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IN THE CARE OF THE STATE AND THE FAMILY: Understanding Care of the Elderly through Macro and Micro Perspectives

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CONTENTS

INTRODUCTION

This discussion paper will examine the provision of care for older people by linking various care at macro (national) and micro (individual or family) levels. This paper argues that these different levels are not mutually exclusive. On the one hand, products of macro level national policies, regulations and programmes must be compatible with the needs of target groups. Therefore, policy makers in particular, need to be well informed of what is really happening in people's lives at the micro level. On the other hand, individuals should be more aware of and better informed about programmes, regulations and activities that are relevant and useful to their interests. This paper also highlights the important role civil society groups can play in bringing macro policies and programmes into the day-to-day lives of the target groups and in helping those people to voice their concerns and interests at high-level forums.

The discussion on a macro perspective is based on the results of two national workshops of the Economic and Social Commission for Asia and the Pacific (ESCAP) on gender-responsive healthcare and social security for the elderly held in Hanoi, Viet Nam (12 to 14 March 2008) and in Ulanbataar, Mongolia (9 to 11 April 2008). This paper selects the two host countries (Viet Nam and Mongolia) and two countries of invited experts (Thailand and India) to be further examined as examples of national situations. The discussion on a micro perspective is based on an anthropological study on support for a particular group of older persons, namely childless elderly widows in urban areas of Indonesia and the consequences of the absence of family support.[1]

In the next section, the paper provides an overview of population ageing, gender concerns and the needs of healthcare with a focus on some aspects in the Asia-Pacific region. Section three examines care for older persons from a macro perspective. In this section, the national situations of the four selected countries are systematically analyzed against four areas of policy interventions. Section four takes a micro perspective and focuses on cases, problems and coping efforts of elderly childless widows in the absence of family support. Concluding remarks, including recommendations, are outlined in the final section.

I. POPULATION AGEING, GENDER CONCERNS AND THE NEED FOR HEALTH CARE

Changes related to ageing are easily associated with decline in some aspects of a person's life such as health and economic conditions. Biologically, normal ageing is indeed an irreversible process that leads to progressive loss of functional capacity of the human

[1] Marianti, Ruly (2002). Surviving Spouses: Support for Widows in Malang, East Java. Ph.D. Thesis, University of Amsterdam.

body. However, ageing is not a disease, but might increase a person's susceptibility to disease and disability. The association with "decline" has resulted in negative images of ageing and stereotypes of older persons such as being unproductive, burdensome, needy or frail. When they are accepted and internalized, the negative stereotypes and images can negatively affect beliefs, perceptions, attitudes about the process of becoming old or even policy decisions concerning older people. In this regard, it is important that *ageing* (as biological changes as well as demographic trends) and *older persons* (as individuals as well as a growing section of the population) are understood and addressed in appropriate manners so that societies, on the one hand can continue to benefit from the potential and capacities of older persons and on the other hand, provide support to them for healthy, active and dignified ageing.

A. Gender and ageing in Asia-Pacific: an overview

Globally, extended life expectancy and rapid fertility decline have caused an increase in the proportion of older persons (those aged 60 years or over) in the population. Between 2005 and 2010, the growth rate of the older population at 2.6 per cent annually is more than twice that of the total population at 1.1 per cent (United Nations 2007a).

Population ageing on this scale is unprecedented, is affecting nearly all the countries of the world and has major consequences and implications for all facets of human life. In the economic sector, population ageing will affect growth, labor markets, pensions, taxation, intergenerational transfers as well as consumption and savings patterns. In the social sector, population ageing will influence family composition and living arrangements, patterns of diseases that frequently occur in the population and the need for long-term health care. The proportion of older persons will continue to increase as long as mortality and fertility continue to decline.

Currently, 9.6 per cent of the population of Asia is over the age of 60. This proportion is likely to increase to 14.9 per cent in 2025 and 23.6 per cent in 2050. In absolute numbers, in 2007, Asia had 385 million older persons (60+), and will have an estimated 706 million older persons by 2025 and more than 1.2 billion by 2050. Additionally, this region will also face a major transition in the population structure between 2000 and 2050. The proportion of the population aged over 60 years is expected to increase by two and half times (from 9.6 per cent in 2007 to 23.6 per cent in 2050), while the proportion of the population under 15 years of age is expected to decline by one-third (from 27 per cent in 2007 to 18.3 per cent in 2050) (United Nations 2007a). As on average women live longer than men, they outnumber men in the age groups of 60+, 80+ and 100+.

Table 1: Proportion of women among persons in different age groups, globally, 2007

AGE GROUPS	PERCENTAGE OF WOMEN
40 – 59	50
60+	55
80+	64
100+	82

Source: United Nations (2007a). *World Population Ageing 2007*

In most countries, women also constitute a majority of the oldest old (aged 80 years and older). Table 2 below shows the trend in some Asian countries.

Table 2: Percentage of women in the oldest old (80+) population in selected countries

COUNTRIES	2000	2007	2025	2050
Cambodia	59.3	69.3	67.9	66.5
India	55	55.3	57.7	58.2
Indonesia	54.2	58.9	53.5	54.5
Malaysia	56.7	57.9	62.1	63.9
Myanmar	56.9	57.4	58.8	60.9
Mongolia	65.1	63.3	61.1	62.0
Philippines	61.9	62.6	60.9	64.4
Singapore	61.6	59.3	60.1	60.7
Thailand	60.6	60.2	65.2	65.4
Viet Nam	57.3	56.4	58.0	60.5

Sources: (a) United Nations (2002b). *World Population Ageing, 1950-2050;*
(b) United Nations (2007a). *World Population Ageing 2007.*

Women not only comprise a larger percentage of the older population, but are also more at risk of poverty and certain health problems than older men due to various intertwined causes. Socio-culturally constructed gender relations and roles have limited women's access to education and capacity development opportunities outside the domestic sphere. It is estimated that, on average, 35 per cent of women and 58 per cent of men aged 65 years or over are literate in developing countries, a gap of 23 percentage points (United Nations 2007a). Also, in most countries, older women have had fewer educational opportunities than younger women now enjoy. Furthermore, older women have fewer opportunities to save over the course of their productive lifetime. Generally, they have spent more time than men as caregivers, engaged in household labor, and subject to limited labor market access and wage discrimination. Consequently, older women also tend to benefit less from pension schemes and social security programmes that are based

on formal wage labor and not on household labor or activities in the informal economy where a higher proportion of women than men work. These gender-based disadvantages are also reflected in the higher incidence of poverty among older women than older men.

While in general, older men are more likely to suffer acute ailments, older women more often suffer from chronic, progressive illnesses that in most cases require long-term care. Women are often encouraged to marry men older than themselves, increasing their chances of becoming widows. Furthermore, while in most cultural contexts widowers are encouraged to remarry, widows are discouraged from doing so or even stigmatized if they choose to remarry. Because of their longevity and lower propensity to remarry, older women are more likely than men to live alone. They often do not have a spouse to care for them when ill or disabled and are at a greater risk of experiencing social isolation. Moreover, in some cultural contexts, widowhood leads to many forms of exclusion and economic deprivation.

Table 3: Gender differences in the socio-economic circumstances of older persons in selected countries

COUNTRIES	Percentage of population over 65 years who are in the labor force, 2007		Percentage of older persons who are illiterate		Marital status (percentage of older persons living alone)	
	M	F	M	F	M	F
Cambodia	42.6	23.8	28.6	84.3	n/a	n/a
India	50.1	11.7	48.0	80.3	1.8	5.0
Indonesia	56.6	29.8	31.4	60.2	2.4	11.9
Malaysia	47.1	25.7	39.8	69.5	4.7	8.7
Mongolia	46.5	19.4	4.4	17.2	n/a	n/a
Myanmar	63	45.5	11.7	35.1	3.1	5.9
Philippines	53.1	28.8	20.1	22.7	4	6.4
Singapore	13.5	3.2	15.5	58.8	1.6	2.7
Thailand	38.0	16.8	20.8	40.1	2.9	5.5
Viet Nam	22.8	15.1	n/a	n/a	n/a	n/a

Source: United Nations (2007a). *World Population Ageing 2007*.

B. Health status of older persons

Health should not be understood only in terms of the absence of disease but as the state of complete physical, mental and social well-being[2]. This broad definition of health is

[2] As rephrased from the Preamble to the Constitution of the World Health Organization (WHO) as adopted by the International Health Conference, New York, 19 to 22 June, 1946.

compatible with the idea of active and productive ageing and therefore very useful for promoting a more positive understanding of health status and health care needs of older persons. Older persons, however, are definitively not a homogeneous group and the situation varies from one country to another.

As the biological process of ageing might increase a person's susceptibility to disease and disability, it is also crucial to have a good understanding of health problems that are usually faced by the older persons. Physiological changes - and their consequences - that are caused by the process of ageing include cardiovascular changes that can result in coronary artery disease and hypertension, changes in respiratory organs that can result in the decline of lung function, neurological changes that can result in peptic ulcers and gastritis and loss of appetite,. The most common chronic diseases are coronary artery disease, hypertension, diabetes mellitus, chronic renal failure, and chronic obstructive pulmonary disease. Table 4 below shows variations in diseases that commonly occur among older people in some Asian countries (World Health Organization, 2004). In addition, psychological changes and problems such as depression and anxiety are common in old age. Non-communicable diseases are the leading cause of morbidity, hospitalization and disability among older persons globally.

Table 4: Common health problem among older person in some Asian countries (2000)

COUNTRIES	DISEASES
India	Hypertension, diabetes mellitus, coronary artery disease
Myanmar	Malaria, cataracts, hypertension, pulmonary tuberculosis
Sri Lanka	Hypertension, heart disease, diabetes mellitus
Thailand	Hypertension, arthritis, heart disease, peptic ulcer, diabetes mellitus

Source: World Health Organization (2004). *Health of the Elderly in South-East Asia A Profile*.

C. Factors determining the health conditions of older persons

The health status of a person can be affected by various factors such as his/her economic condition, mainly linked with income; being male or female; level of educational attainment; marital status; living arrangements; employment and working conditions; social environment such as having a support network and social participation; physical environment such as housing conditions and lifestyle and behavior-related risks to health. These factors do not act in isolation from each other; therefore it is important to understand how each one relates to the health status of a person.

Many health indicators which are related to conditions in society such as life expectancy at birth, infant mortality and maternal mortality rates, are associated with economic

conditions. Poverty is a great barrier to maintaining good health; therefore, poverty will only intensify health problems. The poor often have to work long past usual retirement age and accept work in unhealthy conditions. Unfortunately, sufficient and systematically collected data on the economic status and sources of income of older persons is not always available, although it is highly relevant to assess the health risks of this group.

Gender is an important factor that influences a person's health status. The different roles, rights, responsibilities, duties and relative power that are socially ascribed to sexes on a differential basis will lead to a lifetime of different experiences, including discrimination. Poor older women often feel that they have low status and therefore limited power in decision-making and a weak bargaining position. Consequently, they are not in a position to voice their needs, including those related to their health conditions. Educational attainment is also a determining factor of a person's health status, because it can influence information absorption capacity, problem solving ability, lifestyle and behaviors. In addition, mental stimulation through education has long-term health benefits. Social factors that especially affect the health status an older person are marital status and living arrangements. Couples can have the benefits of mutual care and support while older people who live alone are more vulnerable to lack of care, loneliness and depression.

D. Ageing and rising health care costs

In the period from 2000 to 2004, the total health expenditure as a percentage of Gross Domestic Product (GDP) in many countries in the Asia-Pacific region, especially in South-East Asia, had increased. Table 5 below shows the increase in selected countries. The table also demonstrates that the increase in general government health expenditure corresponds to the decrease in private expenditure on health. The decrease in private expenditure on health, however, is not always parallel with the decrease of out-of-pocket expenditure.

Increasing health care costs are an important obstacle to promoting well-being in general. In more than two-thirds of all countries in the Asian and Pacific region, out-of-pocket expenditure exceeds 80 per cent. This carries significant implications for low-income households, particularly in emergencies or when facing chronic diseases (United Nations 2007c) since medical treatments may be difficult to finance. In a country such as Indonesia, where most people are not protected by adequate health insurance, hospitalization and complicated medical treatments can push people deep into debt and economic deprivation.

Table 5: Proportion of various types of expenditure on health

Country	Total Expenditure (per cent GDP)		General government health expenditure (per cent of total government expenditure)		Private expenditure on health (per cent of total expenditure on health)		Out-of-pocket expenditure on health (per cent of private expenditure on health)	
	2000	**2004**	**2000**	**2004**	**2000**	**2004**	**2000**	**2004**
Cambodia	5.9	6.7	8.7	11.4	78	74	93	85
Indonesia	2.3	2.8	3.7	5.0	74	66	72	75
Malaysia	3.3	3.8	6.2	7.5	48	41	75	74
Philippines	3.5	3.4	7.1	6.3	52	60	77	78
Singapore	3.6	3.7	6.7	6.2	65	66	97	97
Thailand	3.4	3.5	10.0	11.2	44	35	77	75
Viet Nam	5.3	5.5	6.0	5.0	72	73	87	88
Mongolia	7.9	6.0	13.6	9.4	25	33	89	92
India	4.3	5.0	3.1	2.9	79	83	92	94

Source: United Nations (2007c). *ESCAP, Statistical Year Book for Asia and the Pacific 2007.*

As the biological process of ageing increases a person's susceptibility to disease and disability, it can be expected that older persons would use health care services with greater frequency and intensity than younger adults. Additionally, medical advances have postponed the onset of many chronic diseases or disabilities to the very last stage of a person's life. Consequently, a high proportion of health expenditure is often concentrated in old age and population ageing could result in an increased demand for and cost of health services. Nevertheless, the *World Economic and Social Survey 2007: Development in Ageing World* concludes that although ageing will contribute to rising health care costs over the coming decades, it is not the most important driver behind the projected increases. The report also suggests that any increase in health costs due to ageing should be manageable, particularly if governments put greater emphasis on preventive measures that can limit the incidence of chronic diseases (United Nations 2007b). Some non-demographical factors which can also raise health costs and need to be taken into account are: the introduction of new medical technologies, increases in pharmaceutical prices, the rising cost of health care personnel and increasingly demanding patients. To protect people from being unable to finance proper health care, governments should initiate or strengthen existing risk-pooling mechanisms. In addition, health insurance with universal coverage should also be accessible to all, especially to groups such as the older persons with health problems and limited income, who are particularly vulnerable.

II. CARE FOR THE ELDERLY FROM A MACRO PERSPECTIVE: GENDER RESPONSIVE POLICIES AND PROGRAMMES TO PROMOTE WELL-BEING OF THE ELDERLY

In this section, population ageing is analyzed from a macro perspective, namely through regional trends and national situations. Challenges related to the provision of care for an ageing population are understood as public issues which affect large numbers of people and society as a whole. Responses to challenges regarding elder care are examined in national policies and programmes, including the availability of relevant legal frameworks, responsible focal agencies and government spending. The section will examine four areas of policy intervention addressing the needs of the ageing population. The following sub-sections will further explain the areas of policy intervention within the national context of four selected countries (India, Mongolia, Thailand and Viet Nam).

A. Addressing the needs of the ageing population

The report entitled, *Regional Dimensions of the Ageing Situation* (United Nations 2008), underscores that although demographic ageing is a global phenomenon; the pace at which ageing is taking place varies considerably across regions. Europe is experiencing the most rapid population ageing. Asia-Pacific and Latin America and the Caribbean are undergoing a more moderate pace of ageing, even though some countries within these regions are ageing quite rapidly. In Western Asia and Africa the process of ageing is slower because most countries in these regions still have a large number of young people.

In 2005, 54 per cent of the world's population of persons aged 60 or more years lived in Asia. This proportion will rise to 62 per cent by 2050. Within the ageing population, the total number of women is higher than that of men both among the older population (60+) as well as among the oldest old (80+). As discussed in the previous section, the fact that in many countries, the number of surviving older women far outstrips that of men, leads to specific challenges of population ageing that are determined by gender-based differentiation and discrimination. In order to successfully address those challenges, gender responsive initiatives and measures such as policies and legal frameworks, programmes and projects, to promote well-being of the older population need to be explored.

Responses to the needs of ageing populations must be gender sensitive. If the gender dimension is ignored and ageing policies and programmes are considered to be gender neutral, these they will not be able to specifically address the needs of the majority of the older population and will as a consequence, be less effective. Policymakers must carefully consider some forms of gender-based socio-economic disadvantages that have hindered women throughout different life stages. Many older women are widowed and tend to live alone and therefore are more vulnerable to lack of care (especially long-term

care). It is not uncommon for them to be the poorest among the poor. Various gender-based stereotyping, discrimination and exploitation of women that lead to undernourishment, higher illiteracy rates, lower wages, smaller income, lack of entitlement to pensions and high risk of violence, add to women's frailty in old age.

The four areas of policy interventions addressing the needs of the ageing population, with special attention to older women, to be examined are:

1. Enhancing the sources of income of older women to improve their access to healthcare
2. Improving the provision of health services
3. Upgrading infrastructure for the provision of health services
4. Allocating resources for health care

The following sub-sections will analyze the extent to which, and how, the current national initiatives (policies, regulations and programmes on ageing) in India, Mongolia, Thailand and Viet Nam, are able to support the implementation of these policy interventions.

B. Gender responsive policies in four selected countries

In Viet Nam, since 2000, the 0-14 age group of the population has declined while the population in the age group 60+ has continued to rise; leading to a relatively smaller number of young people having to shoulder the responsibility of caring for an increasing number of older people. A consequence of this is that the support base for caring for the population aged 65 and above has been declining.

Currently, the pace of population ageing in Mongolia is relatively slower in comparison to and India, Thailand and Viet Nam. In 2005, the proportion of population aged 60 was 5.9 per cent of the total population. This is lower than many other countries in the Asia-Pacific region; however, in the near future, the ageing population in Mongolia is expected to rise rapidly. Moreover, the share of working age people will decrease, which, similar to the situation in Viet Nam, will also result in relatively smaller number of working people supporting an increasingly large number of dependent older persons.

In 2005, the proportion of population aged 60 years and above in India (7.5 per cent) was comparable to the proportion in Viet Nam (7.6 per cent). In 2025 and 2050, however, the proportion of older persons (60+ years) in India is expected to be smaller than in Mongolia, Thailand and Viet Nam, Compared to other three countries, the estimated proportion of older persons (60+ years) in Thailand in the years 2005, 2025 and 2050 will continue to increase. Due to the rapid increase in the proportion of older people as compared to working aged people, it is also expected that Thailand will experience more

than a threefold increase of old age dependency ratio in 2050, whereas India, with a younger population, will face more than a twofold increase.

Table 6: Population aged 60 years and above in selected Asian and Pacific countries and the total Asian population, in the years 2005, 2025 and 2050

Country	60+ population of total Population (per cent)			80+ population of 60+ population (per cent)		
Year	**2005**	**2025**	**2050**	**2005**	**2025**	**2050**
Asia	9.2	14.8	23.7	10.6	11.9	19.0
India	7.5	11.5	20.2	9.2	10.8	15.3
Mongolia	5.9	10.8	25.1	12.6	8.9	14.2
Thailand	11.3	21.5	29.8	11.5	12.4	23.6
Viet Nam	7.6	13.4	26.1	13.3	10.7	18.4

Source: United Nations (2007d). *World Population Prospect: The 2006 Revision*[3]

It is obvious that the pace of population ageing in the four countries differs. The general trend, however, is similar: all of the four countries will definitely face not only a continuous increase in the proportion of older persons in the population but also feminization of the ageing population. As a consequence, there is a growing demand for initiatives and measures ensuring people's well-being in old age. What initiatives and measures to promote the well-being of the elderly have been taken in the four countries? Do those initiatives and measures relate to the enhancement of sources of income for the elderly, improvement of health services and infrastructures and better resources allocation to promote their well-being? To answer these questions, the present policies, regulations and programmes for the well-being of older persons in each country will be compared and analyzed against the four policy intervention areas in the following sub-sections.

C. National policy and legal framework on ageing in India, Mongolia, Thailand and Viet Nam

Challenges that are triggered by rapid population ageing call for urgent policy formulation and implementation. A number of countries in the Asia Pacific region have a formal national policy, legislation or national plan of action on ageing, whereas many others are still in the process of developing a policy framework. However, most of these policies are gender neutral and do not specifically address the concerns of older women.

[3] As cited in United Nations (2008). *Regional Dimensions of the Ageing Situation*. ST/ ESA/318 (New York)

Additionally, the implementation guidelines are often insufficient. As issues related to population ageing often fall within the jurisdiction of more than one ministry, there is overlap and lack of clarity in the division of labor and responsibility among the relevant ministries in implementing the national policy on ageing. Similar to many other countries in the world, India, Mongolia, Thailand and Viet Nam are concerned about care for and well-being of their senior citizens. The four countries are also searching for ways to deal with the challenges. Table 7 below shows the national focal agencies, policies and regulations or laws on ageing in the four countries.

A coordinating body on ageing has been established in Thailand and Viet Nam. Such a body can be advantageous as it can focus on specific tasks. However, such a body must have strong capacity including sufficient resources and a strong legal basis in order to lead effective coordination among different institutions. In India and Mongolia, relevant ministries have handled ageing issues. Assigning the task of dealing with population ageing to some relevant ministries can ensure institutionalization and sustainability of efforts to promote the well-being of older persons. Ageing issues, however, are only a small part of the ministries' mandate; therefore they might be not be prioritize such issues especially in term of resources allocation. The four countries also have national policies or programmes and laws that aim to protect the well-being of the older population. Nevertheless, the bigger challenge is in the effective implementation of those policies and regulations; so that they do not exist only on paper. For this purpose, monitoring and evaluation must be well integrated in the implementation plan including the documentation and analysis of best practices. Civil society groups' work on the issue of population ageing can play an important role both as a counterpart of Government agencies to ensure implementation of policies regulations and as a pressure group in monitoring and evaluation.

If the existence of national focal agencies, policies, programmes and regulations on ageing can be perceived as a required basis for more elaborate responses to the needs of population ageing, then India, Mongolia, Thailand and Viet Nam, are relatively ready for the next steps. To what extent are these countries ready to carry out the selected areas of policy intervention? The following sub-section will discuss the situation in each of the four countries with regard to these areas.

Table 7: National focal agencies, policies and regulations dealing with ageing in India, Mongolia, Thailand and Viet Nam

(1) National focal agency/ institution/ coordinating body on ageing	
Mongolia	a. Ministry of Social Welfare and Labor (Population Development and Social Security Policy and Coordination Department) b. Ministry of Health (National Gerontology Center)
Thailand	a. National Commission on the Elderly (established in 1982)

	b. The Bureau of Empowerment for Older Persons (a coordinating body, acting as the Commission secretariat, established in 2003) c. Ministry of Social Development and Human Security
India	a. Ministry of Health and Family Welfare. b. Ministry of Social Justice and empowerment
(2) National Policy/ Plan of Action/ Programmes on Ageing	
Viet Nam	a. National Programme on Ageing for period 2005 – 2010 Since 2002 the Government of Viet Nam has prioritized three areas of development to support the elderly: i. Participation in decision-making ii. Provision of supportive and enabling environments (mostly poverty reduction measures) iii. Health and well-being
Mongolia	b. National Programme on Health and Social Protection of the Elderly, 1998 and revised 2004. c. (revised) State Policy of Mongolia on Population Development, 2004 The state policies on ageing that will be implemented until 2015 are reflected in this strategic paper. d. Other relevant policies: -The Integrated National Development Policy -The State Policy on Family
Thailand	a. Second National Plan for Thai Older Persons, 2002 – 2021 b. National Health Policy, 2001
India	a. Indian National Policy on Older Persons, 1999
(3) National Regulations / Laws on Ageing	
Viet Nam	a. The Ordinance on Ageing (2000) and the Decree No. 63 on health insurance for older persons. This Decree grants health insurance to all those who are above 85 and single, without pensions or social subsidies. b. Government Decision No. 1256/2006 for the purpose of supporting health care activities to protect the physical and mental health of the elderly c. Circular N. 116/ 1998, issued by the Ministry of Finance, which provides guidelines on financial support for Vietnam Association of the Elderly (VAE)
Mongolia	a. The Law on Social Protection for the Elderly (1995)

	Other relevant regulations: i. Law on Health Insurance for Citizen ii. Law on Social Welfare iii. Law on Social Benefits and Services for the Elderly iv. Law on Social Welfare for People with Disabilities v. Labor Law of Mongolia (revised in 1999)
Thailand	a. Older Persons Act (2003) b. Thai Constitution for Elderly People (1997)
India	Article 41 of the Constitution of India, which makes it obligatory for the State to: (1) Initiate measures to secure the rights of older persons to public assistance, (2) Make provision for the well-being of the elderly

Sources: (a) ESCAP (2007). "Country Statement Mongolia";

(b) ESCAP (2008a). "Regional Overview on Gender Responsive Health-care and Social Security Policy for the Elderly";

(c) ESCAP (2008b). "Report of the Workshop: National Workshop on Gender Responsive Social Protection and Health Security for the Elderly";

(d) ESCAP (2008c). "Report of the Workshop: National Workshop on Gender Responsive Social Protection – Health Security for the Elderly";

(e) HelpAge International (2007). *Age Demands Action in Vietnam. Progress on implementation of the Madrid International Plan of Action on Ageing (MIPAA)*

(f) World Health Organization (2004). *Health of the Elderly in South-East Asia A Profile.*

D. Policy Area I: Enhancing the sources of income of older women to improve their access to health-care

As previously mentioned, older people in general often have to face a decline of income because they are no longer fully participating in economic activities. Consequently, their ability to finance their daily needs, including paying the increasing health costs, also has decreased. The financial constraints they face might be worse as financial support that the younger population is able to provide to them (e.g. adult children to ageing parents), is expected to decline gradually. This situation is more alarming for many older women because women's incomes, whether from earnings or from retirement pensions are often lower of those of men.

Under the selected policy area of enhancement of income sources for the elderly, three interventions will be explored related to the availability of: (1) gainful employment in old age, (2) old age pensions and (3) different forms of welfare benefits. Table 8 below shows legal and policy frameworks and programmes that are available in the four

countries (India, Mongolia, Thailand and Viet Nam), for facilitating the implementation of the first policy area.

In all four countries, the right of older people to work (including after their official retirement). The laws also have guaranteed them some additional privileges. The Law on Labour of Mongolia prohibits limiting wages of older workers who receive a pension and allows employers to adjust working hours and type of work at the request of the worker in order to protect their health. The Indian National Policy on Older Persons provides protection from age-related discrimination and structural adjustment policies in some sectors. An ESCAP paper (2008, 9-10) underlines the fact that the proportion of economically active older men is higher than that of older women. As they tend to have better qualifications and more experience, older men have benefited more from policies to provide employment for older persons than have older women. In general, it is more difficult for older women to find gainful employment. The role and work performed by women as care givers is often undervalued and inadequately compensated. Therefore, care-giving must be recognized as an important role and made more lucrative so that women care-givers can ensure their own well-being. Policy measures should be put in place to compensate women adequately for their care-giving work.

Old age pensions, especially for the oldest and poorest of the old, are available in all four countries, but they have not effectively reached all the supposedly entitled beneficiaries. In addition, the amount of allowances provided is generally still too low to sufficiently cover their needs. Older people in Mongolia are entitled to conditional cash benefits, discounts, nursing care and community based welfare services. In India and Thailand, senior citizens are entitled to tax reductions. India provides various transportation discounts for the elderly, which is a good example of efforts to reduce financial burdens of older persons.

Table 8: Enhancing the income of the elderly in general to enable access to health care in Viet Nam, Mongolia, Thailand and India

1) Gainful employment in old-age	
Viet Nam	About 70 per cent of older people live in rural areas and earn low incomes from farming and fishing. In addition, older people in Viet Nam hold a key position in preserving and developing traditional occupations in over 2,000 craft villages throughout the country. Many of them are making use of their experience to continue contributing to the society. Thousands of retirees and intellectuals are teaching at community-based education centres, or continuing their research work.
Mongolia	Due to difficulties in increasing pension amounts in line with inflation, the Government of Mongolia has implemented policies promoting employment of older persons to ensure adequate income for those who are able and willing to work. Under the Constitution and the Labor Law, older persons or retirees are entitled to engage in employment and increase their income. The Labor Law prohibits limiting wages of older workers who receive a pension, allows

	employers to reduce work hours at the request of older workers and assign them to a job which does not harm their health. Nevertheless, currently only 12.3 per cent of pensioners are employed. Employment opportunities for older persons are more available in rural areas (in cattle breeding and herding) than in urban settlements. The government of Mongolia is considering: a. Increasing the retirement age to 62 years for both men and women[4]. b. Supporting older entrepreneurs with micro credit schemes and the establishment of co-operatives
Thailand	The Act on Older Persons (2003) stipulates that older persons have the right to appropriate occupations and suitable occupational training.
India	The National Policy on Older Persons (paragraph 31) states: a. Employment to generate income after retirement is an individual choice b. NGO programmes for assisting older persons to generate income will be supported by the Government c. Age related discrimination such as in access to credit, will be removed d. Measures will be taken to protect the elderly from structural adjustment policies in some sectors.
(2) Pension Plans	
Viet Nam	Universal social pension scheme for those aged 85 years and above. The age criterion limits the number of older persons entitled to a pension. NGOs are seeking to reduce the age threshold to provide greater coverage of the allowance.
Mongolia	Universal social pension scheme. At present, 80 per cent of the elderly population, which includes women aged 55 years and older, is entitled to an old age pension, for which the Government allocated 111.6 billion Mongolian Tugrug (US$93.8 million) in 2006. Pensions and allowances provided for under the Social Security Law and Social Security Fund have been increased. The average pension has increased five times compared to 2000, and 2.4 times compared to 2004
Thailand	Thailand's Old Age Allowance which gives around US$15 per month (500 baht) to the poorest older people. This allowance is accessible to approximately 2 million persons (around 25 per cent of the entire older population) Old Age Pension Fund, which operates under the Social Security Fund, is regarded as the Pillar I pension for the private sector in Thailand.

[4] Currently the retirement age is 60 years for men and 55 years for women.

India	The National Old Age Pension Scheme provides a monthly allowance of Rs. 75 to poor older persons aged 65 years and above.
(3) Welfare benefits	
Viet Nam	(1) Social Guarantee Fund for Regular Relief which targets vulnerable elderly alongside other groups in need. Older persons aged 85 and above who are poor, living alone or living with their spouse without any support from their children, or without pension and other social allowance are entitled to a monthly social allowance of 120,000 Viet Nam Dong (US$7.5). In 2004, 87 per cent of older people living alone received allowance of US$5 − 15 and another three per cent were taken in to care in residential settings.
Mongolia	(1) The Law on Benefits and Services for Elderly states that older people are entitled to received various kinds of benefits and services including housing, grant aid and free admission tickets to health resorts or care homes. (2) Law on Social Security for Elderly People (updated in 2005) regulates the elderly' entitlement on: - Conditional cash benefits - Assistance and discounts - Targeted nursing care services - Community based social welfare services
Thailand	(1) The Elderly Fund that was established in 2004, is a source of funding to protect, promote and support older persons (2) Tax Privilege for older persons (3) Assistance to older persons who face social problems such as emergency in housing, foods, clothing and legal proceedings.
India	(1) The Free Food Service under the Annapura Scheme, provides 10 kilogrammes of grains free of cost to destitute older persons not covered under the National Old Age Pension (2) Various tax reductions for senior citizens aged 65 and above (3) Various transportation costs reduction for older persons (e.g. 50 per cent for buses, 45 – 50 per cent for air travel on a few airlines, 30 per cent for trains)

Sources: (a) ESCAP (2008a). "Regional Overview on Gender Responsive Health-care and Social Security Policy for the Elderly";

(b) ESCAP (2008b). "Report of the Workshop: National Workshop on Gender Responsive Social Protection and Health Security for the Elderly";

(c) ESCAP (2008c). "Report of the Workshop: National Workshop on Gender Responsive Social Protection – Health Security for the Elderly";

(d) HelpAge International (2007). *Age Demands Action in Vietnam. Progress on implementation of the Madrid International Plan of Action on Ageing (MIPAA)*;

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(h) World Health Organization (2004). *Health of the Elderly in South-East Asia A Profile.*

E. Policy Area II: Improving the provision of health service

As the biological process of ageing might increase a person's susceptibility to disease and disability, therefore, maintaining good health conditions is one of the main challenges for the elderly. In connection to this, accessibility and affordability of health services are important. Under the policy area of improvement of the provision of health services, three interventions will be explored: (1) providing health care through insurance schemes; (2) meeting special needs of older women affected by HIV and AIDS or disability; and (3) disseminating information on old age related diseases and preventive health education. Table nine below shows some aspects of situation in the four countries that are relevant to improvement of health services for older people.

In many developing countries, medical costs related to long-term care and hospitalization can be a trigger of impoverishment. To increase affordability of health-care services for older persons, augmenting sources of income for them needs to be supported by measures that ensure the health care services will be financed even if the costs might exceed the patient's income. This is especially important for the financially vulnerable elderly. The '30 baht health care scheme' in Thailand is an interesting example of universal health insurance programme as this scheme can provide protection for those who cannot access any other health care scheme. In Viet Nam there is free health insurance, but the coverage is very limited because only those 85 years and above are entitled to the benefits. In Mongolia, the State covers the health costs of elderly people with low income. However, in rural areas, health insurance and good quality health care services and facilities are often inaccessible. Various health insurance schemes do exist in India, but the coverage is inadequate; the majority of the elderly are not protected by any health insurance scheme.

Although older persons have been infected with HIV in all of the four countries, the scale of the spread of infection varies. A greater number of older people – especially older mothers − has been affected by the epidemic through their role as the primary care giver for their adult sons or daughters living with AIDS. The long-term care often causes emotional, physical and financial hardship for these ageing parents; as they also have to raise the orphaned grandchildren. In Viet Nam, special clubs have been established to

support the elderly affected by HIV and AIDS. They can obtain loans from these clubs to open small business and increase their income. In Mongolia, a Law on Prevention of HIV and AIDS has been enacted, but it does not identify any form of social protection for caregivers of people living with AIDS − often the ageing parents.

Different types of institutions have been established in India, Mongolia, Thailand and Viet Nam that conduct research and trainings on geriatrics and provide information on old-age related diseases and health care. But to what extent the knowledge is disseminated and received by the wider public needs to be scrutinized further. Initiatives such as elders' clubs are often only accessible for the relatively well-off who would like to spend their time engaging in useful and healthy activities such as sports and social gatherings. In India, grass roots NGOs have played an important role in disseminating information on health services and facilities available for the elderly. Their activities are specifically aimed at reaching women in rural and remote areas.

Table 9: Improving the provision of health services in India, Mongolia, Thailand and Viet Nam.

(1) Health Insurance Scheme	
Viet Nam	Those aged 85 and above are entitled to free health insurance and funeral support in the amount of Viet Nam Dong 2,000,000 (from January 2007). Almost 70 per cent of the older population received free health insurance cards. They are also entitled to stay in community social houses or government social protection centers, if they wish.
Mongolia	According to the Law on Health Insurance of Mongolian Citizens, the State is responsible for the payment of the health insurance contribution of older persons, who have no other cash income apart from their pensions. A total of US$2.4 million was spent from the health insurance fund for medical services, concession for medicines and other expenses related to health care of the older population. Rehabilitation services and facilities for the elderly have been set up in all provinces and districts. However, there is still an unmet need to advance the health insurance system and improve quality and accessibility of the health care services, especially for the elderly in rural areas.
Thailand	The Thai Government launched a health policy in 2001 which provides health insurance for all people who were not covered by any health scheme, charging them a flat rate of a 30 bath (less than $1) for all government health services. In addition, a health card has been given to appropriate people to enable them to

	access health services, although there are limitations on the number of places registered where the health card can be used. Persons aged 60 years and over can request a health care card from the government hospitals nearest to their homes. The benefit package includes in- and out- patient treatments at registered primary care facilities and referrals to secondary and tertiary care facilities, dental care, health promotion and prevention services, ambulance fees and drug prescriptions.
India	Health insurance schemes in India are quite limited, only covering about 10 per cent of the total population. The existing schemes can be categorized into: (1) Voluntary health insurance scheme or private-for-profit schemes (such as Mediclaim Policy) (2) Employer-based scheme (3) Insurance offered by NGOs or through community based health insurance (this is typically targeted at the poor population in the community) (4) Mandatory health insurance scheme or government run schemes (including the Central Government Health Scheme and Employees State Insurance Scheme) In general, health insurance in India is still inadequate. About 87 per cent of the elderly do not have any health insurance.
(2) Specialized care for older women with disability and/or HIV/AIDS	
Viet Nam	Currently Viet Nam has 129,715 people infected with HIV, 26,840 people with full-blown AIDS. According to a survey conducted by the Viet Nam Women's Union in 2007, about 74 per cent of people living with HIV/AIDS who responded to the survey were being taken care of by their parents or grandparents, 68 per cent of them by their mothers and grandmothers. Findings from another survey conducted by the Viet Nam Association of the Elderly among older people, who had a family member living with AIDS, showed that 82.6 per cent of these elderly had to take care of one to three family members. While older people play an important role in caring for their children living with AIDS, the official policies do little to support them. In collaboration with the Viet Nam Women's Union, HelpAge International has helped 1,394 older people who are members of 67 empathy clubs – including those are affected by AIDS - provide loans to start income generating activities. Most of them have used the loans to open small business like outdoor rice stands. Many raise pigs and farm tiny plots of land.
Mongolia	Mongolia is in the early stage of HIV epidemic with 28 reported cases of HIV infection (Health Statistics, February 2007). While this number may look small compared to number of HIV infected people globally, the number of infections – mainly through sexual transmission − appears to be increasing rapidly in the country. Therefore, control and prevention of an AIDS epidemic has been a

	priority for the Government for many years. The Law on Prevention of HIV and AIDS amended in 2004 refined a formal structure for combating an AIDS epidemic and identified the rights and duties of people infected by HIV so as to be consistent with international conventions and standards. This law does not regulate support for people infected by HIV, namely the care givers who are mainly family members and usually elderly parents).
Thailand	By the end 2007, the estimated number of people living with AIDS is 600,000 and adult HIV prevalence is 1.4 percent. Around 42 per cent of HIV infections have occurred among women. Extensive research on AIDS related care giving in Thailand indicates that parents – usually the mother – provided care for almost two-thirds of the adults who died of AIDS and acted as primary care givers for half of them. The vast majority of those parents were aged 50 and over and 40 per cent were aged at least 60[5]. The research also demonstrates that many adults with AIDS had returned to their parental home after becoming ill.
India	In 2007, the estimated number of people living with AIDS is 2.4 million and adult HIV prevalence is 0.3 per cent. Similar to Thailand and Viet Nam, older people are affected by HIV and AIDS in various ways (e.g. economically and emotionally) mostly through their role as care givers of adult children living with the disease. They also often have to raise the orphaned grandchildren.
(3) Information dissemination on old age-related diseases and preventive health education	
Viet Nam	(1) The National Institute of Gerontology conducts research and provides training and technical support to health practitioners on health care for the elderly. (2) Viet Nam Association for the Elderly (established in 1995) has launched a website that covers news and information on population ageing and older persons. Around 85 per cent of older people in Viet Nam are members of the association.
Mongolia	(1) Rehabilitation Center of Gerontology (established in 1999) is responsible for conducting training and surveys and providing advice on population ageing and health issues of older people at national level.
Thailand	(1) Geriatric training programmes for older persons, care givers and health care providers have been initiated by the Thai Government. These trainings provide

[5] Research conducted in Uganda, Zimbabwe and Ethiopia also showed similar pattern.

	knowledge and skills and are offered in nursing schools and medical colleges. (2) The National Commission on Elderly and the Bureau of Empowerment for Older Persons has a mandate to coordinate dissemination of information, public relation and activities (including studies, data collection and analysis) concerning older persons. (3) The Thai Society of Gerontology and Geriatric Medicine organizes a meeting for health care professionals each year. (4) Education for healthy older persons in art, music, cooking and access to the Internet are provided in Elders' Clubs and at some universities and private organizations.
India	(1) Educational strategies under the national policy for older persons and caregivers include providing information and educational materials relevant to the daily lives of older persons. (2) Educational programmes have been initiated for health care providers such as special training in geriatric care in medical colleges and in-service training on geriatrics. (3) NGOs have an important role to play in disseminating information on services available for the elderly, as well as in assisting the government to implement these policies, especially for ensuring that they benefit older women in rural and remote areas. An example is the Center for Health Education, Training and Nutrition Awareness (CHETNA) that has developed grassroots programmes to improve the quality of life of older women.

Source: (a) ESCAP (2008a). "Regional Overview on Gender Responsive Health-care and Social Security Policy for the Elderly";

(b) ESCAP (2008b). "Report of the Workshop: National Workshop on Gender Responsive Social Protection and Health Security for the Elderly";

(c) ESCAP (2008c). "Report of the Workshop: National Workshop on Gender Responsive Social Protection – Health Security for the Elderly";

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(h)United Nations Population Fund (UNFPA) and Ministry of Social Welfare and Labour (2007). *Population Ageing in Mongolia: Ensuring Dignity in Old Age;*

(i) World Health Organization (2004). *Health of the Elderly in South-East Asia A Profile.*

F. Policy Area III: Upgrading health services infrastructure

Improvement of health services discussed above requires adequate infrastructure. Health infrastructure should respond to community needs that are determined by geographical location in each country. Under this policy area, three interventions are identified: (1) creating more primary health centers; (2) establishing specialized primary health care centers for older people, with a focus on older women; (3) using innovative methods such as mobile medical or home care services to expand the geographical outreach of health services. Table 10 shows availability of primary health centers and some innovative methods promoting the well-being of older persons in the four countries.

In India, Mongolia, Thailand and Viet Nam, primary health centers are widely available. Nevertheless, generally the health-care professionals who work in these centers do not have sufficient knowledge of geriatrics. Therefore, doctors and health workers in primary health clinics should also be trained in interdisciplinary geriatrics including broad understanding of the biological and health aspects of ageing as well as the social and psychological aspects. They must also be trained to understand and address gender-related health care needs. In addition, it is important to deal with barriers faced by older persons to utilize health-care services (including the primary health clinics) such as: limited public transportation and long queues at the clinics. In India, geriatric clinics and wards have been established and separate queues (also for billing and pharmacy counters) for older persons are available. Moreover, NGOs also provide mobile health services for older populations in rural areas. Innovative approaches such as mobile health services can be used for periodic heart, blood pressure, diabetes and eye check-ups, for diagnosis and treatment as well as for providing health education. These services must also be equipped to meet the specific needs of poor older women living in difficult or remote areas.

Socially and politically innovative methods for promoting well-being of older populations can also be found in the four countries. In Viet Nam, there are efforts to strengthen older people's participation in decision making process, for instance by increasing their numbers among local leaders; while in Thailand an 'Older Person's Brain Bank' has been established where senior citizens with knowledge and experiences can contribute their expertise to society.

Table 10: Availability of health centers and innovative methods to promote the well-being of older persons in India, Mongolia, Thailand and Viet Nam.

(1) Health Care Centers (Primary health centers and **specialized health centers for older persons)**	
Viet Nam	Viet Nam has a nation-wide public health care system that aims to reach the general public including those in the remote parts of the country. The facilities within the system, however, lack staff with specialized knowledge and therefore cannot provide geriatric care services. According to a report commissioned by the Ministry of Health in 2007, of 32 health clinics and 10 hospitals surveyed, only 28 have a geriatric ward and only 46 per cent of the health workers have received training in geriatric care. Limited human resources and unavailability of facilities and funding hinder the establishment of geriatric wards in hospitals.
Mongolia	In Mongolia, health facilities at the level of primary and secondary care are organized according to state administrative units: the capital city, *aimags*, *soums* and *baghs*. Every *soum* has a small hospital with 15 – 30 beds, which delivers a narrow range of clinical services and ambulatory care. The *soum* hospitals also provide primary care services and three to four *bagh feldshers*[6] who work in remote health posts and cover the health needs of the nomadic herders. General hospitals are in *aimags* while tertiary level care and specialized care centers are mostly located in Ulaanbataar.
Thailand	In Thailand, health care is provided both by the public as well as private sector. The Ministry of Public Health is the principal agency responsible for promoting, supporting, controlling and coordinating all public health service activities. Public health care facilities are available throughout the country from regional, provincial, district and sub-district levels all the way to village level. In addition, there are health volunteers at the village level. The private sector has played an important role in providing curative care. Health care services are classified into five levels namely, self care, secondary care, tertiary care and specialized care. Specific care for older persons belongs to the specialized care that is provided both by Government as well as NGOs.
India	In India, the elderly can receive all levels of healthcare namely in primary, secondary and tertiary health facilities, including in geriatric clinics and wards. Separate queues for the elderly are available in clinic and hospital, for billing and at pharmacy counters. In addition, NGOs provide services such as rural mobile health services, eye check ups and cataract surgery. Private geriatric clinics and a geriatric hospital are also available.

[6] Medically trained primary health care workers usually work in remote rural regions.

(2) Innovative methods of promoting the well-being of the elderly	
Viet Nam	The strengthening of older people's participation in decision-making processes (i.e. involvement in influencing policies and plans that will affect them) includes: (1) Increasing the number of older people as local leaders (2) Including a representative of the Vietnam Association of the Elderly as a member of Parliament (3) Establishing up 10,000 Elderly Associations within communes (4) Establishing in 2007, a poverty reduction fund of 2.4 billion Viet Nam Dong (US$150,000) per year, to be allocated to support the work of older people's groups in health and livelihood activities at national and local level.
Mongolia	(1) Establishment of a cultural and recreation center in Darkhan–Uul aimag that functions as meeting place for older persons. The center is also equipped with various sport facilities and an activity center. However, the center has faced challenges in its financial sustainability. (2) Around 3 – 4 million Mongolian Tugrug has been allocated in Tuv aimag to solve the housing problem of the older population. The funding is used to provide new houses (gers) for older people and for renovation and improvement of the existing houses.
Thailand	(1) Availability of residential homes for impoverished older persons (2) Establishment of an Elders' Club which functions as the center of a network for older people and for raising awareness on issues concerning older people. Currently there are approximately 4,000 elders' clubs in Thailand. (3) Older Person's Brain Bank, a center comprising senior citizen with knowledge and experiences who are willing to contribute further to society after their retirement.
India	(1) All Indian Movement for Seva (AIM for Seva) has started much needed mobile medical services in four states of India. The mobile medical service is particularly appropriate in rural contexts, as it removes both physical as well as psychological barriers to people accessing medical care. It operates with one doctor and one nurse who visit 4 to 5 villages on a particular day, and hence covers 25 villages per week. This form of service is also financially viable as it minimizes infrastructure costs related to creating hospitals and expands geographical outreach by visiting several villages on a given day. (2) HelpAge International runs an income generating project for older persons and an Adopt a Granny scheme that gives direct financial support to older persons and organizations that provide care for them. (3) There are approximately 728 old age homes in India. Of these, 325 are free of charge, 95 operate on a pay-and-stay basis and 116 have both free as well as pay-and-stay facilities. Around 278 old age homes are available for the sick and 101 homes are exclusively for women.

Source: see Table 9

G. Policy Area IV: Allocating resources for health-care

Increasing health-care requirements of a rapidly ageing population will require immediate policy formulation as well as implementation. Subsequently, the implementation of a national policy will certainly need to be facilitated with sufficient funding. Consequently, it is important that governments allocate enough resources for this purpose. The fourth policy area is therefore allocating resources for health care, under which two main interventions are explored: (1) increasing government spending on health care programmes, with a focus on women; and (2) establishing partnership or cooperation between the public and private sector to serve the older population. Table 11 provides information on expenditures in health and different forms of public-private partnership and collaboration in the four countries.

Aggregate figures of Government health expenditure in a country cannot indicate the extent of their commitment to allocating financial resources for certain segments of population such as older persons. Potential obstacles for that commitment include: challenges Governments face in mobilizing and allocating sufficient resources for health financing in general. In countries where population ageing has resulted in a decline in the proportion of the working-age population, the tax base has also been narrowed. This intensifies the problem that is related to budgetary allocation of health care programmes for the older population.

Furthermore, in Japan, good sustainable elder care programmes have been identified that that are supported by sufficient funding; namely, the Ten-Year Strategy to Promote Health Care and Welfare for the Elderly (Gold Plan), introduced in 1989. This plan was revised in 1994 under the name New Gold Plan and its budget exceeds 6 trillion yen for the entire ten-year period. Another new plan, known as Gold Plan 21, was launched in 2000 with specific measures such as improving long-term care services, developing community support systems and establishing a social foundation to support the health and welfare of the older population. These revisions indicate that the Government of Japan is committed to sustaining a long-term health plan for the elderly in various ways including in budgetary allocation. In Japan, the average government health expenditure during the period of 2000 to 2005 was relatively high at almost 17 per cent (http://web-japan.org/).

In 2001, Thailand became one of the first middle-income developing countries to introduce a universal health care policy. The Government started its 30 baht health insurance scheme to offer the poor and the disadvantaged better and more equitable access to health care and health services. The programme now covers some 20 million people who previously were not covered by any health insurance. Initially it was estimated that public funding totaling 100,000 million baht would be required to sustain the programme and become an unsustainable burden on state revenue. But, the benefits of the programme were soon realized because, to some extent, the universal health insurance

has been able to reduce the gap in provision of health care services for the poor and the non-poor (Youngsuksathaporn, n.d.). Data from Statistical Yearbook for Asia and the Pacific (United Nations 2007) shows that in 2004, the general Government health expenditure in Thailand (11.2 per cent) was higher than in Mongolia (9.4 per cent) and substantially higher than in Viet Nam (5.0 per cent) and India (2.9 per cent). An adequate proportion of the increased budget must be specifically allocated for promoting the health and well-being of the older population.

One of possible solutions for dealing with limitations in budgetary allocations for health care is public private partnership or public-private collaboration. "Given budget constraints, it is becoming increasingly essential for governments to identify private sector and NGO partners in order to enlarge the depth and breadth of services provided. Such partnerships are capable of providing a range of health services that governments alone cannot deliver with the resources available. Governments also have to realize the critical role that non-profit institutions can play in providing outpatient curative and rehabilitative care. These types of partnerships are becoming increasingly popular throughout the region" (ESCAP 2008a, 25 - 26). Examples of these types of partnerships for geriatric health services may be found in various countries such as India, Malaysia, Philippines and Sri Lanka

Different forms of public-private partnerships for addressing HIV and AIDS prevention also can be found in Thailand and Viet Nam. As discussed previously, parents of people living with AIDS are often older people that need to be supported in order to cope with the financial, physical and emotional burden of being the primary care giver of their infected adult children. Therefore, partnerships in HIV and AIDS prevention should also target this particular group.

Table 11: Expenditures in health and different forms of public private collaboration

(1) Government spending on health-care programmes for older persons	
Viet Nam	In 2004, the total expenditure on health care relative to GDP was 5.5 per cent. The per cent of general Government health expenditure is 5.0 per cent while the per cent of total expenditure on health which is private expenditure is 73 per cent. About 88 per cent of the private expenditure on healthcare is the out-of-pocket expenditure. Although Circular N. 116/ 1998 issued by the Ministry of Finance provides guidelines on financial support for the Vietnam Association of the Elderly, in practice the association's activities are far from meeting the needs of the elderly due to the limited budget and human resources available. The National Institute of Gerontology only functions as a hospital for the elderly instead of conducting research on issues related to older persons and providing direction and technical support for the formulation and implementation of national policy on ageing. The Government has issued an Ordinance for the Elderly and Decree No. 63 on health insurance for ageing persons. This Decree grants health insurance to all those who are above 85 and single, without pensions or social subsidies. However, the provinces have difficulties to provide the financial support due to their limited budget. Policies are formulated at the national level but the budget allocation for implementation by the local government is often inadequate.
Mongolia	In 2004, the total expenditure on healthcare relative to GDP was 6.0 per cent. The per cent of government expenditure on health is 9.4 per cent while private expenditure on health is 33 per cent. About 92 per cent of the private expenditure on health is the out-of-pocket. In recent years, there has been a significant increase in resources allocated by the Government of Mongolia for health and social protection in general. This resulted in improved accessibility and effectiveness of health services and social security benefits provided for its citizens. The Ministry of Finance approved a budget of 217.9 billion Mongolian Tugrug. Pensions and allowances provided under the Social Security Law and Social Security Fund have been increased. The average pension has increased 5 times compared to 2000, and 2.4 times compared to 2004. The Social Insurance Fund expenditure at had increased to 7.8 per cent of the country's GDP. About 255.2 billion Mongolian Tugrug (About US$170.5 million) is spent annually from the state budget to fund allowances, benefits and discounts provided by the Social Security Fund in accordance with the Social security Law.

Thailand	In 2004, the total expenditure on health relative to GDP was 3.5 per cent. The per cent of general Government health expenditure was 11.2 per cent while the per cent of private expenditure on health care was 35 per cent. About 75 per cent of the private expenditure on health was out-of-pocket. Since 1970, the Government budget allocation has moved away from national security-related expenses in favour of education and health. As a result, the proportion of total allocation made to the Ministry of Public Health increased from 3.4 per cent in 1970 to 4.8 per cent in 1990 and to 8.1 per cent in 2004.
India	In 2004, the total expenditure on healthcare relative to GDP was 5.0 per cent. The per cent of government expenditure on healthcare was 2.9 per cent, while private expenditure on health was 83 per cent of total. About 94 per cent of the private expenditure on health was out-of-pocket.
(2) Public Private Collaboration to serve the older population	
Viet Nam	An example of public private collaboration in the health sector in Viet Nam is work carried out by Pathfinder, an international organization working on reproductive heath and has supported the Ministry of Health and eight provincial governments in Viet Nam since 1994. In 2004, Pathfinder initiated an innovative project promoting a more effective link and collaboration between the public and private sectors in addressing HIV and AIDS prevention at the provincial level. The activities to facilitate public private collaboration were mostly in the form of capacity development and upgrading of both private and public sector facilities. Together with national and provincial partners, Pathfinder has worked to increase the capacity of public sector referral centers to offer high quality, model services in HIV prevention counseling and referral, standard precautions, and stigma reduction. The improved services are now being promoted within the public sector network as well as to private providers such as private hospitals, clinics, and pharmacists. At the same time, the project has reached out to private sector providers, offering them training in related topics. The project also has promoted the establishment of an advisory group that will help both sectors to work together and has introduced a supervision approach that the public sector will apply in supervising the private sector.
Mongolia	N/A
Thailand	An example of public-private and community partnership in health sector in Thailand is the ESCAP Project (2003 – 2004) to improve access of people living with AIDS to quality-assured related services. This Project defined the different role and function of each stakeholder (i.e. the public sector, the private sector and the civil society organizations) to achieve

	the project goals. The public sector provided the overall guidance and supervision hospital-based technical expertise, human resources and laboratory facilities. The private sector provided financial and in-kind resources to support the Center for People and Families affected by AIDS, including the marketing and retailing of products made by people living with HIV and AIDS. The NGOs carried out income generating activities, identification and mobilization of potential partners for the project and provided technical expertise and trainings.
India	There are various forms of public-private partnership in the health sector of India. A recent study shows a wide spectrum of such partnerships in the health sector in terms of rural verses urban mix, for-profit and non-profit partners, primary care versus specialized care, clinical services to insurance schemes, laundry services to mental health helplines. Karuna Trust in Karnataka state is an example of a public-private partnership in primary health care that runs 26 primary health care centres in all districts of Kanataka state and nine primary health centres in Arunachal Pradesh. In this arrangement, the partners are the Government of Karnataka and Karuna Trust and the services include: contracting out management of the centre and affiliated sub-centers in remote, rural and tribal areas in the state. For specific types of geriatric care, the government can also collaborate with NGOs such as Age-Care India, which is working for the well-being of older people. This NGO has started programmes whereby economically independent older persons from various strata of society engage themselves in community work and offer their services to those who need them.

Sources: (a) ESCAP (2008a). *"Regional Overview on Gender Responsive Health-care and Social Security Policy for the Elderly";*

(b) ESCAP (n.d). "Providing Basic Services to the Poor through Public-Private Partnership: ESCAP Follow Up to the World Summit on Sustainable Development (WSSD): Health Component";

(c) Pathfinder International (n.d). *Responding to HIV/ AIDS Vietnam: Fact Sheet;*

(d) Raman, A. and Bjorkman, J. W. (2008). *Public-Private Partnerships in Health Care in India*, Routledge Studies in Development Economics Series;

(e) www.karunatrust.org

This section demonstrates that population ageing has increasingly become an important socio-demographic phenomenon in India, Mongolia, Thailand and Viet Nam. In all four selected countries, national focal agencies, policies, programmes and regulations on ageing do exist. Thus, it can be said that these countries have the necessary policy and legal framework to facilitate national and international endeavors to promote older people's welfare.

The four selected areas of policy interventions suggest issues that need to be addressed through macro policies. According to the first policy area, older persons must have

opportunities to obtain sufficient income through employment, pensions or social allowances. This issue has been addressed in national policies and regulations on ageing in the four countries, but the existing old age pension schemes and benefits have not reached the targets effectively. Moreover, the amount of provided allowances is often insufficient. The second policy area deals with the provision of better health services for older persons, especially through universal coverage of health insurance. However, this is available in only a few countries. Among the four selected countries, Thailand can provide an interesting example of universal health insurance with its 30 baht scheme. This means, the majority of older persons in the region are not protected yet by any health insurance. Many countries have neither sufficient financial nor institutional capacity to supervise a universal health insurance programme.

The third policy area brings to the fore the necessity of upgrading health infrastructure especially that of the primary health centers. In the four countries, such centres are widely available but most of the health professionals who work in them are not equipped with appropriate geriatric knowledge. Therefore upgrading of health infrastructure must include training of the health workers in geriatrics. The fourth policy area can be perceived as the foundation of any policy design and its implementation; namely, the budgetary allocation. Increasing Government spending on health care and developing cost effective programmes through public-private partnerships are identified as possible policy interventions. Some countries in the region such as Japan are committed to allocating sufficient fund for long-term health plans but many others are (still) not able to do so. The public-private partnership initiatives in health sector have produced some good results in India, Thailand and Viet Nam, but at the current stage they still need strong support in terms of funding and supervision from international donor agencies.

Considering the magnitude and complexity of rapid population ageing vis-à-vis various obstacles at national and regional levels (i.e. limited financial and institutional capacity, disadvantageous socio-political situations including lack of political will and inefficient coordination), the formulation and implementation of macro policies and programmes promoting older people's welfare are often still "patchwork" in any regards. However, every effort to meet the challenges of population ageing is a part of a learning process to achieve better results. Examination of the four selected countries in this section highlights various national initiatives that can be improved in order to ensure healthy, active and dignified old age for all.

III. CARE FOR OLDER PERSONS FROM A MICRO PERSPECTIVE: LEARNING FROM THE ABSENCE OF FAMILY SUPPORT FOR OLDER CHILDLESS WIDOWS IN EAST JAVA, INDONESIA

A. Learning from micro perspective: Ageing as a private issue

In this section, population ageing is analyzed from a micro perspective; namely through the absence of support relationships among family members. Challenges related to the provision of care for older women are understood as private issues that affect individuals and those immediately around them. Responses to the challenges regarding elder care are examined through various resources and forms of support, including the ways in which support mechanisms work − or do not work. The section is based on an anthropological study of support for older widows in urban neighborhoods of East Java, Indonesia[7]. This study was selected for the micro level case study, for a few reasons. First, the study can demonstrate various consequences of ageing in the day-to-day life of older women; and therefore can show a concrete picture of the feminization of ageing. Second, the study identifies factors that determine how family supports work, why they work and in what ways. As will be discussed further in the next sub-section, for many older persons, especially those who live in situations where the social security system is largely inadequate, family is an important source of support. Nevertheless, the availability of family support is precarious. The extent to which it can help older persons sufficiently depends on many factors such as the quality of relationship (emotional closeness), availability of providers, resources and means of support. Detailed insights on these factors can prevent the romanticizing of the importance of family support, especially by policy makers.

This micro level study presents individual cases and detailed analysis of various problems that are faced by a vulnerable group of older people, namely older childless widows, and what coping options are available to them. These problems and coping options do not only reflect situations of the individual widows and their families but also situations in wider contexts such as in the community and society. Cases of elderly childless widows who died alone after a long period of illness without receiving any appropriate health care are certainly not only personal tragedies. Such cases can also indicate the absence of family and community support; and the lack of a general social security system in the country. Therefore, the roots of the problems should be sought at different levels namely, the micro-level (i.e. household, family relations), the meso-level (i.e. communal solidarity including civil society groups) and the macro-level (i.e. national policies and programmes, international assistance). From the policy-making point of view, what happens at the micro level (in this case, problems that are faced by elderly childless

[7] A Ph.D. study conducted under the research project 'Social Security and Social Policy in Indonesia', University of Amsterdam, funded by the Royal Netherlands Academy of Arts and Sciences. The anthropological research was carried out intermittently between 1997 and 1999, and then followed by yearly re-visits until 2004 to the research sites in Malang a city in East Java Province, Indonesia. The research population consisted of 111 widows. The data were collected through in-depth-interviews and a small survey (Marianti 2002).

widows), can provide insights on what kinds of challenges and issues need to be responded to with macro policies and programmes and what the effective policy interventions are in terms of design (e.g. measures, targeting, resources/budgetary allocation), implementation, monitoring and evaluation.

B. Population ageing and national initiatives for older persons welfare: A brief overview of Indonesia's situation

Within a period of a hundred years, the proportion of the population 60 years and above in Indonesia is expected to increase four times, from 6.2 percent in 1950 to 24.8 percent in 2050 and most of the older population will be women. As shown in Table 2 of this paper the percentage of women in the oldest old population is consistently more than 50 per cent since 1975. This trend is expected to continue in 2025 (5.3 percent) and 2050 (54.5 per cent). Table 3 of this paper indicates some gender differences in the socio-economic circumstances of older persons in Indonesia. In 2000, the percentage of older men (48.5 per cent) who were in the labour force was twice as high as that of older women (24.1 per cent) (United Nations 2002b)**;**but the proportion of older women (60.2 per cent) who were illiterate was twice as high as that of older men (31.4 per cent). In term of marital status, the proportion of single older women (11.9 per cent) was substantially higher that of single older men (2.4 per cent) (United Nations 2007a)

The Government of Indonesia enacted 1998 Law Number 13 on the welfare of the elderly. This law states that the Government is responsible for supervising efforts for protecting and promoting the welfare and empowerment of the elderly. According to the law, older persons' well-being is to be enhanced through the provision of health care services, availability of employment, training and schooling opportunities, privileges in using public facilities and religious activities. The law also states the need to establish a national commission for older persons as a coordinating agency on ageing. In 2004, based on Presidential Decree Number 52, the National Commission for Older Persons was established. The Commission has several functions; namely, (1) coordination; (2) analysis and research; (3) advocacy and socialization; (4) monitoring and (5) evaluation.

In cooperation with Yayasan Emong Lansia (HelpAge Indonesia), United Nations Population Fund (UNFPA) and the Department of Social Affairs and HelpAge International developed a National Plan of Action for Older Person's Welfare in October 2003. The plan set out seven strategic steps to improve the welfare of older population: (1) formation and strengthening of older persons' institutions; (2) strengthening coordination between related institutions; (3) strengthening the management of poor, neglected, disabled and victimized older persons; (4) maintaining and strengthening family and community support for the aged; (5) reinforcing health services for older persons; (6) improving older persons' quality of life − economic, mental, religious and self-actualisation; and (7) increasing the availability of special facilities for older persons.

Despite the development of a national plan in 2003, currently, the implementation of national initiatives to promote the well-being of the older population is, in general, still sporadic. Yayasan Emong Lansia provides information on population ageing, relevant activities and publications through a website, which is an example of a continuous initiative to disseminate information on older people in Indonesia. There are also initiatives to provide community-based home care services for the elderly. In the mid-seventies, women organizations in Jakarta organized home care for disadvantaged elderly in their communities. Services provided for them were meals six times per week, religious activities such as reciting the Kor'an once a week, a health examination once in two months, and a donation, given usually on religious holidays. Recently, HelpAge Korea through the Republic of Korea-ASEAN Cooperation Fund, conducted a project on community based home care in nine ASEAN countries including Indonesia. It as awarded to Yayasan Emong Lansia that pre-tested these services by recruiting volunteers as home helpers for poor disadvantaged elderly in the community. This project has been extended for the next three years to include two more provinces namely Jogyakarta and Aceh and it has been adopted by the Government through its Department of Social Affairs" (Abikusno 2007).

Specialized health care services for older persons are available although they are mostly still concentrated in urban areas. Some private and public hospitals have established gerontology units. Some primary health centres (the PUSKESMAS) in big cities such as Jakarta, provide semi-specialist services such as for heart, lung, eye dysfunctions. In total, only around 10 per cent of Indonesians are covered by health insurance schemes. A small group of older persons who are entitled to health insurance are the retired civil servants and members of the Indonesian army (including their spouses and widow/widowers). But the vast majority have to find other ways to finance their health costs. In addition, there is no discount/ costs reduction programme specifically designed for the elderly to help them in coping with health and transportations expenditures.

The situations briefly described above demonstrate that many older persons in Indonesia – and in other countries with similar situations − have only limited options to access old-age care. One of the options is family support. The following sub-sections will examine the 'worst case situation'; namely, when older people cannot access and rely on family support.

C. How important is family support in Indonesia?

In Indonesia the importance of family support is often stressed in ideological terms. The idea that family members should and will assist each other in times of distress has a significant influence on the country's welfare policy. Policy-makers tend to perceive matters such as care and housing for the elderly as family matters, because whenever it is needed the family is said to take care of and protect its vulnerable members (Niehof 1997). Apart from this kinship ideology, the circumstances in Indonesia, notably limitations of other sources of support, such as the community or the state, further

strengthen the idea that the family is the most important source of support. It is important to bear in mind that "family" support usually falls on women to provide. Community-based help, such as neighbourly assistance, represents one real alternative, but it is not without its limitations. In practice, family and neighbourly support are often intertwined in the sense that help from neighbours complements or substitutes for family support.

Neighbourly support is very important for coping with emergency situations or sudden crises. In an emergency, people who can be reached easily because they live nearby tend to be the ones who provide immediate assistance. However, when compared with family support, help from neighbours usually does not include intensive and durable forms of assistance, such as major nursing tasks, such as washing, dressing or feeding a person and helping them with going to the toilet**.** Moreover, the extent to which support can be rendered is, among others things, determined by the availability of means. When means are limited, priorities have to be set and choices made. Support is then provided according to the degree of the provider's commitment to helping certain recipients. In this situation, it is not uncommon for people to opt, in the first place, for their own family. Study of widows in urban Java uncovers a tiered landscape of support relationships, what can be called a 'hierarchy of rights and duties' (Marianti 2002). The study demonstrates that family members occupy a higher place within that hierarchy than neighbours do, in the sense that people are commonly more obliged to help family members than neighbours.

The lack of State interventions is an additional reason why family support is considered so important in Indonesia. The number of people who benefit from State social security insurance schemes is still small so the majority of people do not have direct access to State resources. The exclusivity of the State supervised social security is similar to the market based or private insurance schemes. Although the business activities of insurance companies is growing, buying private insurance policies for better protection against various risks and contingencies is not a realistic option since most since monthly premiums are simply unaffordable for most people. Because most people are not covered by health care insurance, they have to pay cash every time they seek medical care. Therefore, in the case of hospitalization for example, people have to use their savings, pawn or sell their valuable assets including houses and land, or borrow money even at high interest rates in order to pay for medical care. When these options are not accessible any longer, there is no alternative but to turn to their families—and to some extent their neighbours—for assistance and the sick person would usually be taken care of by family members at home, although this results in lack of necessary medical treatment and professional care.

Despite these general circumstances, the actual importance of family support remains debatable. Family relationships are often complex and ambivalent. They are commonly portrayed not only in positive terms of unconditional affection, protection and loyalty, but

also in negative terms of conflict, insecurity and abandonment. This ambivalence emerges as a persistent theme, particularly when support relationships among family members are examined. In other words, family ties do not automatically make people help each other. Several studies have shown how assistance from relatives can play a significant role in helping family members to cope with a variety of problems but at the same time also note the changing and weakening of supportive relationships among family members (Lopata 1987; Finch 1989; Finch and Mason 1993; Niehof 1995; Vatikiotis 1996).

D. Widowhood, widows in Java and their sources of support

The discussion in the following sub-sections shall, analyze the importance of family support in Java by focusing on situations where this support is absent. Attention is devoted to a particular population subgroup, namely widows, for whom family support is likely to be of great importance. The group under study consists largely of middle-aged and elderly women, for whom adult children are ordinarily the most likely source of support. The important role played by children points to potential vulnerabilities among those without children. The absence of family support for widows is commonly connected to childlessness. The discussion below will focus on the problems and coping strategies of childless widows.

Widows in Java, unlike in some other cultures, are not a marginalised or excluded social category. As is outlined below, widowhood per se does not place these women in a distinct set of circumstances, and therefore in many respects, Javanese widows form a heterogeneous group. Problems pertaining to widowhood are very diverse. Nevertheless, the majority of widows are middle-aged or elderly and many of them work in the informal sector. Old-age care and economic security are among their chief concerns. Like the majority of Indonesians, most of the widows studied did not have direct access to state support. Therefore, one of the ways they cope with widowhood is by winning family and community-based support. This raises the main questions to be addressed in this chapter: if adult children are the most important providers of support for widows, what happens to widows who are childless? Which widows suffer most from the absence of family support, in particular, support usually given by children, and how do they cope? What kind of support is available to them?

In urban Java, widowhood is very much a part of people's day-to-day experience, either firsthand or within the extended family or neighbourhood. Given patterns of adult mortality, most women outlive their husbands. Widowhood as a stage in women's marital life is simply one of the inherent risks associated with being married. A widow is not blamed for the death of her spouse, nor does it negatively affect her reputation for the rest of her life. Also, there are no moral, religious or cultural restrictions on the remarriage of widows in Java.

The segregation of widows that is often found for example, in Mediterranean, Middle Eastern or South Asian societies, is largely absent in Southeast Asia. Although the death of a spouse can dramatically change the life of a married person, widows do not show their widowhood in their physical appearance. A widow is not expected to withdraw from economic, cultural or social life and her identity as a widow does not override alternative identities, such as mother, grandmother, neighbour, food trader or representative of an organisation. Indeed, the absence of strong mourning customs and of outward identification of widows and the availability of alternative valued identities for Javanese women suppress the construction of a clear-cut widow identity. Thus unlike in some other societies, where emotional and economic hardships experienced by widows may be the direct result of their socio cultural exclusion, the potential deprivations experienced by Javanese widows are usually not caused by their identity as widows as such. Most of the problems they face are basically practical consequences of losing their husbands and part of a wider set of social problems, notably ageing, gender discrimination, poverty and the exclusivity of many Indonesian welfare schemes.

Most of the widows interviewed were middle-aged and elderly women. Only sixteen per cent were under the age of fifty; fifty-nine per cent were between the age of fifty and seventy and one-quarter were over the age of seventy. Consequently, the widows often faced problems associated with ageing, such as poor-health, decreasing ability to work, and consequently, a growing need for old-age support. Nevertheless, the fact that the majority of the widows were middle-aged or old does not mean that they necessarily shared similar life situations. In fact, they represented a wide of range of socio-economic positions, from the poor petty trader who did not always earn enough to buy her daily food to the respectable pensioner or successful shop owner.

More than 90 percent of the widows had been living in Malang[8] for more than twenty years, and some were actually born there. Most of their relatives, and especially their children, also lived in cities as long-term residents there, most of those who migrated to Malang no longer maintained links with their rural areas of origin, Even those who had relatives in their village of origin were not always able to maintain good relations with kin who still lived there. Family conflict, lack of financial resources for a visit, or simple lack of interest was often mentioned as reasons for losing familial contact.

[8] Malang is a municipality with roughly 700,000 inhabitants, which is growing at a rate of two per cent per year. The city, located in a fertile valley, has a bustling centre with shops, markets, restaurants, hotels and banks. Distributed across the municipal area are a number of small industries, chiefly producing textiles, food and cigarettes. Most of Malang's income derives from these manufacturing activities and from retailing, which encompasses anything from street vendors to air-conditioned department stores. In addition Malang is renowned as a university town, with several state and private institutions of higher education, and is home to several army barracks. Thanks to its proximity to the impressive Bromo volcano and its pleasant climate, Malang also boasts a modest tourist industry.

Widows lived in various household arrangements. In the study, one in ten lived alone, usually because they were childless or their children had migrated, although in a few cases, a son or daughter resided next door or nearby. More than a quarter (27 per cent) lived with their school-aged, unmarried, never-married, widowed, or divorced children, eight per cent lived with their siblings or parents, and about two per cent had non-relatives as tenants. The majority of widows (53 per cent) lived with a married child. However, co-residence with a married child did not necessarily mean that the widows were dependent members of their children's households. Some of them were household heads, as it was the married children who had moved in with them rather than vice versa. The fact that three quarters of the widows were the owners of their house also confirms the view that they cannot automatically be considered dependent.

In order to cope with economic, practical, and emotional problems, widows may obtain various forms of family support. Economic support may be given in the form of cash transfers (gifts, loans, payments), gifts in kind, or accommodation. Depending on the purpose, economic support can be divided further into daily support and support for special circumstances or events, such as funerals, weddings, or hospitalizations. Practical support is usually provided in the form of personal care, assistance with household chores, child-care, and assistance with running a business or in dealing with bureaucracy (for example, arranging a funeral or applying for a widow's pension). Compared with economic and practical support, emotional support is less visible. In general, Javanese people tend to restrain their emotional expression, including emotions aroused by death (C. Geertz 1960:70). Consequently, emotional support tends to be provided in less intensive ways, notably through daily contact, exchanges, and conversations.

Table 12 summarises the relative importance of various sources of support for widows. In general, family members are more likely to provide support than other categories of providers such as neighbours. It is interesting to note that although in-laws are perceived as family members, only a small number of widows (10 percent) still maintain frequent contact with their in-laws after the death of their husband. Aside from the fact that some widows' in-laws have already died, relationships with affinal kin in Java are often tense (H. Geertz 1961: 27).

Table 12: Support providers mentioned by the widows by type of support rendered (per cent)

Support providers	Economic support	Practical support	Emotional support
Children	61	73	60
Parents	1	2	1
Siblings	3	5	6

Combination of sources [a]	16	4	16
In-laws	0	0	0
Neighbours	2	1	17 [b]
Servants	0	2	0
None	17	14	1
Total (N=111)	100	100	100

Source: Fieldwork data 1997-1998, 1999.

Notes: (a) This is usually a combination of parents and siblings

(b) Neighbours are often mentioned as confidants in combination with relatives who live in the same neighbourhood.

Across all kinds of support, economic, practical, or emotional, children are the main providers. There are several reasons for their dominant role. First, in most cases, children have the strongest emotional bond with their mothers. Second, most of the widows' children are economically active adults. Third, many widows' siblings and in-laws belong to the same age group as the widows and are thus potentially recipients of support themselves. Finally, most of the widows' parents have already died. The empirical data leave no room for doubt that any examination of family support needs to pay special attention to the role of children. The absence of family support for widows, indicated in the table by the categories neighbours, servants, and none, points strongly to childlessness. However, before analysing the situation of childless widows, some general points about support relations among family members, including parent-child relationships will be highlighted.

E. Support relationships among family members

People are usually involved in different sets of support relations, either as providers or recipients of support, or both. This 'multiplicity of social security', is a general feature of social organization. The engagement in multiple support relations among family members is made possible by the fact that relations among family members are not limited by their residential arrangements. Safilios-Rothschild (1980: 314) argues that, "Men, women and children may be involved in a number of different sets of relations with kin who may not reside in the same household. These different sets of relations, each with distinct rights and obligations, may be partially overlapping in membership and may extend over several residentially separated households".

Widows receive support from different combinations of family members. The Javanese kinship system is bilateral, a characteristic which may particularly encourage multiple support relations. In this system, descent is reckoned both through the male and female

line, with relatives on both sides being—at least normatively—equally important (H. Geertz 1961:15; Mulder 1996:95; Niehof 1995:87). However, the equal importance of family lines can raise ambiguities in the practice of providing and receiving support. On the one hand, people can choose at least to some extent to who they wish to provide support and from whom they wish to receive it. On the other hand, providers can be burdened by claims for support from both sides of the family. The degree of kinship may influence the quality of support relationships. In general it is first-degree relatives (one's parents, children, and siblings) who are primary providers of assistance.

A support relation is fluid because the parties involved continuously renegotiate it. These adjustments, whether positive or negative, may be stimulated by a number of different factors such as the following:

First, differing needs for support are not always compatible with the ability of families and neighbours to provide assistance. A difficult situation may arise when the availability of means (money, goods, labour, or time) is not elastic enough to deal with increasing demands for support. Financial support from widows' children may be reduced or postponed because the children face other additional expenditures, such as, new school uniforms or books, tuition fees for their children, house repairs or extra financial support for other family members including the in-laws. Such cases show the uncertainty of multiple support relationships in a bilateral kinship system. Multiple support relations are not mutually exclusive. They are connected to each other like the threads of a web in the sense that changes and adjustments in one support relation can influence other support relationships.

Second, changes in the quality of a relationship may result in an adjustment of support provision. It is commonly assumed that people are more emotionally attached to those who are considered near kin or belong to the 'inner circle' in the family network. They are also assumed to be more obliged to provide support and to have a stronger right to claim it. However, the boundaries of 'near—distant' and 'inner—outer' are not fixed and can change over time. Thus, occupying a certain position within a family network cannot assure a fixed support relationship. In practice, the obligations and rights relating to this position have to be effectuated by the actual emotional bonds, which are of course changeable as a result of conflicts and alliances, geographic distance or proximity, or moving into another class (H. Geertz 1961: 25). Changes in marital situation due to widowhood, divorce, or abandonment may also alter genealogical memory and position. As mentioned above, many widows had lost contact with their in-laws after their husbands died.

Third, the roles of provider and recipient change in the course of life. Where continuity of family support is concerned, Hashimoto et al. (1992: 297) have highlighted one of its specific characteristics, that is, the presence of "personal bonds of intergenerational

affection, obligation, and care," which imply "an interdependency among generations across the lifespan." It is not unusual for a widowed mother, now receiving support from her married child, to have been a provider for the young couple during the first years of their marriage. It is conceivable that younger and older neighbours also maintain intergenerational interdependency and reciprocity. Personal bonds among people from different generations in a family, however, are commonly more intensive and stable, because they are coloured by stronger emotional ties and connected with enduring genealogical positions.

The idea of a special bond between parents and children is commonly accepted, even romanticised. This is certainly true of Javanese families (H. Geertz 1961: 26). The dominant role of children in providing support for their widowed mothers, as shown in Table x, is in this respect hardly surprising. But support that flows between parents and children is not only from the younger to the older generation. Flows of support from parents to children—especially wealth flows in the form of inheritance—are even more prevalent than reverse flows (Finch 1989: 17-20; Schröder-Butterfill 2003). In other words, the dominant role of children as providers does not represent the whole picture of parent–child support relations. The relationship needs to be understood relative to the changing situation of adjacent generations in their life courses. The fact that the widows are on average middle-aged or elderly biases the picture towards their being net recipients of support.

Another important issue is the reliability and sufficiency of support. In general, support relationships have two dimensions. The first is a normative dimension, which relates to ideals of what should be done or achieved. The second is an actual dimension, which relates to what people are really able to do in certain circumstances and what the real outcome is. Although these dimensions are usually connected to each other, they are nonetheless two distinct realities. Reliability of family support relates to the normative side of a relationship. According to Finch (1989: 233), "the real importance of family support in practice seems to be its reliability: not that it is being used constantly, but you know that you always *can* fall back on it." Widows' acknowledgement of the main role of children as providers may reflect their belief that they can indeed always turn to them. The higher frequency of actual support rendered by children strongly underpins such beliefs. The extent to which support is sufficient, however, is another question. The insufficiency of support can be caused by various problems, notably an outright lack of means or material constraints, which force people to make difficult choices about how to allocate scarce resources. Poor children may not be able to provide sufficient economic support to a widowed mother even if there is willingness to do so. In this situation duty is not denied, but the capacity to perform the duty is lacking.

F. Childlessness among widows: cases, problems and coping efforts

Among the research population, more than one in ten (11 percent) widows were childless (N=111). Five of the twelve childless widows will be described in detailed below as cases. To begin with, however, it will be helpful to place the childless widows in context. Table 13 compares childless widows with the general research population of widows, according to several characteristics. Both percentages and absolute numbers are given, in view of the relatively small number of childless widows under discussion.

Table 13: Characteristics of childless widows and the research population of all widows (percentages and absolute numbers)

Characteristics	**Childless Widows**		**All Widows**	
	per cent	N	per cent	N
Average age	70 years		63 years	
Residential arrangement				
Living alone	41.6	5	9.9	11
Living with children [a]	33.3	4	80.1	89
Living with other relatives [b]	16.6	2	8.1	9
Living with tenants	8.3	1	1.8	2
Work Status				
Paid work	41.6	5	34.2	38
Pensioner	25.0	3	27.9	31
Not engaged in paid work [c]	33.3	4	37.8	42
House ownership				
Owner of house	83.3	10	85.6	95
Total	---	12	---	111

Source: Fieldwork data 1997-1998, 1999.
Notes: (a) This refers to biological or—in the case of childless widows—adopted children, and may or may not also include children's spouses and children.
(b) This usually means siblings and parents.
(c) Most of these depend either entirely or partly on economic support from various support providers. A few of them raise some income by renting out rooms in their houses.

The average age of the childless widows was higher than the average age of the total research population. This was likely due to older cohorts having been exposed to greater risks associated with childlessness. Child mortality and economic hardship were

particularly severe in Java during the 1940s. Higher ages generally entail a greater likelihood of experiencing problems of physical limitations and ill health, and therefore a greater need for personal care. These problems are exacerbated by the fact that the percentage of widows who are living alone is also much higher among the childless than among the general research population. The comparison of work status and house ownership reveals broadly similar patterns for the childless widows and the research population in general. In other words, childless widows' access to economic resources is comparable to that of widows as a whole. That said, childless widows are more likely to work, and this is doubtless related to their lack of financial assistance on a day-to-day basis. As noted by Esterman and Andrews (1992: 286) "the chances of receiving financial support from family increased with the number of children. Those who were childless were much less likely to have financial assistance from family and generally were in a less favourable family position."

The five examples of childless widows selected for further analysis have both similar as well as different aspects. All of the widows had an average age of seventy-one years, and had health problems, either permanently or periodically. However, they were different in their economic position and in their social relationships. The cases will first be described then discussed.

The first case is Niti, who was in her seventies. She was a pensioner living in a house inhabited by four households. She had inherited half of the house but decided to share it with two of her nieces. These nieces were acknowledged as Niti's daughters (informally adopted children). As a pensioner Niti had sufficient and independent income. Most of the time she was able to perform all household chores including doing her own laundry. But whenever she fell ill the two nieces would assist her. When she died suddenly in 1998 of a heart attack the two nieces were financially as well as practically responsible for her funeral. However, they also inherited the part of the house, which was Niti's.

The second case is provided by Juari, aged sixty-seven. Before she had a stroke at the end of 1998 Juari was a *rujak* (a kind of fruit salad) seller. She lived alone although she had adopted one of her nephews. The adopted son and his family lived in their own house in another part of the city. Juari maintained good relations with several next-door neighbours. Every time Juari fell ill, these female neighbours called the adopted son, took her to a doctor, and regularly dropped in and brought meals for her. Whenever an illness became serious, she would be taken to the adopted son's house for a few weeks. After her stroke Juari was not able to continue working. However, she did not experience serious financial problems because she was able to draw on her savings. Had Juari not died sometime after the stroke, she may well have become materially vulnerable with the gradual depletion of her savings. As it turned out, her adopted son was even able to inherit a small sum of money left over in her bank account.

The third case is that of Prapti, who was more than seventy years old. She lived alone in a beautiful old house, which was located on one of the big avenues in Malang. Prapti's husband was vice-director of a regional bank; therefore she was entitled to a good widow's pension. The couple never adopted a child. According to Prapti an adopted child could never be relied on for love and loyalty, thus, she consciously decided against adoption. Prapti had devoted much of her time to a local women's organisation. She led the organisation for many years before deciding to resign and to function only as an informal advisor. Gradually Prapti had suffered from health problems. Although most of the time she was still able to take care of herself, she had begun to think about the problems she would encounter when her health deteriorated further. Her first strategy was to try and hire a servant, but all of the candidates gave up after only a few weeks. Prapti admits that she may have been too strict with the young girls. In 1999 she then attempted to sell her house to one of her nephews or nieces at a price well below its market value but on condition that the buyer take care of her in that house until her death. None of her relatives was interested in her offer. Her situation therefore remained uncertain.

Eighty-two-year-old Sarah was one of the oldest widows in the research population. For her monthly income, she rented out a few rooms in her house. According to neighbours she also generated additional income as a moneylender. When she was young Sarah was quite a successful jewellery and cloth merchant. She had a much larger income than her husband who worked as a driver. As the main breadwinner and woman of independent means, Sarah used to have an important role in the decision-making processes among the members of her household. She took care of her old parents, her ill sister, and her husband until their deaths. When Sarah was younger she adopted one of her nieces. However, the relationship with the adopted daughter had been severed for many years following a big conflict over Sarah's disapproval of the daughter's future husband. During the last few years, she had suffered from rheumatism and sometimes could not walk for days because of the severe pain in her legs. During these difficult periods, Sarah was usually helped both economically and practically by a next-door neighbour. This neighbour was Sarah's best friend and confidante. One of her nephews had suggested that Sarah sell her house and move in with him, but she did not like the idea of being a dependent member of her nephew's household.

Finally there was the example of Nah, a sixty-four-year-old widow. She lived alone in a one-room wooden house located at the local market of Semeru alley. Although she had relatives—including a brother—in her village of origin, she no longer had any contact with them. According to Nah, her family relationships were a closed book and belonged to the past. She was also a person who did not wish to engage in close neighbourly relationships. Her next-door neighbour called her socially awkward and inflexible. This was because Nah was not one for joining in with neighbourly chats and gossip. She liked keeping her distance and was quite prepared to tell people to "mind their own business". Her lack of social integration was exacerbated by her poverty, which made it impossible

for her to participate in neighbourhood social activities, such as, savings clubs, condolence visits, or weddings, all of which require financial contributions. Nah's main daily activity was selling vegetables. However, her income from this was very low—barely enough to cover her daily expenditures and the rent. Since petty trading was her only source of income whenever she fell ill she had to draw on her savings. In early 1999, Nah died alone one night after having been ill for almost two weeks. Her neighbours, who were curious when she did not open her window and door as usual, found her body the following day. Her funeral was organised by her neighbours, and none of her relatives attended.

As mentioned above, the five elderly widows are similar in that they had permanent or periodic health problems, but they differed in their economic positions and in the ways they had established and maintained social relationships. As pensioners and the owners of their houses Prapti and Niti both had access to a sufficient, independent, and stable income aside from owning a valuable asset, namely, their houses. Juari and Sarah also owned a house, but unlike the pensioners they did not have a good monthly income. They could draw on savings, but these are of course not unlimited. Nah experienced the most severe economic insecurity, because she had neither valuable assets, nor savings, nor a sufficient and stable income.

Concerning their social engagement, Niti, Prapti, Juari, and Sarah are examples of elderly widows who are able and willing to maintain relations with relatives, neighbours, and friends. By living with her nieces and their families Niti was closely and permanently surrounded by relatives. Juari and Sarah did not live with relatives but could stay at their relatives' houses or invite them to their own house whenever they needed care during a period of illness. In addition, they also had good relations with next-door neighbours who provided help and in whom they could confide. Nah was an example where social relationships, both familial and neighbourly, had deteriorated, and therefore only a very limited amount of help was ever provided to her. The fact that almost half of the childless widows in the research population had adopted children is noteworthy. However, the parent–child bond did not always bring about a good result. In general terms, the childless widows were similar to most widows in terms of the economic, emotional, or practical problems they faced, with the exception of having children as a potential source of support. How, then, does the absence of children affect the security or insecurity of widows and the strategies that they can pursue?

Economic insecurity is a general problem for elderly people in Java who are no longer able to work, do not possess valuable assets, and are not entitled to pensions or other formal assistance. Therefore economic insecurities have to be dealt with through other forms of economic assistance, namely, gifts, loans, or small payments from a variety of sources, mainly family and neighbours. Economic support can be further differentiated into support for coping with daily needs and support for dealing with special

circumstances, like hospitalization, funerals, ritual feasts, weddings, or extra expenditures around the time of *Lebaran* (the feast at the end of the Islamic fasting month). Day-to-day assistance can be provided on a weekly, monthly, or even irregular basis, that is, whenever the provider's economic situation permits it. It is the closest relatives, especially children, who most commonly provide this kind of support, which is often referred to as 'pocket money' or 'monthly money'. More distant relatives and neighbours usually do not render regular economic support. Rather they may provide ad hoc economic assistance in response to a special circumstance or crisis. Therefore the absence of children and close relatives may entail a lack of daily economic support. Indeed, most childless widows interviewed do not receive any "pocket money" or "monthly money" from their (distant) relatives, although some of them, such as Nah, had a real need for it.

Although neighbours rarely provide financial support, they may play an important supportive role in other ways. For example, they may bring meals as a combined form of economic and practical support for widows whenever they are ill and cannot cook for themselves (see, for example, Sarah and Juari). Once they recover, this assistance usually stops. This underlines another important dimension of family support by close relatives, which tends to be lacking from assistance rendered by distant relatives or neighbours, namely, its permanence. As argued previously, family support is not always sufficient or regularly provided. However, longer-term economic support, when it occurs, is commonly given by close family members not by distant relatives, neighbours, or the State.

As most widows are elderly and struggling with health problems, their need for practical support—especially personal care—is obvious. In the case of Niti, the care is fully provided by the adopted daughters who live in the same house with her. For the research population in general, personal care, where needed, is also taken care of primarily by children, especially daughters. The examples of Juari and Sarah illustrate the role neighbours can have in providing personal care. However, such care rendered by neighbours only covers minor nursing tasks. Neighbours and distant relatives are commonly not expected to perform intensive or long-term nursing. The elderly widows often said that they could not even expect their daughters-in-law to nurse them in this way. Consequently they preferred to reside with their own daughters. Not surprisingly none of the cases of childless widows involved neighbours helping a sick widow with cleaning herself, dressing, or going to the toilet. At best, a widow can ask her neighbours to do shopping for her.

There were cases outside the research sites that showed what might happen to elderly childless widows who were very ill and had to be nursed intensively. One of these cases was of an old widow who lived in an urban neighbourhood in Salatiga, Central Java. Towards the end of her life this old widow was no longer able to walk and had to be nursed permanently. None of the widow's relatives could be approached for this

responsibility. Therefore the neighbours, represented by the neighbourhood head, decided to inform the regional social affairs office about the problem. A few days later several men from the office came to take the widow to an old people's home. The old widow, who had not been informed that she was going to be taken to a home, tried to resist being moved and cried. It was an upsetting situation for everybody, but there was unanimous agreement among the neighbours that they should not be burdened with intensive nursing tasks for too long. As one of them put it, "none of us can be expected to clean up after her when she soils herself." It would be simplistic to presume that children will perform intensive nursing tasks voluntarily. As shown in a previous section, the obligations to support parents are continuously renegotiated among children. Such negotiation can end in conflict, tension, and jealousy. However, children are much more constrained by social norms from sending their sick parents to an old person's home than are neighbours.

There are two broad coping strategies that can be inferred from the cases of five childless widows described above. First, economic resources, such as income, assets, or savings, can be converted into support. Second, when such resources are not available or are modest, social relationships, including those based on charity, can be drawn on. It is important to note that in practice these two courses of action are not mutually exclusive, nor are they equally open to everyone. An analysis of coping behaviour must thus focus on the questions of who has access to which strategy and to what extent the strategies are able to solve the problems that some elderly widows face.

Wealth transfers from older to younger generations can be examined from different perspectives. Finch (1989), for example, discusses wealth transfers from parents to children, including inheritance, in terms of economic support by the older generation for the younger generation. From this perspective parents are seen primarily as providers and less as future recipients of support. However, giving assets to younger kin may also be recognised as one means of securing old-age care (Hetler 1990). From this perspective—and setting aside the issue of uncertainty of potential sources of support—parents and older kin more generally, are regarded as future recipients of help. The first coping strategy, namely, converting economic resources into old-age support, thus belongs to this latter perspective on intergenerational wealth transfers, because the transfer of wealth is expected to be reciprocated in the future. In general, although expectations of reciprocity were not denied outright, there was agreement that they should also not be overemphasized. Especially when it involved widows' own children, the expected reciprocation of wealth transfers was often expressed in term of mutual affection and care.

Childless widows also transfer wealth to members of their kindred in various ways. Usually transfers are made gradually, over a long period and may be coupled with adoption, as in the cases of Niti and Juari. But transfers also take place in more drastic ways. A childless widow (not included in the five cases) sold her house, invested the

money in extending her sister's house into a two-storey building, and now lives in one of the rooms on the second floor. In this example, the investment resulted in an entitlement to co-residence and a more secure old age. Prapti made a similar effort by offering her beautiful house at a much-reduced price to her relatives in return for continued residence in a room of that house until her death. None of her relatives was interested in the offer because they were wealthy themselves. In this case the spectre of wealth transfer was not interesting enough for the potential support providers to take on the responsibility of potentially having to provide intensive old-age care.

Although support relations should not be reduced to a strictly economic calculation, the trade-off between a potential gain and that which is expected, in return can nevertheless be important, especially where it concerns those who are less obliged to give support in the first place. Converting economic resources into support is a strategy that is in the first instance only available to those with relevant resources. However, because there is an element of exchange in the conversion, it additionally requires two parties who agree upon their rights and obligations. Although this is rare, a wealth transfer may be refused and may thus fail to create a support relationship.

A childless widow in an economically severely constrained situation like that of Nah is totally excluded from pursuing the first strategy—wealth conversion—to secure old-age care. Her case is made more tragic by the absence of significant family ties and good neighbourly relations. Other childless widows, who were in a situation similar to that of Nah, were still able to draw upon neighbourhood networks and charity to obtain daily material support in the form of meals and small-scale credit at local shops. This was not so in the case of Nah. Quite apart from the stigma of being 'awkward' towards her neighbours, she lived in a social environment where charity was a luxury. Most of Nah's neighbours were economically not much better off than she was. In interviews with other inhabitants of this particular neighbourhood, the idiom of 'people are only busy with their own stomach' was often used. In other words, the second strategy, of drawing on long-term social and charitable relations, is only effective if the means to provide support are available within the wider social network.

The cases of childless widows discussed above allow us to conclude that the absence of children can lead to a lack of intensive and durable support, especially that provided on a regular basis. However, the cases also show that the problem of childlessness can be dealt with in different ways and with varying results. The limitations of community-based support and the exclusivity of state-organised support in Indonesia contribute to widows' greater need for, and dependency on, families. However, widows' personal circumstances, including their age, health status, economic position, and social contacts, determine the extent to which a widow actually suffers from her lack of family support and how she can deal with it. In other words, the problems pertaining to childlessness do not affect all widows in the same way.

The gradual or abrupt conversion of economic resources, such as income, assets, or savings, is often an attempt to create reciprocal intergenerational support relationships within the familial sphere. Adoption is an example of this, although people may not directly connect adoption with economic motivations. However, this strategy entails much uncertainty and not infrequently, fails to deliver on expectations. Moreover, family ties in general, including constructed ones as in the case of adoption; provide no guarantee of actual fulfilment of obligations to support. Childless widows who possess only limited economic resources, can to some extent draw upon non-kin relations and relations based on charity. However, this strategy, too, is precarious. A childless widow who lives in a neighbourhood where most people 'are only busy with their own stomach' has to face the fact that her own problems are bound to be seen as secondary. In conclusion, the extent to which family support is important for elderly widows needs to be understood in relative terms, vis-à-vis elderly widows' access to other sources of support. In most cases, both providers and recipients (of support) are agents who act within the constraints of what are often at best, precarious support networks. They have to struggle against the limitations of their material and social means in looking for possible sources of assistance.

G. Childless older widows in Java and policies to promote older persons' well-being

This paper does not intend to make generalization on the situation of the elderly in Indonesia and Asia-Pacific, based on the cases of childless elderly widows examined above. Nevertheless, the micro study highlights some aspects that are specific not only for these cases. Similar to the four countries discussed in the macro perspective section (India, Mongolia, Thailand and Viet Nam), Indonesia also has national policies, laws and focal agencies for promoting older people's welfare. But the implementation of the policies in general is still ad hoc and ineffective because it is not supported by sufficient resources. In addition, there are activities initiated by civil society groups with similar objectives. But those initiatives are sporadic with very limited coverage, therefore can only provide benefits for small group of the elderly in certain neighborhoods. As result, many older persons – such as the childless elderly widows − have to deal with contingencies without a reliable safety net on which one can depend. These situations can also be found in other countries in the Asia-Pacific region. The micro study and its national context, therefore, can illuminate the urgency of developing universal social protection for older population through appropriate macro policies on ageing both at national as well as regional level, which is backed up by adequate social security schemes.

The detailed descriptions of individuals' efforts to gain old age care and support have shown that older persons are definitively not a homogenous group. They have different capacities, access to resources, needs, interests, opportunities and constraints to achieve

and maintain well-being in old age. The design of policies and programmes needs to be well informed of these differences so that the target groups, objectives and measures can be specifically defined. For an example: in countries where Internet connections are primarily accessible for the middle and upper class youth, efforts to disseminate information to poor, elderly people, have to be conducted through media other than the Internet, although presenting information in a website maybe more cost and labor effective. Back to Indonesia, it is unlikely that elderly women such as Niti, Juari, Prati, Sarah and Nah described as the cases above are able to independently access the informative website of Indonesian NGOs that promote older persons' welfare. Moreover, is the information posted in the website compatible to the needs of this group of elderly? Or, is the information actually more relevant to the NGOs, Government agencies and donors in population ageing networks? Which groups are targeted by the website or information dissemination activities and which ones are actually served?

The micro study has demonstrated different "personal troubles" confronted by the elderly childless widows. But, it can be said that all of them are struggling with health problems and the need for practical support and health care. These problems are certainly not only specifically related to the individual cases; these challenges have been widely acknowledged by international networks on population ageing. The micro study has confirmed a few issues that still need to be highly prioritized in macro policies and programmes on ageing namely, provision of affordable health care services for all.

Regarding the enhancement of overall well-being of the elderly, the micro study has provided insights on how complex and precarious support relations among family members are. But in a situation where state supervised social protection is almost lacking and private insurance is unaffordable, support arrangements based on kinship and communal solidarity are the more realistic and relevant option (especially for older persons with lower socio-economic status). Nevertheless, family and community support must not simply be perceived as *the* substitutes for state support. Their omnipresence should not be overemphasized in macro policies and programmes and is definitively not an excuse for ignoring the inadequate social security system. Although the elderly can call upon various methods to cope with their problems, protection against insecurity and hardship should not be understood by the state as a responsibility, which can be handed over to the individual.

IV. DISCUSSION AND RECOMMENDATIONS: LINKING MACRO AND MICRO PERSPECTIVES ON ELDERLY CARE

Ageing and provision of care for older persons can be understood both as *public issues* that affect large number of people and society as a whole and as *private issues* that affect individuals and those immediately around them. Problems related to ageing and care for

the elderly and the efforts to cope with them, therefore, can be found both at macro level (i.e. national, regional) as well as micro level (i.e. individual, households, family). This paper attempted to understand ageing and provision of care for older persons by linking the macro and micro perspectives. The discussion on this linkage will be organized around three questions:

(A) How compatible are the efforts to tackle issues of population ageing at the macro level and the needs of the elderly at the micro level?

Section two of the paper emphasized the issues of old-age health care and income security. Ways of ensuring old-age health care and income security have been elaborately discussed through country experiences and formulated in various policies interventions. The micro study also has shown how important are these issues in day-to-day life of the childless elderly widows. Poor-health, expensive health care and income decline are among the most common and urgent personal troubles for older widowed women. Development of macro policies and programmes promoting old-age health care and income security will meet the urgent needs of older persons at the micro level. At the regional level, the importance of old-age care and income security as areas of policy interventions has been confirmed by United Nations regional surveys in 2002 and 2004 (United Nations 2008). These surveys reveal that access to pension benefits, opportunities for economic participation and advancement of health and well-being into old-age are among the regional priorities in policies and programmes on ageing.

Issues that have proved to be relevant and urgent at different levels such as old-age health care and income security (i.e. access to old-age pensions) certainly should be further elaborated in programmes and activities; and supported by effective enforcement measures and sufficient resources. Therefore, the two ESCAP workshops on Gender Responsive Health-care and Social Security for the Elderly need to be followed up. Under the supervision of ESCAP, a working group that consists of experts from the countries involved could be formed to formulate clear, systematic and practical guidelines to specifically help governments in their efforts to improve health care and to ensure income security of the senior citizens. For countries that have ongoing relevant programmes and activities, the guidelines could function as a tool to assess, evaluate and improve the achievements of their efforts. The formulation and dissemination of such guidelines could also contribute to development of national capacities on ageing, because many countries in the region face challenges in crafting appropriate policies and practical measures to address rapid population graying (United Nations 2008)

(B) How can the selected policy interventions help a particular group of elderly women namely the childless widows to cope with their old-age related problems?

The elderly widows analyzed in the micro study are similar in that they have chronic or periodic health problems. But they differ in their economic positions, from those who have access to a sufficient, independent and stable income aside from owning a valuable asset, to those have neither assets, nor saving, nor a dependable income. With regard to these, improving the provision of health services (policy area II) and upgrading infrastructure for providing health services (policy area III) could significantly help the elderly childless widows (and other older persons in similar conditions) to cope with the chronic or periodic health problems. For policy area II, entitlement to health insurance is a crucial intervention for the financially vulnerable older widows because it could ensure that that they will be able to finance and receive the needed health services, although the costs might exceed their income. Universal health insurance could help a poor elderly person such as Nah (the fifth case in section four), who suffered from a long period of illness and died alone without receiving any health care. Under policy area III, a focus on preventive and primary health care is very appropriate for older widows. In many countries including in Indonesia, primary health care is widely available up to the level of villages or neighborhoods, thus can be accessed by older persons who have limited physical mobility. Moreover, primary health care is commonly cheaper than distant tertiary health care. The report on *Regional Dimensions of the Ageing Situation* (United Nations 2008) mentions that " Preventive and primary levels of health care have become widely accepted as the best strategies for dealing with the challenges of population ageing, especially those in developing countries."

(C) How do specific situations of older childless widows can guide policy makers to develop and implement more effective policies and programmes on ageing?

The micro study has shown that although it is vary complex and precarious, family support is still the most important and realistic option for many older widows in urban Java. This is also true for the most of the older population in many Asian countries. In these countries it is common that the younger generation takes care of the older generation, with minimal intervention from the state. However, societal changes that are triggered by processes such as migration, higher participation of women in the labour market and shifts in lifestyle, are often seen as undermining family values and eroding filial piety. The analysis of older childless widows in section four has demonstrated different realities of support relationships among family members. Children who totally abandon their elderly parents are still relatively rare, but it is not uncommon that children provide insufficient support for their older parents. These findings can guide policy makers to identify the most positive and workable aspects of family support and care for the elderly, without romanticizing intergenerational bonds and loyalty among relatives.

None of the four areas of policy intervention in section three deals with the family support for the elderly. Family support can certainly be integrated in policy area II, especially for meeting special needs of the elderly affected by chronic illnesses and

disabilities. Strengthening the informal care system is one of regional priorities in policies and programmes on ageing. Some countries in the region have used tax exemptions and legal obligations to encourage children to provide support for their elderly parents.

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