



COVID-19 and Older Persons in the Asia-Pacific Region: The Health, Social and Economic Impacts of a Global Pandemic





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Acronyms and abbreviations

ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
HIC	high-income countries
LMIC	low- and middle-income countries
LTCF	long-term care facility
MIPAA	Madrid International Plan of Action on Ageing
WHO	World Health Organization
YLL	years of life lost



Abstract

In the early months of 2020, the plight of older persons in the emerging context of a global COVID-19 pandemic was becoming clear. Due largely to the presence of underlying health conditions, death from SARS-CoV-2 was significantly higher among those aged 80 or older than the global average. In one estimate, older persons, particularly those with comorbidities, accounted for 14 per cent of positive cases worldwide but 80 per cent of COVID-19-related deaths.⁶

In addition to the direct effects, public health orders that included movement restriction orders, lockdowns and other restrictions on normal activities affected the health, social and economic status of older persons in many ways.

Gaining a comprehensive understanding of the impacts of COVID-19 on older persons is difficult given the lack of age-disaggregated data and analysis globally, an issue that pre-dates the pandemic and reflects the invisibility of this population to policymakers.

A focus on Asia and the Pacific is needed to understand the health, social and economic impacts of COVID-19 on older populations in the most populous world region, which is culturally diverse and a driver of economic growth and innovation. Asia and the Pacific is also home to the largest number of older persons worldwide, and population ageing is occurring very rapidly compared to other regions of the world.

Regardless of the level of success of vaccination programmes across Asia and the Pacific, one theme has become clear regarding programme roll-out: the lack of older adult voices. Health and social policies implemented to safeguard older persons and the general population have been developed with no input from older persons themselves.

For many older persons in Asia and the Pacific, the pandemic and related government interventions resulted in significant changes in their lifestyle, and their ability to maintain their physical and mental health.

Older persons accounted for a small proportion of COVID-19 infections but were at heightened risk of death from the virus.⁵ However, the proportion of COVID-19 related deaths in older populations was clearly different across countries, likely reflecting factors such as economic and health resource access. In addition to advanced age, a critical factor linking many of the cases of COVID-19 deaths across the region was the presence of key comorbid health conditions.

The gendered outcomes from COVID-19 were another central component of this pandemic. Broadly speaking, older men in Asia and the Pacific tended to bear the physical health burden of COVID-19, while women tended to bear its mental health and social burden.⁵

Initial social lockdown measures implemented to restrict the spread of COVID-19 were clearly understood as harm-reduction measures to reduce the risk of older persons being infected with the virus. However, acceptance of and adherence to these restrictions varied across the region, likely reflecting differences in population experiences of prior pandemics and contagion control measures.

There is evidence to suggest that the impact of social isolation on older persons in the region was worse for some than for others. Fundamental to the negative impact of social isolation was the loss of social support, particularly for those living alone. However, access to information technology underpinned enhanced connections for some older persons during the pandemic. Social engagement (including online) and volunteering were found to be factors that supported well-being and reduced the impact of potential social isolation. Efforts to improve digital



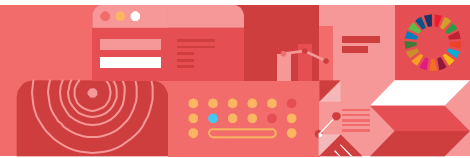
literacy and achieve equal access to digital services would mitigate against potential digital divides and inequalities in future pandemics.

Many countries throughout the region responded to the COVID-19 pandemic with interventions intended to support labour market stability or enhance social protection. Nevertheless, the mix of these interventions varied considerably both between countries and across subregions, and only a minority of such interventions specifically targeted older populations. Consequently, interventions have likely had a mixed effect on older persons across the region, with some enhancing the economic well-being of older adults and others eroding it.

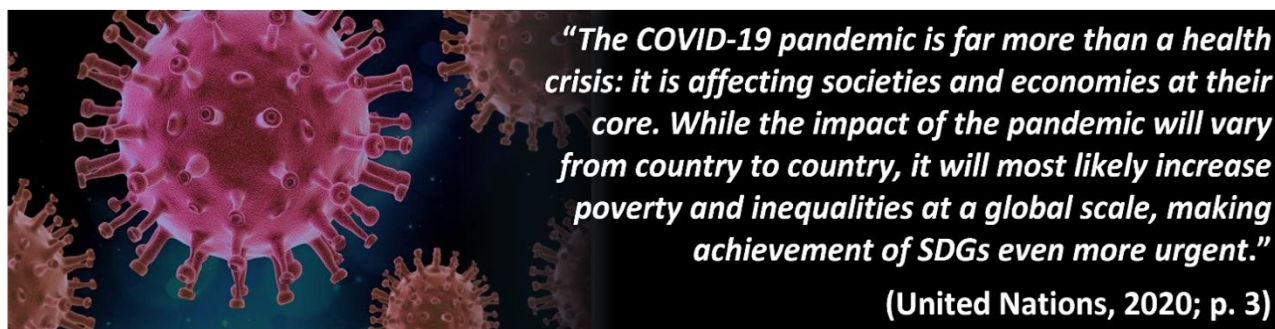
Despite an absence of data with which to explore concerns regarding enhanced workforce exit during the pandemic, there were country-specific data to suggest that COVID-19 significantly affected the income and economic security of older persons – and evidence that economic support measures were available and accessed by older persons even in lower income countries in the region.

This report summarizes current evidence (until December 2021) concerning the direct impacts of the COVID-19 pandemic on older persons in Asia and the Pacific, and the downstream individual and societal consequences – covering economic, health and social impacts – which align well with the three Madrid International Plan of Action on Ageing priority directions. There are also some references to the impact of the pandemic on the respect for human rights of older persons, though this is not the main focus of this paper.

Keywords: Older persons, Asia and the Pacific, COVID-19, health, economic, social



1. COVID-19 and older persons: A global context



Since the early stages of the global COVID-19 pandemic, older persons have universally been identified as a cohort at significant risk of virus-related morbidity and mortality. However, growing concern has been raised that their health, wealth and social connections are also increasingly at-risk due to the social, economic and public health measures intended to limit the spread of the virus.

The COVID-19 pandemic has occurred during a global epidemiological transition over the past century that has seen significant declines in deaths from infectious diseases and the rising epidemic of mortality and morbidity from chronic non-communicable diseases. The overall reduction in disease burden from communicable diseases was accelerated in the year 2000, with the Millennium Development Goals and significant development assistance for health to address diarrhoea, pneumonia, malaria, tuberculosis and HIV. Yet, events since early 2020 have shown that the infectious diseases era has not ended even while countries struggle to make progress on slowing the endemic rise in chronic diseases.^{2,3} Instead, viruses, parasites, fungi and bacteria – combined with antibiotic resistance – are emergent or re-emergent and remain an ongoing concern, including Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV2), Middle East Respiratory Syndrome coronavirus (MERS-CoV), Ebola, Zika, Chikungunya, and avian and swine influenza epidemics.⁴ The societal impacts from the SARS-CoV2 (COVID-19) pandemic elicited a unique warning issued by the United Nations (see introductory quote above).¹¹

In the early months of 2020, the plight of older persons in the emerging context of a global COVID-19 pandemic was becoming clear. By May 2020, the United Nations Secretary-General had issued a policy brief on the impact of COVID-19 on older persons (figure 1). This identified particular risks that COVID-19 presented to older persons. In follow-up, more than 140 Member States highlighted, in a joint statement, their support for the main messages of the policy brief, and they committed to “working with all partners to strengthen global and national target responses to address the needs and rights of older persons and foster more inclusive, equitable, resilient and age-friendly societiesⁱ.” Due largely to the presence of underlying health conditions, death from the virus was significantly higher in older populations, with mortality in those aged 80 or over at five times the global average.⁵ More recent global case data⁶ indicate that older persons comprised only 14 per cent of positive cases worldwide but 80 per cent of COVID-19-related deaths. Multiple progress reports, guidance papers, policy papers and action plans at regional and global levels now identify older persons as a group at high-risk for COVID-19-related morbidity and mortality,^{5,7-9} and this underlines their prioritization for vaccination efforts.¹⁰ Figure 1 highlights the main impacts of COVID-19 on older persons.



Figure 1: COVID-19 impact on older persons

Life and death

Fatality rates are five times higher than global average. An estimated 66 per cent of people aged 70 or over have at least one underlying health.

Vulnerability

Essential care that older persons often rely on is under pressure. Almost half of COVID-9 deaths in Europe occurred in long term care settings. Older women often provide care for older relatives increasing their risk to infection.

Economic well-being

The pandemic may significantly lower older persons' incomes and living standards. Already, less than 20 per cent of older persons of retirement age receiving a pension.

Mental health

Physical distancing can take a heavy toll on our mental health. Living alone and being more digitally included than others, the risks are higher for older persons.



Responders

Older persons are not just victims. They are also responding. They are health workers, careers, and among many essential service providers.

Abuse and neglect

In 2017, 1 in 6 older persons were subjected to abuse. With lockdowns and reduced care, violence against older persons is on the rise.

Source: United Nations. (2020). *The Impact of COVID-19 on Older Persons*. <https://www.un-library.org/content/papers/27082245/7>

Despite heightened morbidity and mortality risks from COVID-19, concerns have been raised that protective public health measures implemented to slow the spread of the virus are also likely to introduce or exacerbate health, social and economic issues for older populations.¹¹ Mandatory shielding, stay-at-home mandates and quarantines exacerbated issues of isolation and loneliness; the need for countries to manage the immediate morbidity and mortality risks of the virus saw a reduction in access to national health and social services for issues unrelated to COVID-19; and reports of abuse and neglect of older persons increased.^{5, 12, 13} Public health movement restriction orders also had a direct effect on common non-communicable disease risk factors – contributing to lowered income, decreased levels of physical activity, dietary changes and increased alcohol consumption – coupled with decreased or no access to health care or routine health maintenance visits. Consequently, assessing the health, social and economic impacts of the COVID-19 pandemic on older adults is a fundamental step enabling government and non-government bodies to tailor future recovery responses to the crisis and to ensure that older persons are not left behind in this effort.

COVID-19 threatens not only the physical and mental health of older persons, but also their economic well-being, safety and human rights The United Nations identifies that, while older adult employment has risen 10 per cent over the past 30 years, it is largely due to the lack of available pensions and social protections, and COVID-19 employment disruptions will likely disproportionately affect these older, vulnerable workers.¹⁴ Data from the Survey of Health, Ageing and Retirement in Europe (SHARE) highlighted both the variation in rates of COVID-19-related unemployment between countries (from 5 per cent in



Netherlands to 39 per cent in France).¹⁵ It also highlighted that the burden of job loss was clearly borne by the most vulnerable older workers, who tended to be:

- Women (with loss more likely the older the women)
- Non-tertiary educated
- On a low-income
- Migrant older workers

In addition to job insecurity, the global shift to online social engagement during COVID-19 social restrictions raises the financial and psychological vulnerability of older persons to online fraud.¹⁶ In a context requiring confidence with digital transactions, older persons who may be less familiar with such processes are at increased risk either from those trying to help them or from online scammers.¹⁷

Gaining a comprehensive understanding of the health, social and economic impacts of COVID-19 on older persons is difficult given the lack of age-disaggregated data and analysis globally, an issue that pre-dates the pandemic and reflects the invisibility of this population to policymakers. From the onset of the COVID-19 pandemic, international efforts have been made to establish data collection, analysis and presentation platforms with which individuals, policymakers and health professionals can monitor the trends in pandemic progress across countries. Some of these include:

- <https://covid19.who.int/>
- <https://ourworldindata.org/coronavirus>
- <https://coronavirus.jhu.edu/data>

Despite best-efforts, the ability to explore the impact of COVID-19 on older persons is undermined by a comprehensive lack of age-disaggregated data worldwide. Building on this issue, HelpAge International¹⁸ recently identified that, while the pandemic has disproportionately affected older persons, there are multiple factors undermining understanding of the degree of impact, range of disruption or their needs, including:

- A lack of age-disaggregated data undermines the ability to monitor and report on national, regional or global trends for older persons.
- Data are not collected on any of the indirect effects of COVID-19 that impact older persons the most (including the loss of access to social and health services).
- The pandemic exacerbates an existing lack of quality data on the lives of older persons.
- Existing data often used to highlight issues with older persons (such as household survey data) neglect the broad array of living arrangements they have and may underestimate poverty in this population.

Governments worldwide identified older persons as a critical at-risk population for whom pandemic responses are specifically targeted to support, yet these same governments often denied older persons any voice in the design of these response measures or a guiding role in their delivery. A recent content analysis of policy documents related to the national and international COVID-19 pandemic response¹⁹ highlights both the inherent ageism in depictions of older persons and their establishment as victims of a pandemic rather than independent and autonomous decision makers. While some policy documents highlighted older persons as core agents of change and autonomy (business owners and family leaders) many reflected inadvertently ageist attitudes that serve to 'other' older persons, either with *positive* language (as paid and unpaid care workers) or *negative* language (for instance, as vulnerable, frail, health service users). The lack of voice experienced by older persons during the global response to the COVID-19 pandemic is best summed up by Rose Kornfeld-Matte,²⁰ (see quote in blue box), who is the Independent Expert on the enjoyment of all human rights by older persons (Office of the United Nations High Commissioner on Human Rights).



Moreover, OHCHR noted that all of the COVID-19 related human rights impacts reflected deficiencies in the protection provided to older persons in the enjoyment of their human rights, such as discrimination based on old age, lack of social protection and access to health services, lack of autonomy, participation in decision-making and the risk of violence, neglect and abuse.¹⁸⁹

“Older persons have become highly visible in the COVID 19 outbreak but their voices, opinions and concerns have not been heard. Instead, the deep-rooted ageism in our societies has become even more apparent. We have seen this in some cruel and dehumanizing language on social media and in the exclusive emphasis on older persons' vulnerability ignoring their autonomy.”

Rose Kornfeld-Matte, 2020

While the pandemic presents all countries with unique challenges, it also provides opportunities for countries to redesign health and social care systems for older persons and ensure that their human rights are respected. The calls to ‘build back better’²¹ provide a logical link to the upcoming 20 year global review (in 2023) of the Madrid International Plan of Action on Ageing (MIPAA). The three MIPAA priority directions align well with areas needed to build systems back better post-COVID-19: 1) Older persons and development; 2) Advancing health and well-being into old age; and 3) Ensuring enabling and supportive environments. This report summarizes current evidence about the direct impacts of COVID-19 on older persons in Asia and the Pacific, and the downstream individual and societal consequences – covering economic, health and social impacts – which align well with the three MIPAA priority directions.

A focus on Asia and the Pacific is needed to understand the health, social and economic impacts of COVID-19 on older populations in the most populous region of the world, which is culturally diverse and the global engine of economic growth and innovation. The diversity of sociocultural heritage, health-care systems, and available resources have implications for the immediate and longer-term direct and indirect impacts on older persons residing in Asia and the Pacific. At the same time, the entire population of the region is affected by short- and long-term impacts of COVID-19 on older persons.



2. COVID-19 and older persons: The Asia-Pacific context

Asia and the Pacific is home to the largest number of older persons worldwide and population ageing is very rapid compared to other regions. It is also the global engine of economic growth and innovation. However, there is variation between countries in population health, geography, economic factors and access to fundamental COVID-19 support mechanisms, such as social protection and employment, which affects the situation of older persons.

Key to quantifying the potential impact of COVID-19 on older persons in Asia and the Pacific is understanding the significant economic, social, political and demographic variation that exists between countries. The region represents 58 countries and territories* and is home to 4.7 billion people (60 per cent of the global population).²² Over the past few decades, it has experienced the fastest economic growth in the world, significant population expansion and large gains in life expectancy. Yet, this is coupled with recent reductions in fertility, and consistently expanding economic inequality.²³

Further variation in government action, social and health system readiness, and public willingness to facilitate pandemic response orders should be expected based on country-specific experiences of prior pandemics (such as SARS-CoV; MERS-CoV), principally in Asia.²⁴ Regarding the COVID-19 response and potential impact in this region, Fitzgerald and Wong²⁵ helpfully highlight this as follows:

“The Asia Pacific region contains a number of first world countries as well as a range of populous and crowded countries, some with prosperous economies, and other low-middle income [LMIC] countries that have tremendous economic challenges and limited health care resources for maintaining everyday wellbeing. The COVID-19 pandemic has unmasked the impact of the health resource inequities and lack of preparedness to upscale a co-ordinated response in many countries in the region.”

(Fitzgerald & Wong, 2020; p. 75)

Any economic impact of COVID-19 on older populations across Asia and the Pacific will also be compounded by variation in the availability of financial support mechanisms, such as jobs and pensions. The recent United Nations report *The Protection We Want*²⁶ contextualized the landscape of social protection for older persons in the region, noting that:

- Pensions (largely a mix of contributory and non-contributory) are the most widespread social

* The Asia-Pacific (ESCAP) region is divided into five subregions:

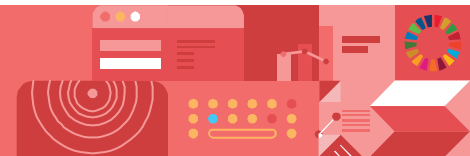
East and North-East Asia (ENEA): China; Democratic People’s Republic of Korea; Hong Kong, China; Japan; Macao, China; Mongolia; Republic of Korea.

South-East Asia (SEA): Brunei Darussalam; Cambodia, Indonesia; Lao People’s Democratic Republic; Malaysia; Myanmar; the Philippines; Singapore; Thailand; Timor-Leste; Viet Nam.

South and South-West Asia (SSWA): Afghanistan; Bangladesh; Bhutan; India; the Islamic Republic of Iran; the Maldives; Nepal; Pakistan; Sri Lanka; Turkey.

North and Central Asia (NCA): Armenia; Azerbaijan; Georgia; Kazakhstan; Kyrgyzstan; the Russian Federation; Tajikistan; Turkmenistan; Uzbekistan.

Pacific: American Samoa; Australia; the Cook Islands; Fiji; French Polynesia; Guam; Kiribati; the Marshall Islands; Micronesia (Federated States of); Nauru; New Caledonia; New Zealand; Niue; the Northern Mariana Islands; Palau; Papua New Guinea; Samoa; the Solomon Islands; Tonga; Tuvalu; Vanuatu.



protection system used to support older persons.

- However, pensions are not yet universal and significant variation in coverage exists; many older persons lack recourse to pensions and rely on their families for support.ⁱⁱ
- Women are more likely to receive non-contributory pensions with lower benefits.

This landscape of patchy social protection, combined with high rates of informal employment,²⁷ results in many older persons in Asia and the Pacific (primarily women) undertaking informal employment, often in roles that are low-paid, hazardous and insecure.²⁸ Such a precarious economic position for older persons (particularly women) heightens the potential health, social and economic impact of a pandemic.

The distinction between countries in their pre-pandemic readiness for vaccination decision-making, prioritization and programme implementation will likely have influenced the health, social and economic impact of COVID-19 in Asia and the Pacific. The World Health Organization's (WHO) roadmap for vaccine prioritization²⁹ identifies older persons as a priority 1 group (second only to frontline health-care workers). However, the effectiveness of any vaccination plan relies on preparedness, particularly having an established national technical advisory group on immunization and a set of fundamental documents guiding decision-making for key at-risk groups such as older persons (including an immunization plan and a healthy ageing strategy).³⁰

A study comparing the vaccination preparedness of 34 countries around the world pre-COVID-19,³⁰ found four distinct archetypes and that countries in Asia and the Pacific sat within three of these:

- *Health security-focus:* Countries under this archetype (Australia; China; Hong Kong, China; Japan; New Zealand; Taiwan Province of China and Turkey) had strong vaccination decision-making processes and guiding documentation for at-risk groups in place, already prioritized older adult vaccinations and pursued a 'population health' imperative via centralized mass-vaccination processes. They utilized government population registrations, public health systems and health communication approaches honed from previous national outbreaks or disasters.
- *Evolving adult-focus:* Countries under this archetype (Malaysia and the Republic of Korea) had weaker decision-making processes in place, including a lack of key guiding documents, and lacked a focus on older adult vaccination. While some evidence of early adoption of adult vaccinations existed in some countries, the financing of vaccinations varied, with some efforts for at-risk groups not publicly funded.
- *Child-focused and cost-sensitive:* Countries under this archetype (India, the Philippines and the Russian Federation) lacked a decision-making focus on older persons. Further, they did not prioritize adult immunization, with no extant adult working groups for existing vaccines, no policies on adult vaccination and limited advocacy for adult immunization efforts. Given limitations on resources, government investment focused on child health and related vaccination efforts.

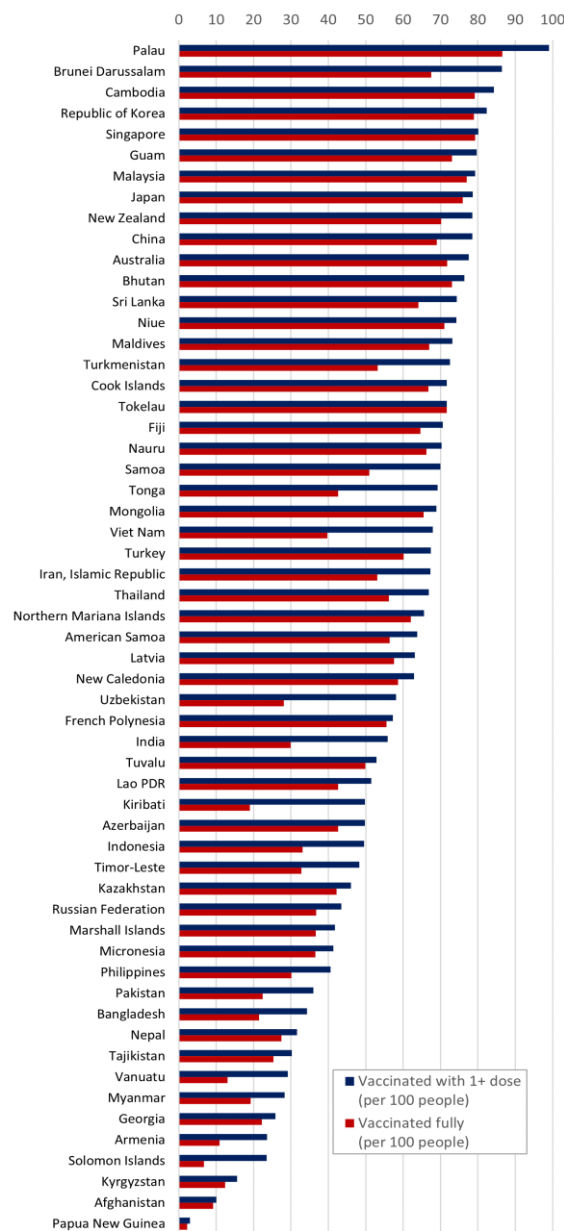
While pre-existing immunization approaches may have differed across countries in the Asia-Pacific region, reports from the WHO *Asia Pacific Observatory on Health Systems and Policies* on six countries during the COVID-19 pandemic showed that older persons were largely prioritized in vaccine roll-outs across the region, but this varied by country. For example, governments in Indonesia,³¹ Singapore³² and Thailand³³ prioritized vaccination for older persons alongside or directly after critical health-care workers, while vaccinations for older persons in other countries were varied or staggered. For example, in the Republic of Korea, patients were first prioritized alongside critical health-care staff for vaccinations, with older persons prioritized next. In New Zealand,³⁴ subcohorts of older persons were sequentially prioritized based on identified vulnerability. Workers in government-managed COVID-19 isolation facilities (and their families) were prioritized first, followed jointly by frontline health-care workers, anyone aged 65 or older with a disability or chronic health condition, and older persons who specifically identified as Māori – indigenous people – or of Pacific Island



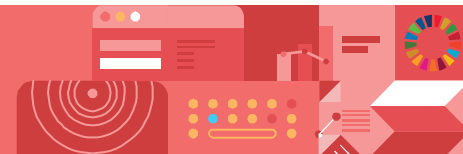
descent. This ethnic subcohort prioritization reflected historic health inequity in New Zealand raising vulnerability of these groups to COVID-19 mortality. The general population of persons aged 65 or older were then included in the third priority group.

Age-disaggregated vaccination data are not available for each country, making it impossible to identify the success of vaccination roll-out efforts for older persons in Asia and the Pacific. However, it is possible to use data from the *WHO Coronavirus (COVID-19) Dashboard*⁶⁵ to identify the progression of population-level vaccination programmes (partial and full vaccination) across countries that – if following the WHO guidelines – should be prioritizing older persons. Figure 2 displays the number of people (per 100) in each country with (a) 1 or more vaccine doses, and (b) full vaccination.

Figure 2: Vaccination rates for countries in the Asia-Pacific region per 100 people, November 2021



Source: WHO (2021). WHO Coronavirus (COVID-19) Dashboard. Available at: <https://covid19.who.int/>



There are differences in the rates of vaccinations across the region. Vaccination programme success (that is proximity to 100 fully vaccinated people per 100 people) appears more likely in countries identified as having pre-pandemic vaccination plans *Health security-focus* or *Evolving adult-focus*. or for small nations.³⁰ However, regardless of country size, 21 countries in the region have a rate of 1 or more vaccination doses that falls below 50 per 100 people, at an average across these countries of only 33 per 100. Further, 27 countries in the region have a fully vaccinated population rate that is below 50 per 100, with an average rate across these countries of 27 per 100. It is important to point out that the data on vaccination rates do not provide information on vaccine efficacy.

Regardless of level of vaccination success across the Asia-Pacific region, one theme has become clear regarding programme roll-outs: they lack older adult voices. Health and social policies implemented to safeguard older persons and the general population have often been developed with no input from older persons themselves, and their implementation has caused significant issues and confusion.

In the first year of the pandemic, HelpAge International³⁶ surveyed organizations working with older persons at the global, regional, national and community levels to ascertain the initial impact of the pandemic. One of the core themes, particularly from those in Asia and the Pacific, was that older persons had been given no voice in any of the decisions being made, nor in the implementation of policies significantly affecting their daily lives. This resulted in difficulties and confusion, both from older persons themselves and from those tasked with interpreting and implementing these policies across a broad and diverse set of communities. The quotes from older participants (in the blue box below) highlight this point.

"It does not seem that current government policies take into account the voice of the elderly."

The Russian Federation (HelpAge International, 2021; p. 7)

"There are various levels of committees that are being initiated by government from grassroot to top-level but there are no older people representatives on them."

India (HelpAge International, 2021; p. 7)

"Despite the issuance of guidelines allowing older persons to go out if deemed 'indispensable', many older persons are still complaining that they have been barred from getting out to do economic activities or buy essential needs. This is because many implementers at the local level have a different interpretation of what is 'indispensable'."

The Philippines (HelpAge International, 2021; p. 8)

"The authorities showed their unwillingness to cooperate with NGOs and the elderly."

The Russian Federation (HelpAge International, 2021; p. 9)

During the initial stages of the 2020 pandemic, HelpAge International³⁷ identified the lack of data on the pandemic experience of older persons, particularly their acute and ongoing requirements. They also undertook a rapid needs assessment of older persons in seven countries in Asia and the Pacific, identifying critical issues concerning their health and disability needs, food and livelihood requirements, and their well-being. Box 1 (on the following page) provides an overview of their key findings. Overall, by the middle of 2020, the COVID-19 pandemic and associated government responses (including social isolation measures) had already had significant health, social and economic impacts on older persons in Asia and



the Pacific. These ranged from loss of income, a concern over their ability to secure sufficient food, to a reduction in medical care and increased worry over greater social isolation.

Ultimately, Asia and the Pacific is a region with substantial variation in preparedness for the COVID-19 pandemic. Vaccination efforts reflect pre-existing differences between countries in population levels, economic wealth and health system readiness, resulting in some countries nearing 100 per cent vaccination, while others struggle to achieve 30 per cent. Regardless, the single factor connecting all countries in the region is that older persons have been significantly materially, emotionally, economically and social affected by this pandemic yet have been denied a voice in the collective response.



Box 1: COVID-19 rapid needs assessment of older persons

In July 2020, a rapid needs assessment of older persons in Asia and the Pacific³⁷ was undertaken by a Global Humanitarian Team led by HelpAge International (the team consisted of the following organization: HelpAge, HelpAge Asia-Pacific Regional Office, HelpAge country offices in Bangladesh, Myanmar and Pakistan, and network members HelpAge Cambodia, GRAVIS in India, Coalition of the Services of the Elderly in the Philippines and HelpAge Sri Lanka). This team explored the health, social and economic needs of older persons in seven countries in the region (Bangladesh, Cambodia, India, Myanmar, Pakistan, the Philippines and Sri Lanka). The goal was to identify specific needs throughout the region and offer recommendations for policy developers and decision makers to tailor responses to the pandemic that would account for the immediate needs of older persons.

Health and disability

- 77% Had some form of disability (for example, mobility, vision, and cognition difficulties).
- 67% Had one or more health conditions (for example, joint pain, hypertension and gastro-intestinal problems).
- 56% Of those with regular health-care needs felt health service access was affected by COVID-19.
- 46% Said their access to medicine had been reduced during the COVID-19 pandemic

Food and livelihood

- 81% Who worked said their income was affected by COVID-19.
- 77% Stated that their immediate priorities were (1) food, (2) income and (3) health and well-being.
- 61% Either ate less or ate poorer quality food.
- 44% Were regularly employed, ran their own business or agricultural activity, or were petty traders.
- 41% Had less than two weeks' supply of food at home.

Well-being

- 97% Lost income and experienced isolation due to social or government-imposed restrictions impeding their movement.
 - 85% Felt depressed due to loss of income, insecurity and isolation.
- Both older men and women reported that they felt the risk of abuse (verbal, financial, emotional, physical, psychological and sexual) had increased as a result of COVID-19.

Case study: India

"I was denied the curfew pass as I was 'disabled' and was asked to call 'relatives' to seek help during the lockdown."

Case study: Viet Nam

"I decided to give up applying for the COVID-19 support package. By the time I manage to prove myself eligible, it would probably have passed the deadline."

Case study: Pakistan

"When I stopped working, I had nothing saved... I feel depressed to see my wife having to work at this age and that my son lost his job."



3. Health impacts of COVID-19 on older persons in Asia and the Pacific

While death has been a too frequent outcome for many, the health impacts of COVID-19 in countries across Asia and the Pacific are clearly patterned by underlying factors including older age. Differential health impacts reflect variation in critical factors, such as individual health and wealth, population age structures and government responses to the pandemic. Perhaps most importantly, there is a clear gender distinction in COVID-19 impacts, with more older men reporting physical health impacts and more older women reporting mental health impacts.

The most immediate health consequence of COVID-19 for older persons in Asia and the Pacific was mortality. Indications from China during the initial stages of the pandemic were that older persons were a small proportion of COVID-19 cases but at heightened risk for death from the virus. However, the proportion of COVID-19-related deaths in older populations was clearly different across countries, likely reflecting factors such as economic and health resource access.

By mid-February 2020, while the majority of COVID-19 cases in China occurred in those aged under 70, those aged 80 years of older had a case fatality rate of 22 per cent and accounted for 15 per cent of deaths.^{38,39} Those aged 60 or older and those with key underlying health issues, such heart and cardiorespiratory disease (increasingly overlapping groups with age), were identified as at high risk of virus-related morbidity and mortality.³⁹ As the months progressed, it became more apparent that those aged 60 or older were significantly more susceptible to COVID-19 infection,⁴⁰ particularly those older adults with the lowest socioeconomic status⁴¹ and through household transmission.⁴² At least one study identified an 11.6 per cent increase in infection risk with every 10-year increase in age.⁴³

Research across Asia and the Pacific during the early pandemic stages supported heightened mortality risk for older populations seen at the outset of the outbreak. Country-based demographic breakdowns of COVID-19 cases in the first COVID-19 wave showed that those aged 60 or older constituted a broad range of those dying from COVID-19; 16 per cent of deaths in Indonesia,⁴⁴ 47 per cent of deaths in India,⁴⁵ 59 per cent of deaths in Nepal,⁴⁶ and 92 per cent in the Republic of Korea⁴⁷ were in adults aged 60 or older, while 77 per cent of deaths in China by April 2020 were in those aged 65 or older.⁴⁸ Modelling of the COVID-19 mortality rates in India showed that mortality was significantly more likely in areas with higher population proportions of older persons.⁴⁹

There is some evidence to suggest that government measures implemented to curb both the rate of population infection and the risk of mortality may have reduced both hospitalizations and deaths in older persons. A study in Turkey⁵⁰ compared the clinical records of people aged 60 or older who tested positive for COVID-19 either before or after a government-imposed curfew. They found that the rate of hospitalizations and intubations dropped significantly after curfew, and deaths almost halved.

Comparative data illustrating age-related COVID-19 mortality across age-groups for countries in the Asia-Pacific region either do not currently exist or are extremely difficult to generate. This is for two key reasons:

- First, as previously indicated by HelpAge International,¹⁸ age-disaggregated data have not been a standard component of national COVID-19 record keeping worldwide, nor has a standard for specific age-groupings been identified or utilized. For example, even the WHO country COVID-19 dashboards do not disaggregate cases or deaths by age.
- Second, existing global comparisons providing age-disaggregated death trends (for example, a

recent World Bank Report)⁵¹ exclude countries with less than 2,000 deaths, and many countries in Asia and the Pacific (for example, Australia, Fiji and New Zealand) have been experiencing deaths below this threshold (to date).

Some global comparisons of age-related COVID-19 mortality trends (including some Asian and Pacific countries) do exist and illustrate age-related patterning of COVID-19 mortality. Figure 3 is reprinted from a World Bank report by Demombynes et al⁵¹ and illustrates the share of COVID-19 mortality by age-group in countries around the world with 2,000 or more confirmed deaths.

Figure 3: The age distribution of COVID-19-related deaths and excess deaths in 2020

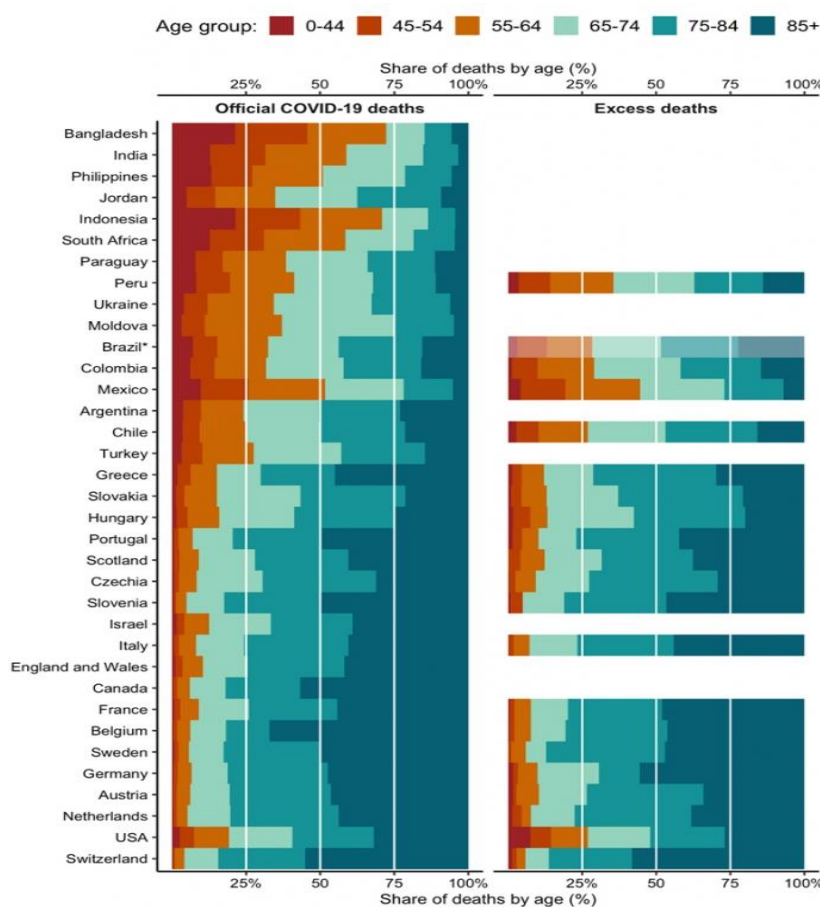


Image reprinted from Demombynes et al (2021). *COVID-19 Age-Mortality Curves for 2020 Are Flatter in Developing Countries Using Both Official Death Counts and Excess Deaths* (p. 7).

Those aged 65 or older constituted the vast majority of recorded COVID-19 deaths in high-income countries (89 per cent). The proportion was lower in upper-middle-income countries (60 per cent) and lower still in lower-middle-income countries (46 per cent). This global pattern was clearly evident for the few Asian and the Pacific countries in this analysis (Bangladesh, India, Indonesia and Turkey).

There are a number of potential reasons for the higher proportion of older person deaths from COVID-19 in higher, as opposed to lower, income countries. However, in an earlier version of her report for the World Bank, Demombynes⁵² suggested the following factors were likely to exacerbate this:



- **Living conditions:** Older persons in low-and middle-income countries (LMIC) are more likely than their counterparts in high-income countries (HIC) to live in multi-generational residences and less likely to reside in long-term care facilities or be hospitalized alongside populations vulnerable to COVID-19.
- **Health risk:** Non-communicable diseases that increase the risk of COVID-19 mortality for older persons (such as heart disease or lung disease) are more likely in HICs and more prevalent in older persons in those countries.
- **Survivorship:** Adults in LMICs with health risks are less likely to live to older adulthood, thus older populations that exist in LMICs are potentially those that are currently healthier and less vulnerable to disease than their HIC counterparts.

Many HICs in Asia and the Pacific have a greater likelihood of residing in long-term care facilities (LTCF). There are significant differences in the proportion of COVID-19 deaths associated with an LTCF in countries across the region, with countries benefiting from prior experience of managing public health epidemics. Yet, in comparison to global trends, the rate of COVID-19-related deaths among LTCF residents in countries in Asia and the Pacific is remarkably low and reflects the broad success of health system prioritization of LTCF residents.

HelpAge International⁵³ identified that within the first year of the pandemic – in countries with ready access to LTCFs – LTCF residents were 60 times more likely to die from COVID-19 than younger adults, and LTCF residents were 13 times more likely to die from COVID-19 than community-dwelling older persons with care needs. Using data from the first six months of the pandemic, it was possible to identify the differences between some countries (including those in Asia and the Pacific) in the percentage of COVID-19-related deaths linked with residents in LTCFs (see figure 4).

Figure 4: Percentage of total confirmed COVID-19-related deaths linked with LTCF, mid-2020

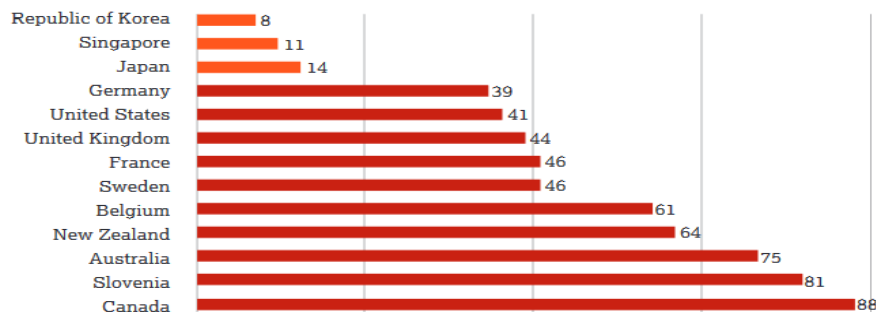


Image reprinted from HelpAge International (2020). *COVID-19, older adults and long-term care in Asia Pacific* (p. 3).

Source: Image created from data downloaded from WHO Coronavirus (COVID-19) Dashboard as of 28 November.

LTCF-related deaths reflected less than 15 per cent of total COVID-19-related deaths in countries such as Japan, the Republic of Korea and Singapore. In contrast, LTCF-linked deaths were a far higher proportion of total country deaths in Pacific countries such as New Zealand (64 per cent) and Australia (75 per cent). These country disparities in LTCF-related deaths have two potential explanations involving both the numerator and the denominator.

- First, a low numerator (number of deaths in LTCFs) reflects the likely success of health system responses in countries such as Japan, the Republic of Korea and Singapore that – having experienced prior pandemics – had management plans, infection control systems and protocols, coordinated

communication networks, and integrated governance frameworks already in place to tackle a new pandemic.^{54, 55} For example, Chow⁵⁶ describes the multiple infection control and management measures implemented in LTCFs in Hong Kong, China during the COVID-19 pandemic, and how they stemmed from expert recommendations after the high LTCF fatality rate during the 2003 SARS epidemic.

- A second explanation is that a low denominator (number of deaths outside LTCFs) potentially reflects the success of public health pandemic response measures at the population level. In 2020, governments in Asia and the Pacific provided some of the world’s most successful pandemic mitigation responses, serving not only to reduce the spread of the virus and related deaths,⁵⁷ but also the potential impact on gross domestic product.⁵⁸

While it is clear that the rate of COVID-19-related deaths associated with LTCF residents differs across the region, international comparisons exploring the proportion of deaths *within* LTCF populations indicates that Asia-Pacific countries have witnessed considerably lower deaths than others.

Figure 5, from the International Long Term Care Policy Network,⁵⁹ highlights differences between countries in percentage of COVID-19-related deaths in LTCFs during 2020 (where country data were available).

Figure 5: Share of LTCF residents whose deaths were linked to COVID-19 compared to LTCF population, mid-2020

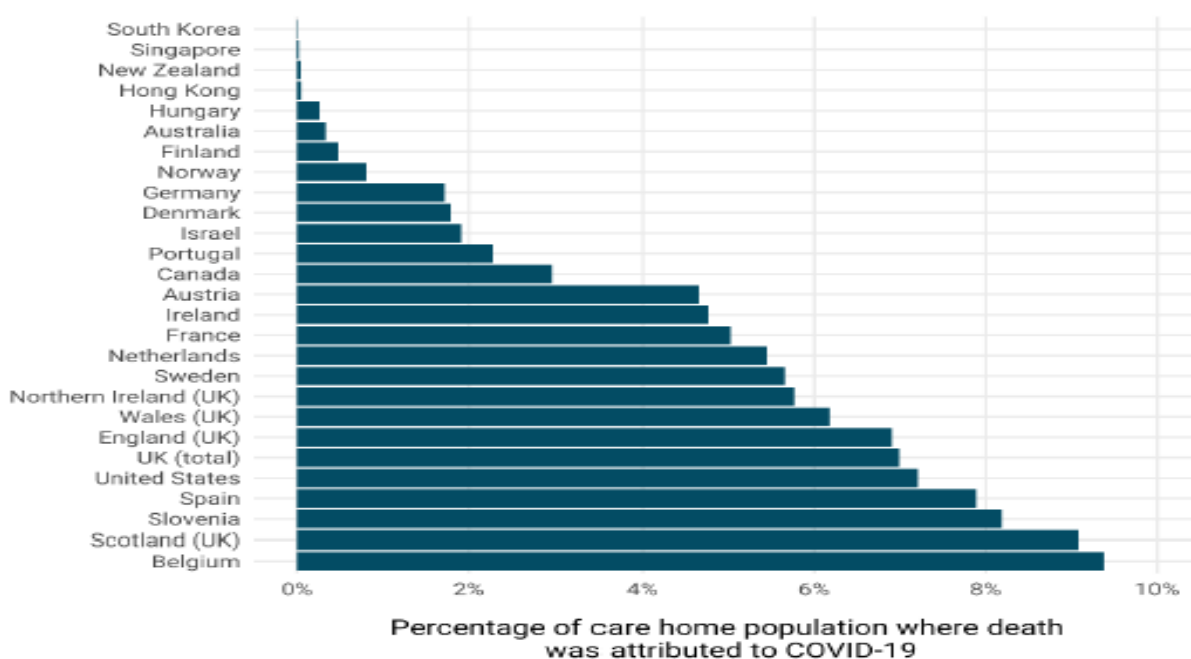


Image reprinted from Comas-Herrera (2021). *Mortality associated with COVID-19 in care homes: international evidence* (p. 24).

The five Asian and Pacific countries all show less than 1 per cent of deaths within their LTCF populations, indicating that government responses specific to ensuring LTCF safety significantly reduced likely COVID-19 mortality in these countries. This is particularly noteworthy in comparison to countries, such as the United Kingdom, where LTCF resident deaths were considerably higher and efforts to lockdown LTCFs were seen as too late and ineffective.⁶⁰



A recently published study⁶¹ estimated the years of life lost (YLL) attributable COVID-19 in 30 countries that had the highest incidence of COVID-19 by April 2020. Included within this study were data from 7 countries from Asia and the Pacific (Australia, China, India, Japan, the Republic of Korea, the Russian Federation and Turkey).

As indicated in figure 6, analysis shows that countries from Asia and the Pacific had 7 out of the 10 lowest YLLs. The Russian Federation was the region’s country with the highest YLL rate for men (89.77) and women (42.13); yet both of these were a fraction of the YLL for the three Western European countries with the worst YLL: Belgium, the United Kingdom and Italy.

Figure 6: Years of Life Lost (YLL) for 30 high-incidence countries worldwide, July 2020

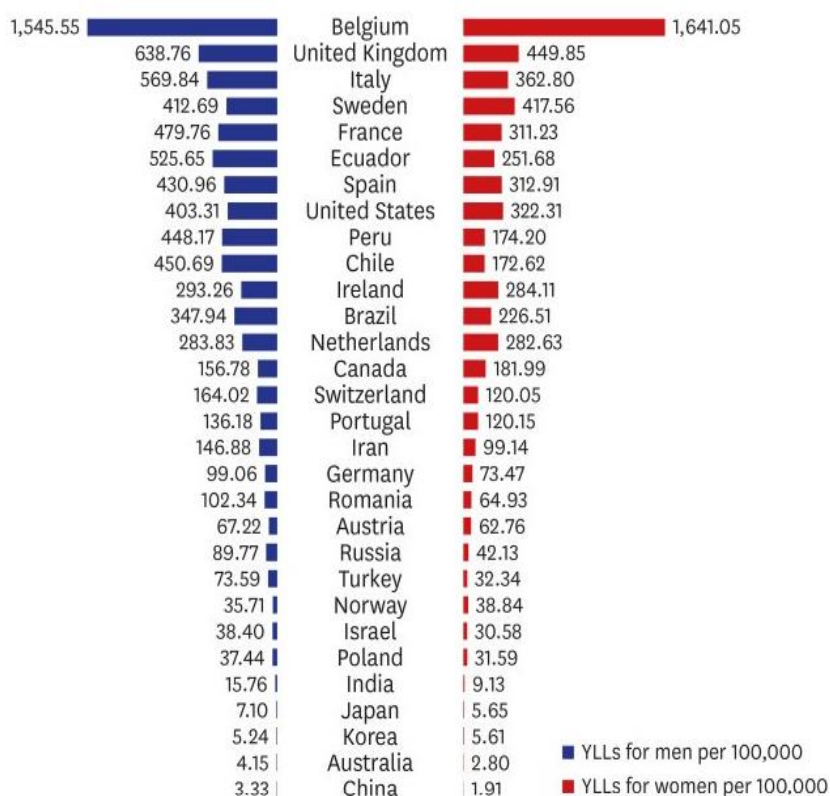


Image reprinted from Oh et al (2021). *Years of Life Lost attributable to COVID-19 in high-incidence countries* (p. 5).

While death from COVID-19 was a reality for some older persons in Asia and the Pacific, the vast majority who contracted the virus lived. However, the experience of COVID-19 infection for many older persons was shaped by the presence of comorbid health conditions that enhanced the severity of the illness and the medical intervention required. Further, the experience of the wider pandemic resulted in significant mental health and emotional consequences for many older persons across the region.

In addition to advanced age, a critical factor linking many of the cases of COVID-19 deaths across the Asia- Pacific region was the presence of key comorbid health conditions.

Those aged 60 or older had significantly higher odds of mortality from COVID-19. This was because the presence of comorbidities significantly increases the severity of COVID-19 cases⁶² and the likelihood of complications or death, particularly in those aged 80 or older.⁶³



Research in China, Indonesia, the Islamic Republic of Iran, Nepal, the Republic of Korea and Turkey explored the prevalence of comorbid health conditions in hospitalized COVID-19 cases (either specific to older persons or at a population level including older persons). Together, their results identify the following comorbidities were not only prevalent among older patients but were also more likely in those requiring longer hospital stays, medical intervention (such as intubation) or who died from COVID-19:

- Cardiovascular disease^{44, 46, 63-67}
- Hypertension^{46, 50, 63, 66, 68}
- Diabetes^{46, 50, 63-66, 68}
- Renal disease^{44, 46, 50, 66}
- Cancer^{46, 50, 64, 65}
- Respiratory disease^{46, 63, 65}
- Cognitive or neurological disorders^{50, 64}
- Malnutrition (including obesity)^{50, 64}
- Liver disease^{46, 67}
- Immunosuppression⁴⁴
- Osteoarthritis⁶⁶

In addition to (or likely because of) having more pre-existing health conditions, older persons in Asia and the Pacific who contracted COVID-19 and were admitted to hospitals, were far more likely than younger patients to have:

- Severe or critical COVID-19 characteristics^{62, 63}
- Much higher odds of medical intervention (such as intubation)^{68, 69}
- Significantly longer hospitalization,⁶⁴ and greater length of recovery from the virus⁷⁰

Despite being at significant risk from COVID-19-related morbidity and mortality, non-COVID-19 medical and health services for older persons were radically undermined by health-care system re-prioritization in response to the pandemic. Between June and August 2020, WHO conducted a rapid assessment of the impact of COVID-19 on mental, neurological and substance treatment services in member States.⁷¹ Data from 130 countries identified that 70 per cent of these treatment services for older persons had either been partially (56 per cent) or completely (14 per cent) disrupted due to COVID-19.

Further research exploring older persons' health service utilization in the Republic of Korea and Turkey found that, during the COVID-19 pandemic, older persons were significantly more likely to:

- Postpone hospital treatment⁷²
- Avoid using health-care services⁷³
- Avoid presenting to trauma services⁷⁴
- Stop attending outpatient clinics⁷⁵

For many older persons in the region, the pandemic and related government interventions resulted in significant changes in their lifestyle, and their ability to maintain their physical and mental health. Fears of COVID-19-related infection and death, potentially reinforced by government quarantine, social distancing orders and online misinformation, have heightened feelings of depression, anxiety and distress across the region.⁷⁶

Studies on the lives of older persons during the pandemic and specifically during lockdown conditions in Australia; Bangladesh; Hong Kong, China; Japan and Turkey provide insight into the shared reality of COVID-19's health impacts on this cohort, regardless of country. Together, the results of these studies show that key



health and lifestyle factors were disrupted by COVID-19 and that many older persons in Asia and the Pacific experienced:

- Decreased physical activity⁷⁷⁻⁸³
- Reduced or disrupted food intake^{78, 81, 83, 84}
- Changes in smoking, including some increasing use^{82, 85, 86} and some decreasing use^{81, 82, 85}
- Reduced alcohol use^{81, 82, 87}
- Weight gain or loss^{77, 78}
- Disrupted sleep^{82, 88, 89}

Studies across the region explored the mental health impacts of COVID-19. Specifically, studies in Bangladesh, China, India, Japan, Malaysia, Nepal and Turkey explored older persons' levels of psychological distress in COVID-19 contexts (including population lockdowns). They found that under the COVID-19 pandemic, older persons experienced:

- Heightened feelings of depression^{67, 72, 78, 90-95}
- Greater levels of anxiety in general^{67, 78, 96}
- Heightened anxiety about COVID-19⁹⁷⁻¹⁰¹ or death¹⁰²
- More apathy⁹¹
- Poorer quality of life⁷⁸

Further, these same studies collectively emphasized that older persons most at risk of heightened depression, increased anxiety or poorer quality of life (or in some cases all three) were more likely to be:

- Aged 75 or older^{78, 91, 99}
- Widowed, single or living alone^{90, 102, 103}
- Those with poorer education^{78, 90, 93}
- Caregivers⁹²
- Those with lower socioeconomic status⁹⁰
- Those with low food security⁹³

Statistics highlighting the morbidity and mortality outcomes of older persons in Asia-Pacific countries do not tell the entire story of the health impacts of the COVID-19 pandemic. There is growing evidence that older persons were – as a cohort – more resilient to the mental health impact of the pandemic than younger populations throughout the region. Further, there are numerous indications of the factors that may have mitigated the mental health impact for older persons.

Despite indications of significant health impacts for older persons from the COVID-19 pandemic, there are also indications that older persons were not so severely affected as other cohorts.

Multiple general population studies from Australia; China; Hong Kong, China; the Islamic Republic of Iran; Japan; New Zealand and Pakistan found that, in comparison to younger cohorts, older persons during the COVID-19 pandemic:

- Were less distressed^{82, 105-109}
- Were less depressed^{82, 94, 106, 110, 111}
- Were less anxious^{82, 106, 111, 112}
- Were less suicidal¹⁰⁷
- Had better well-being¹¹³
- Had greater intention to get vaccinated¹¹⁴



Research throughout Asia and the Pacific highlight potential protective factors that mitigated the physical and mental health impacts of COVID-19 for older persons. The following studies have identified factors at the individual and country level that protected older persons from the mental health impacts:

- Being married or living with others^{89, 90, 102, 103; 115}
- Having higher education levels^{90, 116}
- Having better socioeconomic status⁹⁰
- Having good food security⁹³
- Being in better health⁹⁰
- Living in a rural area¹¹⁵
- Having a strong focus on self-care¹¹⁷
- Having higher trust in one's government's honesty¹¹⁶
- Believing the general public has responded appropriately¹¹⁶
- Believing one's government pandemic response is effective¹¹⁶
- Living in a country with stricter policy measures¹¹⁶
- Having fewer COVID-19 deaths in one's country¹¹⁶

Two studies in the region exploring the population effects of the pandemic found that older persons reported anxiety more frequently than younger adults. Specifically, one community-based study¹⁰³ in Viet Nam found that adults aged 60 or older were almost 20 times more likely to report anxiety than those aged 18–38. The second study,¹⁰⁴ a hospital-based survey in Nepal, found that older persons were almost 3 times as likely to indicate anxiety than those aged 18–24. However, the majority of studies showed that older persons seem to experience fewer mental health impacts than younger persons.

COVID-19 affected older men and women in Asia and the Pacific differently. These gendered outcomes are a central component to the regional story of this pandemic. Broadly speaking, older men tended to bear the physical health burden of COVID-19, while women tended to bear its mental health burden. Specifically, older men were more likely to:

- Catch COVID-19^{45-48, 64, 68, 69, 118, 119}
- Have severe COVID-19 cases and/or require medical intervention^{46, 47, 50, 62, 64, 69, 120}
- Die from COVID-19^{44-48, 50, 62, 118, 121}

In contrast, while older women in Asia and the Pacific had lower odds of COVID-19 morbidity or mortality, evidence shows that they were more likely than older men to have experienced:

- Psychological distress, depression and/or anxiety^{78, 82, 89, 103, 105, 113, 116, 122-125}
- Fear of COVID-19^{97-100, 126} or of vaccine side-effects¹²⁷
- Declining physical activity and fitness^{79, 80, 128}
- Insomnia^{89, 129}
- Abuse¹³⁰
- Poorer quality of life¹³¹

During the COVID-19 pandemic, older women in Asia and the Pacific were generally less likely than men to:

- Use health-care services^{73, 75, 132}
- Be willing or intending to get vaccinated^{114, 133}
- Have access to (and implement) preventive health measures⁸¹



4. Social impacts of COVID-19 on older persons in Asia and the Pacific

Responses to the COVID-19 pandemic in countries across the Asia-Pacific region varied significantly based on in-country preparedness, economic resources, population size and composition, and political will. However, evidence indicates a shared social impact of the pandemic for older persons across the region and identifies key factors mitigating these social impacts, facilitating resilience and enhancing preventive health behaviours in this population.

Older persons were identified internationally as at-risk of COVID-19 morbidity and mortality, leading many governments to institute age-specific social restrictions intended to protect older persons from harm. These included mandates for individual behaviour change (such as social distancing and hand washing), broader community-level change (including limitations on social interactions) and complete population lockdowns. Such measures were noted to have the potential for either initiating or enhancing social isolation in older persons.⁵

HelpAge International¹³⁴ warned against assumptions that COVID-19 would not result in significant social isolation for many older persons in the Asia-Pacific region for multiple reasons (see also the blue box below):

“The pandemic made me feel a sense of emptiness. I lost my joy and passion for life. I have always been a person that loves learning new things, socializing and exploring. Now, I feel that there is nothing for me to live for. Young adults are struggling to adopt to the ‘new’ normal. I do not even have that option. I have to stay home and not get sick.”

Turkey (Ates, 2020; p. 307)

“I stay at home. I haven’t been to any social activities such as wedding ceremonies, housewarming gatherings or any other social gathering. I’ve stopped going out completely.”

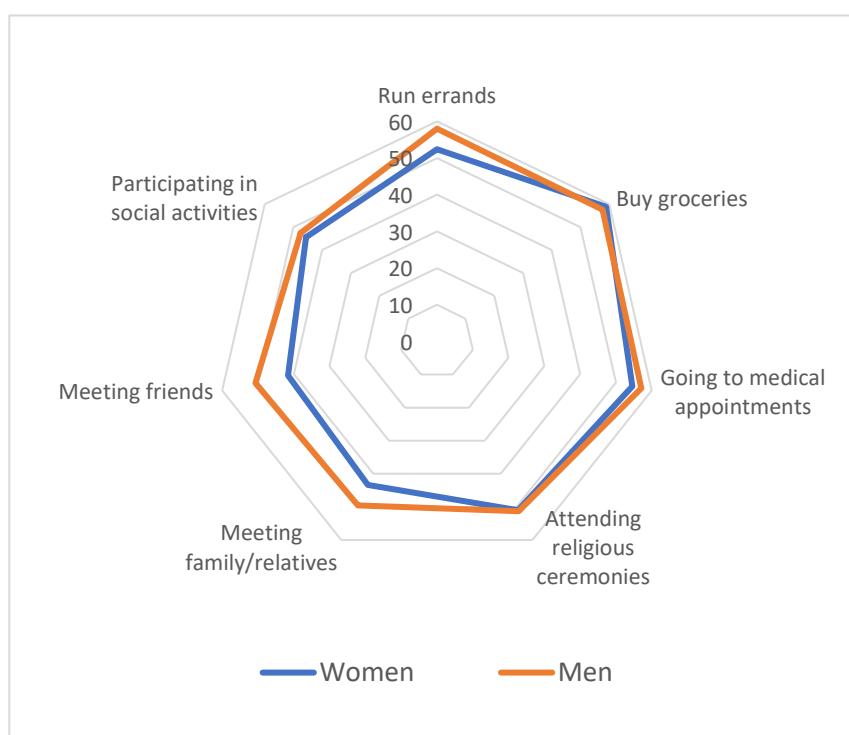
Thailand (HelpAge International, 2021; p 5)

- First, they highlighted that many older persons were already in precarious social and economic situations (including social isolation), and COVID-19 was likely to simply increase these pre-existing challenges. In this regard, the solutions to pandemic challenges being considered by multiple governments in the region are actually solutions needed to resolve issues faced by older persons regardless of the pandemic.
- Second, they highlighted that many concerns over social isolation reflect Western assumptions that older persons live separately to the traditional family structure (in their own home or LTCFs), which in Asia and the Pacific are often incorrect. In many Asia-Pacific countries (including China, Indonesia and the Philippines) less than 1 per cent of older persons reside in LTCFs. Instead, many older persons in the region reside in multi-generational homes, thus mitigating issues with social isolation to a great extent (though simultaneously increasing potential issues related to social distancing).
- Third, they noted that there are no age-disaggregated data with which to accurately gauge and monitor the social impact of COVID-19 on older persons and their social connections.¹⁸ In this

respect, while COVID-19 was likely to significantly increase challenges for older persons throughout the region, government and media rhetoric largely ignored the existing plight of many older persons pre-pandemic. They also failed to establish comprehensive systems for measuring and monitoring the health and social impacts that they clearly feared would befall older persons.

The *Impact of COVID-19 on Older Persons in Thailand* survey, conducted in July 2020,¹³⁵ provided some direct results on the economic realities of 1,230 adults aged 60 or older living in urban and rural locations in all provinces across Thailand. A state of emergency was declared on 26 March 2020, with curfews and movement restriction orders for the following months. Figure 7 shows responses to the question, “Was any of the following daily life routines [sic] affected by COVID-19?”, a slightly higher percentage of older men than older women reported impacts on meeting friends, meeting family/relatives and running errands. This could have contributed to gender differences in feelings of social isolation as a result of the public health orders.

Figure 7: Daily life routines affected by COVID-19 for older men and women in Thailand, July 2020, percentage



Source: Pothisiri W, Buathong T, & B., B. (2021). *The Impact of COVID 19 on Older Persons in Thailand: Evidence from the Survey*. Bangkok, UNFPA.

Initial social lockdown measures implemented to restrict the spread of COVID-19 were clearly understood as measures to reduce the risk of older persons catching the virus. However, acceptance of and adherence to these restrictions varied across the region, likely reflecting differences in population experiences of prior pandemics and contagion control measures. The onset of government-mandated social isolation measures in countries across the Asia-Pacific region revealed a range of levels of adherence from older persons. Population surveys (including older adults) in Bangladesh; Brunei Darussalam; Cambodia; China; Hong Kong, China; India; Indonesia; the Islamic Republic of Iran, Japan; Macau, China; Malaysia; Myanmar; the Philippines; the Republic of Korea, Singapore; Taiwan Province of



China; Thailand; and Viet Nam concerning the implementation of health prevention measures found that the vast majority of older adults:

- Had a good understanding of the virus, including its symptoms and ways to prevent infection^{119, 136-138}
- Wore masks when outdoors^{77, 119, 136-140}
- Undertook other preventive health behaviours, such as hand washing and social distancing^{77, 119, 137, 138, 140}

Further, factors found to support better personal health prevention efforts included:

- Being a woman^{77, 97, 137, 141-144}
- Having higher education levels and/or knowledge of COVID-19^{97, 136, 142-144}
- Having good family or social support^{139, 143}
- Having better well-being¹³⁷
- Being employed,¹⁴¹ particularly in jobs with high interaction levels with others¹³⁷
- Living in an urban rather than rural location^{97, 142}
- Having a smartphone⁷⁷
- Being younger than 50,^{136, 141, 144} though some studies indicate that good knowledge and health practice peak around mid-life^{97, 142} or in those aged 50 or older^{137, 143}

Population-level studies in East and South-East Asia also highlight the difference in impacts pandemic responses have had on younger and older populations, and that older persons were more likely to adapt to the new COVID-19 context. They found that in comparison to younger adults, older persons were:

- More likely to comply with government COVID-19 health and safety mandates¹³⁷
- More likely to have changed travel plans¹⁴⁵
- More likely to avoid crowded or close contact spaces¹⁴⁶
- More comfortable wearing a mask¹⁰⁰ and more likely to undertake preventive health behaviours¹⁴⁶
- Less likely to change their eating habits¹⁰⁰
- Less affected by the lockdown confinement¹⁰⁰

However, this high level of adaptation and compliance may reflect prior experience of some countries with pandemic responses, or simply differences between countries and cohorts. Community surveys in China and Turkey found that many older persons:

- Struggled with key government measures such as obeying curfews (85 per cent), wearing a mask (82 per cent) and staying socially isolated from friends and family (67 per cent)¹²⁶
- Were less likely than younger adults to perform advanced or even basic health protective measures¹⁴⁷

Some older persons were not in a position to adhere to medical or public health mandates because they were unable to access the components necessary. A fundamental requirement for older persons to adhere to government or public health mandates (for example, mask wearing and hand washing) was the provision of materials to enable them to do so. Nevertheless, research from HelpAge International³⁶ found that some older persons had limited or no access to the materials required, as indicated in the blue box below.



“While the [government] and World Health Organization asked the entire populace to use alcohol as a disinfectant, masks for protection and soap for hygiene, older women and men in indigenous population communities do not have the opportunity to access any of these.”

The Philippines (HelpAge International, 2021; p 11)

Evidence suggests that both the COVID-19 pandemic and the associated government social isolation measures across countries in the Asia-Pacific region resulted in the experience of social isolation and loneliness for many older persons. However, the degree of social isolation and loneliness varied depending on the country under study.

Multiple studies conducted in countries throughout Asia and the Pacific found that subjective feelings of loneliness in older persons did increase with the onset of the virus and government-mandated social isolation orders. The previously mentioned survey of community-dwelling Japanese adults aged 85 or older⁷⁷ found that, as a result of strong adherence to social isolation measures, their loneliness increased. Specifically, approximately half reduced their frequency of going outside, 36 per cent reported a drop in the number of people they talked to and 33 per cent a drop in the amount of time spent talking to others. The survey of community-dwelling older persons from Turkey¹⁴⁸ also found that government-imposed curfews for older persons resulted in 14 per cent of them worrying more about their social life and their families. Moreover, those who were most socially isolated experienced greater levels of anxiety as a result.

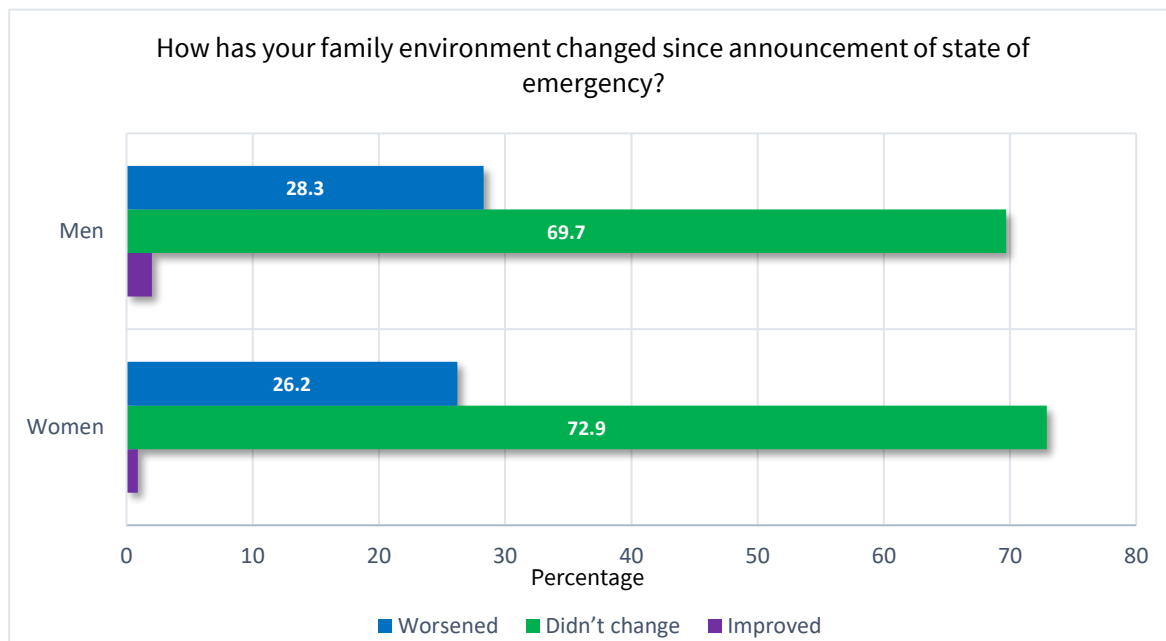
Further research confirmed that, while older persons in Asia and the Pacific may have experienced loneliness and social isolation prior to the pandemic, the onset of COVID-19 and government social isolation measures clearly increased feelings of:

- Moderate and severe loneliness¹⁴⁹
- Social frailty¹⁵⁰

The World Bank *COVID-19 High Frequency Phone Survey* in Armenia¹⁵¹ included 853 adults aged 60 or older collected between July and December 2020. A majority of older Armenian men and women reported no change family environment as a result of the public health orders, but 26 per cent of older women and 28 per cent of older men did report worsening of the family environment (see figure 8).



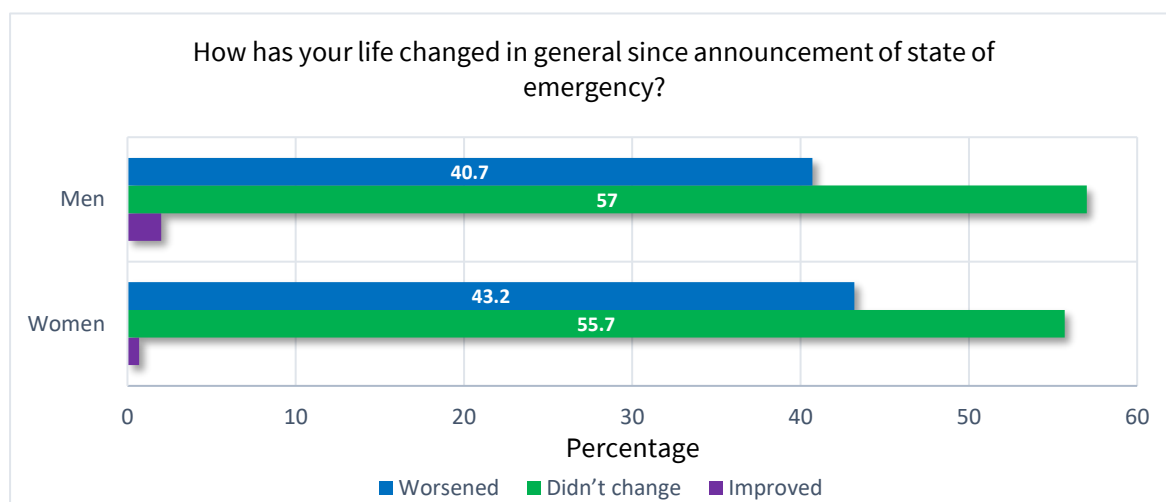
Figure 8: Indication of change in family environment in Armenia during the COVID-19 pandemic, July – December 2020



Source: World Bank (2021) *COVID-19 High Frequency Phone Survey in Armenia*.

Related to this, 43 per cent of older Armenian women and 41 per cent of older men reported that life in general had worsened as a result of COVID-19 restrictions (see figure 9). As with impacts on the family environment, a sizeable portion of the older adult population reported no significant change.

Figure 9: Indication of general life change for older adults in Armenia during the COVID-19 pandemic, July – December 2020



Source: World Bank (2021) *COVID-19 High Frequency Phone Survey in Armenia*.

Evidence suggests that the impact of social isolation on older persons in the Asia-Pacific region was worse for some than for others. Fundamental to the negative impact of social isolation was the loss of social support, particularly for those living alone. Research on the experience of social isolation and



loneliness in countries such as Bangladesh; Hong Kong, China; Japan and New Zealand during the COVID-19 pandemic highlighted that the loss of fundamental social supports due to social isolation was a fundamental driver of poor outcomes for some older persons.

A small study of adults aged 65 or older with hearing loss in New Zealand¹⁵² found that more than 25 per cent experienced a loss of fundamental social support as a result of lockdowns. The importance of such social support for some older persons was highlighted in further research on older persons in Japan.¹⁵³ In comparison to socially active older persons, older Japanese people who were already socially isolated prior to the pandemic saw successive reductions in physical activity across each COVID-19 lockdown, resulting in an increase in subsequent frailty among these older persons.

The importance of social support for older persons during the pandemic, especially the availability of support in the home, was highlighted by research showing poorer outcomes for those older persons living by themselves. In a study of older persons in Hong Kong, China,⁸⁹ the strongest predictors of loneliness over the course of the pandemic were (a) being female, (b) living alone, and (c) having five or more chronic conditions. Further, a survey of over 1,000 community-dwelling adults aged 60 or older in Bangladesh (n=1,032) found that those who lived alone, were socially isolated from others, had less frequent communication with others, perceived themselves to be lonely during the pandemic and were much more likely to experience depressive symptoms.¹⁵⁴

Differences in levels of social support were also evident between older persons and younger adults, and potentially explain differences in mental health outcomes. For example, a population survey of over 23,000 community residents in China aged 18–85¹⁵⁵ explored the role of social support in driving resilience to the mental health toll of COVID-19. They found that older persons' social support contrasted with that of younger adults because it was characterized primarily by proximal contacts (immediate family and friends). However, older persons reported better levels of social support than younger adults, and such support offered resilience to mental health impacts. The finding that older persons experienced less distress than younger adults during the COVID-19 pandemic was also replicated in a survey of over 1,000 people in India aged 18–87.¹⁰⁰ While older persons reported greater fear of the virus than younger adults, they also reported less distress at the COVID-19-related social isolation responses enforced by the government.

Despite the clear evidence of social disruption and social impacts of the pandemic across the region, there were some indications that not all such impacts were negative. A study of almost 3,000 Australians aged 55 or older¹³¹ explored the social and mental health impact of COVID-19 between June and September 2020. Interestingly, while the quality of life of older Australians reduced as a consequence of the pandemic, approximately 37 per cent of respondents agreed that COVID-19 had actually had a positive impact on their personal relationships and 26 per cent agreed that it had improved their social relationships. Further, the results for older persons in the state of Victoria (under lockdown restrictions during this period) still suggested that a significant number continued to experience positive impacts on their personal relationships (34 per cent) and social relationships (33 per cent) despite lockdown. This was mirrored by a study of Māori kaumatua (indigenous community leaders) in New Zealand¹⁵⁶ which revealed that, despite some negative impacts of COVID-19 lockdowns (for instance, enforced changes to funeral customs and missing face-to-face discussions), many kaumatua felt more connected with and supported by family and neighbours during the lockdown than ever before. Further, a smaller study of older Australian adults using care services during the first national lockdown¹⁵⁷ found that, while perceived quality of life was reduced, connections through social networks and a sense of social isolation of these older persons did not decrease.

Access to information technology (for instance, internet-based social devices) may have been a crucial factor mitigating the negative social effects of the COVID-19 pandemic for older adults across Asia and the Pacific, as indicated in the blue box below.



“They went to buy a “ludo” board, but the shops were closed. So my granddaughter has downloaded it on my phone. I am learning to play it. It brings us together on weekends.”

India (Bakshi & Bhattacharyya, 2021; p 197)

“What a beautiful thing the Internet is. I understand most things now. I saw my children through the phone and read the news. Having Internet access in the pandemic was very good”

Turkey (Baser, 2021; p 135)

Studies in Australia,¹⁵⁷ India,¹⁵⁸ New Zealand¹⁵⁶ and Turkey¹⁰² specifically found that older persons used or adopted new online technology during lockdowns, which enabled them to maintain connections with family and friends, and ensure they could undertake key roles such as shopping and seeking medical care. Further, research supports the idea that older adults can successfully adopt and utilize online technology. For example, older adults in Taiwan Province of China¹⁵⁹ successfully adopted an augmented reality-based calligraphy class with comparable satisfaction to those using e-books, and an enhanced acceptance of technology.

However, lack of familiarity with new technology can be a stumbling block to utilization and older adults are still not as accepting of internet-based communication and consumerism as other cohorts.

While online technology may help mitigate the negative effects of COVID-19 lockdowns for many, older persons also highlighted the numerous different barriers to adopting such technology (see also the blue box below). Studies in China, India and the Islamic Republic of Iran during the COVID-19 pandemic highlighted that older persons:

- Preferred seeking news from newspapers or television rather than online news or social media apps^{101, 160, 161}
- Were less likely than younger cohorts to use social or online media for their news¹⁶¹
- Found it more difficult than younger cohorts to use phone-based apps¹⁶²
- Were anxious about using online payment systems¹⁵⁸
- Felt negative about the use of tele-health services¹⁰¹ and more so than younger adults¹⁶³
- Were concerned about falling victim to cybercrime¹⁵⁸

“After a certain point of time, it becomes difficult to follow or remember the steps. So, the more the instructions are simple and ‘nontechnical’ the easier it is.”

India (Bakshi & Bhattacharyya, 2021; p 199)

“I have to ask my granddaughter again and again.”

China (Wang, Katz et al., 2021; p 55)

“There is no guarantee that COVID-19 will be gone forever and at my age, I don’t know technology like young people.”

Malaysia (Chee, 2020; p. 309)



There are potential benefits of older adults being more inclined to use traditional media (television and radio). One study in Hong Kong, China¹⁶⁴ found that older adults were far less likely to be exposed to misinformation about COVID-19 than younger adults. Research from Japan¹⁶⁵ also indicated that there were clear gender disparities in older persons existing adoption of information technology, such as computers and smartphones. Specifically, older men were much more likely than older women to be current users of information technology. This suggests that older women are likely at a social disadvantage when government pandemic responses involve social isolation, as they are less likely to be readily able to transition from face-to-face to online social connections.

In addition to the positive and negative social impacts of COVID-19 on older persons in Asia and the Pacific, research identified some factors underpinning social resilience in the face of COVID-19.

Researchers identified individual strength and resilience factors that supported well-being and reduced the impact of potential social isolation during the COVID-19 pandemic. Overall, they reflect a focus on others through social engagement and volunteering. This helped to reduce distress and improved quality of life during COVID-19. Volunteering was identified as a significant potential source of resilience for older persons during the pandemic. One study explored the role of implicit social capital (that is, a sense of social trust and belonging) and explicit social capital (such as the level of social reciprocity) in mitigating the mental health impacts of COVID-19 in community-based older persons in Shanghai.¹⁶⁶ They found that older persons who were more socially engaged during the pandemic (people who often volunteered) had much better levels of social trust and belonging, which helped reduce depression and improve life satisfaction.

A survey of older Hong Kong, China residents (n=128) explored the role of volunteering on mental health during the COVID-19 pandemic.¹⁶⁷ The majority of those surveyed (77.3 per cent) reported engaging in at least one volunteering activity, with 69.5 per cent of these offering emotional support to neighbours and friends. Those volunteering to help and those with increased self-esteem were more likely to assist in purchasing daily necessities for others during the pandemic. Further, those who helped others buy necessities reported lower depression and anxiety than those who did not. Ultimately, these results suggest that self-esteem acts both as a driver of volunteering and social connection, and as a foundation for maintaining well-being during the pandemic.

Research also supports the potential role of pets as a vector for well-being. For example, a survey of Japanese older persons (n=9,856) explored the mitigating effects of pet ownership on psychological health.¹⁶⁸ They found that older persons that owned a dog during the pandemic reported significantly better psychological health than older persons without one. In this instance, dog ownership appeared to mitigate the social isolation caused by the pandemic, likely as a result of the value inherent in animal-human interactions and possibly due to the dog as a vector for physical health (such as daily walking).

LTCFs are a critical context for exploring the impact of COVID-19. Existing literature is sparse, but there is evidence that the pandemic may have affected mental health in LTCF residents. Further, a comparison of older persons in the community and in LTCFs suggests key shared experiences of the COVID-19 pandemic. HelpAge International⁵³ recently identified some of the known issues (by mid-2020) likely enhancing the social impact of COVID-19 for LTCF residents in the region. Primarily, LTCF residents were more likely to have conditions (such as dementia or frailty) that undermine risk mitigation efforts such as social distancing and personal hygiene.

One of the only studies to explore the impact of COVID-19 on LTCF residents offered a snapshot of the extent of social support and mental health of LTCF residents in Malaysia during 2020.¹⁶⁹ They found that 94 per cent of residents were severely depressed, overall levels of perceived social support were low, and the drivers of



depression were lack of social support, lack of hobbies and being in the home longer than a year. A second study in Hong Kong, China found that the number of LTCF residents admitted to psychiatric units during the COVID-19 pandemic almost doubled, often due to the confrontations with LTCF staff regarding the need to be confined to their rooms.¹⁷⁰

A third study of LTCF residents in Malaysia was a qualitative exploration of the key themes in reaction to the COVID-19 lockdown. The results of this study are included in this paper alongside the results of four other qualitative studies (presented in box 2). Collectively, these results identify commonalities in the experience of COVID-19 for older persons across countries in the Asia-Pacific region.

Ultimately, as an identified population both at high-risk from COVID-19 and as the focus of government safety measures, many older persons' experiences of the pandemic was shaped by:

- Feelings of vulnerability and fear
- Being socially disconnected and isolated
- Forced reliance on (and experiencing the reactions of) others



Box 2: Comparing the COVID-19 experience for older persons: Voices from Malaysia, the Republic of Korea and Turkey

Five qualitative studies from three countries offer insight into the experiences on older persons in countries across Asia and the Pacific during the COVID-19 pandemic. Despite differences in country context and the residential setting (one study focuses on aged-care), three clear themes appear to have shaped a consistent experience of older persons across the region. Specifically, the experience of older persons during COVID-19 in Asia and the Pacific reflects having to live with:

1. Vulnerability to a virus and fear of what that virus might do to them
2. Social disconnection and the isolation stemming from government enforced protection orders for older persons
3. A total reliance on others for support, and dealing with the reactions and behaviours of others

Ates (2020)¹⁷¹ Older persons in Turkey (Community-dwelling)	Baser et al (2021)¹⁷² Older persons in Turkey (Community-dwelling)	Yildirim (2021)¹⁷³ Older persons in Turkey (Community-dwelling)	Kim et al (2021)¹⁷⁴ Older persons in the Republic of Korea (Community-dwelling)	Chee (2020)¹⁷⁵ Older persons in Malaysia (Aged-care facility)
Older persons have experienced vulnerability and fear				
“After watching the news on TV, I was certain I was not going to survive this pandemic. Everyone was talking about the deaths of the older population. I felt like they have buried me alive.”	“I have asthma. If I go out and get infected with the disease, it would first kill me. No, I never got out; I am very careful. I’m scared, of course.”	“ ... I'm so worried, will it end? won't it end? I feel that I am under a burden that I cannot bear. I constantly cry. My health has worsened. If the disease infects me, everyone will run away from me.”	“We can’t see who is infected. That’s why contact with other people is very scary.” “I receive COVID-19-related texts every day. I can’t be relaxed when I see those. I am worried because it can be me at any time.”	“I can’t risk having to leave the home to seek treatment during COVID-19. ... I think about going to the hospital also feel scared.” “What I worry about now is the disease, I watch the news, they said that it is harder for old people like us to survive...”



Older persons have experienced social disconnection and isolation

<p>“I feel worthless. It feels like they have cut off one of my vital veins, and I am dying slowly.” “There is nothing to do at home all day. If that doesn’t drive you insane, I am not sure what can.”</p>	<p>“I did not meet anyone. I have not seen my children for three months. My son is a cancer patient; I can’t even see him. We are at home with my wife...I cry every day.”</p>	<p>“All stopped...my activities that we got together three or five times a week and walked in the fresh air have come to an end. I am locked between four walls ...”</p>	<p>“I would avoid going outside . . . I would not go out of the house unless it’s really necessary.”</p>	<p>“There is no one to bring me out anymore...I really wish to have people from the outside here. They make me feel normal. Now I am just stuck.”</p>
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Older persons have experienced reliance on (and the reactions of) others

<p>“I decided to walk to the supermarket that is right across from my house to get potatoes. The store manager did not let me in because of the age curfew. I felt hopeless.”</p>	<p>“I need a stomach protector and painkillers. We had to go to the family doctor. The nurse got angry at me for putting myself at risk, but what should I do?”</p>	<p>“... I need permission for my essential needs. They put me in a waiting list for bread. It took 2 days... Nobody asks what we need?”</p>	<p>“I feel angry when I hear the news that people go out and about and go on vacations.”</p>	<p>“...abuse is often overlooked because it usually happens when no one is watching. For example, when the caregiver gets frustrated by my weight and start raising their voices when they help me clean up or take baths.”</p>
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5. Economic impacts of COVID-19 on older persons in Asia and the Pacific

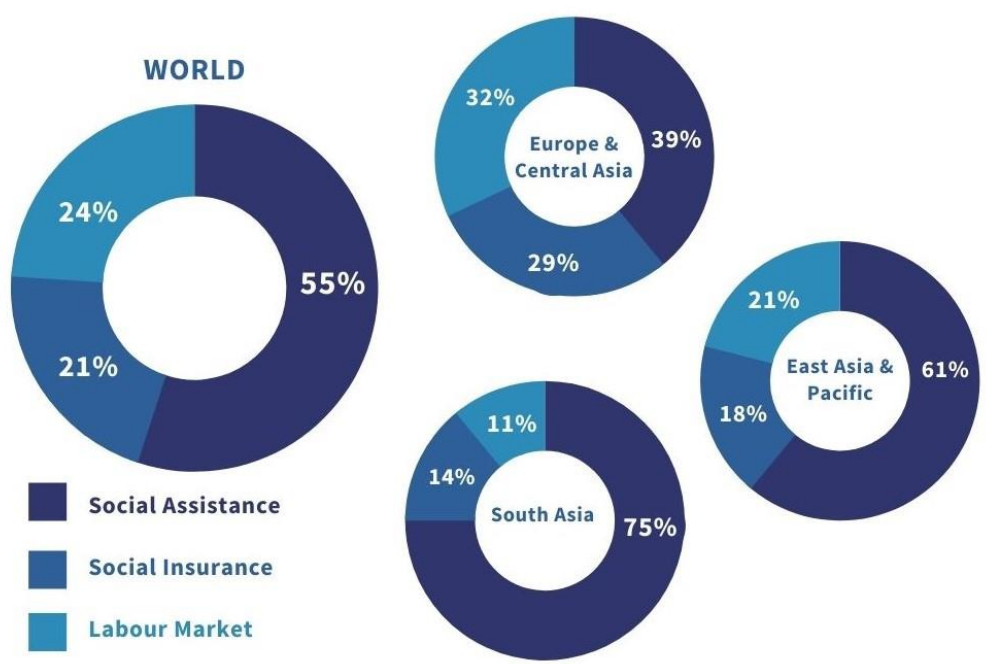
Countries throughout the region responded to the COVID-19 pandemic with interventions intended to stabilize labour markets or enhance social protection. However, the mix of interventions varied both between countries and across subregions, and only some interventions targeted older persons. Consequently, they have likely had a mixed effect on older persons, with some enhancing their economic well-being and others eroding it.

The need for COVID-19 economic support was heightened in the Asia and Pacific region. Substantial pre-pandemic growth in economic inequality likely compounded the fiscal impact of COVID-19 for the most vulnerable (including older persons).¹⁷⁶ Consequently, many older persons across the region already lacking adequate social insurance or assistance programmes were forced to continue working, find additional work (if underemployed or unemployed) or further rely on family for their survival.²⁶

The World Bank¹⁷⁷ highlighted that countries intervened to reduce the economic impact of COVID-19 by offering social assistance packages (cash-transfers, and utility and financial support) and social insurance provisions (paid leave provisions and pension enhancements) and intervening in labour markets (wage subsidies and labour regulations, such as minimum wage increases). On average, countries devoted approximately half of their initiatives toward social assistance and the other half to social insurance and labour market interventions. The mix of initiatives varied considerably between regions.

Three quarters of the social protection interventions in South Asia (comprising many low- and middle-income countries) reflected social assistance support (75 per cent). In East Asia and the Pacific, social assistance reflected 61 per cent of interventions and 39 per cent in Europe and Central Asia (figure 10)

Figure 10: Proportion of regional interventions reflecting social assistance, social insurance and labour market interventions



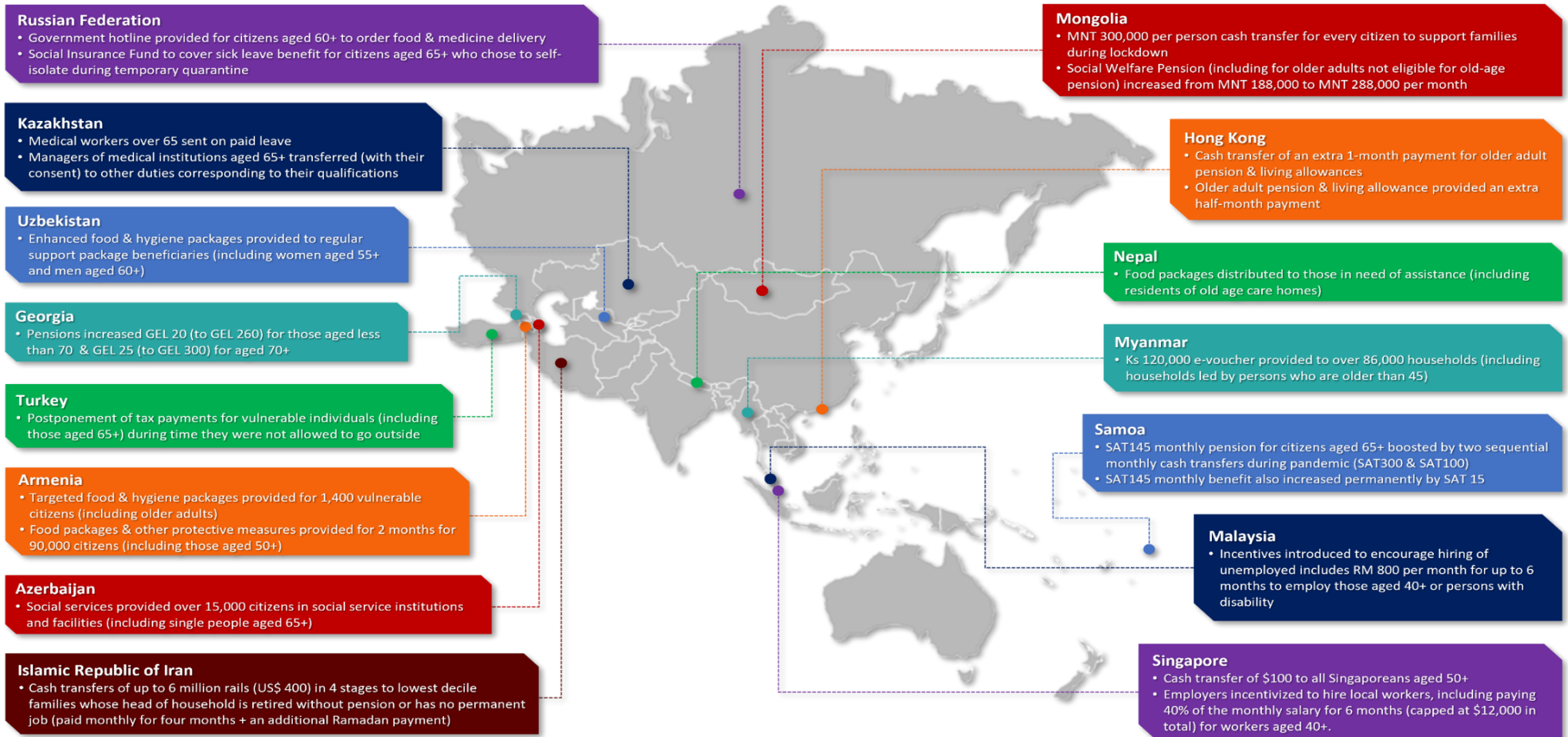
Source: World Bank (2020). Social Protection and Jobs Responses to COVID-19.

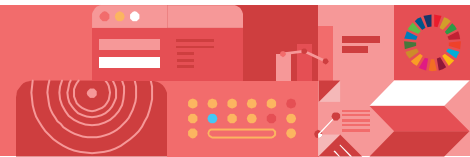


Asia and the Pacific is the region with the lowest level of social protection responses to COVID-19 and significant variation in the types of responses implemented. Current evidence indicates that the Asia-Pacific region had a lower share of countries implementing social protection responses to the pandemic (87.0 per cent), compared to a world average of 92.9 per cent.¹⁷⁸

Further investigation of the World Bank dataset illustrates substantial variation in the degree to which interventions implemented throughout the region have actually targeted older persons. Figure 11 highlights the social assistance, social insurance and labour market interventions by individual Asian and Pacific countries that clearly targeted older populations or specifically included them within the intended subpopulations of interest. Of the 51 countries listed in the Asia-Pacific region, only 12 (24 per cent) specifically implemented changes to pensions servicing older populations.

Figure 11: Specific social protection responses by countries in Asia and the Pacific that targeted older populations





The greatest projected economic risk of COVID-19 for older persons in Asia and the Pacific was that it would likely increase workforce exit for older workers. However, little data are available to identify whether this trend occurred. Instead, the most evident economic impact of COVID-19 on older persons to date has been a reduction in income and economic security (see also blue box below).

“The impact was that there were a lot of problems. We took the ration distributed by the government. We consumed that. There were a few things [at home], we sold one or two things with the help of my daughter. My son drives a rickshaw, and my husband stays at home; we are old. It impacted him [spouse]. He was out of work for three months.”

India (Singh et al, 2021; p.9)

“Despite the issuance of guidelines allowing older persons to go out if deemed ‘indispensable’, many older persons are still complaining that they have been barred from getting out to do economic activities or buy essential needs. This is because many implementers at the local level have a different interpretation of what is ‘indispensable’, this resulted in the unequal implementation of policies.”

The Philippines (HelpAge International, 2021; p 8)

Initial concern about the economic impact of COVID-19 on older persons in Asia and the Pacific centred on the precarious nature of their employment (particularly women) and the role that COVID-19 would have in enhancing workforce exit.

A recent APEC policy brief^{f179} on the future of work in the post-COVID-19 Asia-Pacific region highlighted that older persons were a workforce at particular risk of unemployment for two key reasons:

- Their heightened requirements to socially distance to reduce infection risk paradoxically increases their risk of work exit (voluntary or forced).
- Employers are also less likely to hire from this same cohort, with the loss of such skilled and knowledgeable staff potentially pushing firms toward greater automation.

However, there is insufficient regional data to indicate whether this projected workforce exit for older workers occurred. Despite an absence of data with which to explore concerns regarding enhanced workforce exit during the COVID-19 pandemic, there are ample country-specific data to suggest that COVID-19 significantly affected the income and economic security of older persons in certain countries in Asia and the Pacific: Armenia, Cambodia and Thailand.

The *Impact of COVID-19 on Older Persons in Thailand* survey conducted in July 2020¹³⁵ provides some direct results on the economic realities of 1,230 adults aged 60 or older living in urban and rural areas in all provinces across Thailand. A state of emergency was declared on 26 March 2020, with curfews and movement restriction orders for the following months. As a result, 55 per cent of women and 57 per cent of men aged 60 or older reported having a lower income as a result of the COVID-19 public health responses (see figure 12).

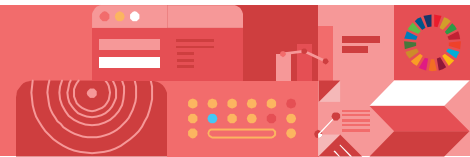
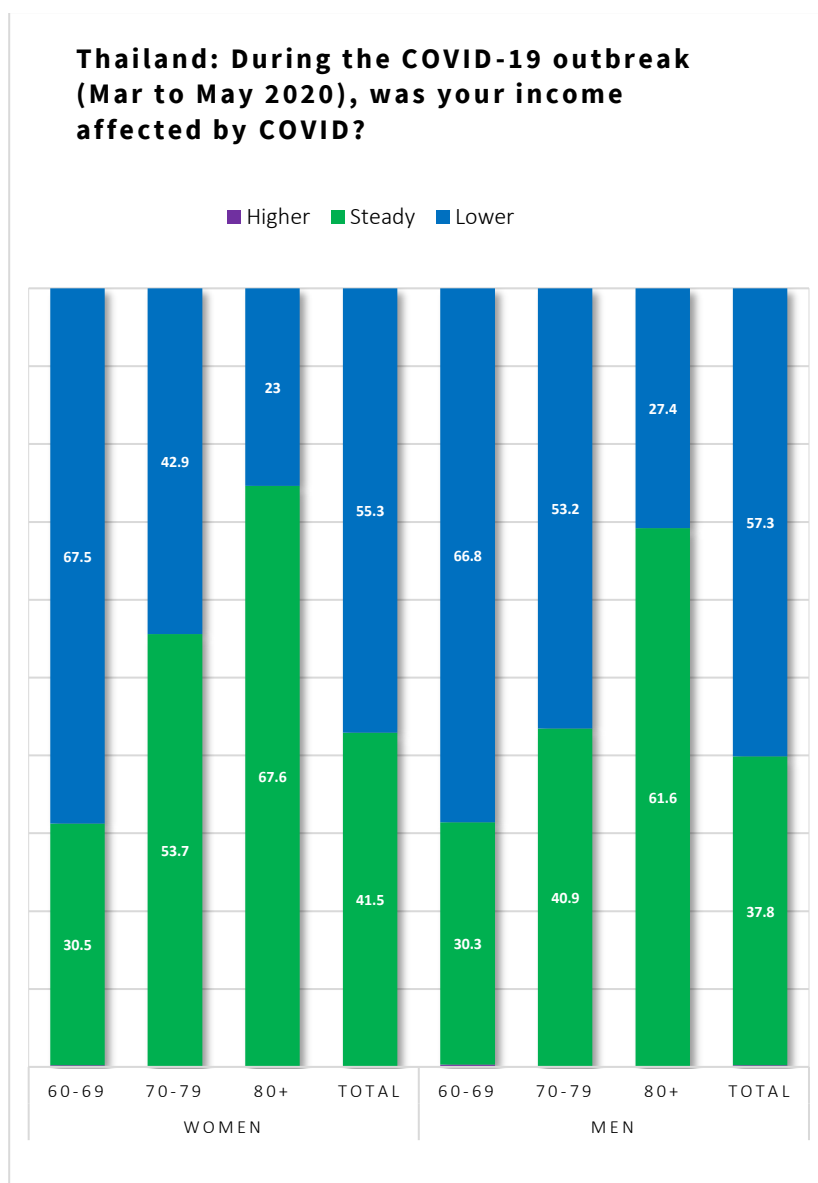
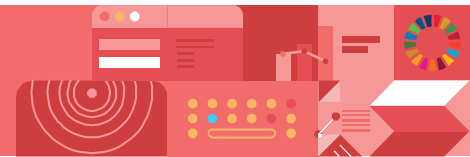


Figure 12. The impact of COVID-19 on income of older men and women in Thailand, 2020, percentage



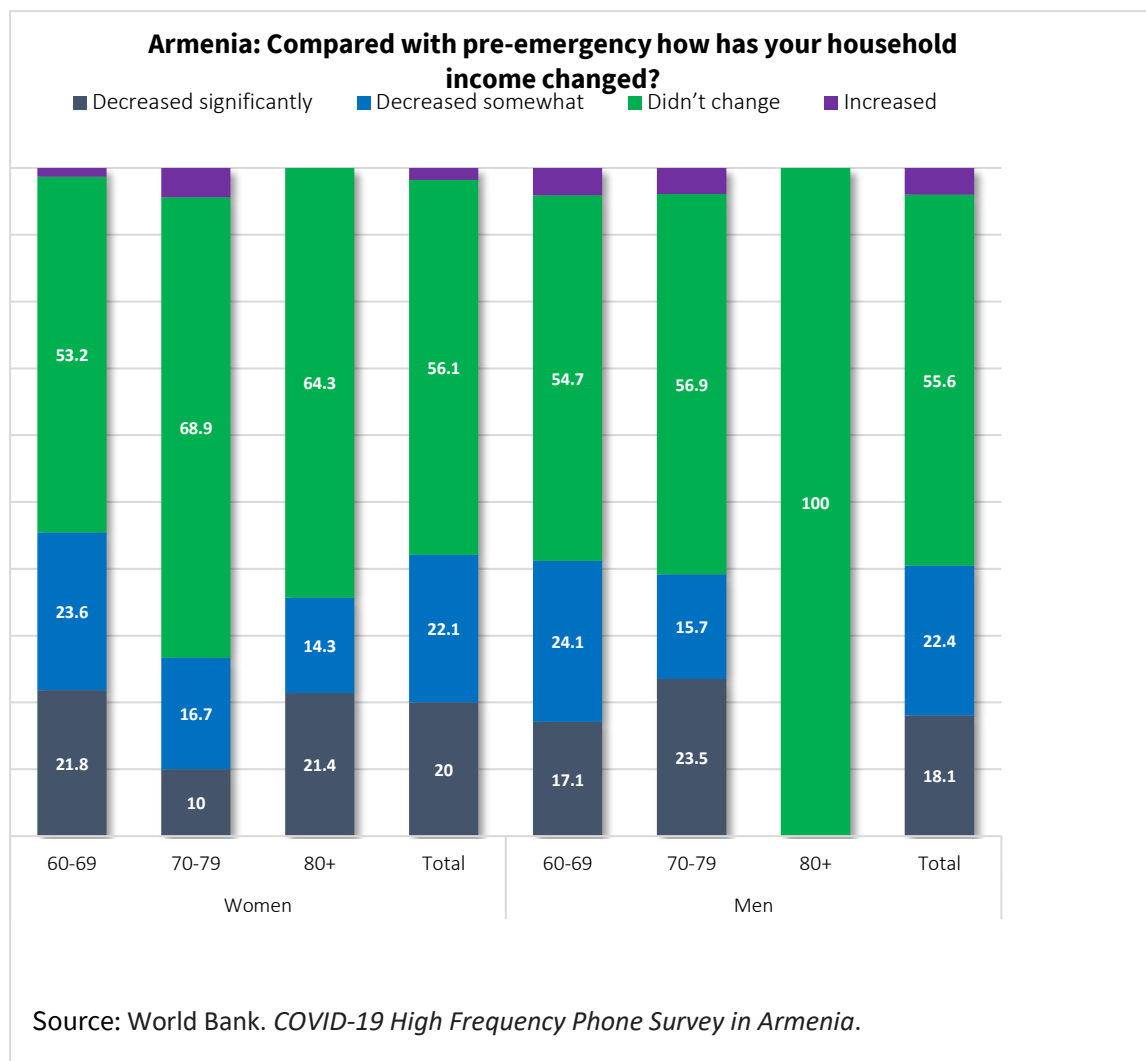
Source: Pothisiri W, Buathong T, & B., B. (2021). *The Impact of COVID 19 on Older Persons in Thailand: Evidence from the Survey*. Bangkok, UNFPA.

Encouragingly, a considerable portion of the oldest age group (aged 80+) for both women and men reported ‘steady’ or unchanged income during this time – however, a sharp age gradient was seen reflecting the realities of the workforce, work options and the Thai economy. These age patterns were similar in urban and rural areas – with older persons in rural areas reporting lower impacts (lower income – 51 per cent in rural areas, 63 per cent in urban areas). The differences between lower and higher educated older persons in those reporting impacts on income were minimal (56 per cent versus 55 per cent, respectively, reporting lower income). A follow-on question, “During the COVID-19 outbreak (from March to May 2020), was your income adequate for living?”, revealed a sizeable portion, 65 per cent of women and 62 per cent of men, reporting ‘always inadequate’ or ‘sometimes adequate’ income for living.



The World Bank COVID-19 *High Frequency Phone Survey* in Armenia¹⁵¹ included data on 853 adults aged 60 or older collected between July and December 2020. A majority of older Armenians reported no change to their incomes (see figure 13).

Figure 13. Economic impact of COVID-19 on household income in Armenia, 2020, percentage



For those that did report a change, more reported a decrease (versus increase) in income. Similar to the situation in Thailand, age differences in income impacts were reported – more pronounced in women in the 60–69 age group than the 70–79 and 80+ groups. Men aged 60–69 and 70–79 had similar rates of decreased income (either significantly or somewhat). Some 45 percent of women and 41 per cent of men aged 60–69 reported that income decreased significantly or decreased somewhat. Urban or rural residence differences were small, as were differences by education levels.

The Cambodia *COVID-19 High Frequency Phone Survey of Households 2020-2021* was conducted over five waves, with the final wave in March 2021 – which included 172 adults aged 60 or older. The sample was drawn from the Living Standard Measurement Study Plus (LSMS+) implemented from October to December 2019. Few age differences were seen when older Cambodians were asked about the impact that COVID-19 had (over a 9-month period) on household well-being and economic status (see figure 14).

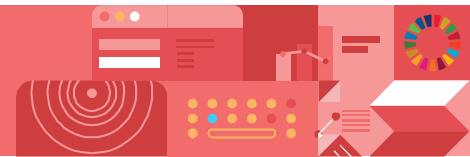
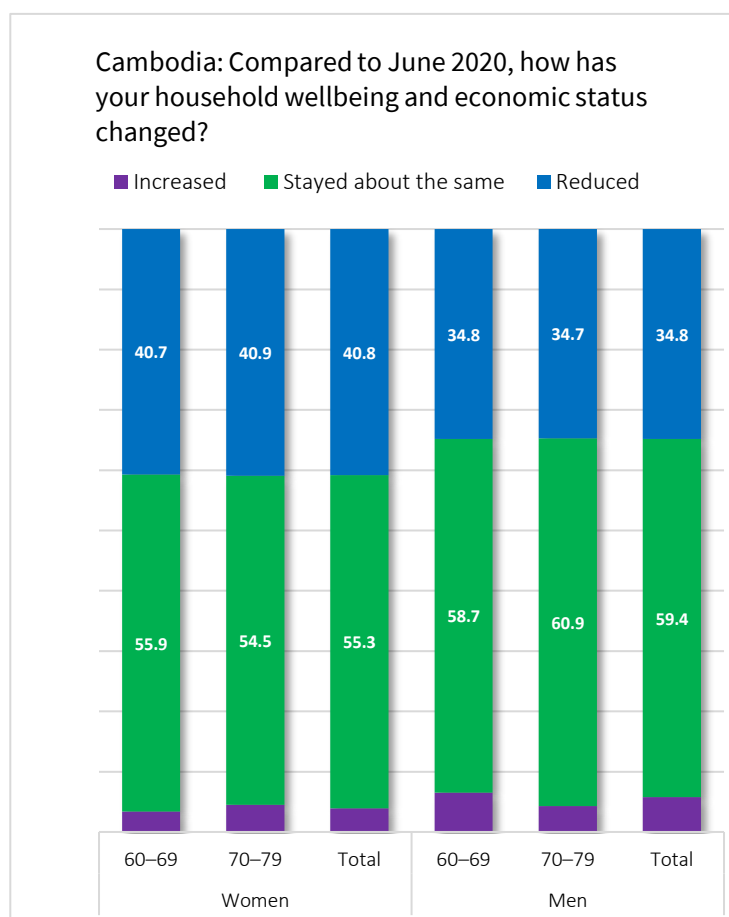


Figure 14. Economic impact of COVID-19 on household income in Cambodia 2020, percentage



Source: World Bank. *COVID-19 High Frequency Phone Survey of Households 2020-2021, Living Standards Measurement Study Plus, Cambodia.*

For both women and men, similar percentages of those aged 60—69 and 70—79 reported reduced or the same well-being and economic status. Differences were seen between the sexes though, with a higher percentage of women than men reporting reduced well-being and economic status (41 to 35 per cent), whereas a higher percentage of men than women reported no change (59 to 55 per cent).

When asked about whether any member of the household had received assistance or support in the previous four months, 27 per cent of older women and 19 per cent of older men reported receiving direct cash transfers (from government, international organizations or religious bodies). A total of 29 per cent of rural dwellers reported receiving direct cash transfers, compared to 13 per cent of urban dwellers.

6. Conclusion and recommendations

There have been numerous health, social and economic impacts of COVID-19 on older adults across Asia and the Pacific, and respect for their human rights has also been affected. However, impacts have not been uniformly felt – instead they differ by country, population and individual-level factors. In particular, there are clear gender divides in key outcomes: while older men bear the brunt of COVID-19 physical health issues (including infection, medical intervention and death) older women are more likely to experience the mental health, social and economic burden.

The COVID-19 pandemic has had a significant impact on older persons throughout Asia and the Pacific, a key group that was often the target of protective social isolation measures. Figure 15 highlights these issues in the global context. However, there were many unintended consequences of government public health response measures that also affected older persons, particularly the limiting of access to care for all health conditions and the considerable mental health, and socioeconomic challenges of social isolation. Of particular note is the lack of agency and engagement older persons experienced in government decision-making across countries in Asia and the Pacific. This likely undermined, to some extent, the measures implemented to protect older persons from the harms of the pandemic, and may indeed have heightened issues with them.

Figure 15. An overview of the impacts of COVID-19 on older persons

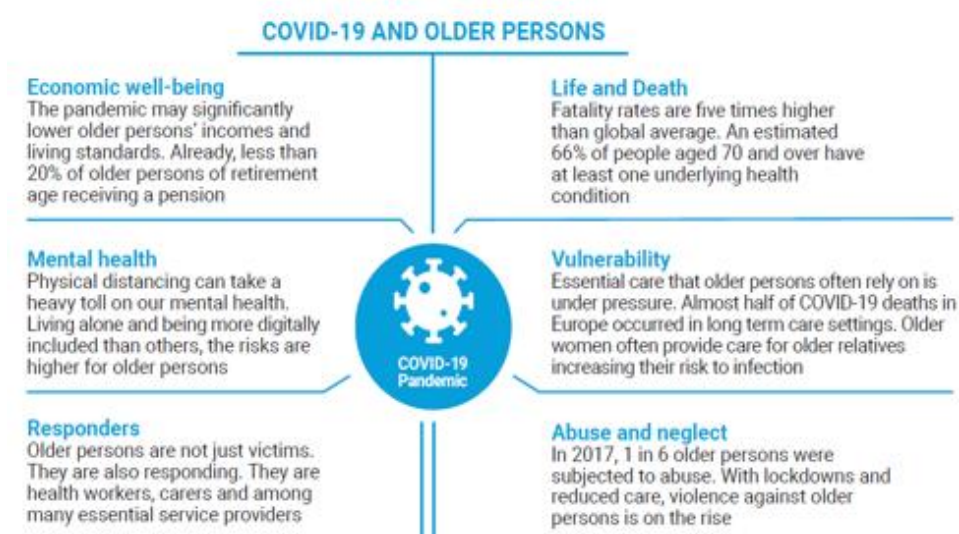


Image reprinted from United Nations (2020). *The Impact of COVID-19 on Older Persons* (p. 4).

While vulnerabilities and stresses were evident in older populations, many governments responded with a range of support options including:

- Direct cash transfers
- Employment incentives
- Food packages
- Pension enhancements
- Medical leave
- Offsets for the cost of utilities (electricity, water, Internet) and rent



Even with income losses and feelings of social isolation stemming from movement restriction orders, older persons demonstrated resilience and social optimism that helped themselves, their families and communities.¹⁸⁰ Older persons were caregivers, provided social support to family and friends, and those working or with income from a pension provided valuable economic support to households.

Two demographic trends have fundamentally shaped the experience of COVID-19 for older persons in Asia and the Pacific, specifically that it:

- Illustrated clear areas of risk and resilience across the lifespan. While older persons may have been more resilient than younger adults to the mental health impacts of the pandemic, they were far more likely to experience the wider burdens of the pandemic, including having to isolate, to lose income and employment, to catch COVID-19, to have severe illness requiring medical intervention, and to die from the virus.
- Highlighted a fundamental gender difference in health, social and economic outcomes. Men were more likely to catch the virus, to experience severe illness from it, and to die; yet older women throughout the region experienced worse mental health, and social and economic outcomes. While older persons experienced significant impacts from the COVID-19 pandemic, there are also insights into factors that have mitigated risks or impacts. The acceleration of digital health adoption during the pandemic has largely been seen as positive, including successful efforts like shifting face-to-face care to telemedicine and e-Health across the region. The virtual space was also used to maintain social connections. These positive developments may contribute to an increased digital divide among older persons who are not digitally literate or have financial constraints that mean they are not able to benefit from these advances.

The arrival of COVID-19 has created unprecedented challenges for health systems,¹⁸¹⁻¹⁸³ as well as economic and social protection systems, and the social fabric of lives. Assessing the social, economic, health and human rights-related impacts of the COVID-19 pandemic on older populations will be important to inform and tailor the responses of governments and partners to recover from the crisis and ensure that older persons are not left behind in this effort, or excluded in future pandemics. Based on this review, a set of action points have been developed around the three MIPAA priority areas:

1. Older persons and development.
2. Advancing health and well-being into old age.
3. Ensuring enabling and supportive environments.

1. Respect older persons agency: include older adults in pandemic response decision-making systems

- Older persons in communities across Asia and the Pacific have indicated that decisions are being made for their protection but without their input. This lack of engagement is obvious in the multiple international reports highlighting the actions required to protect the health and well-being of older persons, but (with one exception²⁶) ignoring any mention of including older persons in strategic planning and decision-making.
- Government and non-governmental organizations in Asia and the Pacific focusing on the health and well-being of older persons need to invest in decision-making models that include representatives of older person communities to ensure responses are co-designed and fit-for-purpose. This focus on the inclusion of older persons extends to each of the following action points.

2. Prioritize the health, social and economic needs of older women

- Older men had a documented vulnerability to COVID-19 infection and the morbidity and mortality



outcomes of the virus. However, older women throughout Asia and the Pacific were consistently affected more heavily by the wider, indirect social, economic and mental health burden of this pandemic.

- Governments and international health, aid and labour organizations need to focus more of their health, social and economic support activities on the protection and enhancement of older women.

3. Older persons are economic resources: strengthen social protection systems [MIPAA #1]

- The impact of the pandemic on global economic growth has been massive.¹⁸⁴ This has translated into financial impacts on older persons, yet they have remained resilient. Pensions for older persons are the most widespread social protection scheme in the region, yet in many cases, coverage and support levels remain low.²⁶ Despite this, where pension income was available, it was often stretched across the household.^{176, 178}
- Governments need to extend coverage of old-age pensions, particularly to older women, which would have a pronounced impact on the livelihoods of older persons and household well-being.

4. Integrate responses to communicable and non-communicable diseases into health and surveillance systems, and “count” age: strengthen health and social care systems [MIPAA #2]

- The COVID-19 pandemic has exposed dysfunction and fragility in many systems.^{5, 185} Even with older age being a known risk, age-disaggregation of data has still not been a priority in health information and surveillance systems. “Building back better” has been a consistent response to the many sectors severely affected by COVID-19. But risk- and evidence-informed approaches with age-disaggregated data will be essential for a coordinated and sustained response. This pandemic has shown the need for systems to “count” age (particularly older adult populations), and reduce vertical approaches.
- Government and international health surveillance organizations need to develop new (or enhance existing) health information data collection systems that automatically disaggregate data by age. Further, the health and social care systems linked to the health information systems should account for the intersection of older age, and communicable and non-communicable diseases. This means systems that can pivot to (or facilitate in delivery of) telemedicine or contactless care when required.
- Vaccines, diagnostics and therapeutics are known and cost-effective public health interventions to prevent, treat and eradicate diseases, in particular among older persons. In this regard, health systems need to be strengthened, and public and private sector institutions need to urgently step up manufacturing, distribution and redistribution of effective and safe vaccines in large supplies, with long shelf-life and without earmarks.

5. The supportive environments of the future will require a mixture of in-person and digital connections: strengthen digital literacy and opportunities among older persons [MIPAA #3]

- COVID-19 restrictions greatly reduced older persons’ abilities to access relevant health and social care information and messages. This places an emphasis on digital technology as a solution. While many older adults have successfully adopted technology to enhance their health, and economic and social lives, it is clear that they are more likely than younger adults to need such technology. Yet, they have more limited access to, knowledge of and utility with such technology, which can exacerbate social disconnection. Many older adults rely heavily on home care and community services, which can be restricted or cancelled depending on COVID-19 policies. This is especially a concern in terms of food security, where older persons may be unable to access food themselves without significant risk to their health.




- A number of digital solutions (such as the uptake of telemedicine, task shifting and redirecting patients living with non-communicable diseases to available services) have demonstrated the capacity of health systems to make these changes. Here again, COVID-19 has provided a unique opening to rethink health systems,¹⁸⁶ but research will be needed to turn digital solutions and responses to COVID-19 surges into lessons learned and feasible, sustainable solutions for health systems. Research is needed into how digital and other solutions have contributed to health system transformations – and the direct and indirect health consequences for older Asia-Pacific populations.^{187, 188} Using these research results, development assistance for health would be needed for lower income Asia-Pacific countries to embed these solutions into their health systems and policies for universal health coverage. Virtual and contactless delivery services would need to be strengthened – and older persons supported to efficiently access these services.
- 6. Country-specific responses (complementing broad regional approaches) are required to fit the varying contexts in which older adults live in Asia and the Pacific**
- A World Bank report indicated that the experience of COVID-19 (rates of mortality) is often not generalizable between low, medium and high-income countries. This paper shows that the COVID-19 experience (both the rate of death and the wider health, social and economic impacts) has also considerably varied across countries in Asia and the Pacific.
 - Governments, international agencies and non-government stakeholders need to tailor regional or national pandemic responses more clearly to the characteristics and capabilities of their older populations. This entails engaging older persons in decision-making to recognize whether outcomes are feasible (such as pivoting to virtual care or volunteering, or online social engagement) or risks can be mitigated (such as, social isolation due to preventive measures). With active input from older adults, and given the nature of support available and the presence or absence of factors identified in this paper, the forthcoming Asia-Pacific and global MIPAA reviews could identify key action points to support successful outcomes for older persons now and in the future.



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