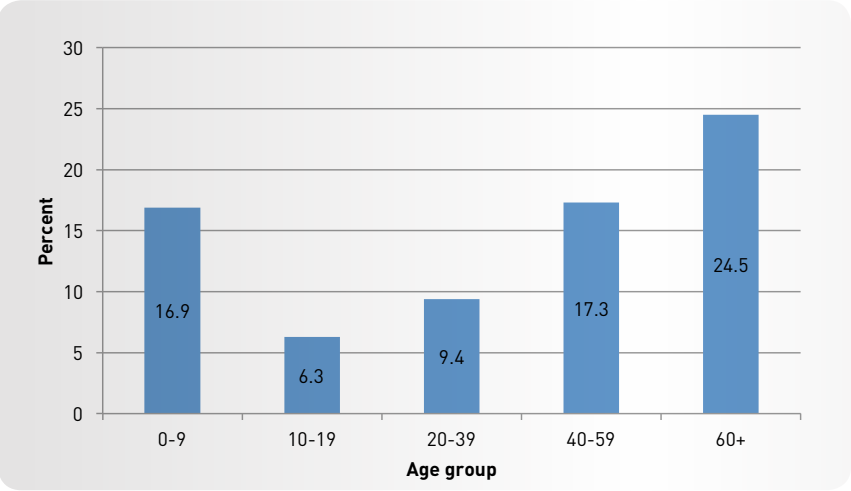
HEALTH STATUS

Old age is associated with declining health and disability, increased risk of chronic non-communicable diseases such as joint pains, high blood pressure, diabetes, heart disease and dementia. There is reduced capacity for self-care such as bathing, dressing, transferring, using the toilet, eating, and walking, which means that fewer older people will be able to live independently in their community (Kol, Som et al. 2014).

Figure 4 shows that up to a quarter of Cambodians aged 60 years and above reported illness or injury, the highest proportion compared to other age groups (NIS 2015). Figure 5 shows that up to 44% of the Cambodians aged 60 years and above suffered some form or degree of disability, and 12% suffered disability that caused a major impact on their daily activities such as seeing, hearing, walking, concentrating, self-care and communicating (NIS 2015). These disabilities make elderly very dependent on other people, especially their family members.

Many elderly Cambodians still work for a living; thus any illness, injury or disability has an impact on them financially. A major impact was reported to be the loss of time for work, hence loss of income, for themselves as well as for their children if they are dependent on their children for care (Kato 2000). Elderly people viewed the loss of time for work due to illness more important than the cost of medical care for the illness itself.

FIGURE 4. Proportion of Cambodian people reporting of having been ill or injured, by age groups, 2014



Source: Cambodia Demographic and Health Survey (CDHS) 2014

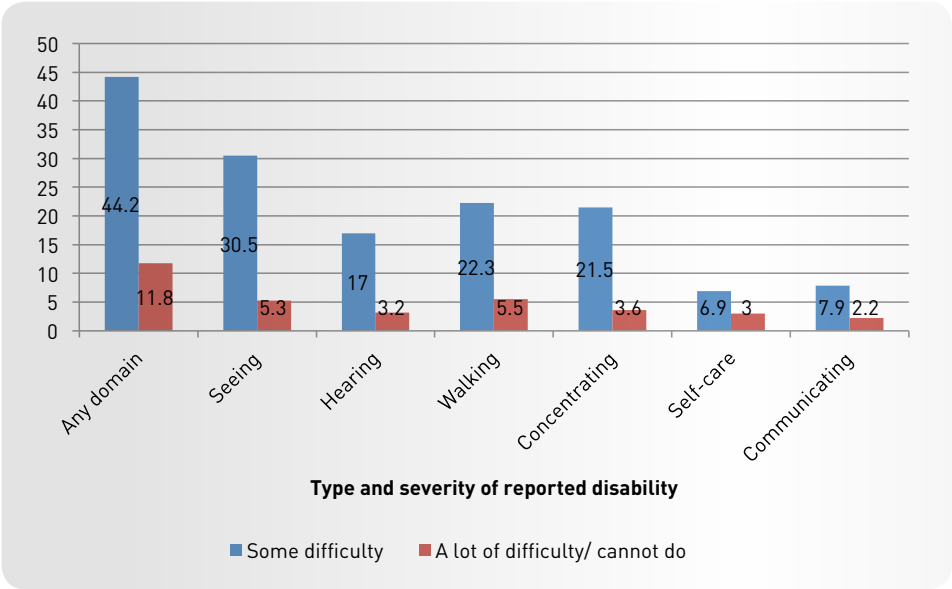


FIGURE 5. Types and severity of disabilities reported by Cambodian people aged 60 years and above, 2014

Source: Cambodia Demographic and Health Survey (CDHS) 2014

ECONOMIC ACTIVITY AND AVAILABLE OPPORTUNITIES[2]

Cambodians have a local saying which goes "Make the best efforts while we are young so that we can live a comfortable life when we get old." This has been a popular message taught by parents to their children. For Cambodians, life is considered successful when the children already have a family of their own, work in a decent job, and earning a decent living. To prepare for the future of their children and have decent savings to support themselves when they're old would be a life wish for most Cambodians. However, poverty forces many Cambodians to continue working to earn their living despite their decreasing ability during the age of retirement. Up to 55% of people aged 60 years and above are still economically active (NIS 2012). The proportions are starkly different across gender (67% among males and 43% among females) and rural urban divides (68% in rural area and 41% in urban area).

"Poverty forces many Cambodians to continue working to earn their living despite their decreasing ability during the age of retirement. Up to 55% of people aged 60 years and above are still economically active. The proportions are starkly different across gender (67% among males and 43% among females) and rural urban divides (68% in rural area and 41% in urban area."

The difference between rural and urban areas can be explained by different levels of access to jobs and levels of support or saving. The main income generating activities of the rural elderly are farming, gardening and petty trades. These are jobs that people can do at will according to their physical ability and with their limited resources. In urban areas, however, petty trade, wage labour, small business and professional/ technical occupations are the main income generating activities to which access may not be easy for older people. With regards to savings and support, rural elderly are mostly poor who could not afford to have enough savings and less likely, as compared to their rural counterparts, to have good arrangements for their children so that they could support them in return. For rural elderly, there is no retirement. They work for as long as they are physically able. The main reason for them to stop working was reportedly poor health, followed by sufficient support from relatives including children. Among those not working, only one percent in rural and two percent in Phnom Penh said they stopped working because they have enough savings, according to a survey report (Kato 2000).

The contribution of the elderly to the total household income is lower as compared to their contribution to the total employment of households. This arises mainly because the 'per person' average wage/earning of the elderly is lower as compared to their younger counterparts (NIS 2012). The elderly contribution to total household income is significantly higher in rural areas and poor households. Hence, the elderly population contributes to livelihood of households approximately in the same proportion as their share in the population. This reflects that the elderly population is approximately as productive as their younger counterparts.

The elderly from poor households contribute to household income largely from self-employed activities, while elderly from better off households have better access to wage labour markets and contribute significantly to total wage earnings of households. It is quite evident that elderly from rich households work in the labour market to augment household income and for personal income security while those from poor households participate in labour market mainly as a coping mechanism to supplement household income.

[1] This section had been extracted from the report on demographics of population ageing in Cambodia (NIS, 2012) with some degree of modifications.

STATUS IN EMPLOYMENT

An analysis of the status in employment of elderly population reveal that unpaid family workers and elderly own account workers together constituted about 94.97% for men lower than that of women with 98.34% in rural areas, while in urban areas, these two (unpaid family workers and own account workers) constituted about 65.90% for men which was lower than that of women with 86.55%.

Among the elderly employed, men were predominant. In the case of elderly women, the highest proportion was in that of unpaid family workers.

TABLE 6. Percentage Distribution of Elderly employed persons, among the elderly persons aged 60+, by status in employment, sex and place of residence, Cambodia, 2008

Sex	Place of Residence	Status in employment					
		Number of Elderly Workers	Employer	Paid Employee	Own Account Worker	Unpaid family worker	Others
Males							
	Rural	229,261	0.12	4.83	84.71	10.26	0.08
	Urban	30,732	0.51	33.44	61.91	3.99	0.14
Females							
	Rural	244,124	0.10	1.52	44.51	53.83	0.05
	Urban	22,161	0.23	13.14	59.31	27.24	0.08

Source: Report of the "Demographics of population ageing in Cambodia (NIS 2012)

Social Security for the Elderly

FAMILIAL SUPPORT

Traditionally, family is the most reliable source of support for Cambodian elderly. It is where they receive basic necessities such as food, clothing and modest amount of money for social and religious activities (POPCouncil 2006). Caring for elderly parents is a traditional and religious obligation for good children (Kato 2000). Leaving parents alone or taking them to nursing home would be viewed as disrespectful and strange. The tradition has been observed even among Cambodian migrants living in high income countries where elderly support system is well established (SERMRC 2011). For this tradition, Cambodian families have the tendency to bear more children so that they can share the burden in supporting their parents when they get old. Older people with more living children are perceived to enjoy better livelihood than those without or with less living children (POPCouncil 2006). Older people without living children are usually cared for by their relatives such as nephews or nieces. This tradition, coupled with many competing priorities, had so far precluded the state support system.

Although this turn-taking kind of parent-children relationship is still strongly accepted and believed, the practice is becoming more and more challenging. Rapid population growth during the last few decades has led to a depletion of land cultivation, the main source of family income, thus making life more difficult. There are no more "housewives" to take care of housework including caring for elderly parents as everyone needs to do income generating activities usually outside the house. Worse, many Cambodians now seek jobs in the urban areas which is far from their home villages. As a result, elderly members of the family are not properly taken care of. More so, they even have to help take care of the housework and their grandchildren who are left with them by their children.

PUBLIC HEALTH CARE

As people age, health care demand also increases and becomes more complex (WHO 2015). A quarter of Cambodians aged 60 years and older reported that they have been ill or injured. Theirs has the highest proportion compared with other age groups (NIS 2015). Data gathered from health information reported that nearly 60% of patients aged 50 years and above were hospitalized due to chronic diseases such as high blood pressure, cardiac conditions, diabetes and cancer, while elderly admitted for infectious diseases, injuries accounted for less than 20% of all in-patients of the same conditions (Platt 2010). The same schemes were observed among out-patients.

Although health care seeking behaviours seems to follow the same pattern as other age groups, with 93% of sick elderly seeking care for the first time at health facilities (NIS 2015), the increased complexity or care for elderly clients requires special attention. Cambodian health care system is designed to respond primarily to national priorities which remain largely to be communicable diseases such as malaria, tuberculosis, HIV/AIDS, acute respiratory infection. Access to specialized care for elderly conditions remains very limited. Only a few national hospitals located in the capital city have specialized services for cancer treatment and care. Only one hospital, Khmer-Soviet Friendship Hospital in Phnom Penh, has a specialized department for elderly care.

Two third of sick people seek care at private health care facilities which are usually more expensive and without formal health financial schemes. The Ministry of Health issued a policy to provide medical care free-of-charge to "unsupported" elderly at public health care facilities. However, the implementation is still not systematic. Several financial schemes have been implemented with the attempt to remove economic barriers to healthcare access by the poor, and including the elderly. Health Equity Fund, a demand-side financing scheme is one of them. Poor patients can use public health services which are paid for by the Fund which have been put together by government and development partners. However, the Health Equity Fund covers only episodes of illness and hospitalization, but not chronic conditions. Other forms of health care financing schemes are in place such as community-based health insurance although coverage is very limited and excludes chronic health conditions.

> ***"Cambodian health care system is designed to respond primarily to national priorities which remain largely to be communicable diseases such as malaria, tuberculosis, HIV/AIDS, and acute respiratory infection. Access to specialized care for elderly conditions remains very limited."***

PUBLIC PENSIONS

Cambodia had implemented a law on social security schemes since 2002. Said law has a chapter on public pension which includes old age pension and allowance, invalidity pension, survivor's pension and allowance (RGC 2002). To manage the schemes, National Social Security Fund (NSSF) was created in 2007. To qualify for an old age pension, an NSSF member must:

- be at least 55 years of age
- has been a member of NSSF for at least 20 years
- has been contributing to the NSSF for at least 60 months during the 10 years prior to the date of entitlement

The old age pension scheme covers only retirees from government service and formal sector workers. Civil servants who fulfill the conditions for old age pension scheme receive the amount equivalent to 80% of their last salary. Those who do not fulfill the conditions (e.g., contributing less than 60 months to NSSF) may get the allowance in a lumped sum. Older people who were not employed by formal economic sector, and which comprise the majority, do not benefit from this scheme.

Social security scheme is one of the areas getting much attention from the government and other stakeholders. This mechanism is considered to be weak at this stage as it was reported that only 5% of older

persons received a regular pension in 2010 (Platt 2010).

SOCIAL CAPITAL (COMMUNITY NETWORKS)

Growing old takes it toll on older people not just physically but also psychologically. A community study reported that older people had negative feelings on becoming older (Kato 2000). The most common feeling of older people is frustration that they are no longer able to do what they used to do and the way they did when they were younger. They are frustrated that they are no longer able to earn a living and solve their own problems. Another common feeling of older people especially the poor is worrying about many things such as their own well-being, food for their children and grandchildren, lack of money to buy medicines when sick, lack of money for their own funeral, no possession to pass on as inheritance to their children and grandchildren.

To deal with these psychological impacts of ageing on older people, social support is needed. Thus the Older People Association was established. However, it has not been fully operational and its functions are not clear. In the community, especially in rural areas, Pagoda is a place where older people can gather to perform their religious obligations or traditions and also to get together to share their experiences, issues, feelings with peers. Pagoda could play an important role in providing psychological support for elderly to help reduce their feelings of loneliness and frustration. Sense of community is very important for older people. If they have children living in both urban and rural areas, they will more likely choose to live with their children in a rural area despite lesser means of access to necessary services as compared to an urban area. It is because life in the rural areas is more communal and easy-going than in urban areas where life is rather seclusive and does not suit the social needs of the elderly.

Feminization of Ageing

The Sex Ratio of the elderly is indicated by the growing number of women in older ages compared to men and is an important concern for policy relevant research but the sex ratio in Cambodia is men compared to women. The sex ratio shows an increasing trend from 69.1 men per 100 women in 2008 to 67.0 in 2018 and a projected 76.3 by 2030. Figure 6, and Table 2. Among the oldest old, the sex ratio is expected to be as low as 61.4 men per 100 women by 2030. This trend poses more specific challenges relating to very old women who are also likely to be widowed.

> ***"The Sex Ratio of the elderly is indicated by the growing number of women in older ages compared to men. This trend poses more specific challenges relating to very old women who are also likely to be widowed. No special rights for elderly women compared to elderly men are clearly spelled out in any existing policy."***

TABLE 7. The Sex Ratio (number of male per 100 females) of elderly in different age group, 1998-2030

Age Group	1998	2008	2013	2018	2023	2028	2030
60 - 69	73	72	71	67	74	83	85
70 - 79	71	67	68	69	67	63	66
80+	64	60	61	61	62	62	61
All elderly (60+)	72	69	69	67	71	75	76

Source: Population projections for Cambodia, 2008-2030

Policy Responses to Implications of Ageing

Population ageing has come to the attention of various stakeholders including the government, media, and civil societies. Health and well-being of elderly is a responsibility of the Ministry of Social Affairs and Veteran and Youth Rehabilitation which has one department that is specifically dedicated for this. In addition, the government created an inter-ministry national committee for elderly (RGC 2011) which is composed of 16 government ministries and organizations under the honorary chairmanship of the Prime Minister and the executive chairmanship of the Minister of Social Affairs and Veteran and Youth Rehabilitation. The roles of the committee are: (1) to develop national policy promoting the well-being of elderly; (2) to organize the international day of elderly which is on October 1 of every year; and (3) to support the Association for Older People and effective management of resources allocated for their welfare. Strategies for elderly have been clearly spelled out in various policy papers such as the Strategic Plan of the Ministry of Social Affairs and Veteran and Youth Rehabilitation (MoSVY 2014), the National Social Protection Strategy for the Poor and Vulnerable (MoP 2011), and the Integration of Demographic Perspectives in Development of Cambodia (MoP 2013).

The Ministry of Social Affairs, Veterans and Youth Rehabilitation is in the process of addressing issues related to health, economic conditions, participation in society and general welfare of elderly citizens. Recognizing issues and concerns pertaining to the elderly, the ministry puts together necessary guidelines. Yet, there is a need to collectively strategize this specific cross-cutting area and come out with a unified plan of action that addresses this future challenge.

The following are perspectives and directions for addressing elderly issues in Cambodia.

POLICY DIRECTIONS

- Align the National Policy Guidelines for older persons with Madrid International Plan of Action on Ageing (MIPAA), 2002
- Design programmes in line with MIPAA and integrate them into the existing development programmes; and
- Strengthen the role of National Committee for Older People headed by a Senior Minister to facilitate implementation of programmes that are cross-cutting in nature.

“Health and well-being of elderly is a responsibility of the Ministry of Social Affairs and Veteran and Youth Rehabilitation which has one department that is specifically dedicated for this. Recognizing issues and concerns pertaining to the elderly, the ministry puts together necessary guidelines. Yet, there is a need to collectively strategize this specific cross-cutting area and come out with a unified plan of action that addresses this future challenge.”

PROGRAMMATIC DIRECTIONS

- Increase awareness of actions undertaken by the government and strengthen implementation thereof;
- Review the need for establishing old-age homes vis-a-vis the socio-cultural setting in the country;
- Strengthen and expand home-based care and social security (old-age pension scheme indexed to inflation) for elderly citizens, especially those who are in the lower income bracket;
- Conceptualize an effective system to allow meaningful use of the skills and wisdom of retirees in development planning, and introduce vocational programmes for elderly people to make them self-reliant;
- Ensure that public facilities for older persons must comply with standards and requirements' and in turn could be offered tax-incentives, lower bank interests and travel concessions; and
- Undertake policy research from census and other data sources to understand social, economic, health, psychological and emotional state of older persons and study the impact of youth migration on the welfare of older persons.

Recommendations

Population ageing is an inevitable and welcome phenomenon for economic development. However, this comes with consequences which need to be properly addressed.

- One of the most pressing needs among the elderly is health care services which is increasingly needed as people age. Although Cambodia has many competing health care priorities, specialized health care for elderly should be in the pipeline and preparations should already be in place at this stage because these services are skills-based, resource-intensive and require time to develop.
- Tax-based state security fund for elderly should be worked out so that more if not all elderly will benefit from the scheme. Currently, only those employed in the formal sector have their pension funds. This may be small in the beginning and not that significant in terms of social security support, but it is important to get the system in place and rolling to provide confidence and psychological support for elderly.
- Develop a "senior citizen" programme that allows privileges for elderly to avail of services such as health care and transportation. Not only will the programme provide easier access to services needed but should create a culture of caring. The programme should involve both state-owned as well as privately owned services. Mechanism must be worked out so that all stakeholders can get involved. State subsidies may be an inevitable option. Thus far, the Ministry of Health has the policy of free health care for "unsupported" elderly which is not systematic and lacks implementation mechanism.
- Elderly should be considered national treasures despite their decreasing abilities. In this sense, community-based self-supporting programmes should be encouraged. These programmes could allow the elderly to continue using their skills in handicraft, music, religious traditions, education and others that can contribute to society. These could create opportunities for elderly citizens to earn their living and enjoy a better quality of life. The Ministry, in coordination with non-government organizations, could also provide education and training on nutrition, physical fitness, care for chronic diseases, and manageing disabilities to the elderly themselves, as well as to their caregivers. Although Cambodia still embraces the age-old and beautiful tradition of caring for elderly family members, demographic and economic changes posed challenges to it.
- Establishing nursing homes for elderly could work for the long term particularly in urban areas based on need, traditional acceptability and affordability. It could be undertaken by the Association, by concerned non-governmental organizations, or even the private sector.

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