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Aging in Comparative Perspective

Processes and Policies

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International Perspectives on Aging

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Preface

Over recent years, there has been much political discussion surrounding the relatively recent global social development of aging populations. People are living longer than ever before due to the advancements in medical treatments and interventions and improvements in the provision of health care. This phenomenon has placed new pressures on social, cultural, political and economic processes. The focus of this book is to examine aging populations by selecting several countries that are experiencing these new pressures on their society.

We would like to thank certain people who have helped us to write this book. First, to our families for allowing us to lock ourselves away in order to dedicate the time necessary to focus on research and the writing up. Second, to Jason Powell who supported us and inspired us to write this book. Third, to Janice Stern who has kept us on track. Finally, to those who reviewed and proof read certain chapters: David McEvoy, Sara Parker, Samantha Fletcher (initial research assistance) and Hazel Gee.

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Contents

Chapter 1
Introduction: An Aging World

It is now well known that population aging will be a major feature of human societies across the globe in the twenty-first century. Over the recent decade, there has been much academic discussion on the rapid increase in population aging (Biggs & Powell, 2001; Pain & Hopkins, 2010; Powell & Owen, 2005; Sanderson & Scherbov, 2007; Tosun, 2003; Wacker & Roberto, 2009). Population aging has caused political challenges in the economic and social activities affiliated with a growth in the elderly population. This introductory chapter outlines the key themes and issues relating to aging. The first part will outline the structure of the chapters. This will lead to an overview of comparative aging in the sample countries. Following this discussion, the global impacts of aging will be outlined.

Key Themes and Issues

In a world faced by such spectres as climate change, international terrorism and pressures on food production, population aging should be one of the bright spots of the human condition. Figure 1.1 gives, from a global perspective, a holistic approach to the key facts of an aging population. As a species we are living longer, and many of us are living healthier, more productive lives at a later age than most of our ancestors would have thought possible. Whether it is mountain climbing, skydiving or marathon running, the media regularly informs us that Mr/Mrs Smith has climbed Everest/skydived/completed the New York marathon at the age of 65/75/85. But at the same time, such positive reporting is more than offset by gloomy prognoses presented on aging societies, with their growing pension crises, increased demands of older people on the shrinking working population and consequent pressure on the public sector safety net, via subsidized healthcare insurance or a full-blown welfare system. Futagami and Nakajima (2001 p. 31) have noted that the relationship between population and economic growth can be distinguished in two ways. First, as people are living longer, "the ratio of retired people who generate dissavings to

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- People in all parts of the world, and particularly in developed nations, are living longer than ever before
- This unprecedented population aging trend has profound effects on society and its intuitions, including health care
- Biomedical research and better healthcare measures, as well as other factors, have enabled people to live longer and reduced disability rates
- Increased life expectancy, however, brings new challenges, including longer lifetime exposure to toxic agents and greater demands on healthcare systems and social entitlements
- Individuals, society, government, and the research community all have a responsibility to meet these challenges and improve the quality of life

Fig. 1.1 The true facts of global population aging. Source: Butler (Butler 1997)

working people who save for their retirement will be higher, and hence the aggregate saving rate will be reduced. The reduction of the saving rate will decelerate economic growth through a slowdown of capital accumulation." Second, the other view on the relationship between population and economic growth is one supported by Pecchenino and Pollard (1997) that "economic growth may be increasing in longevity" (Futagami & Nakajima, 2001 p. 31).

Coupled with this debate are the terminologies in relation to population aging. Harper and Laws (1995) have stated that research conducted on population aging has developed stereotypes of all age groups and created inconsistencies in age norms. Aging has been defined by Phillips et al. (2010 p. 12) as:

> A process whereby people accumulate years and progressively experience changes to their biological, social and psychological functioning as they move through different phases of life course.

It is the intention of this book to carefully weigh up such contrasting points of view, examining the positive and the negative elements of aging. This research has followed a qualitative theorizing approach. Academic literature and documentary data sources, such as reports and media sources, have been used. This follows the methodological approach adopted by Cook et al. (2010). Broadly, however, we concur with the authors of the *International Handbook of Population Aging* who:

> do not portray population aging as a crisis. However, they do recognize that there are profound global implications of the population aging now occurring (Uhlenberg, 2009, p. 4).

The "challenges and opportunities" that such population aging presents will be examined with reference to seven selected countries, at different stages in the aging process, namely:

- United States of America
- United Kingdom
- Sweden
- Japan
- China
- Nepal
- South Africa

The USA has been selected because it has regularly featured in the list of societies with a high proportion of older people, but with the caveat that, due to such reasons as the continuation of a significant proportion of very poor people, greater gender equity compared to many other countries, and relatively high level of female economic resources (Rowland, 2009) plus continued immigration, the ratio of younger people has remained higher than in other wealthy countries.

In addition, under the leadership of President Barack Obama, new legislation on health reform has been introduced which creates health more affordable and fairer to all American citizens. The UK is selected as our home country, one which has until recently been home to one of the oldest populations in the world and has had a significant welfare state development, now under threat due to the perceived high levels of debt within the country and consequent aim of the new coalition government to reduce debt levels via curtailed state expenditure.

Sweden is chosen because, along with France, it was one of the first countries whose population was seen to be aging, in the late nineteenth century. It is another country associated with high levels of state welfare expenditure, again until recently when more fiscal cutbacks have occurred. Japan, in contrast, has aged recently, following World War II when fertility levels dropped and aging became more and more prevalent. Japan is now widely recognized as becoming the oldest population and the home of the "oldest-old", with those 85 years or more becoming a high proportion of the total population. Powell (2009) has noted that the most striking increase in an aging population is Japan because by 2030 almost 24% of all older Japanese are likely to be at least 85 years old. The last three countries selected are more representative of Third World countries rather than the First World countries already listed, namely China, Nepal and South Africa. China continues to hold the highest number of older people in the world, with 195 million people aged 65 or over by 2025 and 332 million in that category by 2050, according to UN estimates (cited in Rowland, 2009). However, this society has aged very recently, in part due to the knock-on effects of the Chinese Government's Single Child Family Programme combined with the high levels of economic growth exhibited in recent decades. Nepal and South Africa, in contrast, have only just entered the field of aging societies, and only at the starting level, namely 7–8%. Both of these countries have suffered from factors that constrain the growth of the elderly population, especially the Civil War in Nepal, apartheid followed by the spread of high levels of HIV/AIDS in South Africa.

In developing this comparative analysis of these countries, we follow Schafer and Ferraro (2009 pp. 33–34), who contend that:

> the social processes, economic experiences and physiological risks linked to human aging are more thoroughly understood when explained in an international context.

Although as social scientists we shall not be considering "physiological risks", we shall focus upon social processes and economic experiences within each of the selected countries. But we begin with a brief context, to see how these countries relate to each other in terms of demographic aging.

Table 1.1 Population percentage aged 65 or more over time for sample countries

1950	1975	2000	2025	2050
UK 10.7 (4th)	Sweden 15.1 (1st)	Sweden 17.4 (3rd)	Japan 28.9 (1st)	Japan 36.4 (2nd)
Swed 10.3 (8th)	UK 14.0 (4th)	Japan 17.2 (4th)	Sweden 25.4 (4th)	Sweden 30.4 (10th)
	USA 10.5 (23rd)	UK 15.8 (11th)	UK 21.9 (15th)	UK 27.3 (28th)
		USA 12.3 (33rd)	USA 18.5 (35th)	China 22.7 (44th)
			China 13.2 (51st)	USA 21.1 (50th)

World ranking in brackets (10% and 1 million cut-offs)
Source: Rowland (2009). Extracted and analysed from Table 3.3, pp. 44–45

Comparative Aging in the Sample Countries

Population aging began in the countries of Western and Northern Europe, with, as noted above, France and Sweden being identified from the late nineteenth century as having aging populations, and a Swedish researcher, Gustav Sundbärg, being the first to present the concept of "regressive" (older) age structures compared to "progressive" (younger) ones, according to Rowland (2009, p. 42). By that date, Sweden had 8.4% of its population aged 65 or over (7% is widely recognized as being a significant cut-off point beyond which to identify an aging population, with France reaching this in 1865 (ibid.)). Rowland goes on to show that, despite these early indications, it took a long time for this percentage to double to 14%, France taking 115 years (1865–1980) and Sweden 85 years (1890–1975). The United States will take 69 years to do this (1944–2013) and the United Kingdom has taken 45 years (1930–1975). In contrast to these, Japan has taken a mere 26 years to reach this target (1970–1996) and China is estimated to do likewise (2000–2026). Nepal and South Africa do not figure at all in such data or forecasts.

Rowland presents highly useful Tables based mainly on UN projections. We extract the relevant data from these sample countries but Nepal and South Africa are not in these tables at all due to the relevant cut-off points employed, while Japan and China are latecomers, except for that for absolute numbers of older people.

Table 1.1, then, gives the percentage aged 65 years or more, but with 10% as the cut-off, and for those countries whose population is 1 million or more, from 1950 to 2050, for our remaining 5 sample countries. The table is instructive. Sweden features highly throughout, as does the UK, but these countries have slipped down the aging table from 4th and 8th in 1950 to 10th and 28th, respectively, by 2050. Japan did not enter until 2000 but is 1st by 2025 and 2nd (after Spain) by 2050. The USA enters in 1975 at 23rd, but is 50th by 2050, after China, which enters in 2025 and rises slightly by 2050. For those with a more pessimistic view of population aging, you can read the table in reverse order, so the USA would therefore seem to be best placed in this regard by 2050, and China close after.

On the other hand, if you are pessimistic, then Table 1.2 can support your pessimism in that it shows the high numbers of older people within four of our sample countries. As the nation with the largest population on earth (although India is coming up fast), China features throughout at number one, despite what was a relatively

Table 1.2 Population numbers aged 65 or more over time for sample countries, in millions

1950	1975	2000	2025	2050
China 25 (1st)	China 41 (1st)	China 87 (1st)	China 195 (1st)	China 332 (1st)
USA 13 (2nd)	USA 23 (3rd)	USA 35 (3rd)	USA 64 (3rd)	USA 84 (3rd)
UK 5 (6th)	Japan 9 (6th)	Japan 22 (4th)	Japan 36 (4th)	Japan 40 (6th)
	UK 8 (7th)	UK 9 (10th)	UK 13 (11th)	UK 16 (20th)

World ranking in brackets (5 million 65 or more cut-off)
Source: Rowland (2009). Extracted and analysed from Table 3.4, p. 47

low percentage in 1950 and 1975. By 2050, the estimate is of an amazing 332 million people being aged 65 or over in China. This is the sort of figure that Kofi Annan had in mind when he said in 2002 that aging was no longer a First World issue (ibid.). So there are not only high relative figures for aging expected this century, there are also high absolute figures of people aged 65 years or more.

Table 1.2 shows that by 2025, in only 4 of our 7 sample countries, there will be around 300 million people aged 65 or more; by 2050, in these same 4 countries this number will increase to over 470 million, a truly astounding figure. The scale of aging is unprecedented. These are projections of course, and we must be careful not to take them too literally, in that there remain considerable threats to the aging process, such as the environmental threats—increased rate of hurricanes, typhoons, erratic monsoon patterns leading to major floods for example, the struggle against old infectious diseases such as malaria contrasting with the struggle against new forms of infection such as SARS or Avian Flu—associated with such factors as climate change and changing population concentrations and interactions. Elsewhere, Cook and Dummer (2009) and Dummer, Halsall, and Cook (2011) have explored some of these negative impacts on longevity, arguing that although Malthusian checks on population growth have largely been overcome, they nonetheless pose a significant threat in this century, while "neo-Malthusian" checks have joined the ranks of such dangers to long-term health progress. In other words, "diseases of poverty" still pose a threat today, even as the epidemiological transition towards lower birth and death rates continues, and "diseases of affluence" are on the increase. We must be careful, therefore, not to take these forecasts as a "done deal"; although it does seem highly likely that human aging is an unstoppable force, there remain significant potential constraints to slow down but hopefully not reverse this force in the future.

Implications of Global Aging

Despite the caveat noted in the last paragraph above, assuming that these forecasts are broadly correct gives rise to a huge number of implications for most countries across the globe. It is clear that it is the economic implications that give the most concern to many national and international policymakers and decision takers.

How can this aging process be paid for is the main question. Old people are viewed as expensive to maintain, particularly once they live beyond a specific age, usually regarded as 80 or 85. The proportion of the population of working age continues to shrink as part of the new ratios of age groups within society, and there is a fear that very few workers will be left to support those children that continue to be born, though often not at the same rate as before, along with this burgeoning older population. The "dependency ratio" of dependants to workers continues to increase, with more dependants per worker, and older people are seen as replacing children as more expensive dependants than children ever were. At least that was the stereotypical analysis until recently. Now, such analysis often seems rather less sure, with children now being regarded as far more expensive to support than was previously the case. Further, while nearly all children are dependent on support systems, by no means all older people, even including the oldest-old, are in the same boat. While some, perhaps many, older people require support systems to be in place, there are others who are able to maintain independent living for a considerable life span.

Chapter 2
Aging in the United States

As we have shown in the Introduction, aging in the United States is not merely a reflection of the country's high level of economic development, because longevity gains in some ethnic groups are offset by continued poverty in other sectors of the population, and high fertility levels among specific immigrant groups, such as Hispanics. Due to these and other changes working through US society, the country is actually predicted to fall down the international aging table, from 23rd in 1975 to 50th by 2050, but nonetheless with 84 million people aged 65 years or more. Given that these 84 million live within the number one economy in the world (notwithstanding the rise of the Chinese and Indian economies) this means that many millions of people in the US are more likely to be able to access economic resources at a higher level than many of their counterparts in other parts of the globe. However, being part of the leading economy may also mean that their aspirations may also be unrealistically high, in that they may desire more second homes in sunny climes, more winter cruises, more expensive technological support systems, for instance, than may be feasible, whether in a strictly economic, social, political or environmental sense. In this chapter we explore a number of such issues, focusing on the many millions of US citizens who are growing old in such a wealthy society.

Towards a World of Silver Surfers and Golden Oldies

If you are 80 years old in 2010 then you were born in 1930, if 70 then 1940. What sort of events and experiences have impacted on your life and lifestyle? Well clearly growing up in the aftermath of the Great Depression would be one such major event and perhaps your parents were employed via President Roosevelt's New Deal, or perhaps your father was injured or killed in World War II. Later conflicts in Korea, Vietnam, Iraq and Afghanistan would have affected family or friends directly or indirectly, while the shock of the attack on the Twin Towers of 9/11 would have been significant, as was Pearl Harbor or the assassination of JFK. However, your

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family has probably prospered, despite or because of such conflicts and you have yourself have generally had a comfortable lifestyle notwithstanding economic setbacks such as the Global Recession of 2008–2010. You now live in a comfortable condo complex in the sunny South, and your son visits once or twice a year when he can get away from work and family demands on his time. You do worry sometimes about your savings, how long they will last, and you are concerned at some of the changes that you have seen in US society. You hanker back sometimes to your early life in the Village, and have the odd twinge of regret at leaving it all behind, but it was for the kids wasn't it? Now you laze by the pool, play a few hands of poker and surf the net—you're sure glad that you made the effort to learn how to use the Web, and you've got your webcam set up to communicate more easily with the family via Skype. Is this you? Or your mom or pop? Or your grandparents? Or their friends? Schulz and Binstock (2006, pp. 3–4) for instance note that the "vast majority" of older US citizens live:

- Reasonably healthy and active lives.
- Have generally adequate income.
- Significant wealth, for many.
- Independently.
- Have benefited from a dramatic rise in the number of years in retirement.
- Can access special agencies in every state, plus national facilities for older people.

But, in contrast, perhaps you are one of the minority who recently lost your home when Freddy Mac or Fannie May collapsed; you had to move back in with the kids and you rely on welfare handouts? Life has always been a struggle and it remains so, but thank goodness for Obama's health reforms; at least you don't have to worry about how those likely life-threatening diseases will be treated and paid for.

In other words, there is a need to avoid stereotypes of older people in the US, as for other countries. They are hard to pigeonhole, they vary considerably by income, ethnicity, location and life experiences. Further, the "baby-boomers" after World War II are probably younger in thought and perspective than were their predecessors at a similar age, influenced perhaps by the rise of the teenager in the 1950s and the "Swinging Sixties" and such happenings as Woodstock or "going to San Francisco" for the Summer of Love. In terms of aging trends, however, we can point to some salient facts drawn from key publications. LaPierre and Hughes (2009), for example, note that population aging in the US (and Canada) is not a new phenomenon, taking place "from the time the nations were established as independent states" (p. 192), and the change from being agricultural economies thru industrialization to become highly urbanised post-industrial economies which have undergone "profound transformations" in such spheres as technology, family structures, and the value of work. However, the US demographic transition actually began while the country was an agricultural society, with fertility decline beginning in the early nineteenth century, albeit from a far higher level than in Europe for example, befitting a new society. They present data and graphs which show a long-term decline punctuated only by the rise in fertility in the 1940s and 1950s (76 million births in

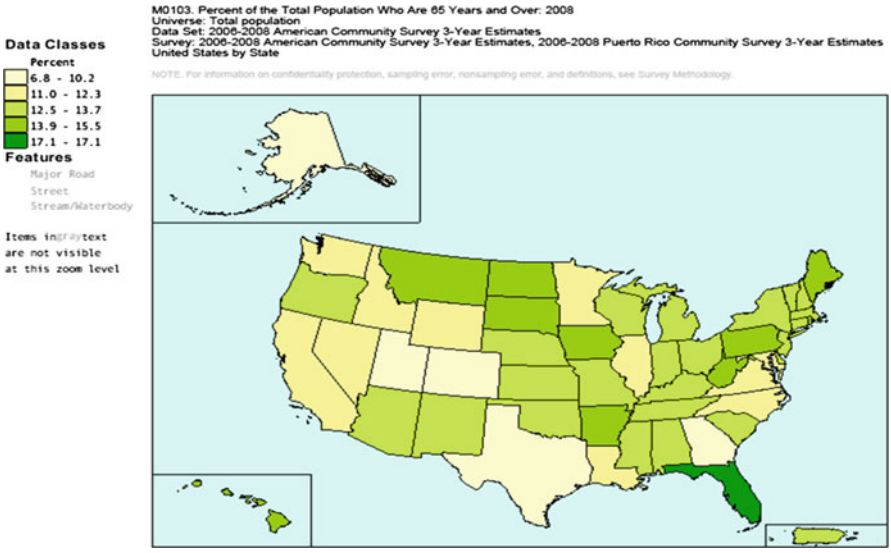

Fig. 2.1 Percent of the total population who are 65 years and over in America

the 18 years from 1946 to 1964 according to Schulz & Binstock, 2006, p. 1) before long-term trends reasserted themselves. By the early twenty first century US "fertility hovers just below replacement level at about two children per woman. This level is higher than that observed in most developed nations" (LaPierre & Hughes, 2009, pp. 193–4). In contrast, mortality decline is largely a twentieth century phenomenon, and mortality rates actually increased in the second half of the nineteenth century, perhaps in part as a result of high immigration levels due to the Irish potato famine and political upheavals in Europe—the fabled "huddled masses" being welcomed into the New World. The Nineteenth Century Civil War must also be factored in to these calculations, while "tropical diseases" in the Southern States could also be lethal, particularly to new arrivals.

The US Census Bureau provides data from community surveys 2006–2008, for the distribution of older people across the States. Figure 2.1 gives the percentage aged 65 or over, and it shows the spatial concentration to lie primarily in Florida, by far the State which contains the highest proportion of older people, plus a range of other States lying towards the East and/or North, such as Maine, West Virginia, North and South Dakota. In contrast those States with lower percentages are Alaska, Utah, Texas, Georgia, California and Nevada for example. Several of the latter have relatively low proportions of white populations, while the former are more likely to have the reverse, but it is a complex picture, and Florida with its Cuban links has a relatively low proportion of whites, whereas at the bottom of the aging table, Utah has 90% white population (Table 2.1).

Across the country, the complexity of US population composition due to immigration means that we must focus more closely on different cohorts within US society. It was estimated by 2007, for example, that there were 38 million foreign-born

Table 2.1 US aging data, by state

Area	Percent 65 or over	Percent 85 or over	Percent white	Dependency ratio
United States	12.9	1.8	74.3	20.5
Florida	17.2	2.8	76.7	28.3
West Virginia	15.8	2.1	94.4	25.1
Maine	15.6	2.2	95.3	24.4
Pennsylvania	15.4	2.5	83.8	24.7
Iowa	14.8	2.5	92.7	24
North Dakota	14.7	2.7	90.7	23.3
Montana	14.6	2.1	89.6	23.1
Hawaii	14.5	2.5	26.8	23
South Dakota	14.5	2.5	87.1	23.8
Vermont	14.5	2	96.1	22.2
Arkansas	14.3	2	78.6	23.4
Delaware	14.3	1.8	72.6	23
Rhode Island	14.3	2.4	82.8	22.3
Connecticut	13.9	2.2	79.9	22
Ohio	13.9	2	84	22.2
Alabama	13.8	1.7	70.4	22.2
Missouri	13.7	2	83.9	22
South Carolina	13.7	1.7	67.5	21.8
Massachusetts	13.6	2.1	82.7	21
New Hampshire	13.5	1.9	94.9	20.9
New Jersey	13.5	2	70.1	21.4
Oklahoma	13.5	1.9	75.4	21.8
Oregon	13.5	1.9	86.2	21.2
Wisconsin	13.5	2	87.6	21.2
Michigan	13.4	1.8	79.6	21.3
Nebraska	13.4	2.2	88.8	21.8
New York	13.4	2	66.7	21
Tennessee	13.4	1.7	79.3	21.2
Kentucky	13.2	1.7	89.2	21
Arizona	13.1	1.8	77.7	21.7
Kansas	13	2.1	85.7	21
New Mexico	13	1.7	70.1	21.1
Indiana	12.9	1.8	85.7	20.9
Mississippi	12.8	1.7	60	20.9
Minnesota	12.7	2	88	20.1
North Carolina	12.7	1.6	70.3	20.2
Illinois	12.4	1.8	71.4	19.6
Louisiana	12.3	1.6	64.3	19.7
Wyoming	12.3	1.6	91.6	19.4
Maryland	12.2	1.6	61.2	19
Virginia	12.2	1.5	70.7	18.9
Idaho	12.1	1.6	92.4	20
Washington	12.1	1.7	80.5	18.8
District of Columbia	11.7	1.6	36.1	16.9
Nevada	11.6	1.2	74.9	18.5
California	11.2	1.6	60.9	17.7
Colorado	10.6	1.3	83.7	16.4
Georgia	10.3	1.2	62.2	16.3
Texas	10.2	1.3	71.4	16.5
Utah	9	1.2	90	15.1
Alaska	7.6	0.7	68.6	11.4

Source: US Census Bureau (2010)

living in the US, with more than 10 million of these (29%) being illegal immigrants. Migrants, both legal and illegal were spatially clustered into five main States, such as California or Florida, States which thus bear a related welfare burden, and for which taxation is thus a controversial issue. Further Keating and Wetle (2008, p. 99), for example, point out that:

> In the US, life expectancy at age 65 differs by gender and race. For white women and men it is 19 years and 16 years respectively; for Black women and men it is 17 years and 15 years.

There is also the challenge of socio-economic inequalities, and these authors note that 13% of older women live in poverty compared to 7% men, but for older Black or Hispanic women the proportion in poverty reaches 40% (ibid., p. 100). Poverty is not an exact predictor of longevity but the lack of it is a key factor in ensuring that people not only reach an old age but also that they can live a more active life once they have reached it. But the picture is complex (Fig. 2.1):

> Thus, members of minority groups are likely to enter old age with poorer health and fewer resources than majority whites, especially in the U.S. However, minorities are not always disadvantaged: U.S. Hispanics are advantaged relative to whites on some dimensions of health and Asian-Americans economic achievement outstrips that of whites. Members of various groups bring these advantages and disadvantages to old age where they help to shape how they age and the needs they experience (LaPierre & Hughes, 2009, p. 205).

Think of contrasting diets for example; in Europe the "Mediterranean" diet with high proportions of pasta, olive oil, fish and tomatoes for instance is now considered preferable to the high meat and potato diet of Northern Europe, while a traditional Asian rice-based diet would also be seen to be advantageous in comparison to the wheat-based nutrition system traditional in the West. But as migrants adapt to new host societies they can be drawn into less healthy junk food and processed food systems as their lifestyle changes so, once more, the outcome is complex and highly variable, while diets of the host group are not static when faced by the opportunities for a "Mexican" or a "Chinese" that new migrants provide.

Pension Provision in a Deregulated Society

Although there are those in the US who view their own society as over-regulated, to European eyes at least, the US is a relatively deregulated society, in which welfare provision for older people is more likely to be provided via the Market rather than the State, via private pension and saving schemes. As in other societies, the main area of debate is how far State provision should go in order to provide a minimum level of income for older people, and to what extent taxpayers should fund this floor level of provision. In the US "older adults with little or no income or assets can apply for Supplemental Security Income (SSI)…available to the blind, the disabled and the elderly" (LaPierre & Hughes, 2009, p. 210). Despite the costs involved, these authors note that "government forecasters predict only a small increase in the proportion of the U.S. population who will receive SSI benefits over the next 25 years" (ibid.), in large part because those aged 65 or over comprise only 20% of SSI

recipients, and many qualified older people never apply for these benefits. Indeed, it is forecast that SSI payments "will actually decline from 0.285% of GDP in 2005 to 0.243% of GDP in 2031" (ibid.). Even if we assume some element of error or over-optimism in this forecast, it is highly likely that there is considerable validity in this estimate.

However, it is another form of support, namely Social Security (comprising two elements, Federal Old-Age Survivors Insurance (OASI) and Disability Insurance (DI), together known as OASDI) for which the outlook is "troublesome" and despite an increase in eligibility for full payments to 67 years compared to 65 previously "the long-term solvency of the Social Security program is still in jeopardy" (ibid., p. 211). These payments are taxed, and earmarked for the Social Security program and Medicare, the government health insurance for older people, but a 2008 report suggests that by 2017 the annual costs of this program will exceed taxation income. Currently, there is a surplus income that has given rise to the Social Security Trust Funds for each element, effectively "an IOU from the U.S. government, which has been using these excess funds for other programs" (ibid), but these Trust Funds will be completely used up by 2041, meaning:

> At that time the government will have no choice but to either increase taxes, or restrict or reduce benefits, as income from tax revenue will only cover 75-78 per cent of promised benefits between 2041 and 2082 (ibid.).

The US Government has been given warnings by the Social Security Board of Trustees about this growing problem "for decades" and since 1991 the Trustees have recommended action, for fear that the longer the situation is left unaddressed, the more drastic will be the eventual outcomes via increased taxation, decreased benefits or a combination of the two.

The third stream of pension support is via the private sector, via defined benefit plans or defined contribution plans. The former is based on final salary for each year of service and is paid annually as a lifetime annuity, while the latter is based on contributions to a retirement savings account that is invested, with the employer deciding "how and when to withdraw the funds" (ibid., p. 213). For the past 30 years or so a steady 52% of US retirees take such a pension income but with a shift towards the contribution plans rather than benefit plans. Those who utilise such private provisions "are more likely to be male, older, non-Hispanic, white, married and high-income earners" (ibid), thus there is a link back to comments at the end of the previous section, whereby certain cohorts are at a higher risk of not having the income that may might wish or need upon retirement.

One of the reasons why some commentators and analysts become so agitated about the potential costs of older people to society is that dependency ratios for people aged 65 or over compared to those aged 16–64 are set to increase considerably in the twenty first century. However (and as one of the authors has pointed out in his ongoing analysis of gerontological issues in China, e.g. Cook & Powell, 2005, 2007), dependency ratios for those aged 15 or less are on the decline too, while in any case there can be unemployment among those that young and old are dependent upon, or older people may not be "dependent" at all. Addressing the first of these points LaPierre and Hughes (2009, p. 221) present a highly informative table of past

Table 2.2 Changing dependency ratios, 1870–2050

Year	65 or over	0–15 years	Total
1870	0.05	0.68	0.73
1900	0.07	0.56	0.63
1930	0.08	0.47	0.56
1960	0.15	0.52	0.68
1990	0.19	0.33	0.52
2020	0.26	0.31	0.57
2050	0.35	0.33	0.68

Source: LaPierre and Hughes (2009), Table 10.6, p. 221. Final column may vary due to rounding

and projected dependency rates for the US, from which we have selected those at 30 year intervals for Table 2.2, as shown. Because the US had high fertility levels, as noted above, dependency ratios in 1870 were higher than for today due to the high number of children being born, and then the gradual decline in the birth rate led to a reduction in total dependency ratios until the combined impact of the baby-boomers with the increase in numbers of older people sparked an increase by 1960. Further falls in the birth rate led to further decrease thru 1990, and then an increase once more thru to 2050. Even by 2050, however, their projection is still less, in total, than for 1870. This is an encouraging sign, and although concerns over too high proportions of older people will not disappear, the prognosis is certainly not all doom and gloom as some would have it (Table 2.2).

Taking Stock in the Aftermath of the Banking Crisis

The previous sections make full use of the excellent chapter by LaPierre and Hughes, a chapter that is based on a wealth of references and a deep coverage of the key concerns posed by aging in the US (and Canada). However, although published recently in 2009, the time lag to publication plus recent events means that we must take stock of the aftermath of the ongoing banking crisis and also President Obama's healthcare reforms, reforms that are proving to be highly controversial. Ongoing debates in the US have become more intense, with those who are worried about the country's high level of debt being particularly concerned to reduce State expenditure. Some have even accused the Social Security system of being a Ponzi scheme, after the fraudster Carlo (Charles) Ponzi (and more recently Bernie Madoffs, who emulated him successfully for many years before being caught) who introduced a pyramid plan that provided huge returns to investors—as long as new investors were continually brought into the scheme. As Skidmore (2010, p. 162) notes:

> Profits to the early investors came from amounts paid in by subsequent investors, but the promised returns were so great that paying each wave of investors required a geometric increase in the number of investors in the next wave. If every investor remained in the scheme, the successive requirements for new investors to keep the system going would fairly quickly exceed the population of the earth. Obviously, this is unsustainable. Ponzi schemes inevitably collapse.

Some analysts such as those associated with the Cato Institute or the Tea Party worry that the Social Security system is based on a similarly false premise, placing an intolerable burden on future generations. Skidmore, author of a recent book on U.S. Social Security (2008), and editor of Berkeley's journal *Poverty & Public Policy* refutes these concerns, noting that the program "has operated efficiently and economically since its first regular benefits were issued in 1940…has become an integral part of the fabric of American life, and is probably the most popular government program in the country's history" (ibid., p. 164).

Health Threats or Active Aging?

Anyone can become ill, at any age, but the expectation is that older people, especially the oldest old aged 85 years or over, will become more dependent on healthcare provision. President Obama successfully passed his healthcare reform bill in the House of Representatives on 21st March 2010, arguing that the reforms were necessary in order to make health care more affordable and health insurers more accountable. However, some of his own supporters in the Democrat Party opposed the bill, and no Republicans voted in favour of it. Buoyed by their success in the mid-term elections of November 2010 the Republican Party, aided by such allies as the Tea Party Patriots, have vowed to continue their opposition at every stage of the legislation in order to block or reverse the progress of this bill. At the time of writing, however, a key debate in the House has been postponed due to the horrific shooting of Congresswoman Gabrielle Giffords and others in Tucson Arizona in January 2011, in which 6 died, including a 9-year old child, while the congresswoman was shot in the head and is seriously ill. Many politicians are blaming the shootings by a young man, Jared Loughrin, on the vitriolic level of debate on these reforms, which Giffords supports (Sarah Palin for instance had placed Giffords in the crosshairs of a rifle sight on her website, along with other supporters of the reforms). Claims and counter-claims are now being made, but many outside the US do find the high level of political abuse rather strange, going beyond the bounds of normal political discourse in democratic society.

So, why the high level of concerns both pro and anti the healthcare reforms? It is clear that the polarisation reflects two broadly contrasting views of US society. Those who oppose the reforms prefer the individualist approach to society, in which individual freedom from government and governance is a central feature. Such people believe that citizens should be left alone by government, which should "butt out" from things that do not concern it. There is a real worry among such opponents that the reforms will be too costly and too bureaucratic, and they see the National Health Service in Britain for example, as an organisation that is "socialist" in its operation, leading to unnecessary expenditure and over-staffing. In contrast, those in as the Tea Party for instance would prefer private sector provision in health care, continuing as at present via private health insurance. The private sector can keep costs down in a way that government cannot, and offers a more effective and efficient means of catering for the needs of people in general, and older people in particular, in the twenty first century.

Table 2.3 Public-sector healthcare provision, 2007

Per cent public provision	Type
57.2	Medicare: government-funded for over-65 s
24.7	Medicaid: government-funded for those on low incomes
4.5	Military veterans: government-run scheme
4.2	Military currently serving: government-run scheme
9.5	"Other" including state children's health insurance policy for children whose parents do not qualify for Medicaid and Uninsured who receive treatment in emergency rooms only

Source: Editor's Choice (2010)

[a] Total cost of this public sector provision in 2007: $754 billion

Those who support President Obama's initiative generally represent those who do not trust the private sector sufficiently to keep costs down. They point to the recent failure of the banks as a warning as to what might happen in the healthcare industry too, and are concerned that too many Americans at present have no health insurance at all, or have too low a level of insurance to be able to afford big healthcare bills should major surgery or care provision become necessary. They wish to see a system that caters for the less well off as well as the better-off, and believe that public-sector provision is the best way forward. The US census, for example noted that in 2008, 46.3 million Americans were uninsured, out of 300 million, although this figure included 9.2 million non-citizens plus 18 million people who earn over $50,000 per annum, and who presumably feel that they have access to sufficient financial resources should health concerns escalate. The authoritative BBC website contains a very effective summary of these key issues as well as useful data to assist our understanding of this difficult issue (Editor's Choice, 2010). Table 2.3 summarises healthcare provision in 2007, with the per cent cost of public-sector provision

Despite the high cost of this provision ($754 billion in 2007), this is less than one third of total costs, which reached $2.2 trillion that year, 16.2% of GPD, which is twice the average of OECD countries. Mechanic and McAlpine (2010) note that this share of GDP rose to 18% in 2009 and is forecast to rise to 34% by 2040 unless costs can be curbed. It is the private sector expenditure that forms the vast bulk of these costs, being roughly of the order of $1.2 trillion in 2007, compared to $0.5 trillion in 1990. Employer-funded health insurance, paid for by salary deductions make up the main element of this, in which those insured can also be liable to "a deductible" of part of the cost of treatment in addition to that for which they are insured (ibid.). It is this high cost, allied to what Weissert and Weissert (2010) call the "mediocre" quality of health care in the US that means that the Obama reforms, although controversial and contributing to high Democrat losses in the mid-term elections of November 2010 (Saldin, 2010), may not be able to address these major problems, because the Reform Bill has plumped for a system in which there is a universal mandate in which everyone must have health insurance even if the employer does not provide this, and for the less well off this will be subsidised. This move placated the powerful health insurance lobby but does not address the cost dimension, although Obama argued that the scheme would be affordable via making Medicare less wasteful. The aim is to reduce the federal deficit by $100 billion over the next decade, but this is likely to be very difficult to achieve in practice, to say the least.

Is there an alternative perspective on these seemingly intractable problems? One possibility is to reduce the stereotyping of older people, and to recognise that many will not be as dependent on welfare support in the future as may currently be thought. To paraphrase and build upon Cook & Powell, 2007, who refered to older people in China, some will be illderly, some wellderly, some Han, some-nonHan, some wealthy, some poor, some with family support, some not, some will be vulnerable and some will be active. In other words, growing old in the US as elsewhere contains a myriad of individual possibilities, and is not necessarily as gloomy a prognosis as some would have it. For example, the first Active Aging Week in the US for those aged 50 or over was held September 29 to October 5, 2003. In this first attempt, the emphasis was on fitness, with Jazzercise (http://www.jazzercise.com), the world's leading dance-fitness program, with 5,000 instructors worldwide and the International Council on Active Aging (ICAA, http://www.icaa.cc) coming together to launch that Active Aging Week (http://www.seniorjournal.com, 2003). They offered free "Simply Lite" fitness classes across a range of cities, including Washington DC, Miami, Chicago, Dallas and New York. At the time of writing, the latest (8th) Active Aging Week was held September 20–26th 2010. Now, however, the focus was more sophisticated. As the Journal on Active Aging (2010) noted prior to the event:

> Because wellness is a multidimensional model – one that encompasses physical, spiritual, vocational, intellectual, social, emotional and environmental wellness – a myriad of activities can enhance health and well-being.

The key is to find the right activities for the individual and so there was a wide range of activities made available, including health fairs, lectures, concerts, dances and others, organised on the theme of how to "be active your way", the theme of Active Aging Week 2010. The journal contained a planning guide to the event, with the aim being for people to organise their own week within a self-help program.

This feature, co-operation assisted by an umbrella organisation such as the ICAA in this case, also helps point towards future alternatives. As Mechanic and McAlpine (2010) point out in their analysis of healthcare reforms, there has been an erosion of trust in recent years, such as trust in government, trust in healthcare professionals and trust in experts more generally. But despite this erosion there remains a high level of trust in one's personal physician, who is more likely to be viewed as acting in one's interest, to a greater extent than for many other professionals or interest groups. It will not be easy but somehow such trust must first of all be sustained in the face of difficulties such as the high cost of health care, then it must be built upon and then extended to other groups also, if this is indeed possible. To be possible, the extreme top rhetoric would have to be toned down, albeit without removing the recognition that strong disagreements do exist, and that these disagreements have to be faced, discussed and worked through. As Mechanic and McAlpine (2010), conclude:

> There are many thoughtful proposals for a more rational health care system, but the challenge is in our politics, not in our imagination. The health reform legislation passed in 2010 is a massive change with many important advances and opportunities. These modifications are not fully comprehensive or efficient, but we will have to muddle through as we go and iteratively build coalitions to implement further needed changes in covering the uninsured, cost control, reimbursement, and regulatory processes (Mechanic 2006). While at this time polarization and distrust are at high levels, building the needed organizational structures and norms will require renewal of more trustful and cooperative efforts.

Chapter 3
Aging in the UK

If you were born in the UK in 1930 then you have seen many changes in your lifetime. Perhaps you were born in inner London, and you have some vague childhood memories of your parents' struggle against Mosley's blackshirts in the East End. You certainly remember the bigger struggle against fascism in World War II; you were evacuated to the country along with your younger sister and you have never forgotten the kindness you were shown by the people who looked after you. Then came the prosperity of the 1950s and much of the 1960s before the increasing difficulties in the 1970s and 1980s. But you worked in the private sector, you and your family came out of these difficulties more or less unscathed and you now have a prosperous old age, with a second home in Spain to which you relocate each winter. You feel sorry for your grandchildren though; the so-called "jilted generation" who seem to be excluded from much of the prosperity that older people have enjoyed. But you help them out as much as you can with deposits for a home of their own from your savings. You were shocked by 9/11 then the London bombings a few years ago and also the bombings in Madrid; but you've been just as shocked by the 2011 riots in London and other cities of the UK. You felt that things were getting bad for some but to you that is no excuse for the looting and disorder that you witnessed on your TV screens.

Or perhaps you weren't born in the UK, but were invited in from the Caribbean during the 1950s to work in the public sector. You endured some of the worst of white racism against you and your family, but thankfully things seem to have improved in that respect in recent years, although you have concerns about the activities of the English Defence League. Your family has been affected by the public sector cuts that have been made by the new Coalition Government, and your son has lost his job in the local government sector. You do worry at times about the future of the family; from your local government pension plus state pension you have enough to get by, but your daughter works in the National Health Service and she too faces redundancy due to the cutbacks. As for your grandchildren, you are thankful that none of them were involved in the 2011 riots, but you know that several of their friends were. You can't condone this, but you have some understanding of the pressure on young people, especially young black people, in the UK today,

I.G. Cook and J. Halsall, *Aging in Comparative Perspective: Processes and Policies*, International Perspectives on Aging 1, DOI 10.1007/978-1-4614-1978-5_3,

with police "stop and search" unfairly targeting young black males in particular, and the consumerist pressures of wider society, plus the gang culture that Prime Minister Cameron has condemned. You hope that more can be done to help young people and that the cutbacks won't harm society any more than is necessary.

Is this you, or your parents or grandparents? In this chapter we shall consider the aging process and the policies put in place to address an ever aging population. The chapter is divided into four parts. The first part examines the demographic trends and social and economic indicators that identify the aging population. The second part moves on to discuss the pressures that an aging population places on the Welfare State. The third part focuses especially on "diseases of affluence" that afflict people in a prosperous society. Finally, there will be a summary on the new concept of the Big Society and how this relates to the aging population in the United Kingdom.

Demographic Trends, Social and Economic Indicators

> Our objective is to listen to them and support them, as we take the Bill through. No change is not an option. With an ageing and increasing population, new technologies and rising costs, we have to adapt and improve. Innovation and clinical leadership will be key. We want to reverse a decade of declining productivity. We have to make productive care and preventive services the norm, and we must continue to cut the costs of administration, quangos and bureaucracy. The House knows my commitment to the National Health Service and my passion for it to succeed. To protect the NHS for the future must mean change-not in the values of the NHS, but through bringing forward and empowering leadership in the NHS to secure the quality of services on which we all depend. (Andrew Lansley, Secretary of State for Health, 4th April 2011, Hansard).

As this chapter is being written the National Health Service is undergoing major restructuring. The above quote from Andrew Lansley, the current Health Secretary, demonstrates the reasons why the Coalition Government (of Conservatives and Liberal Democrats; see Kellner (2011) for a brief summary of the 2010 election results that brought the coalition to power) believes that health service *has* to change, due to the social pressures of a changing society. One of these pressures is the diseases of affluence of an increasingly aging population. Aging in the United Kingdom is well documented, and many believe that the pressures of aging pose almost intolerable demands on the British welfare state. Throughout the 1980s to the present day there have been fundamental changes on how the welfare state's services are delivered in the United Kingdom, and overall the private sector has, in many ways, encroached on the boundaries of the welfare state's jurisdiction. A further complication is the fact that successive governments, since the 1980s, have interfered with the welfare state system, using their influence as a political tool to further a party's popularity or to malign the opposition. For example, since New Labour came to power in 1997 there have been substantial changes to the National Health Service. New Labour in particular promised that the National Health Service would deliver to the people.

Analysing demographic trends in the United Kingdom is accurately achieved by examining past census data, which is obtained from the responses to the National Census, which is administered every 10 years. As Jackson (1998) notes current trends in population change in the United Kingdom predict that in the next 30 years the United Kingdom's population will experience a rise in an older population, shifting the balance of society. An explanation for this shift is "The consequence of relatively high fertility in the early 1950s, and the baby boom of the 1960s followed by a long and sustained period of low fertility, is a bulge generation which will reach retirement age from the year 2010 onwards" (Jackson, 1998, p. 129). It has been anticipated that the numbers over the retirement age will increase from 10.4 million back in 1991 up to 13.5 million or so in 2030. Dorling and Thomas (2004, p. 30) have provided a critical analysis of the 2001 population census data for the United Kingdom. Their key findings revealed that:

> Much has been written about the rise of older people, but a great deal of that rise has still to occur. 4.0 million people were aged 75-89 in 2001, 6.6% of the population, increasing their share by a third of a percentage point from 1991 when 3.8 million had attained this age.

Rowland (2009, Table 3.3, p. 44), cited in the Introductory Chapter, uses UN data to summarise the percentage of population aged 65 years or over for the countries with the highest percentage. The United Kingdom has been in the top group for many years, being 4th in the list in both 1950 and 1975 (with 10.7 and 14.0% respectively), but although the percentages increase considerably through to 2050 projections, the UK's place in the hierarchy slips to 28th by 2050 as other countries catch up and outstrip the percentage 65 or over in the UK. Thus, in 2000, the UK's place is 11th with 15.8%, then down to 15th in 2025 albeit with a projected rise to 21.9% and then 27.3% in 2050 but with a far lower place as many new countries shoot up the table. However, as Dorling and Thomas suggest, the proportion of the UK's "oldest old" is likely to increase disproportionately and this trend will be evident when the statistical results for the 2011 census are published. This ever increasing trend will bring new pressures and challenges to the Government.

Jackson (1998) has highlighted a number of problems associated with an aging population which needs to be addressed. It is noteworthy that these problems still exist today. The most prevalent of these problems is the current pension system. In the late 1990s, Jackson warned that the problem with the public pension system is that too many people are retiring at the same time thus creating an imbalance between those contributing through pay and those drawing from the public pension system. There is also the gender dimension to add because women in advanced capitalist societies such as the UK live longer than men, and thus as Rowland (2009, p. 46) notes, drawing on work by Kinsella and Phillips, "older women are more likely to face the prospect of living along and reaching ages where infirmities are prevalent" and thus they are more likely to need support from the wider society in which they are located. Part of this support will be pension income that is under growing pressure. In response to this developing situation, two independent reports by Lord John Hutton which were published in October 2010 and March 2011 were published that

advocated that people who work in the public sector should contribute more to the system. In his final report he stated that:

> As I set out in my interim report rising life expectancy has led to a substantial increase in the proportion of adult life that a public service worker can expect to spend in retirement. To adjust to this change I am recommending that Normal Pension Age is linked to State Pension Age and tracks planned increases. In principle the link to State Pension Age would apply across all public service workers, as this marks the end of a working life that may span professions and sectors. (Hutton, 2011, p. 4).

Adopting Hutton's approach to addressing the public pension problems associated with the United Kingdom's increasingly aging population has brought about new discourse in society and it will be interesting to see if these changes will, long term, be accepted by the wider public. Another concerning pressure generated by the increasingly aging population is the demands placed on the Welfare State. The next section will discuss these pressures, but before we move onto this topic it is worth discussing the topic of migration of older people in the UK, both incoming and outgoing, because, as Tony Warnes (2009, p. 349) notes "The exodus of British pensioners is considerable and probably unmatched from any other country". This process began in the 19th Century to the fashionable resorts on the French Riviera, although as Warnes cautions it is difficult to know whether people from the UK actually "retired" there as opposed to having long winter or summer holidays in such locations. He neatly summarises the process of marketing such places:

> Fashionable holiday destinations, whether Cannes in the nineteenth century or Indian Ocean islands today, attract rich holidaymakers and property developers, speculators and investors, among whom a small minority acquire properties for their own retirement. Realtors then promote the location as "highly desirable for retirement" and the presence of older affluent holidaymakers gives the impression that the resort is a retirement destination but often very few have actually made it their principal home (Warnes, 2009, p. 344).

Now, as Warnes summarises, British retirees are located in Australia (one quarter), Canada (one fifth), the US (one sixth) and the Republic of Ireland (one tenth) but these established destinations are being increasingly threatened by high growth rates for countries like Spain, France, Nigeria and Sweden. From just under 680,000 in 1995 there were just over one million UK older people living overseas by 2006, and the forecast for 2015 is 1.5 million, with the caveat that there is a strong link with (high) property prices therefore the recent property market downturn may reduce this potential number. Warnes categorises the migrants into four main groups: return of natives to "first world" countries, ditto to "third world" countries, family-joiners and amenity seekers. Around £2 billion (circa $3 billion) of UK pensions were paid overseas by the late 2000s, and many surveys of those who have emigrated suggest that they are generally happy with their lot. However, there is always a danger if, for example, severe ill-health strikes and/or one spouse (usually the husband) dies that a few can end up in highly difficult situations such that:

> Those in desperate situations characteristically turn to formal welfare agencies or a national consul for help to "get them home". In the UK case, however, a citizen who has not been habitually resident in the country is not entitled to other than emergency treatment on the National Health Service and if they have no "local connection", no local government is required to offer social services support a legacy of poor-law entitlement rules (Warnes, 2009, p. 358).

Partly no doubt, in response to such dangers, there is a new phenomenon of "transnational residence" whereby those that can afford it maintain residences in two, or even sometimes three, countries in order to maintain access to UK welfare facilities on the one hand, and to low-cost living in, say, their country of origin on the other. These need not be especially wealthy retirees but includes those who have the support of family and friend networks to maintain two residences and thus a potential healthy lifestyle that can avoid the worst of British winter conditions.

Two final points about migration are worth making here. First, older people are part of the immigrants to the UK, and Treas and Batalova (2009, p. 374) for example note that 2.5% of new migrants are aged 60 or over, usually in the "family-joiner" category noted previously. This compares with 4.4% for the US and is a reminder of the complexity of global conditions. Second, there is the whole issue of "replacement migration" discussed in detail by Keely (2009). For aging societies one way of avoiding the dangers of the forecasts of population decline in future years (especially in Europe) would be to actively encourage replacement migration. Keely is probably correct when he views this as "not politically possible" (p. 400) mainly for cultural reasons, but it remains a possible means of ensuring that the proportion of younger people in the UK, as in other countries, remains high enough to support older people should the need arise, and help avoid the pressures on the welfare state that will now be discussed.

Pressures on the Welfare State

A key aspect of the welfare state is the implementation of Social Policy. In United Kingdom politics social policy is a key process that formulates new frameworks in making changes in the National Health Service. As Béland (2010, p. 12) notes, social policy in the broadest sense "…often emphasize[s] its relationship to citizenship and the quest for a more inclusive society". The importance of citizenship is at the core of social policy formulation and the Sociologist T.H. Marshall (1964) stresses that when it comes to welfare there are certain elements which must be considered, especially class inequality and capitalism.

Since the introduction of the Beveridge Report (1942), the United Kingdom benefited from the introduction of the Welfare State. As Hughes (1998, p. 6) outlines "The welfare state in the post-war Britain has had an existence which is more than simply a collection of institutions and practices aimed at the delivery of social welfare". The main aim of the Welfare State is to bring together a number of agencies and institutions to deliver a sustainable social welfare programme. However, as stated previously this type of approach in the United Kingdom has brought about conflicts and differences on how the Welfare State should function. These conflicts and differences directly challenge the original ethos, which formulated the Welfare State in 1945. A contemporary example of this is the current changes that are occurring in the National Health Service. These changes are related to the Social Care Bill which was presented to parliament in 2011. The Social Care Bill intends to modernise the National Health Service and most importantly tackle the problems and

challenges to the welfare state that an ever increasing aging population presents. The Social Care Bill is formulated into several key parts:

1. Establish an independent NHS board to allocate resources and provide commissioning guidance
2. Increase GPs' (General Practitioners) powers to commission services on behalf of their patients
3. Strengthen the role of the Care Quality Commission
4. Develop Monitor, the body that currently regulates NHS foundation trusts into an economic regulator to oversee aspects of access and competition in the NHS
5. Cut the number of health bodies to help meet the Government's commitment to cut NHS administration costs by a third, including abolishing 152 Primary Care Trusts and Strategic Health Authorities

(NMC Review, 2011)

Again as stated above the changes in the National Health Service are in response to the increasing problems associated with the aging population in the United Kingdom. Taylor and Field (2007, p. 124) by using the work of Robine and Michel (2004) have argued that the picture of the United Kingdom population aging can be summed up into four parts: (1) "increased survival of sick people and the expansion of morbidity; (2) control of chronic disease progression, resulting in increased years of life and the increase of functional limitation and disability; (3) improved health behaviours and health status of people entering old age, leading to the compression of morbidity; (4) emergence of very old and frail cohorts, with a new expansion of morbidity".

In addition to this there are added pressures that an increasingly aging population in the United Kingdom places on the National Health Service and the welfare state. As Blane (1986, p. 163) notes:

> Elderly people are major users of health services. Half the patients in non-psychiatric NHS hospitals are more than 65 years old and the greater use of general practitioner services by elderly people is financially recognized in the form of a higher capitation fee for those over retirement age. As a group they are, therefore, of major concern to all who work in the health service.

Diseases of Affluence and Their Impact

A major feature of life in an affluent society such as that of the UK (and despite the fact that there is poverty within such a society) is the rise of "diseases of affluence" that replace the "diseases of poverty" to which most societies were prone—often communicable diseases linked to conditions of poverty and/or poor sanitation, such as typhoid or cholera which were such major killers in the early nineteenth century. Known as the epidemiological transition, many societies have now moved from being prone to the latter diseases through to the (non-communicable) diseases such as cancer, cardiovascular disease, hypertension, Type 2 diabetes and obesity. Some suggest that these are mainly "lifestyle diseases" rather than due to affluence per se,

and see overconsumption of sugar, salt, processed foods, meat and meat products, cigarettes and alcohol, combined with a lack of exercise, as being the main contributory factors to many of the illnesses that beset countries such as the UK.

For example, Type 2 diabetes is on the increase, with 2.6 million in the UK now diagnosed and up to a further 750,000 unknowingly having this disease. Gale (2010) reviews four major studies to conclude the following:

1. In one health area, costs of this disease increased from 8.7% of acute total hospital expenditure in 1994 to 12.3% in 2004.
2. Prescription costs have increased from £290 million (circa $430 million) in 2000 to £591 million (circa $886 million) in 2008, adjusted for inflation.
3. This now constitutes the highest single item in the NHS prescription budget, at around 7% of the budget.
4. Nearly half of the prescription cost is for insulin, which has increased rapidly in price in recent years.
5. With better prescribing practice, adhering to NICE (National Institute for Health and Clinical Excellence) guidelines, £150 million (circa $225 million) could be saved annually by the NHS in a "painless" way.

Similarly, obesity is a major problem. The major survey of older people conducted in 2005 concluded (Criag & Mindell, 2007, p. 12) that:

> 72% of men and 68% of women were either overweight or obese. A greater proportion of men than women were overweight (47% compared with 39%) but a greater proportion of women than men were obese (28 and 24% respectively).
>
> There was a greater difference between the proportion of women and men who were overweight or obese in the older age groups than in the younger age groups. The proportion who were morbidly obese was highest among women aged 65-69 (3%).

Because BMI (Mass Body Index) is more likely to contain a higher proportion of fat in older people, one danger is the build-up of abdominal fat around the waist. Obesity is linked to diabetes and arthritis, while in males there is a greater danger of strokes, and for women, of falls with consequent injuries.

It is issues such as these that give rise to worries concerning the higher proportion of older people in the UK. But with the link to lifestyle noted above, such health problems can be ameliorated if not cured via an emphasis on better eating, giving up smoking, drinking less alcohol and taking more exercise, and there is increasing public awareness of these alternative lifestyle choices. Further, although such ill-health is often associated with older people, more people at earlier ages are being diagnosed as obese, as being alcohol-dependent, having type-2 diabetes and so on, so there is not a straightforward correlation with age. There is also a greater concern to regulate how such products as tobacco, alcohol and junk food are advertised and sold. Mitchell, Cowburn, and Foster (2011) for example, show how local government (which is increasingly being required by central government to take the lead on public health) could use existing legislation to combat obesity. It could do this via Planning controls of unhealthy takeaways, control of fast-food vans, funding public transport and promotion of physical activity and access to green spaces. These authors argue that restrictions on noise, litter, and other factors in an "obesogenic

environment" by the local authority are not only desirable but feasible. Some will oppose such measures as being symptomatic of the "nanny state" but others will welcome the attempt to get people, young and old, to live more healthily.

The Big Society and Its Impact

> The Big Society is what happens whenever people work together for the common good. It is about achieving our collective goals in ways that are more diverse, more local and more personal. (Department for Communities and Local Government, 2010, p. 2).

An alternative to the nanny state is the "Big Society" which has become one of the key concepts in British Politics today. This policy idea was launched in the 2010 Conservative Manifesto. The Times Newspaper on 14th April 2010 described the concept of the Big Society idea as "…an impressive attempt to reframe the role of government and unleash entrepreneurial spirit". It has been agreed by many political commentators that the reason why the Conservative Party and the Liberal Democrats formed a coalition in May 2010 was due to the policy ideas of the "Big Society". The Big Society initiative forms a substantial part of the legislative programme of the Conservative-Liberal Coalition Agreement.

The thinking behind the Big Society is nothing new in British Politics. When New Labour came to power in 1997 the country saw a series of politicised policies launched with the specific aim of tackling social divide across Britain. In the last decade there has been much debate on how communities function at a local level (Atkinson & Helms, 2007; Boddy & Parkinson, 2004; Flint & Robinson, 2008; Imrie & Thomas, 1999). Tony Blair in 1997 declared that New Labour was the party for middle Britain but at the same time Labour was warned that if "we raise the standard of living of the poorest people in Britain we will fail as a Government" (Lister, 1998, p. 216). New Labour perceived solving deprivation in Britain was through the concept of community governance and wanted to encourage a stronger and cohesive relationship between central and local government. Governance in the broadest sense:

> …involves venturing into broad debates about policy and administration, about politics and policy, about levels of government, about the states and citizens, about authority and legitimacy, and about what shapes cultures and processes of governance. (Healey, 2007, p. 15).

The terminology of the "Big Society" has caused much criticism in the media and academic circles (Evans, 2010; Hayton, 2010; Newman, 2010). One of the biggest problems with the idea of the Big Society is that the general public as a whole do not understand what it means. This is evidenced when we see that the idea of the "Big Society" has been launched 4 times, first at the Manifesto launch in April 2010, second at the coalition launch in July 2010, then in February 2011 and finally May 2011. Furthermore, this persistence by David Cameron of continually pushing the idea of the Big Society was admitted by a Whitehall source when they reported that "It won't be branded as a re-launch because that would be an admission of failure, but it cannot be allowed to fail because it was central to Cameron's

manifesto" (Maddox, 2011, p. 2). Moreover, there is a general agreement that the Big Society's two main principles are: (1) the state should be smaller and (2) the general public should be more involved in the decision-making (Taylor, Mathers, Atfield, & Parry, 2011).

The vision behind the concept of the Big Society was first discussed in November 2009 at the Hugo Young Memorial Lecture, when David Cameron used this terminology as a platform which offered a solution to tackling Britain's economic and social problems (Evans, 2011). At the 2010 General Election the Conservatives used this concept as a policy initiative and as the Conservative Manifesto (2010, p. 37) states "The Big Society runs consistently through our policy programme. Our plans to reform public services, mend our broken society, and rebuild trust in politics are all part of our Big Society Agenda". Currently there is an accusation from the opposition that the Big Society concept is simply an attempt to hide Government spending cuts. According to Brindle (2011) the Big Society has developed "…a growing sense that the brand is damaged goods, a vessel fatally holed below the waterline". This is also confirmed by the introduction of the Localism Bill the main aim of which is to decentralise power from the centralised state to local communities.

The ideology of the Big Society originates from Phillip Blond, a political scholar, who is currently a director of the think tank *ResPublica*. Phillip Blond gained eminence back in November 2009 when he gave a speech on the Future of Conservatism. In that speech he argued for an advanced acceptance of the worthiness of "Civic Conservatism" in relation to the state and an appreciation of the potential transformative impact of this on society. As Kisby (2010, p. 486) notes David Cameron perceived the Big Society as:

> the implicit ideas that 'responsibility' ought not to be defined by individual citizens - through the payment of taxes to the state-ensuring that all citizens' basic needs are provided for. Rather, it is principally about citizens having a moral obligation to undertake voluntary activity in the community and to take responsibility for their own individual welfare needs.

The big society has different agendas within the public and the private sector. The new concept termed the big society has placed brought a contemporary emphasis on how the healthcare system works and is integrated into the welfare state. Politicians advocate that the big society encourages patients to take greater control of their own health care. However, using this style of approach in the National Health Service has the danger of dividing different social groups. The older generation in particular has the potential to become divided because this generation may find it more problematic to make their own choices in health care. There is the added complication of economic factors whereby particular services will be priced out and as a consequence withdrawn. In view of these issues it will therefore be interesting to see if the big society will have any positive impact on the United Kingdom's aging population.

Chapter 4
Aging in Sweden

Sweden is a small country of less than ten million, but one that has a relatively high international profile, being generally viewed, we suggest, as a prosperous and progressive nation, a perception that is based on its liberal views, neutrality, an advanced welfare system and a strong economy that has led to a high standard of living. According to the BBC country profile, "public–private partnership is at the core of 'the Swedish model,' which was developed by the Social Democrats, who governed for most of the last 70 years until 2006" (BBC 2011b; Haag, 2011). As noted in our introduction, Sweden was one of the first countries in the world (along with France) to be recognized as having a significant population of older people, and its mean life expectancy for men is currently assessed as being 80 years for men and 84 years for women, according to UN data. The country was quick to recover from the global recession of 2008 (Haag, 2011), and its liberality is shown by the fact that "The country is also a common destination for refugees and asylum seekers—immigrants make up more than 10% of its population" (ibid.). Sweden joined the EU in 1995, but like the UK in 2003 rejected the idea of becoming part of the Eurozone and retains a separate currency, the krona, seemingly a wise decision at the time of writing due to the pressures on the economies of Ireland, Greece, and Portugal.

Despite such positives, a major issue of the Swedish model has been the high level of taxation required to fund generous social security. For many years the majority of voters have accepted this high level, in part because they saw the potential benefits for themselves as much as for others, but there were cutbacks in expenditure during the 1990s because of economic crisis (and earlier in the 1970s after the "oil shock" of that era), and in the last 5 years there has been a shift from the left toward the right in Sweden's political makeup and perspective, under coalition governments (termed the Alliance for Sweden) led by the Moderate Party leader Fredrik Reinfeldt, from 2006, and as a minority government from the 2010 elections. Immigration has become a big issue for some in recent years, as in other European countries, and in 2010 the first far-right party, Swedish Democrats, won seats on an anti-immigration platform. Again as in other countries, the center-left party, the Social Democrats, who

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had governed the country for many years, lost votes on a large scale, and suffered their worst election performance since 1921 (Rayman, 2010).

In this chapter we shall consider the following sections:

- The historical emergence of aging
- A welfare exemplar under fiscal threat
- Agism in a liberal society
- Aging and experiential issues

The Historical Emergence of Aging

If you were aged 80 in Sweden in 2010 you were born in 1930 in a prosperous country and lived a generally comfortable life, avoiding the worst of the travails of your European neighbors because of your country's neutrality in World War I. Your country has been well-run during your lifetime, and you have yourself prospered in Sweden's post-1945 economic development that has made you and your peers' income level among the highest in the world on average. You live a comfortable life in retirement and have had, and still have, many foreign holidays, mainly to the Mediterranean area, though increasingly further afield. Your hero was Dag Hammarskjold who had such a high international profile that he became Secretary General of the United Nations for two terms in the 1950s before his untimely death in a plane crash in the Congo in 1961 (United Nations, n.d.). Your family too has prospered and although you don't see your son and daughter as much as you might wish to, because they are so busy, you are mostly content. You do worry sometimes about the future of the country, and wish that taxation levels weren't so high, and you are attracted increasingly toward parties like the Swedish Democrats, that have a strong anti-immigration platform. Is this you? Or perhaps you are an immigrant yourself, a refugee from the upheavals in Central Africa in the early 1960s. You have never been particularly wealthy but you believe that high taxation is the price that must be paid for a stable society and are fearful for your family because of the pressures of the modern world in general, and in Sweden in particular. Is the age of prosperity and social cohesion coming to an end, and what will the future bring for your grandchildren and great grandchildren? In other words, as for the other countries in our sample, stereotypes of aging need to be avoided, even in a generally prosperous country like this one which outsiders probably think of as being a white nation, with few migrants, rather than the 10% noted above.

Nonetheless, despite internal variation you do have in common the fact that you live in a society that has long had to deal with the issues in and of aging. As noted in the introduction to this book, it was Gustav Sundbärg way back in 1900 who identified his country as moving from a "progressive" (younger) to a "regressive" (older) age structure because by this time Sweden had 8.4% of its population aged 65 or over, well ahead of all other countries except France (Rowland, 2009, p. 42). Goldstein (2009, p. 13) presents an instructive graph that compares life expectancy and fertility levels for Sweden and India over time, Sweden from 1800 to 2050, and

India 1900 to 2050. The graph shows, for example, that India did not reach Sweden's life expectancy of 1800 until about 160 years later, of 1900 until about 80 years later, and of 1950 about 75 years later in 2025 (forecast). However, many other countries, such as India, are expected to eventually catch up as the twenty first century unfolds, and as we noted in our introduction Sweden is expected to fall from eighth oldest country in 1950 to tenth in 2050, which does not seem like much change, but this is after in the interim rising to third in 2000 and fourth in 2025, according to Rowland's analysis (2009, p. 44).

Sundstrom (2009, p. 91) presents us with the fascinating information that when Sweden's population data was first collected in 1749 the results were considered a state secret because the country only had 1.8 million inhabitants, a considerable decline following major wars with Russia, crop failures and epidemics. At this time 6% of the population was 65 or over. Stereotypes of the past are often based on assumptions of extended families, large numbers of children, and of most people being married, especially formally in church, but Sundstrom shows that such assumptions would be misguided for Sweden and other Nordic countries in recent centuries at least. And so, for example, there was an increase in the proportion of never-married people in the eighteenth and nineteenth centuries that "reflected increasing difficulties that young adults had in establishing independent lives" (ibid.). For example, due to differential emigration by gender there were 1,200 women to every 1,000 men in Sweden in the early 1900s, and by the 1920s "19% of the women and 12% of the men were still single as they approached old age (60–64)" (ibid., p. 92). This trend continued for several decades, but had changed completely by 2000, with never-married single people 65+ dropping from 15% in 1950 to 8% in 2000. The currently married percentage had increased by 5% (46–51%), but divorced people had increased in percentage too, however, from 2% in 1950 to 13% in 2000. Of those that were married, in the 1930s surveys, there were a high number of childless marriages, while many others had one or two children only, to the extent that "over half of old people from an era without modern birth control techniques were childless or had just one or two children" (ibid., p. 97). Once again this has changed in the modern era, with the proportion of the childless old declining from around a quarter to 15% or less.

Another feature of demographic change is that it is increasingly common for three or four generations to be alive at the same time, therefore the gloomy prognosis of old people being alone is often confounded by more rather than less kinship ties, although kin are not necessarily resident in the same locality. When they are, another gloomy prognosis that older people are dependent is also confounded, and even by 1980, for example, "50% of Swedes aged 55–64 reported 'regularly' doing child-minding" (ibid., p. 102) showing that it was their children who were reliant on them, rather than the other way round. There is always pressure, however, concerning the high proportion of older people, not least because of the pension funding issues common to other societies, as we have already seen in this book. As noted above, the "Swedish model" of welfare was lauded for many decades, but the first major strains began in the early 1990s, and significant welfare policy changes have been made in the last 2 decades. These will be considered in the next section of the chapter.

A Welfare Exemplar Under Fiscal Threat

As far as we can ascertain, it was Thorslund (1991) who was one of the first to suggest that the increasing number of very old people would change the Swedish model of the welfare state. At that time, since the 1960s the number of institutional beds for old people had doubled, and although there was an increase in the number of personnel in home-help or home-care for example, there was also a higher demand for these types of services. He predicted that such personnel would be insufficient by the turn of the millennium. Such a gloomy forecast was borne out in dramatic fashion by the fact that in the 1990s "Sweden's economy plunged into crisis… [a] fiscal crisis in 1993, threatening the funding of welfare state redistributions and benefits" (Freeman, Topel, & Swedenborg, 1997, p. 1). This crisis was a major shock to many analysts both in Sweden and outside, who previously viewed the Swedish model as offering a "third way" of operating a capitalist system (ibid.). The rapid economic growth of the 1950s and 1960s had already slowed in the 1970s and 1980s, but the Swedish model had been sustained, and was regarded as being especially successful in reducing inequalities in Swedish society and poverty. The US National Bureau of Economic Research (NBER) joined with their Swedish counterparts from the SNS, the Center for Business and Policy Studies, to analyze via a series of joint chapters that combined at least one American and one Swedish economist in each, the details of the Swedish model and the prognosis. They noted that:

> Over the long run, Sweden will have to move toward a more human and physical capital intensive society if it wants to maintain high wages and living standards for less-skilled workers. The implicit message in these results is that many features of the Swedish model were not sustainable over the long run (ibid., p. 27).

This book came out in 1997. By 1995 there had already been some recovery in the Swedish economy, and the same editors came together with similar colleagues for a follow-up analysis that came out in 2010. Before examining these recent findings, it is useful to briefly examine an IMF analysis that came out between these two texts. The idea for their evocative title, *Sweden's welfare state: can the bumblebee keep flying?* had come from a Swedish prime minister who noted that Sweden's welfare state was like a bumblebee which with a heavy round body and small wings should be unable to fly; but it does. These authors noted that:

> The welfare state in Sweden has many impressive achievements. Sweden's quality of life, public health and educational attainment indicators are among the best in the world. The country is politically stable, with high employment and participation rates and remarkably low levels of labor conflict. A high level of economic and gender equality, as well as substantial public support for the creation and preservation of human capital …[gives Sweden] dynamic advantages (Thakur, Keen, Horvath, & Cerra, 2003, pp 2–3).

Despite such plaudits, they conclude that maintaining such a large welfare state "may involve substantial economic costs" and in particular the tax burden "is among the highest in the world." This leads to disincentives in their view against further economic progress.

Now, these are IMF employees, and the IMF is noted for its promotion of economic policies that generally seek to reduce the role of the public sector. Similarly,

in their second book, Freeman, Swedenborg, and Topel (2010) noted that their first book had been criticized as being slanted toward the Anglo-American market-driven form of capitalism, but defended themselves against this charge by noting that all chapters, as we note above, had been written with Swedish colleagues, that US analysts had been impressed with Sweden's elimination of poverty but that Swedish contributors too, had been worried about the high level of expenditure that this entailed. They noted that Sweden's recovery had been based on "substantial and in some cases painful policy reforms" that included market deregulation, expenditure cuts, a reduced public sector, and higher taxes, and argued that because of the "strong safety net support for those at the bottom of the income distribution …poverty remained low" (ibid., p. 6). Employment had not returned to the heady days of previous decades, however, and if the long-term sick and early retirees were added to the totals these reached 16% unemployed in 2005, according to their colleagues Lungqvist and Sargent (p. 13). On the positive side, investment in education was paying off, with Sweden becoming top of the global rankings in terms of numbers of graduates and of PhDs per capita. In all, they felt that while many had been too optimistic precrisis concerning the Swedish model, equally during the crisis many became too pessimistic. They conclude that:

> Sweden's recovery shows that it is still possible to run a reasonably successful market economy while still devoting considerable resources to a welfare state that maintains economic equality and to surmount an economic crisis… [but] This is probably easier to do in small economies than in larger ones and in more homogeneous countries than in more heterogeneous ones, so Sweden's experiences are not easily transferable to the United States or other large economies. It is also easier to do so in a society where the vast bulk of its citizenry is committed to egalitarian goals, as in Sweden (ibid., pp. 17–18).

Among other points, these economists noted that Sweden's policy makers had made "economically sensible" solutions to problems such as in the field of pensions. Pension reforms began in 1992 via the Pensions Working Group (established in 1991) that led to new legislation on pension reform in 1994 and the setting up of the Implementation Group to lead the ensuing changes. After the 2006 elections this group was replaced by the Pension Group in December 2007, led by Court of Appeals Judge Lars Goran Abelson, chief author of the report by this Group that we briefly summarize here (Abelson et al., 2010). This report notes that the original reforms of 1994 were introduced after "a harrowing political battle and high drama" (p. 26). This pension reform is based on a number of overarching principles:

- A *public, universal and compulsory pension system* is the cornerstone of the individual's pension protection. The old-age pension system must be autonomous and separate from other social insurance categories.
- Old-age pensions must relate to individuals' earnings over all periods of gainful employment during their lives. This standard protection is complemented by a basic protection for persons unable to earn any—or sufficient—income-based pension.
- The income-based portion of old-age pension is founded on the principle of *lifetime earnings*…

- The pension system is strictly *contribution-based*, that is, pension disbursements correspond to contributions paid into the system by or for the individual. Pensions are paid out to men and women on a gender-neutral basis despite differences in average life expectancy.
- The income-based part of old-age pension has two separate components: *income pension and premium pension*.
- *Income pension is financed as a distribution system,* that is, pension contributions paid in during a particular year are used to finance the income pensions disbursed during that year.
- *Premium pension is financed as a premium reserve system*, that is, pension contributions paid into it are saved (placed in funds) for the individual's future premium pension.
- A contribution charge of 18.5% of the individual's pension base is paid into the old-age pension system, 16% being transferred to the income pension system and 2.5% to the premium pension system.
- The running costs for income pensions will be *tied to national economic growth* so that the pension system keeps in step with earnings trends in society. The system will also adjust to *changes in the life expectancy* of the population.
- There is to be *great flexibility and choice* for individuals—from the age of 61 but with no upper age limit—when it comes to drawing all or part of old-age pension (ibid., pp13–14, our italics).

After the legislation of 1994, public budgets were further reformed, including pensions, in 2000, and this 2010 document reflects further amendments following the fall of the Social Democrats in 2006. The key point is, as we have italicized in this list above, that there is a two-pillar system, involving a distributional income pension as the base with a premium reserve system as the icing on the cake, as it were. There are also contrasts depending on date of birth, between those born before 1938, 1938–1953 (where there are also internal contrasts depending on birth year) and 1954 and after. Pension credits are based on income but there are also allowances for, e.g., childcare or national service, at varying rates, and credits can be transferred across spouses, while pension contributions are 7% from the individual and 10.21% from the employer and this total is equivalent to the 18.5% of pensionable income noted above (ibid, p. 17). For high earners, the 10.21% from the employer applies also to income over the set ceiling and is thus regarded as a tax that is put into the national budget, rather than a pension contribution to those high earners. The concept of a premium reserve system is interesting, and worth quoting in detail:

> The premium pension is wholly fund-financed. Premium pension credit has been calculated since 1995. Premium pension capital is invested according to the wish of the individual saver, who selects which fund or funds should manage the money, and asset management is done in mutual funds managed by independent fund managers. To ensure true freedom of choice for the individual saver, the number of funds must not be too limited. For those who do not choose a fund, the capital is placed in a generation fund in the Seventh AP Fund, which, unlike the other AP funds, is thus not part of the buffer fund for the income pension system. The saver must be able to select that fund and also to select an alternative fund within the Seventh AP Fund with a higher or lower risk (ibid., p. 18).

Table 4.1 Orange envelope example for 2009, average Swede's envelope for basic income pension

Changes in your pension account for income person during 2008	SEK[a]
Value 2007-12-31	639,035
Pension credit added for 2007	28,956
Inheritance gain	1,987
Charge for administrative costs	−156
Change in value	40,140
Value 2008-12-31	689,622

Source: Abelson et al. (2010), Table p. 66
[a]Swedish Krona

Table 4.2 Orange envelope example for 2009, average Swede's envelope for premium pension

Changes in your premium pension account during 2008	SEK[a]
Value 2007-12-31	51,747
Pension credit deposited for 2007	5,016
Inheritance gain	110
Administrative fees etc.	−73
Change in value	−17,690

Source: Abelson et al. (2010), Table p. 84
[a]Swedish Krona

The income-based element can be claimed from the age of 61 years, at different percentages, 25, 50, 75 or 100, and the claim for either income-based or premium pension can be made separately. Further, people "who have not earned enough credit for an income-based pension are entitled to a *guarantee pension*. A full guarantee pension requires 40 years of residence in Sweden between the ages of 25 and 64. To be eligible for any guarantee pension at all requires at least 3 years of residence. Guarantee pension may be drawn at the earliest from the age of 65" (ibid., p. 21, our italics). People have the right to retire at aged 67 (it was 67 until 1976 when it was reduced to 65, but then once again became 67 in 1994), but can retire earlier. If they keep working after this age they can add to their pension pot up to the set ceiling, but can retire earlier from 61 years if they wish to do so. So these reforms seek the best of all possible worlds: a compulsory basic system that is combined with a premium reserve within which the individual has choice of investment.

People receive what is known as the "Orange Envelopes" that give details of their basic pension income, and premium as Tables 4.1 and 4.2 show. The change in value was negative for the premium system that is more investment-oriented, but this was a bad year for growth and there would have been a recovery in the next few years (ibid., p. 90). In any case, people can switch their premium pot to another fund, and the report suggests that 57% of savers on average do choose which fund to invest in. It seems to us that, all in all, Swedish policymakers are making a good attempt at dealing with a difficult and complex set of circumstances.

Agism in a Liberal Society

Given Sweden's liberal traditions, and its long-term engagement with having a high proportion of older people, it is interesting to discover whether these factors have led to lower levels of agism than can be experienced in other less-liberal societies. From our analysis it would seem that yes, this is indeed largely the case, in part due to the activities of pensioners themselves, and their activist groups, plus generally sound inter-generational relationships, with reciprocity between older and younger generations. For example, Jonsson (2005) analyzed the campaigns of the National Organization of Pensioners (PRO) from 1941 to 1976. During this period this trade union- and SDP-backed organization was the larger of the two main Pensioner Organizations. The other was the Swedish Pensioners' Organization (SPF) that was formed in 1939 in reaction to a "perceived treachery" by the Social Democratic government that had ruled Sweden since 1932, according to Jonsson. The SDP had won a reelection in 1936 on the basis of a promise to improve pensions, but their pension reforms of 1938 were regarded as inadequate by many, hence the SPF founding by syndicalists and communists in the main. These were seen by the ruling Social Democratic Party as too radical, hence their backing for the PRO that was formed in 1941/1942, marking the abandonment of "a principle of not supporting interest organizations for special categories connected to the working class" (p. 294). This support meant that for decades the PRO was 10–30 times bigger than the SPF, which collapsed in the 1950s. The latter had a rebirth in the 1960s however, but now with a liberal/conservative slant. When the SDP lost the election in 1976, "PRO stopped growing and the new liberal/conservative government recognized SPF as a legitimate representative of pensioners. In the year 2003, PRO gathered 380,000 of Sweden's approximately two million seniors, while 220,000 pensioners were members of SPF" (ibid.).

A major thrust of SDP vision of Swedish society was as a "People's Home," presented by then Prime Minister Per Albin Hansson in 1928. The SDP wanted to become a party for all, not just the working class; not surprisingly this led to accusations of betrayal and sellout by radical activists and critics, hence the SPF had a more radical stance while the PRO was associated with government, and therefore had a less critical perspective, focusing on positive change rather than critique of policy. Jonsson gives the fascinating example of the criticism of Swedish old-age homes presented by a famous Swedish author, Ivar Lo-Johansson in 1949 via radio reports, articles, and two books. Lo-Johansson showed how miserable conditions were in these homes, which were "characterized by inactivity and a patronizing mentality" (ibid., p. 296) and this criticism was so trenchant that it led to many policy changes in the 1950s, a time coincident with socioeconomic progress in many areas. In contrast to such criticisms, the PRO perspective emphasized positive transformation in contrast to the past miseries of the poor law era. After the economic problems of the 1970s, Sweden's government moved to the right and the PRO became the group that was more critical of government policies. Cutbacks at

this time, and then more deeply in the 1990s brought the rise, as in other countries too, of an anti-agist perspective due to the:

> injustices that plagued Swedish pensioners. Old people were said to be invisible in media, culture, politics and science, scapegoats in debates about the crisis in the economy, victimized by criminals, neglected in nursing homes and regarded as second-class citizens in general (ibid., p. 298).

So even in a liberal society, with generations of activist pensioner organizations, optimistic perspectives on present and future progress can change for the worse, and agism can still be found, albeit perhaps buried more deeply, and hence less obviously, than in some more illiberal societies elsewhere.

Other examples of agism include studies by Soderham, Lindencrona, and Gustavsson (2001) and by Erlingsson, Carlson, and Saveman (2006). Soderham and colleagues studied the attitudes of nursing trainees to older people. They found that those who were less favorably disposed to older people were more likely to be younger (aged under 25 years), and/or have limited previous experience with older people and/or be male. They advised, therefore that training should include goal-directed experience of elderly care in order to encourage positive feelings and what they called "special considerations" as regards older people among very young and male students especially. Erlingsson, Carlson, and Saveman engaged in focus group interviews with, for example, police, church people, caregiver support organizations in order to discover their perceptions of elderly abuse. Their findings were quite perturbing in that they found an element of victim-blaming among their interviewees, and a degree of tolerance of elderly abuse, with the view that anyone could be provoked to abuse, and that abusers could also be victims. They called for further research, including among family members, in order to address this issue. Jonsson and Larsson (2009) examined what could be regarded as "inadvertent ageism" via the exclusion of older people in disability activism and policies. Disability activists are associated often with progressive policies, combating stereotypes and campaigning for equal rights for disabled people. The authors found that in Sweden the Disability Commission set up to examine disability in Swedish society excluded those aged over 65 from consideration, because their disabilities and impairments "were thus constructed as a natural aspect of old age. The implicit message was that older disabled people were worthy of less help. People above the age of 65 could belong in the target population if their impairments had manifested themselves *before* that age" (p. 72). Such a view of a "divided life course" could be contrasted with the Swedish Investigation on the Elderly of the early 2000s which sought to overcome stereotypes of the elderly and discrimination against older people by dispensing with the age barrier, or age ladder, to encourage what others have called "age irrelevance." Swedish disability policy, by setting up an age barrier of 65 years is an example of "institutional ageism" according to Jonsson and Larsson, and an oversimplification of the disability situation that people can face:

> From the position of resisting oppression, policy makers and members of the disability movement have inadvertently contributed in the construction of stereotyped images of old age and supported a system that provide less services to disabled people above the age of 65 (ibid, p. 76).

Aging and Experiential Issues

In order to combat stereotypes of aging, and to dispel some of the myths surrounding older people, it is essential to have more studies of the actual experience of older people. Eriksson (2008) contributes one such study, based on what is known as the H70 Panel of data collected in 1971 from 1,148 70-year olds, and flowed up into their 90s since. Eriksson focused on loneliness, with the stereotype of older people being that they are more likely to suffer loneliness than are younger cohorts in society. She studied seven aspects of social participation in these older people and found that, contrary to stereotypes, in all but one was there greater dispersion of findings by age; in other words age brings greater variety of experience rather than less. Loneliness levels were far lower than stereotypes would suggest, and therefore great caution must be expressed when dealing with older people, whether as family, carers, medical professionals, not to let stereotypical assumptions cloud judgments and interventions.

A study in press by Nagga, Dong, Marcusson, Skoglund, and Wressle (2011) was conducted of 496 85-year olds in Linkoping in Sweden. Despite this cohort (from a target of 650) being within the category of the "oldest old" and hence in that group thought to be frail or vulnerable, results were similar to those of Eriksson. For example, 50% reported "no problem" with mobility, and only 2% "severe problems". Eighty five percent reported "no problem" with self-care and 5% "severe problems." Similarly, 74% reported "no problem" with their usual activities, with 8% reporting "severe problems." There was a higher level of pain/discomfort noted in the sample, with 61% reporting "moderate problems" but even here only 6% noted "severe problems." In terms of anxiety/depression 64% reported "no problem" and only 2% "severe problems." This was not to say that participants had no worries, and the authors show that 36% reported worries "of which the most frequently mentioned were fear of illness, of becoming dependent on others, relatives' health, loneliness and an uncertain future, which represented 66% of all contributing factors" (pp. 4 of 7). Despite these concerns, the study found "a fairly positive image of healthy perception, good functional ability as well as low utilization of health care among the majority of participants, despite a high prevalence of multimorbidity and frequent assistive technology use" (pp. 5 of 7). Of those that used in-patient services, however, these were the ones that needed more medical resources, social assistance and had lower self-rated health, but this was partly a function of professional judgments rather than evaluated need.

In sum, the authors conclude:

> A straightforward next step is to further highlight certain analytical factors such as gender, social service provided, family support as well as specific diseases that influence health care consumption patterns in the elderly. Every change in an aging population can have a major impact on health care economics and policy (page 6 of 7).

Such findings are encouraging, particularly because their participants were more likely to be living in their own homes (89%) than are many comparable populations elsewhere, and this accords with the "guiding principle" of Swedish "eldercare" of such cohorts remaining in their own homes for as long as possible.

Chapter 5
Aging in Japan

Japan has become one of the wealthiest societies in the world, and also (by 2005) the oldest. Imagine the contrasts you have seen if you are now in your eighties in this country: in your childhood you saw the rise of Japanese militarism, entry into World War Two via the attack on the US at Pearl Harbor, and the shock of eventual defeat precipitated by the dropping of the atomic bombs in Nagasaki and Hiroshima. The old order gave way to a new peaceful democratic society, albeit one in which powerful vested interests still largely predominated. Perhaps you became a salaryman with one of the new successful Japanese corporations like Sony or Toyota, and you and your family became wealthy. In your old age you are content with your life, and happy for your descendants. You now have a house in Thailand where you live during the winter, in what has become known as a "pendulum life" and your son and daughter's families use it too, for summer vacations. The bursting of the property bubble was a financial shock, however, as was the loss of pension records in 2007. The Tohoku earthquake and resulting tsunami of 2011 was an even greater shock, however, as was the accompanying failures at the Fukushima Daiichi Nuclear Power Plant and you are reminded that Japan lies on the Pacific Ring of Fire and thus remains vulnerable to disasters. Perhaps, alternatively, you were a fisherman who lived in Miyagi Prefecture that bore the brunt of the giant waves that reached up to six miles inland; previously you had had a quiet life until the tsunami struck and now all that you once knew in the locality is in ruins, and many of your family and friends died as a result. Yes, the Ring of Fire is a reality for you and many like you, and life will never be quite the same again for at least a generation. You are grateful to have been spared but you would rather that you had been taken and one from the younger generation had survived in your stead. The final section of this chapter will conclude by exploring the selflessness of your generation in the face of such disastrous happenings.

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Growth of the Oldest Old

Writing some years ago in the journal *Foreign Affairs*, Ezrati (1997, p. 1) noted that:

> Japan's population is aging faster than that of any other country in the world. The unprecedented increase in retirees relative to the size of Japan's work force will force radical change if the nation is to avoid a fiscal crisis, or worse. These seemingly innocent demographic changes will force Japan to shrink its famously high savings rate, reverse its proud trade surplus, send more industry overseas, liberalize its tightly controlled markets, and take on a more active, high-profile foreign policy. Ultimately, these changes will shift the balance of power in East Asia.

The implication of this analysis is that Japan would by now be in demographic crisis, and yet at least until the impact of the earthquake and tsunami noted above, Japan has remained one of the most powerful economies in the world. In January 2010, for example, Japan was the second largest economy in the world in terms of Gross Domestic Product. This has occurred despite the well-documented fact that Japan has an ever increasing aging population. Yashiro (1997, p. 245) has noted that: "Aging of the population is a major long-term concern as it relates to the Japanese economy and society. While aging is a phenomenon common to many industrial economies, the most striking feature in the case of Japan is the high speed at which the process is occurring." Further to this an article in 2006 in the British media suggested that Japan's aging trend was becoming "inexorable" because the country had the lowest ratio of children under 15 and has the highest proportion of over 65-year olds in the world (Dejjevsky, 2006).

Following the Second World War the population in Japan increased rapidly. The main reasons for this are largely economic and social. Bailey (1996) notes the shift from being a country defeated in 1945 to becoming one of the most successful economic forces in the world. For example, in 1949 Japan had a trading deficit of 146 million yen whereas by 1986 it had a trade balance surplus of 22.3 billion yen (Hunter, 1989, p. 307). Similarly, Japan had a GNP per head in 1950 that was lower than that of Mexico or the Philippines, but this had become the second largest in the world by 1968 (Ogawa, Matsukura, & Maliki, 2009, p. 134). This was linked to massive (re-) industrialization and urbanization; by 1964 Tokyo, the host city of the Olympic Games that year, became the first city in the world to reach a population of ten million (Duus, 1998). Mosk (1983) suggests that there was a "gradual" decline in marital fertility in the 1950s, but Ogawa and colleagues suggest that the TFR (Total Fertility Rate) actually halved between 1947 and 1957 (Ogawa et al., 2009, p. 134), while Taeuber (1956) notes that the prewar decline in death rates among infants and young children speeded up in the postwar years. Therefore, "in 1952–1953 the death rates of males in their twenties were only one-third what they had been 5 years before" (Taeuber, p. 25). In part, such changes reflect not only the changing nature of Japanese society but also the major social and political effects of the postwar US occupation plus new legislation for birth control and conception. After the war for example, abortion was legalized and this had a dramatic influence on birth rates because abortion "was a substantial way of limiting birth" (Sato and Iwasawa, 2006).

In 2002, Japan's National Institute of Population and Social Security Research published the population projection of Japan for the next 100 years. They estimated that population would peak in 2011 at 127 million, and then decline to 117 million in 2030, mainly due to the continuing low rate of fertility. Far fewer children are being born than in past times, and although at the other end of the spectrum life expectancy continues to increase markedly, this is not enough to cover the loss of potential newborn children. In 1947 average life expectancy was 54 years for women and 50 for men, but these figures had increased by around 30 years by 2006, to 85.8 for women and 79.0 for men (Ogawa et al., 2009, p. 134), with the figure for females being the highest in the world. Takayama (2003) has calculated that the number of older people in the population was 24.3 million that year, and by 2018 this is estimated to be 36 million. A number of medical experts (see Fujiwara et al. 2002) in 2002 concluded that mild cognitive impairment (Alzheimer's and conditions arising as a result of suffering a stroke) is on the increase therefore this population trend places pressure on Japan's welfare state. Wasserman and Jones (2003) have warned that (as in other countries like China today, as we show in Chap. 6), there is an increase in medical expense for Japan's younger generation and:

> it is increasingly difficult to care for older people at home because more women are joining the labour force, and there are fewer children to share the care giving responsibilities.

In similar vein, Cargill and Sakamoto (2008) have noted social security payments are high and are constantly directed toward welfare for the elderly. Cargill and Sakamoto (2008, p. 264) suggest that:

> This poses a serious problem because Japan's aged population is large and will grow larger and faster than in other industrial countries, and the number of workers who will finance the elderly's social security and health care will shrink at the current rate of child birth and immigration. Thus, Japan's welfare spending for the elderly will increase greatly, but will not have sufficient workers to finance the spending.

In a more optimistic analysis Ogawa et al. (2009) show that, although these points are valid, and also that surveys suggest that the key group of middle-aged women are increasingly less likely to see themselves as care-givers for their parents, many older people themselves no longer see their children as the source of their old age security. Further, their analysis predicts that:

> the number of the healthy/active elderly persons is projected to increase substantially from 19 million in 2000 to 30 million in 2025. These projected results suggest that Japan's productive capacity might expand considerably in the years to come if these healthy/active elderly persons could participate in the work force and be gainfully employed (p. 144).

These findings are similar to those for other countries examined in this book. We appreciate the financial concerns expressed by many analysts faced by these increasing number of older people in societies around the globe, but it is useful to remind ourselves that, even in the oldest old society of Japan, old people are not necessarily dependent on younger generations for financial security, as will become clearer in the next section.

Pensions in an Aging Society

Japan has had a long associated history with the politics of Liberalism, albeit of a heavily conservative variety, and it was only in 2009 that the Liberal Democratic Party (LDP) lost the election to the Democratic Party of Japan (DPJ), the first time (apart from a brief 11-month spell in opposition in 1993) in 54 years that the LDP had been defeated in the postwar era. Until this event Japan has been used as a case study example of Liberalism working within an increasingly globalized economy. One of the criticisms of the development of Liberalism is Japan's response to economic development. Fukutake (1974) has noted that by the 1970s there was an imbalance between Japan's social and economic development because from the Meiji period social development tended to be ignored in the continuous pursuit of economic growth. Maeda and Ishikawa (2000) have noted that Japan did face setbacks in the Great Depression and World War Two but between 1900 and 1970 Japanese manufacturing industry expanded 150 times. Hence, Fukutake warned that a new emphasis needed to be placed on social reform via a three-step approach: (1) creating a better standard of living; (2) new investment in education and (3) making social security fairer to everyone. In effect he felt that there needed to be a new priority placed on social welfare within Japan's society.

Although Japan's welfare budget is one of the smallest of the world's major industrial nations, paradoxically pension support has been embedded for many years within the country, beginning in the nineteenth Century when, in 1875, a noncontributory pension was established for retired and navy servicemen and then in 1884 for government officials. Moreover, by 1890 laws institutionalizing this pension system were enacted. Then noncontributory pension systems for schoolteachers and policemen were introduced but it was not until 1920 that a system was set up for blue-collar government workers. Then, according to Horioka (2001, p. 101): "a Mutual Aid Pension (Kyōsai Nenkin) System for national government employees was not established until 1949, and similar Mutual Aid Pension Systems for employees of private schools, employees of public enterprises, employees of agricultural, forestry, and fishery organizations, and local government employees were not established until 1953, 1956, 1958, and 1962, respectively." Beyond these government and local government employees, Ogawa et al. (p. 138) state that full universal coverage (also including medical benefits) began in 1961. They show that there are six public pension schemes in all, but two of them, the Employees Pension Scheme and the National Pension Scheme (NPS) cover 90% of the workforce. The early schemes were "organized under the principle of reserve financing" according to these authors, but these reserves became increasingly stretched as demands increased via greater longevity, therefore pay-as-you-go became the major method of financing.

The historical challenges of the Japanese Pension System have been well documented (e.g., Horioka, 2010; Horioka et al., 2007; Hurd & Yashiro, 1997; Shinkawa, 2005; Takayama, 1992, 1998). Recent debates on the Pension system have corresponded with the view that the state of the Japanese public pension system is more serious than in any other country across the world. This is because of the aging

population. Horioka (2001, p. 99) feels that the pay-as-you-go system is "fraught with problems." Furthermore, Horioka has stated that the public pension system in Japan has three main policy objectives: (1) old age security, (2) income redistribution, and (3) macroeconomic stabilization. The aging population has created pressure on the system and has caused a rethink because, as Horioka (2001, p. 102) points out:

> One oft-stated goal of a pension system (be it public or private) is to provide old age security, by which I mean the guarantee of an adequate income during retirement, regardless of how long one lives, or to put it differently, to eliminate longevity risk (the risk of uncertain lifetime). In my opinion, this should be the one and only goal of a public pension system. It is difficult, if not impossible, to simultaneously achieve two or more policy goals using the same policy instrument, and thus, each policy instrument should be assigned to the one policy target to which it is best suited. And the policy target to which the public pension system is best suited is old age security.

The initial benefits in the 1960s were to some extent modest until 1973. Throughout the 1980s there were changes in the system because of an imbalance between benefits and contributions and the rapidly aging population. Hence, a major pension reform package was passed in 1985 and took effect in April 1986, but these reforms were deemed to be insufficient and in 1989 and 1994 additional reforms were implemented. The revised changes that occurred in 1994 were twofold. Firstly, the basic pension age in Japan would slowly rise from the current age of 60 to 65 over the 2001–2013 period. Secondly, by autumn 1994 there would be a new rate of increase in after-tax ages (Horioka, 2001). These changes that were made in 1986 and 1994 were due to the number of older people living longer and also to the relative generosity of pension incomes compared to those in comparable wealthy countries (for the latter see Table 5.1). Hensahall (1999, p. 139–140) noted in the 1990s the average life expectancy in Japan from birth advanced steadily and:

> For females, it is now 83.0 (up from 70.2 in 1960). This is the highest in the world by a significant margin topping France's 81.8 (up from 73.6 in 1960). For males, it is now 76.6 for males (up from 65.5 in 1960)…. If both sexes are combined, Japan has the world's highest overall longevity. Elderly people, usually defined as 65 or older, now account for 16 per cent of the population, as opposed to the 5 per cent mark typical for much of its modern history.

Such increases led to pressures for further changes to the Japanese Pension System in the 2000s, and so a major pension reform was instigated in 2004, with a "primary objective" to "address the sustainability of pension schemes, which meant the reduction of benefits to a considerable extent" (Ogawa et al., 2009, p. 139).

Since then, as these authors note the Japanese Pension System as a whole has been hit by a major scandal of careless recording of pension records in the switch from hand-written records to a computer-based data system. Millions of records cannot be accurately identified—up to an amazing 50 million according to Ogawa and colleagues (ibid.). "Because there are millions of elderly persons who cannot receive pension benefits, Japan's public pensions system will be drastically changed, depending on how this political issue is settled in the near future" (ibid.). We were sure that this was a major contributing factor to the defeat of the LDP in 2009

Table 5.1 Elderly income comparison, mid-2000s

Country	Mean disposable income of elderly	GDP per capita	Percentage receiving below $7,000	$10,000
Canada	17,000	21,000	1	11
Finland	12,000	19,000	7	41
Germany	14,000	20,000	8	27
Italy	13,000	20,000	20	45
Japan	18,000	23,000	14	26
Netherlands	12,000	19,000	9	51
Sweden	12,000	19,000	4	28
United Kingdom	12,000	19,000	17	53
United States	18,000	26,000	12	27

Source: Choon, Kitamura, and Tsui (2008), p. 3

(a view subsequently confirmed via perusal of such websites as those of *The Times* which corroborates the 50 million figure), and belies the perception of outsiders that Japan is a well-organized and efficient society. Takayama (2010) has analyzed what went wrong In a nutshell, before 1997 people could have multiple pension identification numbers, from different localities or employment or pension scheme for instance, and in 1997 when seeking to establish a single identification number the body charged with doing this (the Social Insurance Agency (SIA)) found 300 million separate numbers for the 100 million or so who were eligible for pensions. They sent postcards to everyone asking them to reply with their multiple identification numbers but received only a 9% reply, just over nine million people because people did not realize the importance of this query (any social scientist who has conducted a postal questionnaire will no doubt sympathize!). By law the new number could not be issued until the SIA was informed by the person concerned of his/her old numbers, therefore the process of change was "painstakingly slow" according to Takayama and so by 2007, 50 million records had still not been integrated. He identified five main reasons for what went wrong, which we condense as:

1. Careless mistakes by programme participants, their employers, and agency staff in writing the application forms, in employers' reports on their employees' details, and in processing pension records [plus] … fraudulent activities by employees and/or their employers.
2. …The general public … illusion that government officials were able to do and did everything correctly without making any mistakes. An effective system of checks with feedback to correct any errors of pension records on a regular basis was never implemented in Japan.
3. …variations in the correct pronunciation of Japanese names written in Chinese characters… In the process of transferring these written records to computer records via punch cards, Japanese names written in Chinese characters could not be handled properly because of technological limitations at that time. …Card punchers were forced to mechanically assign one pronunciation to each Chinese character, irrespective of whether it was the correct one or not. Mistakes made in the process of transferring the records from the old format to the new one remained uncorrected for a long time.

4. … there has been no integrated collection of social security contributions and taxes in Japan. This gave rise to the possibility of fraudulent reporting on pensions by employers, such as underreporting of the number of qualified employees, of monthly salaries and bonus payments, etc.
5. no effective monitoring mechanisms have been set up in the field of pension administration…mainly due to reluctance on the part of the SIA to disclose information. It was only in May 2007 that the SIA made public the number of floating pension records after insistent inquiries by a member of parliament of the opposition party (Takayama, 2010, Sect. 6.3).

The reliance on an elite, passive bureaucracy meant that a crisis was not only possible but indeed likely, and it was only via the insistent questioning by a Japanese MP that the information about this situation was eventually released. Since then the SIA has much improved its record keeping, but there are still over 11 million records that have to be integrated. One can only imagine how worrying this must be for retired people who seek to ensure that they receive what they are due.

Impact of the Global Credit Crunch

As noted above, until recently, Japan was the second largest economy in the world and challenged the United States of America for the position of the world's top leading economy. Blömstrom, Gangnes, and La Croix (2001, p. 1) noted that for several decades the Japanese economy had outgrown the US and this phenomenon has been described as "nothing less than a miracle." For example they stated that "…the appreciation of the yen had pushed Japanese per capita income (calculated on an exchange-rate basis) almost 50% above US level in 1995." But on 14th February 2011 it was announced to the world's media that China had now replaced Japan as the world's second largest economy. This meant that following the Japanese economy shrinking in the final months of 2010 that Japan surrendered its 42-year-old ranking. According to Moore (2011), weak consumer spending and a steady yen witnessed the fall of Japan's Gross Domestic Product by an annualized rate of 1.1pc in the final quarter. However, due to the earthquake and tsunami that occurred in March 2011 the International Monetary Fund has downgraded its outlook on Japan's economy and has forecast that Japan's economy will grow by only 1.4% compared with the previous forecast of 1.6% (BBC 2011c). Hence, it is reasonable to assume that in view of all of these demands and pressures, Japan, being one of the leading economies in the world, has and will experience new pressures in Welfare, in particular Education, Employment, Health Care and most notably, Pensions.

Such pressures have been found before, however, and are not just a reflection of current economic problems. For example, it is well known that Japan's overreliance on overseas property market investments led to the bursting of its "bubble economy" when these property markets collapsed in 1990. A Japanese economist, Yoshikawa called the 1990s "Japan's lost decade" due to the poor government policies in response to such problems, while Ogawa et al. (2009, p. 137) also note the failure of Japan's "corporate paternalism" at this time, including the overgenerous, lump-sum

severance benefits which could amount to 46 months of final monthly salary for someone who had worked for the company for 35 years. Such final payments, as in other countries subsequently, have accordingly been reduced since the mid-2000s as the postwar baby boomers have begun to retire. Also, when faced by a shrinking labor pool due to declining national fertility levels, employers have sought to encourage older people to remain working; Japan's participation rate for older Japanese male workers therefore reached 29% by 2006, far outstripping the 10% or so for many European countries, and the 18% of the United States (ibid.).

Another source of pressure is that Japan's aging population may influence share prices due to the impact on the national saving rate due to the need to "draw-down" assets. Kihara (2009), among others, has examined the danger of a possible "Asset Market Meltdown" after the retirement of the baby-boom generation. He studies various Asian countries and confirms the work of other economists elsewhere and confirms (p. 142) that "population aging has a substantial and negative impact on the saving rate." Given that the impact of the 2011 tsunami/earthquake has been estimated at $300 billion, and coupled with the serious global economic situation at the time of writing, there is a clear danger that Asset Market Meltdown will occur. To combat this danger will require a range of policies that include, *inter alia*, further increase in labor force participation rates by women and older people, increase in the retirement age, greater international linkages and international cooperation involving the growing economies of China and India, for example, while:

> further development of less volatile financial assets with stable income, local currency denominated bonds for instance, are required both for remedy of world financial markets, and for ensuring stable income of increasing retired generation (ibid., p. 155).

Counter-Stereotypes: Crime by the Old and High Risk Volunteering

Biggs and Sakamaki (2008) and Ryall (2008) among others reported Japanese data on an interesting phenomenon that tends to contradict general stereotypes of older people, namely a marked increase in crime by older people. In 1998, there were 13,739 crimes committed by the "elderly" but this had risen to 48,597 by 2007 according to Ryall. Most of these were petty crimes such as pickpocketing or shop-lifting, but there was also an increase in violent crimes including a man in his 70s robbing a store at knifepoint, and 85-year-old man murdering his wife because he did not want her to live on after his death, plus:

> A 77-year old woman slashed two women with a knife near a Tokyo railway station in August [2008]. She wanted police to take care of her after she ran away from a shelter for the homeless (Biggs and Skamaki, 2008).

Unsurprisingly, such incidents provoked intense Japanese media interest as well as a book by Tomomi Fujiyama entitled *Bousou Rojin* (The Elderly Out of Control). Reasons put forward for this crime wave included the relatively high proportion of older people living well below Japan's median income levels, notwithstanding the relative wealth of many older Japanese, the lack of respect and reverence showed to older Japanese unlike in the past, and the fact that this generation had the highest level of crime rates when they were young. There was also family breakdown in terms of lack of family support compared to past times. Fujiyama was quoted by Ryall as stating that the problem will get worse as economic conditions worsen, and as social budgets come under pressure. There may well be a pointer for other societies too, as they face similar types of social change as aging occurs.

Finally, to end this chapter on a more upbeat note, there is another side to Japan's older population, a spirit of sacrifice for the national good. This was shown after the nuclear problems at the Fukushima Nuclear Power Plant complex, when radiation levels increased to a dangerous state, well beyond the annual recommended safe limits. As Buerk (2011) notes, this led to retired 72-year-old engineer Yasuteru Yamada deciding to lead a team of former workmates and other members of The Skilled Veterans Corps of retired engineers and other professionals to enter the Power Plant in lieu of younger workers. His reasoning was that he had 13–15 years to live, but that any radiation-induced cancers would take 20–30 years to develop. He argued that he and his colleagues, gathered via email and twitter were not like the kamikaze (suicide) pilots of World war Two, therefore, but instead would be able to continue their lives after the work to control the meltdown at the plant had been completed. Truly this is an inspirational account to help counter aging stereotypes of the infirm, and sometimes selfish aging Japanese population.

Chapter 6
Aging in China

As we have noted in the Introduction, China has come rather late to the global aging table, not featuring until relatively recently in terms of percentage population aging. However, and as befits the world's largest country in terms of population, the absolute number of older people in China is higher than for other countries. Further, the speed of aging in China has been rapid, especially since the founding of the People's Republic of China in 1949. China is moving quickly to become the world's second largest economy, within a system of 'socialism with Chinese characteristics', unique across the globe, which combines a strong developmental State run via the Chinese Communist Party (CCP) with capitalist methods of economic progress. Economic growth rates in recent decades have regularly been of the order of 8–10%, and the society has also highly urbanised. Aging has been an important feature of China's contemporary population change, but the speed of change—social, economic and demographic—has brought many pressures and raises many issues for China itself and the world more generally.

Rapid Aging in a Developing Country

If you were aged 80 in 2010, you were born in 1930, if 70, then 1940. At either of those ages, you have been a part of some of the greatest social and economic change possible within any one country during a person's lifetime. If you were born in Shanghai in 1930 for example, you will remember a childhood dominated by foreign expatriates and then the Japanese invasion in 1937 and your family may have become refugees fleeing into the interior, eventually to Chongqing, the wartime capital. You would have witnessed aspects of the Civil War as well as the War with Japan, and the eventual founding of the People's Republic of China in 1949, as a Communist society dominated by the CCP. You and your family were caught up in the euphoria of the Great Leap Forward and then your son became a Red Guard in the Great Proletarian Cultural Revolution in the late 1960s. He denounced your

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bourgeois tendencies and you and your wife suffered horribly for a time. You lived a life of shared poverty, in the *danwei* (workplace) with few material comforts. You were 46 when Mao died and then after the struggle with the Gang of Four, things began to change, although Shanghai was restricted in its growth until Jiang Zemin was Mayor on the 1980s. Since then, life has become more and more comfortable. You are reconciled with your son and you and your wife lavish much of your pension and savings on your grandson. You keep yourself busy, going out regularly to the People's Park to play *mah jong* and you keep yourself fit with *taijiquan*. China has changed so much and your modern apartment is one of many thousands in the city now. Life is good, though sometimes you hanker after the old days in the shared accommodation in the danwei. Yes, life was tough then, but there was a social side that is hard to keep going today. Well, is that you? Or are you a poor farmer who still has to work on the family plot at an advanced age because your son has gone to the city for work? Life is a constant struggle to survive, and you wish that you had more help in your old age, even with the extra Government assistance that has been announced recently.

These brief sketches show that, as with other countries, it is dangerous to overgeneralise and stereotype China's older population, whose situation is highly variable. Notwithstanding China's rapid economic growth, the country is still in the category of "Third World" or "developing" given that average incomes are still on the low side, while a significant proportion of the population still lives in poverty, despite the economic progress within China's growing middle class. There are also deep-rooted spatial inequalities in China—which the authorities now prefer to term "uneven development"—with major contrasts between China's "Gold Coast" that includes most of China's main cities with the exception of Chongqing in the interior, and China's interior provinces, especially in the West.

Reflecting such spatial contrasts, aging in China is also highly uneven, as Table 6.1 shows. The table is organised with the highest percentage of older people at the top, declining down the page, and updates those for earlier years within Cook and Powell (2005, 2007). Not surprisingly, the data show similar patterns, although the fact that the information is based on sample surveys means that some percentages are different, most notably Shanghai, which is still top in terms of percentage of older people, but here the percentage is 13.0 compared to 15.4 for the 2004 data in Cook and Powell (2007).

As a rough guide, nearer the top of the table are the cities that are run direct via the PRC Government, namely Beijing, Tianjin, Shanghai and Chongqing, plus coastal provinces, plus the odd exception such as Sichuan Province in the centre of China. In contrast, at the foot of the table are interior provinces mainly in the West such as Inner Mongolia, Ningxia, Tibet, Qinghai and Xinjiang Provinces. Of course, there will also be internal contrasts within the Provinces, and we would expect urban areas to contain a higher proportion of older people, plus remote villages where the older people are more likely to form a residual population, the younger people having emigrated for job opportunities in the Gold Coast.

Du and Tu (2000, pp. 79–80) suggest that, in comparison to other developing or developed countries, there are four factors unique to China's aging process. Firstly, it

Table 6.1 Demographic data by Province, 2008

Province	Population	0–14	15–64	65 and over	Gross Dep. Ratio	Child Dep. Ratio	Old Dep. Ratio	65 and over (%)	0–14 (%)
National total	11,78,521	2,04,088	8,62,020	1,12,413	36.72	23.68	13.04	9.5	17.3
Shanghai	16,854	1,332	13,324	2,198	26.49	10	16.5	13.0	7.9
Tianjin	10,114	1,087	7,785	1,242	29.92	13.96	15.96	12.3	10.7
Chongqing	25,545	4,857	17,633	3,055	44.87	27.55	17.33	12.0	19.0
Jiangsu	69,168	9,515	51,535	8,118	34.22	18.46	15.75	11.7	13.8
Sichuan	73,722	12,794	52,488	8,440	40.45	24.37	16.08	11.4	17.4
Liaoning	38,988	4,729	29,840	4,419	30.66	15.85	14.81	11.3	12.1
Anhui	55,498	11,163	38,372	5,963	44.63	29.09	15.54	10.7	20.1
Zhejiang	45,900	6,435	34,576	4,889	32.75	18.61	14.14	10.7	14.0
Hunan	57,648	9,611	41,978	6,059	37.33	22.89	14.43	10.5	16.7
Beijing	14,813	1,438	11,852	1,524	24.99	12.13	12.86	10.3	9.7
Hubei	51,697	7,591	38,869	5,237	33	19.53	13.47	10.1	14.7
Fujian	32,484	5,764	23,473	3,247	38.39	24.55	13.83	10.0	17.7
Shandong	84,970	13,245	63,440	8,285	33.94	20.88	13.06	9.8	15.6
Shaanxi	33,999	5,592	25,147	3,260	35.2	22.24	12.97	9.6	16.4
Guangxi	43,252	9,453	29,753	4,045	45.37	31.77	13.6	9.4	21.9
Jilin	24,764	3,029	19,475	2,260	27.16	15.55	11.61	9.1	12.2
Heilongjiang	34,688	4,408	27,116	3,163	27.92	16.26	11.67	9.1	12.7
Hainan	7,665	1,650	5,329	686	43.85	30.97	12.88	8.9	21.5
Hebei	62,981	10,115	47,362	5,504	32.98	21.36	11.62	8.7	16.1
Jiangxi	39,623	8,995	27,306	3,322	45.11	32.94	12.17	8.4	22.7
Gansu	23,739	4,899	16,902	1,939	40.46	28.99	11.47	8.2	20.6
Guizhou	34,126	8,888	22,460	2,778	51.94	39.57	12.37	8.1	26.0

(continued)

Table 6.1 (continued)

Province	Population	0–14	15–64	65 and over	Gross Dep. Ratio	Child Dep. Ratio	Old Dep. Ratio	65 and over (%)	0–14 (%)
Yunnan	40,947	9,063	28,659	3,225	42.88	31.62	11.25	7.9	22.1
Shanxi	30,779	5,602	22,752	2,424	35.28	24.62	10.66	7.9	18.2
Henan	84,906	16,848	61,415	6,643	38.25	27.43	10.82	7.8	19.8
Guangdong	85,714	15,835	63,402	6,477	35.19	24.98	10.22	7.6	18.5
Xinjiang	19,004	3,978	13,660	1,366	39.12	29.12	10	7.2	20.9
Qinghai	5,007	1,088	3,576	343	40.03	30.44	9.59	6.9	21.7
Tibet	2,576	566	1,839	172	40.09	30.75	9.34	6.7	22.0
Ningxia	5,533	1,266	3,909	358	41.55	32.39	9.16	6.5	22.9
Inner Mongolia	28,161	3,251	16,795	1,769	29.89	19.36	10.53	6.3	11.5

Source: National Bureau of Statistics of China (2010). Available at http://www.stats.gov.cn/tjsj/ndsj/2009/indexch.htm Table 3.10. Accessed January 18th, 2011
Note: Data in this table are obtained from the National Sample Survey on Population Changes in 2008. The sampling fraction is 0.887%. Data for Beijing, Tianjin and Shanghai include floating population. Final two columns are authors' calculations

Table 6.2 Contrasting national totals 2000–2008

Year	Total population	Age 0–14	Per cent	65 and over	Per cent	Gross dependency ratio	Old dependency ratio
2000	1,267,430,000	290,120,000	22.9	88,210,000	7.0	42.6	9.9
2008	1,328,020,000	251,660,000	19.0	109,560,000	8.3	37.4	11.3

Source: National Bureau of Statistics of China (2010). Available at http://www.stats.gov.cn/tjsj/ndsj/2009/indexch.htmTable 3.3. Accessed January 28th, 2011

has occurred at unprecedented speed, taking 20 years less than in Japan, for example, for the aging percentage to grow from 5 to 7%, and "The time interval between 7 per cent to 14 per cent is also very likely to be less than the 26 years it took for the same increase to occur in Japan" (ibid.). Such a figure compares with 45 years for Germany and the U.K., 85 years for Sweden and 115 years for France. The arrival of an aged population has also been early, in that China's modernisation process and level of development of a social security and service system were also at a premature stage, meaning that "It is certain that China will face a severely aged population before it has sufficient time and resources to establish an adequate social security and service system for the elderly" (ibid.). There will also be marked fluctuations in the total dependency ratio due to China's rapid decline in fertility, and they anticipate that dependency levels will be high at an early and higher level than previously thought. The final factor of note is the strong influence of the PRC's fertility policy, a point that will be dealt with further in the next section.

Table 6.2 shows the contrasts in some of China's overall rates of dependency between 2000 and 2008, as calculated by the National Bureau of Statistics (note that these figures are national counts, not based on the sample survey of Table 6.1, hence the totals are different).

The data show, inter alia, the relative decline in those aged 0–14 between 2000 and 2008, and the increase in the proportion aged 65 or over. The Gross Dependency Ratio actually declines by 2008 due to the loss of children in the population, although the "Old Dependency Ratio" increases to 11.3% in 2008 from 9.9 in 2000. We await the results of China's Census in 2010 with interest to confirm or refute these trends, with the likelihood being that they will indeed be upheld.

In terms of China's future, despite contrasting forecasts in terms of detail, analysts nevertheless agree that aging will continue apace perhaps reaching 27% by the end of this century (Cook & Powell, 2005, 2007). It is predicated that regional contrasts will gradually be smoothed out, as will urban–rural contrasts, but this will depend on whether uneven development is resolved via a combination of government policy and private investment as the century unfolds. Cook and Dummer in a number of studies (Cook & Dummer, 2004, 2007; Dummer & Cook, 2007, 2008) have examined health inequalities in China, as well as making comparisons with India. They find severe health issues in rural China, but that compared to India the PRC government has been more successful in tackling these issues, a point that has been borne out since publication via a renewed emphasis on investment in rural health insurance as part of the 4 trillion yuan ($586 billion) stimulus package

announced by the Chinese government in 2009 in response to the global recession (Fahey, 2010, p. 384). There are some unique features to China's aging, however, and an important one is the impact of State Population Policy, in particular the Single Child Family Programme, so it is worth discussing this in more detail.

Impact of the Single Child Family Programme

Whatever one's views of the rights and wrongs of Communism, it is clear that the Chinese Communist Party (CCP) brought a greater degree of stability to China than had been known for some decades. The impact of the decline and eventual overthrow of the Qing Dynasty in 1911 followed by struggle between, variously, the Guomindang (Nationalist Party), local and regional warlords, the CCP and the Japanese invaders meant that, by 1949, when the People's Republic of China was founded "China was a shattered, ruined land" (Han Suyin, cited in Cook & Murray, 2001, p. 5). The CCP rebuilt the economy and despite the excesses of the Maoist Great Leap Forward and later Great Proletarian Cultural Revolution (ibid.), the country has built a stable and strong society that some feel may threaten the United States' position as leading superpower in the world. Be that as it may, a controversial feature of PRC policy has been the Single Child Family Program (known popularly as the One Child Policy), which has sought to curb China's burgeoning population growth, with its consequent pressure on China's environment.

Debate concerning population restrictions began in the 1950s, but Mao's view was that "every mouth comes with two hands attached" therefore little was done to limit population increase. However, by the 1970s population increase was such that the debate was reopened. At first, the policy of "wan, xi, shao" was attempted, which means "later, longer, fewer" in that births should be later, with later marriage encouraged, there should be longer intervals between births, and there should be fewer births than before. Despite strong efforts, however, this policy had little impact; therefore, the full-scale Single Child Family Program (SCFP) was introduced in 1980. The policy encourages birth control and discourages births via incentives to have fewer children and disincentives to have more than one child, unless in rural areas where the first child is female (due to traditional attitudes to the worth of male as opposed to female labour in peasant society), or in minority populations where the PRC government chose to tread warily for fear of being seen as discriminatory towards ethnic minorities. Some have viewed this as an essential policy. For example, writing in 1992, leading Chinese demographer and statistician Li Chengrui (1992, p. 95) suggested that:

> It is obvious to all that great achievements have been made in family planning. If we did not carry on family planning, China's present population would not merely be 1000 million, but 1100 million. The remarkable results of China's population control not only have great significance to China, but also contribute to world population control.

Others would see the policy as too invasive and, via sterilisation and abortion, sometimes forced, as being too draconian and an infringement of human rights

(for a recent analysis of the links between the science and the policy of population control in China see Greenhalgh, 2008). In practice, due to the exemptions offered, as well as the fact that those who were better off could afford to ignore the financial penalties involved, it was never a "one child" policy; rather it became "a one-and-a-half child" policy (Cook & Powell, 2007, p. 132).

In many ways, the policy was successful in curbing population growth, but the cost was high. One aspect of the cost that was largely unforeseen was that as aging became a feature of China's demographic structure, so there were fewer younger people being born as a result of this policy at the very time that there was a higher proportion of older people. This has had a potential positive effect in the sense that total or gross dependency rates could be kept under control, due to child dependency being at a markedly reduced level, but in the long term it means that for those older people who become vulnerable further down the aging process, there are fewer children and grandchildren potentially available to look after them. Further, China's younger people are often now known as "Little Emperors" or "Little Empresses", because they are the product of a changing family system in which they are not only the single child, but also the focus of doting and giving from their parents plus two sets of grandparents, for whom grandchildren are a relative novelty. In other words, there are concerns that this generation of single children are growing up spoilt and over-materialistic, being part of the "spiritual pollution" that can come into China via the Open Door Policy. Possibly, therefore, there will be issues in the future as this generation is unwilling to look after older parents or grandparents, not the least because there will be fewer of them compared to those who are older.

There is also the issue that tremendous social and economic change has been taking place in China while this family planning process has been ongoing, therefore as regards the reduced fertility, the 70% drop in less than 20 years that has occurred:

> Researchers have been careful to note that the reduction was not only a consequence of government policy but also a response to social and economic development (Chen & Liu, 2009, p. 159).

To say the least, there is some considerable irony here, because this means that the policy was introduced at the very time that China was rapidly modernising and urbanising, and with such modernisation and urbanisation one would expect a "natural" decrease in fertility levels, meaning that the policy was perhaps not quite as necessary as it originally seemed to be.

You Must Look After Your Parents'. Legislation on Care of Older People

Whatever the debates concerning the changes wrought via the SCFP, the combination of government policy and rapid socioeconomic change meant that the PRC increasingly felt the need to legislate on older people, to prevent families from ignoring their parents or grandparents. In developing this legislation, an internal

system of "support contracts" was introduced in Jiangsu Province in the 1980s, before being rolled out to other areas (Powell & Cook, 2000, p. 86), while externally Singapore would seem to have been used as a model, and the Government brought in legislation to enable older people to take their children to court if necessary in order to obtain financial support from them. This was done via the "Law on the Rights and Interests of the Elderly" promulgated in 1996 (Cook and Powell, 2007, p. 138). The Law also aimed to encourage "respect for the elderly", which was in danger of declining in the face of rapid modernisation and disruption to traditions of filial piety, an integral part of once-dominant Confucian doctrine in which, as Fairbank, 1959 (cited in Powell & Cook, 2001, p. 55) put it:

> The mixed love, fear and awe of the children for their father was strengthened by the great respect paid to age. An old man's loss of vigor was more than offset by his growth in wisdom. The patriarch possessed every sanction to enable him to dominate the family scene.

To that point, we can add that as the mother aged, she too gained increasing respect within a highly patriarchal system, for she had increasing status within the family.

Since the passing of this Law, researchers have reported that, for instance, older people did on occasion take their children to court as the law allowed, but some of them found this to be a shaming process, and committed suicide—"gerontocide"—due to the humiliation that they endured (Cook and Powell, pp. 84–85):

> In June 2004, for example, a 76 year old man blew himself up in a courtroom in protest during a case against his family, who had offered only 350 Yuan a month to support him when 600 Yuan was required (8 Yuan = 1USD).

However, others such as Zimmer, Kwong, Fang, Kaneda and Tang (2007) via the Beijing Multidimensional Longitudinal Study of Aging have found that filial piety is still a strong feature within China, with, for example, co-residence levels with older parents being broadly maintained over time, with studies showing "little evidence of any weakening of traditional systems" (ibid., p. 24). Likewise, Silverstein, Cong and Li (2007) show that reciprocity exists between grandparents and grandchild care within rural China, enabling and facilitating economic development within the family as a whole, so the picture is not universally negative in the face of rapid change.

In December 2006, the Chinese Government published a White Paper titled *The Development of China's Undertaking for the Aged* available online via the official government website, www.chin.org.cn. Much of this was taken up with ensuring progress in the establishment of an old-age security system. Most of the advance on this has been in urban areas. The White Paper shows:

> In recent years, the Chinese government has gradually established a uniform basic old-age insurance system in urban areas that covers all the employees of different types of enterprises, persons engaged in individual businesses of industry or commerce, and people who are employed in a flexible manner. By the end of 2005, the number of people participating in the basic old-age insurance scheme across China had reached 175 million, 43.67 million of whom were retirees. The disbursement of the old-age insurance fund was 404 billion yuan.

The state is also making provision to supplement the basic pension in response to price fluctuations and wage rises for current employees in the appropriate job.

Further, "A retirement system for staff members of government agencies and public institutions has been established; these people get their pension either directly from the central government finances or from their former employers at the rate stipulated by the state" (ibid.).

The situation in rural areas is more problematic and important given that the White paper estimates that this is where 60% of older people are located, notwithstanding the high proportions in cities noted above. Linking to the notion of support contracts discussed previously:

> The Law of the People's Republic of China on the Protection of Rights and Interests of Elderly People stipulates that an elderly person's guardian is obligated to till the land contracted to the elderly person he/she supports, and also to tend forestry and livestock under the elderly person's charge. The revenue from this will go to the elderly person as a guaranteed source for his/her basic livelihood. The state encourages people to sign a "family support agreement" which stipulates how the elderly person is to be provided for and what level of livelihood he/she will have. Village (neigborhood) committees or other relevant organizations will supervise the implementation of the agreement…By the end of 2005, some 13 million "family support agreements" had been signed (ibid.).

There is also a bonus system for those rural residents who have adhered to the 1 child policy (1 son or 2 daughters), plus an "aid system" for 22.33 million urban and 8.65 million rural poor people, as well as a special allowance for those aged over 80. Such measures have been added to via a new rural pension scheme that was begun on a pilot basis in August 2009, and it was estimated that by year-end 2010, 100 million rural residents would have joined China's government-subsidised rural pension scheme (Deng, 2010). A range of healthcare measures, including a basic medical insurance scheme, have also been targeted at older people, for example via a rural cooperative medical system, while in urban areas over 15,000 community health centres had been set up by the end of 2005, according to the White Paper.

These and other measures dealt with in the White Paper are to be welcomed. Due to China's rapid economic growth, and notwithstanding the impact of the global recession, the coffers of China's Government are full, especially of US dollar bonds (a controversial issue at the time of writing via US claims that the Chinese currency is undervalued), therefore the State can, and should, subsidise older people's income and health needs. There are those who worry, however, that the pressure from those such as the Cato Institute in the U.S. to partially or fully privatise the Chinese social security system will place the most vulnerable at risk, including for instance recent rural to urban migrants, unmarried women or low-wage workers because the new scheme will be less redistributive than that it replaced (Williamson & Deitelbaum, 2005, p. 268). Others such as Bingqin Li (2007, pp. 45–46) are concerned that the separation of urban and rural pension schemes may not be viable at a time of such high levels of rural–urban migration, in which migrants must contribute to urban pensions, but also support older people back home in the villages. She suggests that migrants need to be able to "carry" their pension across these urban–rural boundaries, just as they too carry their selves across them, to be able to "translate" their rural pension entitlement into an urban one, or vice versa. In the very long-term, therefore, the urban–rural pension dichotomy is unhelpful.

Active Aging in China

As for other countries studied in this book, for China active aging is a productive way forward, to help ensure that people as they age remain healthier via activity than might otherwise be the case, as well as to ease concerns over dependency rates of older people on the working age population. Cook and Powell (2003) and Chen and Chen (2009) have studied this topic for China, and this section will draw heavily upon these publications. First, then, it is important to consider the view of the ruling CCP itself towards older people, and as Cook and Powell note this

> has been highly variable, and sometimes contradictory. For much of the time the Party has viewed the elderly essentially as dependants, to be looked after by work unit or family as the case may be. And yet within the Party hierarchy, the elderly assumed a major role, either within its formal structures such as the Politburo, or when ostensibly retired from these organisations informally via more shadowy 'advisory' bodies which retain great power (Cook and Powell, 2003).

Examples that they cite include the fact that leaders such as Mao Zedong, Zhou Enlai, Deng Xiaoping and more recently Jiang Zemin worked into their seventies or eighties. There was, for example, the propaganda stunt of Mao's swimming across the Yangtze River at the age of 72 in 1965, in order to have a national impact and make a comeback from being shunted aside into semi-retirement following the post-Great Leap Forward reverses (especially wide-scale famines) in 1959–1962. As Cook and Powell note:

> Where he swam, off Wuhan, the river is nearly two miles wide, and beset by difficult currents. Mao, however, was always a strong swimmer. Moreover, provided the swimmer follows the current downstream, at an angle to the river, and swims in the warm summer waters great distance can be achieved. The impact on China, and indeed overseas opinion, was startling. For home consumption, 'this exercise at such a place was no doubt partly designed to refute the fears and superstitions of the people who still dreaded the 'River Dragon', which devours swimmers (Fitzgerald, 1976, p. 138).

Mao built on this success to launch the Great Proletarian Cultural Revolution the following year, having reconfirmed his cult status.

Then there was the example of the role of the "eight elders" during Tiananmen in 1989. Deng was 85 at this time, and some of the other elders were even older. Thought by the outside world to be retired and powerless, they were critical of what they saw as too soft a response by Zhao Ziyang (then General Secretary of the CCP) and his colleagues on the Politburo Standing Committee to the ongoing student protest in the Square. They still had power and exerted it to order that Beijing be put under martial law. Zhao Ziyang and his supporters were ousted, and Jiang Zemin was appointed as Zhao Ziyang's successor at a meeting on May 27th. "Finally, on June 2nd, the fateful decision was taken to clear the Square by force, and on June 4th 1989, the terrible die was cast at Tiananmen, despite Deng Xiaoping's instructions to avoid bloodshed in the Square itself" (ibid.). Despite this terrible blow to China and Deng's reputation, his South China tour 3 years later that led to a renewal of the Open Door policy and renewed investment from overseas led him becoming

Time's "Man of the Year" accolade in 1992 in his late eighties. He died at the age of 93 in February 1997.

These examples show how older people in China could remain politically active at a great age. The irony is that at an earlier age Deng Xiaoping called upon Party cadres to retire in order to encourage the breakthrough of younger cadres into positions of power and influence! Within China's peasant society, of course, the lack of a welfare system meant that welfare meant that many older people had to work in the fields at an advanced age, a situation that is still found today, in comparison to the cities where retirement is more feasible. In urban areas, the challenge is to remain active—physically, mentally, socially—via a wide range of activities such as *taijiquan*, *qigong*, open air dancing, opera in the parks, taking one's caged bird for a walk, or kite flying. Writing some years ago, Yu suggested that there were 10 million older people active in such ways, and

> In Beijing alone there are some 200 practice grounds in parks, public squares, roadside gardens and other open spaces where volunteers teach these exercises [shadow boxing; deep breathing exercises] every morning. So far more than 400,000 persons, many of them old people, have taken advantage of these free lessons. Some senior citizens take part in long-distance jogging, ball games or swimming, and senior citizens' sports meets have been held in Beijing, Shanghai, Guangzhou and other cities.
>
> Less arduous forms of recreation abound as well. In Beijing, for example, there is an army veterans' chorus. Another group of veterans has just published a collection of poems. Clubs, parks, activity rooms and homes for the aged are being established in many cities (Yu, 1987, pp. 212–213).

Impressive though these figures are, by 2006 the Government White Paper discussed above noted that promotion of mass sports and fitness exercises among older people had grown to the extent that, by 2005, "all counties and higher administrative units, 70 percent of urban communities and 50 percent of rural areas had established sports associations for seniors…In recent years, the state initiated the National Fitness Project which helps to set up public sports and fitness grounds and facilities, and to provide space for elderly people to do physical exercises" (White Paper, 2006). The "Millions of Seniors' Fitness Exercise Activities" mean that "it is estimated that there are now more than 58 million elderly people doing regular sports and fitness exercises in China" (ibid.) Today, visits to China's cities are inspirational in the sheer breadth of activities in which older people engage, and in recent years, for example, exercise equipment has been placed in accessible open spaces to be used by adults of all ages, but in practice it is most likely to be older people.

Despite such activities, Chen and Chen (2009, p. 75) show that, in terms of government policy, although many policy documents contain the word "active" (*jiji*), there is little reference to "active aging" (*jiji laoling hua*). They suggest that the word active:

> has tended to be used in a conventional way to describe such specific aspects as participation and more frequently in describing governmental and societal work rather than individual lifestyle…the missing or rare inclusion of the newest catchphrase of "active aging" in so many policy documents…as well as the ambiguity/ flexibility of the idea itself have resulted in different interpretations and left some unclear about its meaning and relevance as something possibly new to the country's practice (ibid., p. 77).

Nevertheless, they show that many Chinese researchers are now studying this phenomenon, and that it is probably second to "healthy aging" as a contemporary topic. They welcome internationalisation of perspective of this as helping "Chinese scholars and policy makers to stay on the right path and be integrated into the mainstream, with great implications to Asia's development along with the rest of the world" (ibid., p. 79). They concur with Cook and Powell (2003) that such an approach "does not seek to minimise the issues concerning the frail elderly" (ibid., p. 81 and see also, Cook and Powell, 2005, p. 84); therefore, there will still be a great need to deal with such issues as dementia for example, not to assume that all elderly can be active throughout their lifecourse.

Chapter 7
Aging in Nepal

Much of this book is concerned with countries which have had aging as a feature of their demographic profile for some years. Nepal, however, is one of the exceptions to this, not least because it is one of the poorest countries in the world; hence, aging has been the exception rather than the rule, until very recently. This chapter will draw heavily upon the work of Parker and Pant (2011, 2009) and is co-authored by Dr Sara Parker who has been working and researching in Nepal since the early 1990s.

A Newly Aging Society

If you were 80 in Nepal in 2010, then you were born in 1930, if 70 then it was 1940. Especially if you were 80, you were one of relatively few to reach that age. You are probably male, from the high Brahmin caste, live around the capital Kathmandu and for most of your life you have worked for a Governmental department, supported in recent years by remittances from your youngest son who is working at a University in America, although the remittances have been less since the onset of the global recession. You live with your eldest son and his family and are fortunate that his wife is a qualified nurse and looks after you so well. You have seen so many changes in your lifetime, including the development of Kathmandu itself, but especially the end of the Rana regime, introduction of democracy and ten years of political unrest and more recently the momnarhy beign overthrown by the People's Movement. Thankfully, there is now a time of peace and you can enjoy your sunset years, although you miss the monarchy that was overthrown in 2008. Is this you? Or are you a poor aging female from the low *Dalit* caste struggling to survive in the terai of western Nepal? Your sons both died in the Civil War, ironically one from either side of the conflict, and you are left to work the family plot with their widows and children as best you can. In other words, and as for the other countries studied in this book, there is the same need to avoid stereotypes of aging. Nepal is a small nation whose population is just over 23 million but "is a nation that is socially, culturally

I.G. Cook and J. Halsall, *Aging in Comparative Perspective: Processes and Policies*, International Perspectives on Aging 1, DOI 10.1007/978-1-4614-1978-5_7,

Table 7.1 Changes in life expectancy and death rates in Nepal, 1970–2008

	1970	1990	2008
Life expectancy	43	54	67
Crude birth rate	44	39	25
Crude death rate	21	13	6
Infant mortality rate (under 1)	21	99	41
Under-5 mortality rate	21	142	51

Source: UNICEF (2010)

and environmentally diverse" as Parker and Pant, 2011, note, and 59 ethnic groups account for 37% of the population. DFID (2003) estimates that 15% of the population is from the Dalit community which is often the landless and the most marginalised sector of the population.

Recent data show that Nepal's per capita income is only US$470 per head (World Bank, 2010) and the country is ranked a very low144 on the Human Development Index (HDR, 2009). Moreover, within Nepal inequalities seem to have increased in recent years, both in a socioeconomic and spatial sense (DFID, 2003). The country became a Republic in 2008 following the "People's War" and the dissolution of the monarchy the year before. The conflict impacted on all sectors of Nepali society, causing not only a high death rate but also severe trauma and disruption of governance. Under the circumstances, it is quite remarkable that aging has now passed the 7% level, a key cutoff point towards an aging society, especially in that for a number Asian, and especially South Asian countries, aging is still the exception rather than the rule, although this will change as the twenty-first century unfolds (Cook and Dummer, 2009; Parker and Pant, 2011). By 2008, average life expectancy had reached 67 years, which compares to only 54 years in 1990 and 43 years in 1970 (UNICEF, 2010). Until recently, Nepal was one of the few countries where men outlived women; life expectancy is now estimated to be 67 years for men and 69 years for women (BBC, 2011a).

Table 7.1 illustrates such changes over time, for a number of variables. As Parker and Pant (2011) note:

> The emergence of an aging population is a relatively new phenomenon in Nepal and as such has received little attention in terms of research and policy focus. The main health focus in Nepal over the past two decades has been to reduce both maternal and infant mortality. Despite the recent political unrest, maternal mortality in Nepal has decreased over the past decade mainly due to poverty reduction, an increase in accessibility of both education and health services and family planning (Barker, 2007; Khatri, 2010; UNFPA Nepal, 2008)… Reductions have also been noted in the death rate as well as infant mortality rates.

In terms of numbers, by 2006 1.6 million Nepalis were aged 60 or over, with high growth expected to reach 7.2 million in that age cohort by 2050 (Help Age International, 2009).

The socioeconomic and spatial diversity noted above, however, means that there is similar diversity in the distribution of older people, not least by ecological zone and by gender, with fewest older people (just under 8% only) in the mountain zone and more females than males in the mountain and hill zones, whereas there are more males than females in the terai (Subedi, 2005). Most societies around the globe now have more older females in general than males, but in a traditionally highly patriarchal

society such as that in Nepal, it was not until 2008 that there were more older females than older males (HDR, 2008). Women, for example, would traditionally eat last and least, within the family, and would be at high risk of death in childbirth. Such issues will be explored further in the next part of the chapter.

Internal and external migration is important for older people in Nepal, either because they themselves are beginning to migrate to urban centres, especially the Kathmandu area, or are affected by the emigration of their sons in particular. The Geriatric Centre Nepal (2010) suggests that 85% of older people live in rural areas. While a high percentage, this is lower than it was in 1981, for example, when 93.6% lived in rural locations (Subedi, 2005), and more older people are showing an increasing tendency to now migrate to urban areas (Chalise and Brightman, 2006). Nonetheless, as in other Third World societies, the population of older people in rural areas is often residual, with emigration of young males leaving older people, women and children to farm the rural plot, as part of the "Empty Nest Syndrome" found in many societies. For those left in the rural areas, life can be hard indeed, with the lack of labour to work the land as Parker (2005) notes; but if the older people leave too, then there is a loss of indigenous knowledge and cultural systems that often underpin agrarian society (ibid.). In this situation, remittances are crucial to family survival and the local economy alike (Seddon et al., 2002; Subedi, 2005).

Health and Gender Issues

Nepal has a romantic image, one of a mountain paradise, and there is much beauty in this mountain country. For females, however, life is particularly hard within this traditional patriarchal society. Until recently, as highlighted above, not only was overall life expectancy low, for females it was lower than men, an unusual situation globally, although one that tends to be found in traditional agricultural societies such as China or India where preference for sons is an important feature of rural life, even today, and where social structures and belief systems are male-dominated. The impact of this and other related factors such as neglect of girls' health, high infant and child mortality rates and lack of access to adequate health services for reproductive health care and for contraception was identified by the Asian Development Bank (ADB, 1999) as being key factors in inequality (p. 11). Not only do such factors mean that females are more likely to suffer ill health than are males, but also, as the World Health Organisation (WHO, 2007) or Parker and Pant (2009) note, such discrimination and gender inequality mean that women who do reach old age remain vulnerable to poor health in their advanced years. Apart from the inequities already noted, the WHO (2007: p. 5) also identify gender inequalities in many societies with, for females, low incomes and inequitable access to decent work due to workplace gender discrimination, care-giving responsibilities associated with motherhood, grandmothering and looking after one's spouse and older parents that prohibit or restrict working for an income and access to an employee-based pension, or widowhood for example, which often leads to a loss of income and potential social isolation.

Parker and Pant (2009: p. 97) state:

> A major factor contributing to women's poor health in Nepal is the patriarchal nature of Nepalese families. Practices relating to marriage and family life are clearly gender defined in Nepal and the roles of men and women within families are stereotyped. Women have a lower status in economic, social and family hierarchies. Women's roles have been fixed and limited within a private place not in the public arena. Women are disadvantaged and domesticated according to Nepalese tradition and as a result they are subservient to men in all aspects of life.

A recent study on healthcare utilisation and needs in Bhakptapur in the Kathmandu Valley suggested women had more unmet needs than men and that these unmet needs increased dramatically with age (Kshetri and Smith, 2010). Women also suffer disproportionately from low literacy rates compared to men, within a society in which literacy levels can be very low, estimated at 41.7% in the early 2000s, and for older people it has been reported as being a shocking 27% for males and a dreadful 4.07% for older females (ibid). There is also an urban–rural disparity that means that literacy levels can be abysmal for females in remote rural areas, especially something that Parker (2005) addressed within the action research that formed her PhD thesis.

In other words, women in Nepal face a complex of difficult and interwoven problems, problems that can be worse for older rather than younger women as elements of modernisation occur for younger women, in urban areas in particular. To these problems must be added the impact of the People's War upon Nepali society, a war that has been estimated to have cost 12,000 lives and led to the displacement of 100,000 people (BBC, 2011a). Much of this impact has a gendered dimension with, arguably, women suffering more from the social and economic disruption that war causes, such as disruption to family support systems including support at childbirth, and forced emigration from the family home. For older women, such issues are compounded by the dependency structures inherent in the society in which they were brought up. Parker and Pant (2009: p. 98), for example, related a study in the Kathmandu valley by Chalise et al. (2008) that found that older men are more likely to receive social support than do older women. "The authors felt that traditional ideals which dictate that women should be shy, patient, good, sequestered, devoted, faithful, and restrained may explain this difference" (ibid). Further, as Kansakar (n.d.) notes: "For many older women when their husbands died all of a sudden, they even faced the problem of survival if sons refused to take care of them. Older women who had never worked outside home were then forced to find work. This is equally difficult in that employers are usually reluctant to hire older women".

Vulnerable or Active Aging?

One of the themes that is emerging in this book is the contrast between vulnerable aging and active aging. Kansakar (above) shows that women can be especially vulnerable in their old age due to a complex of reasons centred upon patriarchy and

poverty in Nepalese society. In ancient China, "why water another man's garden" was one phrase used to justify not investing in the education of female children, children who would marry and move into the patrilocal residence with their husband; hence, the "watering" would be for the benefit of the husband's family, not one's own. The situation is similar in Nepal where, as noted above, literacy rates are highly gendered, especially in the older population due to historic norms. There are also the marked contrasts between urban and rural levels of illiteracy, as in other societies, with illiteracy being a feature of rural society. The result of this is that:

> Low levels of education and literacy needs to be taken into consideration when designing policies to meet the needs of the elderly and appropriate means of communicating with the elderly. Depending on written media is not enough; other more visual and oral forms of communication need to be incorporated into dissemination strategies (Parker and Pant, 2009, p. 98).

So vulnerability can come via dependency on the male, who will increasingly die before his wife as the global pattern of aging unfolds in this country, via illiteracy, lack of access to employment and another factor is differential migration, compounded by the recent conflict. Rural–urban migration is a feature across the globe and can leave rural villages vulnerable due to a lack of labour at key times, of planting and of harvesting in particular. In Nepal, as elsewhere, the older population becomes increasingly residual and female. Village life that was once full of cultural resonance and meaning becomes "hollowed out" with the lack of younger people to engage in cultural practices and traditions. A vicious circle occurs in which those who are left have to work harder and harder to sustain the local environment and may thus themselves seek to leave, as Parker and Pant (2009) note. Remittances from the young people in the towns, cities or overseas can suffice to sustain the local economy, but the distorted demographic structures in the village mean that environmental and agricultural sustainability becomes ever more difficult.

Gautam (2008) conducted an in-depth study of the impact of migration on older people in the Galkot area (Kandebash VDC). Among other points, Gautam notes that:

> The old-age couples are now looking after the empty homes waiting for children in the hope of meeting each other and staying together sooner or later in the future. [however] Young and adult migrants are largely moving for economic reasons. They [can] afford various modern facilities (television, mobile cell, car, motorbike, computer, internet, readymade clothes etc.) and take food and breakfast prepared in standard hotels and restaurants in foreign countries. While they return back to their villages, they feel various difficulties including consumption of modern utilities. Migrants' level and pattern of consumption are changing continuously. Their expectation towards the future of their children is found highly increased. They, therefore, focus [on] their spouse and children rather than old-age parents. On the other hand, migrant's wife living at home convinces her husband move to urban centres leaving old couples at home. Migrant is unable to reject his spouse and suggests her to stay in urban centres educating their children. Thus old-age couples are being alone in villages. This circumstance is leading [to] the old-age couples face physical and mental problems (pp 149–50).

It would seem that it is often the mental side of separation that is in many ways the hardest to bear. Gautam found that the vast majority of older people left in the village suffered from anxiety, extra burden, helplessness and "loneliness feeling".

They become anxious because whenever they hear about extreme events such as accidents, murder or fighting happening in distant locations, they imagine that their children are involved. This leads to sleeplessness and stress. The extra burden is found due to the wide range of private and public activities that they are now compelled to do in lieu of their offspring, including "kitchen works, animal husbandry in shed, compulsory labour contribution in social and public activities, member of wedding party, a mourner at a funeral, helping everyday activities to neighbour, participation and performance of cultural activities. The leader of social and developmental activities often talk about rejecting old people in labour contribution because they are physically weak and cannot contribute as other young labour force" (Gautam, 2008, p. 157), and this leads to even more shame and a feeling of humiliation. They feel helpless due to the loss of their children for "we raise children but no one is with us now" (ibid., p158—in Nepali, *chhora chhori payo, hurkayo, badhayo, aakhir kehi pani chhaina*). This coping with absence leads to feelings of loneliness even if both members of the couple are present; imagine the loss when one of them dies. In all, Gautam suggests that:

> Ninety percent of the couples are feeling unhappy while living alone at home even though they have cash support. Hundred percent old couples expressed their views that they would feel happy if the whole family members were together. Most of the couple's eyes were wet with tears while talking about their son in foreign cities (ibid., p. 157).

Not surprising, therefore, that in the face of such heart-rending situations, 59% of these older couples expressed a desire to leave the village for an urban centre, even though they had lived there all their lives.

Despite such problems in a rural setting, vulnerability may also be encountered in a completely different setting, namely an urban care home. Given the widespread expectation in Nepali society that family members will look after their older parents, there is considerable stigma associated with being a patient in a care home, with "Older people in old people's homes in Nepal are perceived by the wider society to have families who do not care for them, hence they are totally marginalized" (Parker and Pant, 2011). These authors cite several studies that show, for example, that there is a higher level of parasitic infection in the government-run old people's home than in privately run homes, or in the community, and that there are growing questions in the local media concerning the poor quality of care homes in general. Although data are hard to assemble, the Nepal Participatory Action Research Network (NEPAN, 2008) has identified that across the country there are 50 day-care centres, 20 old people's homes and over 100 clubs for older people, run by over 50 different organisations. Likewise, the Geriatric Centre Nepal (GCN) in 2010 estimated about 70 such organisations as being engaged with older people, with around 1,500 in all living in old people's homes, a category that excludes those in community hospitals. Whatever the figures, all are agreed that such homes are set to increase in future, due to the changes that are working through Nepali society.

In common with other Third World societies, another aspect of vulnerability is poverty, in part as a result of the lack of pension provision within societies where it was expected that sons in particular would look after their aging parents, and that

parents would reside with their sons or daughters. With emigration, whether to the growing towns and cities, or to overseas locations, the latter is more and more infrequent; therefore, a basic income for older people becomes more and more necessary as they are required to live in separate households. Parker and Pant (2011) cite studies that show, for example, that the official government pension is given to only 7% of the population, mainly former State employees such as civil servants or soldiers. They note that:

> The government is currently preparing legislation that will address the basic fundamental right of the elderly, including rights to pensions and health care provision. Following the Madrid Plan of Action, the government has formulated a National Plan of Action in its Tenth Plan (2002-2007) for senior citizens (Dahal, 2007).

More recently, addressing the UN Commission on Social Development in February 2011, Deputy Permanent Representative of Nepal, Mr. S.D. Bairagi, noted the strong commitment of his country to the eradication of poverty in general, and as far as older citizens were concerned, to social security for senior citizens in general and widows in particular, plus the Health Centre for Elderly People Programme which "aims at providing appropriate care, medical treatment and attention to the conflict-affected elderly citizens" (Bairagi, 2011).

The Role of the International Community

Mr. Bairagi concluded his statement noted above by declaring his country's need for enhanced support and cooperation from the international community in order to complement Nepal's development efforts. This is also a theme found in Parker and Pant's research. Nepal is a small country for which aging is a recent phenomenon, therefore international engagement in this area is particularly welcome. This has already begun with many overseas embassies and NGOs being involved in different facets of Nepali governance, including support for political parties to build up their networks and knowledge base, including an emphasis on the parties becoming more socially inclusive to help combat gender, caste or other types of inequalities in Nepal (Wild and Subedi, 2010).

In similar vein, undertaking research via the Norwegian Embassy, Hattleback (2008, pp. 23–4) believes that:

> In addition to a subsidized health service, different types of social-security nets will be beneficial. A good security net will target people who otherwise are not able to participate in normal economic activities, whether it is due to caste-based discrimination, or disabilities. One will have the choice between general programs, like old-age pensions, and targeted programs, like the land-redistribution program for the ex-Kamaiyas. General programs are costly as economically productive people may get incentives not to work so hard, and even rich countries are now rolling back some of the most expensive general social-security programs. Targeted programs are, in fact, hard to target as the needy are not always easy to identify. However, in the Nepali context it may be easier than elsewhere, as specific castes and ethnic groups are discriminated against socially and economically.

There is an Association of more than 70 International NGOS (AIN) that includes, for example, such NGOs as Oxfam, Save the Children, Habitat International and the WWF. They have developed a poster that lists guidelines for how they should work in Nepal (AIN, 2010). This is especially important given the complex political environment in that country. For example, they note the importance of such principles as Common Response in which they are all "working for poverty reduction, sustainable development, and protection and promotion of human rights", being Grounded in civil society in which "we honestly represent and respect the interests of the members of civil society we work with and they actively participate in the development, implementation and evaluation of our programs" and having Longer term partnerships "to assist communities and organizations develop their capabilities to improve the implementation and sustainability of their programs" (ibid.). Given the political sensitivities of their engagement in Nepal AIN held a meeting with the Prime Minister in January 2011 to help clarify how they should operate within the country. The meeting was deemed necessary by AIN due to the difficulties in resolving the nature of local partnership agreements (AIN, 2011) and is a pointer to the danger of international agencies being seen to ride roughshod over local sensibilities, especially in a small poverty-stricken country such as Nepal.

To avoid treading on local toes, partnership will be important, for instance with NEPAN, the Nepal Participatory Action Network that was founded some years ago in 1995. As Parker and Pant (2009, footnote 2, p. 102) note:

> NEPAN envisages a situation in Nepal where the poor and underprivileged people become the main focus for sustained, equitable and humanistic development. It promotes and facilitates participatory development approaches for the empowerment of the people through research, advocacy, lobbying and capacity building activities.

NEPAN is, among other activities, promoting the Nepal Age Demands Action agenda, which recommends that the Nepal Government:

- commit to fulfilling all the clauses of the Senior Citizens' Act on Aging and ensure the full participation of older people in its monitoring and implementation
- commit to funding primary healthcare for older people
- reduce the social pension age requirement from 75 to 65 years
- introduce a plan to prevent and punish social discrimination of older people (ibid., p. 104).

Through the combined action of NEPAN, AIN, the Nepal Government and foreign governments and corporations working together, aging in Nepal can be more fully researched, understood and appropriate policies developed to assist in supporting the growing numbers of older people. Many of these older people will need little in the way of support to maintain their active and independent lives, but others will require voluntary, public and private sector involvement, as in other countries, to ensure that their vulnerability to the impact of poverty, ill-health and social isolation is minimised. Nepal is a country that attracts enormous good will from other countries and other peoples. It will be important that this international good will is harnessed and linked effectively to local agencies in order to ensure that aging in Nepal can be a success story as it develops further in the future.

Chapter 8
Aging in South Africa

All the countries in our sample have witnessed great changes in the last century or so. Arguably, however, the changes in South Africa have been the greatest of all. The country witnessed the full force of a horrific apartheid regime and the armed struggle to overthrow it. That this has been done successfully is in large part testimony to the example provided by Nelson Mandela who came out of prison in Robben Island not hell-bent on revenge on his captors, but instead hell-bent on building a new country in which racism has no part. If you were born as a White Afrikaaner in 1930, you were born into a White society that saw itself as superior to the Black society around it. Your ancestors were involved in the Great Trek north and fought the British in the Boer Wars, and your parents were involved in beginning the apartheid regime of separate development for different races in the 1930s. You could not envisage that Black people could run their own farm successfully, never mind the country. And yet after all the hatred and all the conflict, you have been won round and you and your family are now prospering in the new South Africa. Nelson Mandela even wore the shirt of the *Springbok* South African rugby team when they won the Rugby World Cup in 1995. Your country still faces problems, but you now have a different view of Black people, and a (sometimes grudging) acceptance that this is their country just as much as it is yours.

Is this you, or your other White relatives? Or were you a Black woman born in poverty in Soweto in 1930, who faced the full horrors of the apartheid system including the Sharpeville massacre in 1960? Many of your family suffered terribly in the ensuing decades, but you voted in the historic elections of 1994, and 16 years later, you applauded the *bafana* South Africa Football Team in the FIFA (Soccer) World Cup of 2010. Although you were disappointed that they didn't get past the first round, you appreciated the chance to show your country off on the world stage, *vuvuzelas* and all. Desmond Tutu's Truth and Reconciliation Commission has helped heal the emotional wounds from the apartheid era, although scars still remain. Nowadays, you still have worries about your family, the often high level of violence in the area, and the impact of HIV/AIDS on the younger generations. But it is now your country, and you and your relatives will work hard with all sectors of society

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to overcome the negative legacies of the past. To you, and many others, Nelson Mandela is a saint and you will weep when he is gone; but you will also appreciate the contribution of him and many others to the ANC-led (African National Congress) struggle against apartheid.

Aging in an Unequal Country

South Africa's Census was held in 2011 and data are still being processed, therefore the Government of South Africa (2010) is the most recent detailed statistical data, based on sample cohorts. This publication shows, for instance, that the population of the country is just under 50 million, distributed across a number of provinces, many with post-apartheid names such as the most populous Gauteng centred on Johannesburg with 11.2 million people (22.4% of the total population), Kwazulu/Natal with capital Pietermaritzburg is next with 10.7 million (21.3% total) or other provinces such as the smaller Mpulamanga focused on the smaller city of Nelspruit with 3.6 million in all. Government data show that 7.6% of the population is aged 60 or over, with 1.6% aged 75 or over. Life expectancy is a low 53.3 years for males and 55.2 years for females. Table 8.1 shows, however, some of the key changes in demographic data in recent decades. Life expectancy for males and females peaked in the early 1990s at 62 for males and 68 for females. It plummeted in the early 2000s to 44.6 for males and 46 for females, with some recovery in recent years to the 50s. This decline was due to the rapid onset of HIV/AIDS that has had a huge impact on the country, along with others in Africa, contributing massively to the high death rates shown in the bottom row and last two columns of the table.

The scale of infection by HIV is massive. The Government Office data for 2010 show that, for example, the HIV prevalence rate is 10.5% of the total population, with 5.24 million estimated to be HIV-positive, although some unofficial estimates go as high as seven million. Among adults aged 15–49, the rate is estimated officially to be 17%. New HIV infections were reckoned to be 410,000 in 2010, with 40,000 of these in children. Government statisticians estimate that 1.6 million people aged 15 or above, plus 183,000 children, would need antiretroviral therapy (ART).

Table 8.1 South African demographic data, 1980–2010

Data	1980	1990s	2000s	2010
Total population (million)	24.9	41.7 (1994)	46.6 (2004)	50
Male life expectancy (year)	60.9	62.0 (1994)	44.6 (2003)	53.3
Female life expectancy (year)	63.9	68.0 (1994)	46.0 (2003)	55.2
Percent aged 60–74	5.2	4.7 (1990)	5.5 (2001)	6.0
Percent 75 or over	1.2	1.3 (1990)	1.8 (2001)	1.6
Birth rate/1,000	16.5	34.0 (1994)	19.7 (2003)	21.3
Death rate/1,000	8.3	8.0 (1994)	19.3 (2003)	13.9

Source: Encyclopaedia Britannica (1985–2011)

Those adults actually receiving ART increased from 133,000 in 2005 to 920,000 in 2009, with children's percentages increasing from 7 to 38% in the same period. Children of HIV-positive mothers cannot be diagnosed with HIV until aged 18 months due to the presence of antibodies in their mother's blood, but they are recommended to receive the drug cotrimoxole as a precaution, and then as a definite treatment if they are so diagnosed. Two percent of children received this drug in 2005, increasing to 29% in 2009. The Government website states that they assume UN estimates for the median time of death from HIV infection as 10.5 years for a man and 11.5 years for a woman. The percentage of HIV-positive women is high, and "Approximately one-fifth of South African women in their reproductive ages are HIV positive" (ibid, p. 6). AIDS deaths were approximately 198,000 (37.6% of all deaths) in 2001, 314,000 (47.5% of all deaths) in 2005 and then a slight reduction to 281,000 (43% of all deaths) in 2010. The scale of death in young and middle-aged adults means that there are now nearly two million AIDS orphans in the country.

The government website gives a detailed breakdown of age data against ethnicity, and this is summarised in Table 8.2. The categories for ethnicity are African, Coloured, Indian/Asian and White, with totals of 79.4, 8.8, 2.6 and 9.2% of the total current population, respectively. From the Government data, we have calculated the percentage of the total ethnic group in that category, whether male or female. Thus, only 5.1% of all African males are aged 60 or over, whereas 18.6% of White males are within this age cohort. The contrasts increase across the table as can be seen, with 22.0% of White females being aged 60 or over. Indeed the percentage of White females aged 75 or over is higher than the percentage of African males aged 60 or over, at 5.9% compared to 5.1%. Given that ethnicity is in effect a surrogate variable for wealth, and despite there being wealthy Africans and poor Whites, one can see from the data that there is diverse longevity, linked to poverty levels, across the ethnic divides. Such diversity is long embedded, and writing during the apartheid regime Potts (1985) showed the high levels of poverty, infant mortality and diseases such as pellagra, kwashiorkor or tuberculosis in the *Bantustans* in which the Black Africans were concentrated. There were also significant contrasts within South Africa's urban areas between the different ethnic groups. She provides a table (p. 6) that shows, for example, that the Black population with 72.5% of the total population in 1980 earned only 26% of national income in 1977 compared to Whites with 15.6% of population 1980 and 64% of national income 1977.

In the face of such a scale of crisis among Black South Africans in particular, it is clear that international assistance must be a crucial part of the response to these health inequalities. We concur with the view of Kates and Lief (2006, p. 2) that "analyses indicate that if effective HIV prevention programs, coupled with treatment, were truly brought to global scale, and on a sustained basis, millions of future infections could be prevented and HIV-related mortality reduced". These authors summarised the situation at that point in time, noting, for example, that international assistance had grown from $1.6 billion in 2001 to an impressive estimated $8.3 billion in 2005, but that financial needs of low-income countries faced by HIV/AIDS would rise to $22 billion by 2008. There was an important role for President George

Table 8.2 Age by ethnicity, including percentage of ethnic group, 2010

Age	African male	African female	Coloured male	Coloured female	Indian/ Asian male	Indian/ Asian female	White male	White female
60–74 (‘000s)	808.6	1092.5	117.3	154.6	54.2	64.1	332.3	376.2
60–74 as percent ethnic group	4.2	5.4	5.5	6.7	8.4	9.8	14.8	16.1
75+ (‘000s)	179.8	300.3	22.6	40.4	11.8	17.8	84.1	138.5
75+ as percent ethnic group	0.9	1.5	1.1	1.8	1.8	2.7	3.7	5.9
Total by ethnic group and gender, (‘000s)	19314.5	20.368.1	2,124.9	2299.2	646.6	653.3	2243.0	2341.7
Total percent ethnic group	5.1	6.8	6.6	8.5	10.2	12.5	18.6	22.0

Source: Government of South Africa (2010)

Bush's PEPFAR (President's Emergency Program for AIDS Relief) initiative, announced in 2003 as a $15 billion 5-year programme, and:

> Other recent initiatives include the U.K.'s International Finance Facility (IFF) proposal; the French "solidarity" levy on airline tickets, which took effect on July 1 of this year and seeks to raise funds for the International Drug Purchase Facility, or UNITAID, for the purchase of bulk medicines for HIV, TB, and malaria; proposals to create Advance Market Purchase Commitments for vaccines and other technologies; and Japan's announcement in 2005 of a new "Health and Development Initiative" which provide $5 billion over five years to help developing nations fight infectious diseases, including HIV/AIDS (a successor to Japan's Okinawa Infectious Diseases Initiative that ran from 2000–2005) (ibid., p. 5).

The work of the Bill and Melinda Gates Foundation was also thought worthy of mention for the scale of private philanthropy involved. Since then, however, we have had the global recession that features so widely in this book, so what of the situation at the time of writing? Have the promises of aid been met, and what is the likelihood of assistance in a time of austerity? We can turn to the World Health Organisation (WHO) website to answer some of these questions. They show that, at least from 2000 to 2009, Official Development Assistance (ODA) increased globally by 202%, from around US$6.7 billion to over $20 billion (World Health Organisation, 2011a). Sixty-two percent of commitments were to tackle Millennium Development Goal (MDG) 6, which includes reduction of HIV/AIDS plus malaria and other communicable diseases. In terms of ODA for South Africa, this was $595.7 million in 2009 (World Health Organisation, 2011b), compared to $218.8 in 2005 and only $90.8 million in 2002. Further, in 2002, only about one third of ODA was for MDG6, but this had risen to around 80% of ODA by 2002 and around 96% by 2009. As the Director-General of WHO noted in an address to the London research centre Chatham House in June 2011, "The number of people in low- and middle-income countries receiving antiretroviral therapy for AIDS moved from under 200 000 in late 2002 to nearly 7 million today. The number of under-five deaths dropped to its lowest level in more than six decades" (Chan, 2011). However, she continued that:

> As the drive to reach the goals taught us, commodities, like pills, vaccines, and bednets, and the cash to buy them will not have an impact in the absence of delivery systems that reach the poor. When the overarching objective is poverty reduction, if you miss the poor, you miss the point.
>
> In my personal view, one of the biggest bonuses of all this progress came in the form of a frank realization, in the large single-disease initiatives, in the Global Fund, in the GAVI Alliance, that goals cannot be reached and progress cannot be sustained in the absence of well-functioning health systems (ibid.).

In South Africa, as elsewhere, therefore, it is not just about financial resources, important though these are, it is also about ensuring that healthcare delivery systems are fit for purpose, even in the face of the scale and magnitude of South Africa's HIV/AIDS threat.

Aging, HIV and AIDS; the Old as Carers

Within this book, we have seen examples of older people confounding aging stereotypes. One aspect of this is that older people often offer care to their grandchildren instead of being given care themselves. The decimation of a generation in South Africa, as in other countries of sub-Saharan Africa has meant that older people, grandmothers especially, have had to take over caregiving for their orphaned grandchildren. Schatz and Ogunmefun (2007) conducted a study in a rural area of multigenerational households, interviewing grandmothers in households that had experienced HIV/AIDS deaths, deaths from other reasons, and no death households. They show that:

> It is not just the epidemic proportions that make HIV/AIDS different from other diseases, however. The age and gender structure and long duration of the illness make the effects of HIV/AIDS on individuals, families, and communities much different than other diseases common in Africa. For the elderly, the primary experience of HIV/AIDS is through their interactions with kin who are at risk and who are sick, rather than through their own risk or sickness. Thus, the elderly are more likely to be *affected by* rather than *infected with* HIV/AIDS (p. 1390).

The authors show how important is the state pension to these households, with the pension becoming a key feature of the household budget, as a means of survival given the death of the wage-earning middle generation. Sagner (2000) shows how the means-tested pension was introduced for Whites as far back as 1928, and because it was to be given to Whites, it was also provided for Indians/Asians and for Coloureds at that time. Sixteen years later, it was also given to Black Africans. Sagner shows that it was introduced largely as a means of consolidating support for Government from poor Whites who were the main beneficiaries of this welfare policy. Extension to Blacks was at a lower rate, and there was a differential rate of pension between urban and rural Blacks; it was not until after the end of apartheid in 1994 that equalisation of these pensions took place. Pelham (2007) draws upon Sagner's work to show that the pension provision increased social solidarity, valued older people more than previously, and helped ameliorate inequalities. Even though the pension is not large (roughly US$95 per month), it nonetheless has become the largest item in the welfare budget, via the Department of Social Development, totalling approximately US$1.6 billion in 2006. The benefit was double-edged, however, for it helped South African mine-owners to keep wages of Blacks down; it also became a useful means of social control in the Bantustans during the apartheid era.

Despite these latter criticisms, for rural grandmothers it has become vital, as Schatz and Ogunmefun note:

> the older women in our study are using their pensions for much more than their own subsistence. For example, Thandazile, who together with her husband supports 12 people, including seven grandchildren, four of whom are AIDS orphans, said, "Now that I am getting my pension, I am able to look after my children and grandchildren" (HIV/AIDS Household). Our respondents generally did not see their pensions as money meant specifically for their own upkeep, but rather as a subsidy for the household as a whole, or at least for themselves and their grandchildren (p. 1392).

These women will pool their pensions with other household income to buy household necessities rather than luxuries and would generally be critical of other women who kept their pensions purely for their own use. It is suggested that old men, in contrast, are less likely to utilise their pensions in this way and more likely to purchase cigarettes or alcohol for personal use. Despite the pension, however, this is life just above a subsistence level, with no leftovers and no extras; welfare would need to be additional in order to lift the household beyond this level. The South African Government has indeed sought to do this in recent years as will be discussed further below.

Exploring the Legacies of Apartheid on the Old

Working for the OECD, Stewart and Yermo (2009) have conducted a major analysis of pensions across Africa. As regards South Africa they note that the means-tested pension discussed above is non-contributory and provided to women at age 60 and men at 65. It reduces to zero when income reaches a threshold point, just under 2000 Rand per month at the time of their analysis. They note that 75% of retirees receive most or all of this pension, and this income "provides a reasonable replacement rate to lower income workers who reach retirement age as well as acting an important source of poverty relief for those who are unemployed through most of their working lives. Originally, in the Apartheid era it was introduced to cover small numbers of low-income, White workers, but was gradually extended to all South Africans, with parity payments for all ethnic groups achieved in the 1990s" (p. 28). There are also occupational and private pensions available and "The South African government is currently undertaking extensive reforms of the system to improve both the depth and coverage of pension benefits" (ibid.).

They note that most employees in the private sector are in "defined contribution" (DC) schemes whereas those in the public sector are mainly "defined benefit" (DB) arrangements. Large trade unions offer their own DC schemes, and in all Stewart and Yermo identify a proliferation of pension funds, 13,700 by 2004, covering 9 million people and having R1.1 billion in assets. Retirement Annuities are also available. It is clear that reforms are necessary and they note (p. 29) that Government:

> reform proposals include the introduction of a contributory social security pillar as well as (where applicable to persons) supplementary mandatory contributions to the private retirement funding arrangements in order to improve the coverage rate and tackle 'leakage' problems (early withdrawals leading to substantial sums of money being taken out of the funded pension system). The primary objective of this reform is to ensure a basic level of income during retirement for all South Africans.

As an update to this, Government Ministers and opposition politicians have begun to raise the possibility of a universal pension (i.e. not means-tested due to the stigmatisation that this entails, but one that must therefore have mandatory contributions in lieu); see Willmore (2011) for further details. One issue that has arisen is that pensions can be used for political patronage and as a means of ensuring political

allegiance, and there is some concern that this is happening today just as it happened when the pension system was established in the 1920s. There are also worries that the country's financial resources are being usurped by those in power, worries that led Zwelinzima Vari, General Secretary of COSATU (Congress of South African Trade Unions), to state in 2010 that South Africa had become a "dysfunctional" country that was "heading rapidly in the direction of a full-blown predator state in which a powerful, corrupt, and demagogic elite of political hyenas increasingly controls the state as a vehicle for accumulation" (Legassick, 2011, p. 463).

This rather extreme view is difficult to assess. Certainly, the budget of the Social Development Ministry is now enormous, at just over R86 billion in 2009–2010, so there must be possibilities for graft with such large sums involved. However, these sums offer succour to millions of people, and their most recent annual report (Government of South Africa, 2011) for the year 2009–2010 shows that they extended the Child Support Grant to 18-year-olds (previously 15-year-olds) which brought in an extra 9.1% of children into this safety net, while as regard older people they equalised the age at which people received the means-tested pension, to 60 years instead of 65 years for men. This meant that in 2009–2010 more than 198,000 men were provided with such pensions, a total of 2.55 million in all.

In terms of satisfaction with life as an older person, Moller (2011) and her colleagues have conducted a longitudinal study of older households (defined as 55 years or over) in Western and Eastern Cape in 2002 and 2009 (comparative studies have also been conducted in Brazil for 2002 and 2008) for rural Blacks, urban Blacks and urban coloureds, both the latter in Cape Town. There were around 1,000 in each time sample, with around 79% overlap from 2002 to 2009. The main research questions were "Does the income from the old-age pension and other social grants enhance the material and perceived well-being of social pensioners and members of older households? Do social grants give a "hand-up" to self-reliance, or do they promote dependence on handouts?" (p. 7). The study found not only higher living standards in 2009 compared to 2002, but also a corresponding higher level of satisfaction with life in 2009 compared to the earlier date. Urban Blacks had improved their economic situation to a level near to that of urban coloureds, but it was rural Blacks for whom the situation was most difficult. They remained most dependent on the pension provision, and also the most vulnerable but overall "results from our study suggest the social grant system and other social assistance make the difference between fortune and misfortune for vulnerable households" (p. 9), thus corroborating the other studies cited above.

It is worth citing some of the data from Moller's surveys. In terms of the broad profile of respondents in 2009, rural Blacks were more likely to have received no education (19.6%) and less likely to have had higher education (3.2%) compared to urban Blacks (8.7% none and 5.3% HE respectively) or urban coloureds (3.9% none, 9.3% HE). Incomes were similarly different with average monthly incomes in Rand being 1489.4 for rural Blacks compared to urban Blacks (2621.8) and urban coloureds (2227.9), with the higher rate for urban Blacks partly reflecting the fact that only 34.6% of this group were reliant on the means-tested pension discussed above, compared to 42.9% of urban coloureds and 53.8% of rural Blacks. Households

Table 8.3 Contrasts in quality of life, 2009 survey, and select comparisons with 2002

	Rural Blacks		Urban Blacks		Urban coloureds	
Answer to question	2002	2009	2002	2009	2002	2009
Very satisfied/satisfied with current household situation		29.7		32.5		84.5
Very dissatisfied/dissatisfied with household situation		42.6		51.9		6.9
Things will be better in 5 years time		42.6		49.8		45.3
Things will be worse in 5 years time		32.3		34.6		26.2
Financial situation now very good/good		7.5		16.0		29.8
Financial situation now very bad/bad		48.5		50.9		18.3
Pension/social grant ensures we are better off		30.6		22.5		17.6
Worse off due to inflation/ price increases/recession		40.6		21.8		60.4
Life now very satisfied/satisfied	9	28.9	11	43.4	56	86.2
Life now very dissatisfied/dissatisfied	88	34.8	70	43.4	10	5.7
Family relations key in QoL		35.5		30.2		41.5
Shelter/roof over one's head key in QoL		22.2		20.4		(1.6)
Financial security/material well-being key to QoL		18.3		22.2		(1.7)
Other key factor, community						10.8

Source: Moller (2011)

were generally around the same size, at six persons, and around 60% of respondents were female. Rural Blacks tended to live in traditional dwelling huts (80.7%), while 67.1% of urban Blacks lived in detached dwellings on separate stand compared to 83.3% or urban coloureds. A high proportion of rural Blacks were born in the area (87.5%) compared to 26.9% of urban coloureds and only 2% of urban Blacks, presumably a reflection of the end of apartheid and the consequent freedom to move to the cities. One key finding of the survey in 2009 was that over 60% (64–68%) of Blacks, both rural and urban, had suffered financial difficulties in the last 3 years, compared to 31% of urban coloureds (p. 19). Urban Blacks, however, had more financial resources to deal with such eventualities; in rural areas, over half the income was on food and lower incomes obliged many respondents to run up debts with local grocers when times were bad. Likewise, only a tiny fraction of rural Blacks had access to tobacco, alcohol or entertainment, in line with the work of Schatz and Ogunmefun cited previously. Despite such income restrictions, compared to the results for 2002, fewer households in each group had debts in 2009; therefore progress had been made during the decade (see Moller's Table 8, pp. 20–21, for details), while housing conditions had also improved over the intervening years.

As regard satisfaction with varying aspects of quality of life, Table 8.3 contains data selected from several of Moller's tables. They provide fascinating contrasts over time and space, and by ethnic categorisation. And so, as Table 8.3 shows, urban coloureds in 2009 are most likely to express the view that they are very satisfied/satisfied with their current household situation, and least dissatisfied. Similarly,

a higher percentage of this group is likely to say that their financial situation now is very good or good, and less likely to say that it is very bad or bad. The pension social grant is important to ensure that rural Blacks are better off, with 30.6% stating this as a factor, but for urban Blacks the job market is more important. The latter group is less likely to state that they are worse off due to inflation/price increases/the recession, compared to rural Blacks, and especially urban coloureds. There are some negatives in these findings, but compared to the year 2002, as the appropriate highlighted rows of the table show, there is a marked change in satisfaction levels with higher levels of positive satisfaction and lower levels of dissatisfaction as can be seen for all groups. When asked to list three factors key to quality of life, all groups highlighted family relations to the greatest percentage, while for Blacks, regardless of whether rural or urban, the need for shelter/having a roof over one's head was another important factor, no doubt in part as a response to freedom from the iniquities of the apartheid era. Likewise, financial security/material well-being received significant mentions, but for the well-embedded urban coloureds these were relatively unmentioned, and for them it was "community" that was another important answer. Moller explains the high percentage of urban Blacks, 50.9% giving the answer of their financial situation being very bad or bad as being due to the high expectations and mixed employment fortunes of Black migrants from the Eastern Cape to Cape Town, but despite this viewpoint, she concludes that nonetheless there is a "tentative" finding that they are catching up with urban coloureds and that they are now more likely to have middle class expectations than before. Despite the current pressures, therefore, the apartheid era for this group at least is a long way away.

Chapter 9
Lessons to be Learned

The multi-faceted problems that an increasingly aging population is presenting, at a global level, are the theme throughout this book. The justification for selecting certain countries as the focus of the research was influenced by contemporary social and economic indicators that are associated with the problem occurring at a significant time in the world's current economic climate.

As it was discovered, each country selected faced different challenges when dealing with aging. The first chapter examined how the issue of aging is addressed in the United States. What is interesting to learn about this country's approach to the dilemma of an increasingly aging population is the healthcare system's shift from private to public. This is a similar situation to that of the United Kingdom, but for different reasons. The health system in the United Kingdom remains public, but as the research revealed there are to be massive changes in the National Health Service and one of the reasons why this is the case is the growing pressures on state provision that an increasingly aging population places.

In the case of Sweden, it was found that the country's increasingly aging population is one of the highest in Europe, along with that of France. This situation was acknowledged and established long before other countries. Japan has also had a long history of the problems that an increasingly aging population presents. One of the main challenges to Japan is the state pension system and the drain that this places on the country's economic stability. For China, one of the issues that came out was the historical impact of the single child family programme. Whereas Nepal is perceived to have a new aging society, this development is recognised by the international community. Finally, South Africa has challenges to longevity in the form of HIV and Aids.

As we have seen throughout this book, the worries concerning financial support for older people, in particular the "oldest-old", remain. At the time of writing, the economic outlook is gloomy, with concerns that the world is entering a double-dip recession that will be extremely painful for many to bear, especially given the impact of the last recession on mortgage provision and incomes. For the first time, the United States economy has lost its AAA rating of credit-worthiness from the rating agency

I.G. Cook and J. Halsall, *Aging in Comparative Perspective: Processes and Policies*, International Perspectives on Aging 1, DOI 10.1007/978-1-4614-1978-5_9,

Standard and Poors and the Eurozone is under pressure with fears over the high levels of debt spreading from Greece, Ireland and Portugal to include Spain and Italy. The "Asset Market Meltdown" discussed by Kihara (see Chap. 5) could become a reality, and the pressures on welfare provision are intense, with a view to cutting the public-sector deficit in many countries. It was the deep division between Tea Party republicans and President Obama over the size of the US debt that led to the last-minute resolution of the budget in 2011, with neither side being fully satisfied with the outcome. Standard and Poors regarded this last-minute decision making as unacceptable, leading to their downgraded rating for the US. In this context of economic downturn and public-sector debt, we can see why decision makers will worry about the resources that the growing number of older people will require. Nevertheless, we argue that support for the vulnerable old is a mark of a humane and caring society. Markets decline but they also rebound, and pension schemes around the world still control trillions of dollars of assets that can be used to cushion the hard landing if a double-dip recession does occur. From our examination of the countries summarised above, we believe the following points to be pertinent to policy:

1. Despite ongoing and forecast financial concerns over pensions, the need for a basic state pension is paramount, as the example of South Africa shows. Without their pension, millions of families could not survive in a time of crisis. Older people in South Africa, in rural areas especially, have supported their grandchildren from their pension due to the loss of the family breadwinner to HIV/AIDS.
2. We would prefer such a pension to be universal and not means-tested. We accept that better-off older people who do not need it will thus receive a state pension, but it is a time-wasting, costly and cumbersome procedure to probe into peoples' finances in order to determine eligibility. It is also demeaning [sic] and best avoided.
3. As the example of Sweden and other countries show, pension provision cannot rely on one single type of funding, and must be multi-pillar, as in China too for example. The system must be contribution-based and the Swedish model of an income pension financed from that year's pension contributions plus a premium pension financed as a premium reserve system that is fund-financed, with pensioners receiving their annual "Orange envelope", is a sensible way of proceeding.
4. The onset of old people's dependency is not inevitable, as we have seen in a number of chapters. Old people can become dependent due to severe illness and/or income and mobility restrictions, but old people can be helped to remain active via moderate exercise and mental stimulation, as in China where tai chi can be a gentle form of exercise that brings enormous benefits, as a recent scientific analysis published in the British Journal of Sports Medicine (2011) has just confirmed.
5. Government and local government can encourage such activities via targeted funding to groups that encourage active aging (such as those noted in Chap. 2), restrictions on sales of junk food, use of noise and litter legislation to discourage unhealthy eating and other means as shown in Chap. 3.

6. We are unsure of the term “Big Society” (see Chap. 3), in part because we feel that “Little Society” at the community level is often more accurate, but can see that governments alone should not be left to provide people support. Traditionally, families and communities were important providers of welfare, and we feel that the lowest spatial and social level is often the most effective for day-to-day support of vulnerable old, and the vulnerable young for that matter. But funds must be provided, even in times of economic hardship, to support these low-level activities.
7. Stereotypes of the old still abound, even in a liberal society like Sweden, as we have shown. Then there are the counter-stereotypes that we have provided, as in South Africa or, more dramatically, in Japan for instance. Throughout this book, we have sought to avoid the term “elderly” except where it has occurred in a reference or quote because the term has negative connotations of infirmity and dependence. Society in general needs to resist such stereotypes and recognise that older people are very diverse—in their wealth, ethnicity, health level, risk-taking and other variables—just as the rest of society is diverse. We encourage all to recognise such diversity, and not to over-exaggerate the single variable of age as a causal factor in any analysis.

References

Abelson, L. G., Ackerby, S., Bergendahl, I. R., Oscarson, S., et al., (Pension Group) (2010). *The Swedish pension agreement and pension reform* (DS2009: 53, Trans.). Stockholm: Regeringskanliet. (Ministry of Health and Social Affairs).

Asian Development Bank (ADB). (1999). *Women in Nepal. Country briefing Paper*. Kathmandu: Asian Development Bank.

Association of International NGOs (AIN). (2010). *AIN recommended INGO-NGO partnership guidelines for working in Nepal*. Retrieved March 14, 2011, from http://www.ain.org.np/news_img/5qn605eyposter.jpg

Association of International NGOs (AIN). (2011). *PM assures AIN of prompt resolution of pending agreements*. Retrieved March 14, 2011, from http://www.ain.org.np/view_activities.php?id=90

Atkinson, R., & Helms, G. (2007). *Securing an urban renaissance: Crime, community and British urban policy*. Bristol: Policy Press.

Bailey, P. B. (1996). *Postwar Japan: 1945 to the present*. Oxford: Blackwell.

Bairagi, S. D. (2011). *Statement to the United Nations at the forty-ninth session of the Commisssion on Social Development*. Retrieved March 9, 2011, from http://www.un.org/esa/socdev/csocd/2011/Nepal.pdf

Barker, C. E. (2007). Support the safe motherhood programme in Nepal: An integrated approach. *Reproductive Health Matters, 17*(33), 45–50.

BBC. (2011a). *Nepal profile*. Retrieved February 25, 2011, from http://news.bbc.co.uk/1/hi/world/south_asia/country_profiles/1166502.stm

BBC. (2011b). *Sweden profile*. Retrieved April 28, May 12, 2011, from http://news.bbc.co.uk/1/hi/world/europe/country_profiles/1021823.stm

BBC. (2011c). *IMF cuts Japan Growth Forecast in Wake of Quake Damage*. Retrieved April 14, 2001, from http://www.bbc.co.uk/news/business-13045328

Béland, D. (2010). *What is social policy? Understanding the welfare state*. Cambridge, UK: Polity.

Biggs, S., & Powell, J. L. (2001). A foucauldian analysis of old age and power of social welfare. *Journal of Aging and Social Policy, 12*(2), 93–115.

Biggs, S., & Sakamaki, S. (2008). Retrieved August 9, 2011, from http://www.bloomberg.com/apps/news?pid=newsarchive&sid=as80aWlHdA1M

Blane, D. (1986). Elderly people and health. In D. L. Patrick, & G. Scambler (Eds.), *Sociology as Applied to Medicine* (pp. 153–165). London: Balliere Tindall (2nd edition).

Blömstrom, M., Gangnes, B., & La Croix, S. (2001). *Japan's new economy: Continuity and change in the twenty-first century*. Oxford: Oxford University Press.

Boddy, M., & Parkinson, M. (2004). *City matters: Competitiveness, cohesion and urban governance*. Bristol: Policy Press.

I.G. Cook and J. Halsall, *Aging in Comparative Perspective: Processes and Policies*, International Perspectives on Aging 1, DOI 10.1007/978-1-4614-1978-5,

Brindle, D. (2011). *The Big Society Horse Lives on*. Retrieved February 25, 2011, from http://www.guardian.co.uk/public-leaders-network/blog/2011/feb/24/big-society-is-bad-pr-but-its-not-finished-yet

Buerk, R. (2011). Retrieved August 9, 2011, from http://www.bbc.co.uk/news/world-asia-pacific-13598607

Butler, R. N. (1997). Population aging and health. *British Medical Journal, 315*, 1082–1084.

Cargill, T. F., & Sakamoto, T. (2008). *Japan since 1980*. Cambridge: Cambridge University Press.

Chalise, H. N., & Brightman, J. D. (2006). Aging trends: Population aging in Nepal. *Geriatrics & Gerontology International, 6*, 199–204.

Chalise, H. N., Saito, T., Takahashi, M., & Kai, I. (2008). Relationship specialization amongst sources and receivers of social support and its correlations with loneliness and subjective well-being: A cross-sectional study of Nepalese older adults. *Archives of Gerontology and Geriatrics, 44*(3), 299–314.

Chan, M. (2011). *The increasing importance of global health*. Speech to Chatham House, 13th June 2011. Retrieved June 23, 2011, from http://www.who.int/dg/speeches/2011/globalhealth_20110613/en/index.html

Chen, S., & Chen, E. Y. (2009). Active aging and China: Perspectives and issues. In J. L. Powell & I. G. Cook (Eds.), *Aging in Asia* (pp. 67–88). New York: Nova Science Publishers.

Chen, F., & Liu, G. (2009). Population aging in China. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 157–172). New York: Springer.

Choon, C. N., Kitamura, Y., & Tsui, A. K. C. (2008). The pension system in Japan and retirement need of the Japanese elderly. In L. H. Guan (Ed.), *Ageing in Southeast and East Asia: Family, social protection and policy challenges, Chapter 1* (pp. 1–21). Singapore: Institute of Southeast Asian Studies.

Cook, I. G., & Dummer, T. J. B. (2004). Changing health in China: Re-evaluating the epidemiological transition model. *Health Policy, 67*, 329–343.

Cook, I. G., & Dummer, T. J. B. (2007). Spatial and social marginalisation of health in China: The impact of globalisation. In H. X. Zhang, B. Wu, & R. Sanders (Eds.), *Marginalisation in China: Perspectives on transition and globalisation*. Aldershot: Ashgate.

Cook, I. G., & Dummer, T. J. B. (2009). Patterns and processes of longevity in Asia. In J. L. Powell & I. G. Cook (Eds.), *Aging in Asia* (pp. 173–199). New York: Nova Science Publishers.

Cook, I. G., & Powell, J. L. (2003). "Active ageing" and China: A critical excursion. *Sincronia, 2*.

Cook, I. G., & Powell, J. L. (2005). China, ageing and social policy: The influence and limitations of the bio-medical paradigm. *Journal of Societal and Social Policy, 4*(2), 71–89.

Cook, I. G., & Powell, J. L. (2007). Ageing urban society: Discourse and policy. In F. Wu (Ed.), *China's emerging cities, Chapter 7*. London: Routledge.

Cook, I. G., Halsall, J. P., & Powell, J. L. (2010). Comparative aging and qualitative theorizing. *Qualitative Sociology Review, 6*(1), 48–59.

Criag, R., & Mindell, J. (Eds.). (2007). *The health of older people. Survey of key findings. Health Survey for England 2005*. London: The Information centre, National Statistics.

Dahal, B. (2007). *Elderly people in Nepal: What happened after the MIPPA 2002 Country Report?* Macao Conference paper available via. Retrieved March 9, 2011, from http://www.unescap.org/esid/psis/meetings/AgingMipaa2007/NEPAN.pdf

Dejjevsky, M. (2006). Japan: A Country in Crisis. *The Independent*.

Deng, S. (2010). 100 mln rural China residents enjoy new pension scheme: Official. Xinhua.

Department for Communities and Local Government. (2010). *Decentralisation and localism bill: An essential guide*. London: HMSO.

DFID. (2003). *Country Strategy Paper.* Retrieved October 12, 2003, from http://www.dfid.gov.uk/Pubs/files/cap_nepal_draft.pdf

Dorling, D., & Thomas, B. (2004). *People and places: A 2001 census atlas of the UK*. Bristol: Policy Press.

Du, P., & Tu, P. (2000). Population ageing and old age security. In X. Peng & Z. Guo (Eds.), *The changing population of China* (pp. 77–90). Oxford: Blackwell.

Dummer, T. J. B., & Cook, I. G. (2007). Exploring China's rural health crisis: Processes and policy implications. *Health Policy, 83*, 1–16.
Dummer, T. J. B., & Cook, I. G. (2008). Health in China and India: A cross-cultural comparison in a context of rapid globalisation. *Social Science and Medicine, 67*(4), 590–605.
Dummer, T. J. B., Halsall, J. P., & Cook, I. G. (2011). Longevity in the 21st century: A global environmental perspective. *International Journal of Society Systems Science, 3*(4), 307–324.
Duus, P. (1998). *Modern Japan*. Boston: Houghton Mifflin.
Editor's Choice. (2010). *Q&A US healthcare reform*. Retrieved January 11, 2011, from http://news.bbc.co.uk/I/hi/americas/8160058.stm, updated March 22
Encyclopaedia Britannica. (1985–2011). *Brittanica World Data Annual: South Africa, 1985, 1995, 2005, 2011*. Chicago: Encyclopaedia Britannica.
Eriksson, B. G. (2008). Ordinal dispersion of ratings of social participation as a functioning of age from 70 years of age among the H-70 panel, Gothenburg, Sweden. *Archives of Gerontology and Geriatrics, 47*(2), 229–239.
Erlingsson, C. L., Carlson, S. L., & Saveman, B.-I. (2006). Perceptions of elderly abuse: Voices of professionals and volunteers in Sweden—an exploratory study. *Scandinavian Journal of Caring Sciences, 20*(2), 151–159.
Evans, S. (2010). Mother's boy: David Cameron and Margaret Thatcher. *The British Journal of Politics and International Relations, 12*(3), 325–343.
Evans, K. (2011). Big society in the UK: A policy review. *Children and Society, 25*(2), 164–171.
Ezrati, M. (1997). *Japan's Aging Economics*. Retrieved December 21, 2010, from http://www.foreignaffairs.com/articles/53050/milton-ezrati/japans-aging-economics
Fahey, M. R. (2010). *World affairs: China, in Britannia book of the year: Events of 2009* (pp. 382–385). Chicago: Encyclopaedia Britannica.
Fitzgerald, C. P. (1976). *Mao Tse-Tung and China*. Harmondsworth, Middlesex, England: Penguin.
Flint, J., & Robinson, D. (2008). *Community cohesion in crisis? New dimensions of diversity and difference*. Bristol: Policy Press.
Freeman, R. B., Swedenborg, B., & Topel, R. H. (2010). Introduction. In R. B. Freeman, B. Swedenborg, & R. H. Topel (Eds.), *Reforming the welfare state: Recovery and beyond in Sweden* (pp. 1–23). Chicago: Chicago University Press.
Freeman, R. B., Topel, R. H., & Swedenborg, B. (1997). Introduction. In R. B. Freeman, R. H. Topel, & B. Swedenborg (Eds.), *The welfare state in transition: Reforming the Swedish model* (pp. 1–32). Chicago: Chicago University Press.
Fujiwara, Y., Watanabe, S., Kumagai, S., Yoshida, Y., Takabayashi, K., Morita, M., Hasegawa, A., Hoshi, T., Yokode, M., Kita, T., & Shinkai, S. (2002). Prevalence and characteristics of older community residents with mild cognitive decline. *Geriatrics and Gerontology International, 2*(2), 57–67.
Fukutake, T. (1974). *Japanese society today*. Tokyo: University of Tokyo Press.
Futagami, K., & Nakajima, T. (2001). Population and economic growth. *Journal of Macroeconomics, 23*(1), 31–44.
Gale, E. A. M. (2010). Commentary. Diabetes in the UK: Time for a reality check? *Diabetes Medicine, 27*, 973–976.
Gautam, T. R. (2008). Migration and the problem of old age people in Nepal. *Dhaulagiri Journal of Sociology and Anthropology, 2*, 145–160. Retrieved February 28, 2011, from http://nepjol.info/index.php/DSAJ/article/view/1361/1337
Geriatric Centre Nepal. (2010). *Status Report on Elderly People (60+) in Nepal on Health, Nutrition and Social Status Focusing on Research Needs Report for Government of Nepal Ministry of Health and Population*. Kathmandu Retrieved June 7, 2010, from http://www.globalaging.org/health/world/2010/nepal.pdf
Goldstein, J. R. (2009). How populations age. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 7–18). New York: Springer.
Government of China (Information Office of the State Council). (2006). *The development of China's undertaking for the aged*. White Paper Retrieved January 18, 2011, from http://www.china.org.cn/english/aged/192020.htm

Government of South Africa. (2010). Retrieved June 17, 2011, from http://www.statssa.gov.za/PublicationsHTML/P03022010/html/P03022010.html
Government of South Africa. (2011). *Social Development Report 2009–2010*. Retrieved July 5, 2011, from http://www.info.gov.za/view/DownloadFileAction?id=133157
Greenhalgh, S. (2008). *Just one child: Science and policy in Deng's China*. Berkeley: University of California Press.
Haag, M. (2011). *Sweden. World Affairs. Brittanica Book of the Year. Events of 2010* (pp. 466–467). Chicago: Encyclopaedia Brittanica.
Hansard. (2011). http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110404/debtext/110404-0002.html
Harper, S., & Laws, G. (1995). Rethinking the geography of aging. *Progress in Human Geography, 19*(2), 199–221.
Hattleback, M. (2008). *Inclusive growth in Nepal*. Bergen, Norway: Chr. Michelsen Institute. Retrieved March 9, 2011, from http://www.cmi.no/publications/file/3068-inclusive-growth-in-nepal.pdf
Hayton, R. (2010). Conservative party modernisation and David Cameron's politics of the family. *The Political Quarterly, 81*(4), 492–500.
HDR. (2008). *Human Development Reports Statistics*. Retrieved February 1, 2009, from http://hdr.undp.org/en/statistics
HDR. (2009). *Build your own tables Human Development Report 2009*. Retrieved October 12, 2010, from http://hdrstats.undp.org/en//buildtables/##
Healey, P. (2007). *Urban complexity and spatial strategies: Towards a relational planning for our times*. London: Routledge.
Help Age International. (2009). *Older people and climate change*. Briefing paper and Agenda for action Retrieved May 25, 2010, from http://www.helpage.org/Researchandpolicy/Climatechange/Background
Hensahall, K. G. (1999). *Dimensions of Japanese society: Gender, margins and mainstream*. London: Macmillan.
Horioka, C. Y. (2001). *Japan's public pension system in the twenty-first century*. Retrieved July 27, 2011, from http://unpan1.un.org/intradoc/groups/public/documents/apcity/unpan030985.pdf
Horioka, C. Y. (2010). Aging and saving in Asia. *Pacific Economic Review, 15*(1), 46–55.
Horioka, C. Y., Suzuki, W., & Hatta, T. (2007). Aging, savings, and public pensions in Japan. *Asian Economic Policy Review, 2*(2), 303–319.
Hughes, G. (1998). Picking over the remains: The welfare state settlement of the post-second world war, UK. In G. Hughes, & G. Lewis, (Eds.), *Unsettling welfare: reconstruction of social policy* (pp. 3–38). London: Routledge.
Hunter, J. (1989). *The emergence of modern Japan: An introductory history since 1853*. London: Longman.
Hurd, M. D., & Yashiro, N. (1997). *The economic effects of aging in the United States and Japan*. Chicago: The University of Chicago Press.
Hutton, J. (2011). *Independent public service pensions commission: Final report*. London: Pensions Commission.
Imrie, R., & Thomas, H. (1999). *British urban policy*. London: Sage.
International Council on Active Aging. (2010). Active aging week Sept. 20–26 2010. *Journal on Active Aging*, March/Apr 2010. Retrieved January 13, 2011, from http://www.icaa.cc/actieagingweek/planningguides/active-aging-week-JAA-MarApr.pdf
Jackson, S. (1998). *Britain's population: Demographic issues in contemporary society*. London: Routledge.
Jonsson, H. (2005). Social democratic ageing in the People's Home of Sweden. *Journal of Aging Studies, 19*(3), 291–308.
Jonsson, H., & Larsson, A. T. (2009). The exclusion of older people in disability activism and policies—a case of inadvertent ageism? *Journal of Aging Studies, 23*(1), 69–77.
Kansakar, K. (n.d.). *Project Proposal Prepared by Keshari Kansakar*. Retrieved February 25, 2011, from http://www.globalgiving.org/projects/caring-and-sharing-for-older-people-in-nepal/

Kates, J., & Lief, E. (2006). *International assistance for HIV/AIDS in the developing world: Taking stock of the G8, other donor governments, and the European Commission*. Retrieved June 22, 2011, from http://data.unaids.org/pub/Report/2006/20060731-kff-international-assistance_en.pdf

Keating, N., & Wetle, T. F. (2008). Editorial. Longevity, health and well-being issues in aging in North America. *The Journal of Nutrition, Health and Aging, 12*(2), 99–100.

Keely, C. B. (2009). Replacement migration. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 395–403). New York: Springer.

Kellner, P. (2011). *World affairs: United Kingdom. Brittanica book of the year 2010* (pp. 477–481). Chicago: Encyclopaedia Britannica.

Khatri, R. (2010). *Gender mainstreaming and maternal mortality in Nepal*. Kathmandu: CERID.

Kihara, T. (2009). Aging, growth and financial markets—economic implications and challenges confronting East Asia. In J. L. Powell & I. G. Cook (Eds.), *Aging in Asia* (pp. 129–157). New York: Nova Science Publishers.

Kisby, B. (2010). The big society: Power to the people? *The Political Quarterly, 81*(4), 484–491.

Kshetri, D. B. B., & Smith, W. C. S. (2010). Self-reported health problems, health are utilisation and unmet health care needs of elderly men and women in an urban municipality and a rural area of Bhaktapur District of Nepal *The*. *Aging Male, 2010*, 1–5.

LaPierre, T. A., & Hughes, M. E. (2009). Population aging in Canada and the United States. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 191–230). New York: Springer.

Legassick, M. (2011). *World affairs: South Africa. Brittanica book of the year 2010* (pp. 462–463). Chicago: Encyclopaedia Britannica.

Li, C. (1992). *A study of China's population*. Beijing: Foreign Languages Press.

Li, B. (2007). Pension reform in China—who are left out? In I. G. Cook & J. L. Powell (Eds.), *New perspectives on China and aging* (pp. 29–48). New York: Nova Science Publishers.

Lister, R. (1998). From equality to social inclusion: New Labour and the welfare state. *Critical Social Policy, 18*(2), 215–255.

Maddox, D. (2011). Cameron's big society in Crisis. *Scotland on Sunday,* 2. Retrieved October 27, from http://www.scotsman.com/news/cameron_s_big_society_in_crisis_1_1493051.

Maeda, D., & Ishikawa, H. (2000). Ageing in Japan: Retirement, daily lives, pensions and social security. In D. R. Phillips (Ed.), *Ageing in the Asia-Pacific Region: Issues, Policies and Future Trends* (pp. 113–132). London and New York: Routledge.

Marshall, T. H. (1964). *Class, citizenship, and social development*. Garden City, UK: Doubleday and Company.

Mechanic, D. (2006). *The truth about health care: Why reform is not working in America*. New Brunswick, NJ: Rutgers University Press.

Mechanic, D, & McAlpine, D. D. (2010). Sociology of health care reform: Building on research and analysis to improve health care. *Journal of Health and Social Behavior, 51*, S147. Retrieved December 10, 2010, from doi: 10.1177/0022146510383497, http://hbs.sagepub.com/content/51.1_supplS147

Mitchell, C., Cowburn, G., & Foster, C. (2011). Assessing the options for local government to use legal approaches to combat obesity in the UK: Putting theory into practice. *Obesity Review, 12*, 660–667.

Moller, V. (2011). *Perceptions of fortune and misfortune in older South African households: Social pensions and the 'Good Life'*. Institute of Social and Economic Research (ISER), Rhodes University, Research Report Series No. 16. Retrieved July 5, 2011, from http://www.sed.manchester.ac.uk/research/agingandwellbeing/documents/ISERResearchReport16Brazza2.pdf

Moore, M. (2011). *China is the world's second largest economy*. Retrieved February 18, 2011, from http://www.telegraph.co.uk/finance/economics/8322550/China-is-the-worlds-second-largest-economy.html#

Mosk, C. (1983). *Patriarchy and fertility: Japan and Sweden 1880–1960*. New York: Academic.

Nagga, K., Dong, H. -J., Marcusson, J., Skoglund, S. O., & Wressle, E. (2011). Health-related factors associated with hospitalization for old people: Comparisons of elderly aged 85 in a population cohort study. *Archives of Gerontology and Geriatrics,* in press. Accessed via *Science Direct*, June 2011.

National Bureau of Statistics of China. (2010). *China statistical yearbook 2009*. Beijing: China Statistics Press. Retrieved January 18, 28, 2011, from http://www.stats.gov.cn/tjsj/ndsj/2009/indexeh.htm, Tables 3-3 and 3-10.

NEPAN (2008). Nepal: NGO report on MIPAA progress 2002–2008. Completed questionnaire by NEPAN (February 2008). Available at http://www.globalaging.org/agingwatch/events/ngos/nepal.pdf. Accessed January 29, 2009.

Newman, J. (2010). Towards a Pedagogical Sate? Summoning the 'empowered' Citizen. *Citizenship Studies, 14*(6), 711–723.

NMC. (2011). Retrieved June 1, 2011, from http://www.nmc-review.org/issues/issue-one/case-study-the-health-and-social-care-bill-2011/

Ogawa, N., Matsukura, R., & Maliki, N. (2009). Rapid population aging and changing intergenerational transfers in Japan. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 133–156). New York: Springer.

Pain, R., & Hopkins, P. (2010). Social geographies of age and ageism. In S. J. Smith, R. Pain, S. A. Marston, & J. P. Jones (Eds.), *The sage handbook of social geographies* (pp. 78–98). London: Sage.

Parker, S. L. (2005). *Reflecting on REFLECT in Sikles, Nepal: A dialogical inquiry into participation, non formal education and action-orientated research*. Unpublished PhD Thesis, Liverpool John Moores University.

Parker, S., & Pant, B. (2009). Ageing in Nepal: Emerging Issues and Challenges. In J.L. Powell, & I.G. Cook, (Eds.), *Ageing in Asia* (pp. 89–108). New York: Nova Science Publishers.

Parker, S. L., & Pant, B. (2011). Longevity in Nepal: Health, policy and service provision challenges. *International Journal of Society Systems Science, 3*(4), 333–345.

Pecchenino, R., & Pollard, P. (1997). The effects of annuities, bequest, and aging on an overlapping generation model of endoogenous growth. *Economic Journal, 107*, 26–46.

Pelham, L. (2007). *The politics behind the non-contributory old age social pensions in Lesotho, Namibia and South Africa*. Chronic Poverty Research Centre, CPRC, Working Paper 83. Retrieved June 23, 2011, from http://www.dfid.gov.uk/r4d/PDF/Outputs/ChronicPoverty_RC/83Pelham.pdf

Phillips, J., Ajrouch, K., & Hillcoat-Nalletamby, S. (2010). *Key concepts in social gerontology*. London: Sage.

Potts, D. (1985). The geography of apartheid: The relationship between space and ideology in South Africa. *Contemporary Issues in Geography and Education, 2*(1), 2–7.

Powell, J. L. (2009). Editorial: Introduction to special issue on comparative aging. *Ageing International, 34*(3), 91–101.

Powell, J. L., & Cook, I. G. (2000). A tiger behind and coming up fast: Governmentality and the politics of population control in China. *Journal of Aging and Identity, 5*(2), 79–89.

Powell, J. L., & Cook, I. G. (2001). Understanding foucauldian gerontology: The Chinese state and the surveillance of older people. *International Journal of Society, Language and Culture, 8*(1), 1–9.

Powell, J. L., & Owen, T. (2005). The bio-medical model of ageing: An anti-reductionist analysis. *International Journal of Sociology and Social Policy, 29*(5), 44–62.

Rayman, S. (2010). Sweden baffled—but rise of the right was obvious. Retrieved February 22, 2011, from http://www.bbc.co.uk/news/world-europe-11374155

Robine, J. M., & Michel, J. P. (2004). Looking forward to general theory on population aging. *Journal of Gerontology: Medical Sciences, 59A*, 590–597.

Rowland, D. T. (2009). Global population aging: History and prospects. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 37–65). New York: Springer.

Ryall, J. (2008). Retrieved August 9, 2011, from http://www.telegraph.co.uk/news/worldnews/asia/japan/3213349/Japan-struggles-with-elderly-crime-wave.html
Sagner, A. (2000). Ageing and social policy in South Africa: Historical perspective with particular reference to the Eastern Cape. *Journal of Southern African Studies, 26*(3), 523–553.
Saldin, R. P. (2010). Healthcare Reform: A Prescription for the 2010 Republican Landslide. *The Forum, 8*, 4, article 10. Retrieved January 13, 2011, from doi: 10.2202/1510-8884.1404, http://www.bepress.com/forum/vol8/iss4/art10
Sanderson, W. C., & Scherbov, S. (2007). A new perspective on population aging. *Demographic Research, 16*, 28–58.
Sato, R., & Iwasawa, M. (2006). Contraceptive use and induced abortion in Japan: How is it so unique among the developed countries? *The Japanese Journal of Population*, *4*(1), 33–54.
Schafer, M. H., & Ferraro, K. F. (2009). Data sources for studying aging. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 19–36). New York: Springer.
Schatz, E., & Ogunmefun, C. (2007). Caring and contributing: The role of older women in rural South African multi-generational households in the HIV/AIDS era. *World Development, 35*(8), 1390–1403.
Schulz, J. H., & Binstock, R. H. (2006). *Aging nation: The economics and politics of growing older in America*. New York: Praeger.
Seddon, D., Adhikari, J., & Gurung, G. (2002). Foreign labor migration and the remittance economy of Nepal. *Critical Asian Studies, 34*(1), 19–40.
Seniorjournal. (2003). *First Active Aging Week Focuses on Fitness for Senior Citizens*. Retrieved January 13, 2011, from http://www.seniorjournal.com/NEWS/Fitness/3-09-08Week.htm
Shinkawa, T. (2005). The politics of pension reform in Japan: Institutional legacies, credit-claiming and blame avoidance. In G. Bonoli & T. Shinkawa (Eds.), *Ageing and pension reform around the world: Evidence from eleven countries, Chapter 8* (pp. 157–181). Cheltenham: Edward Elgar.
Silverstein, S., Cong, Z., & Li, S. (2007). Grandparents who care for their grandchildren in rural China: Benefactors and beneficiaries. In I. G. Cook & J. L. Powell (Eds.), *New perspectives on China and aging* (pp. 49–71). New York: Nova Science Publishers.
Skidmore, M. J. (2010). The U. S. System of Social Security: Emphatically Not a Ponzi Scheme. *Poverty & Public Policy, 2*, 4, Article 8. Retrieved December 2, 2010, from doi: 10.2202/1944-2858.1138, http://www.psocommons.org/ppp/vol2/iss4/art8
Soderham, O., Lindencrona, C., & Gustavsson, S. M. (2001). Attitudes towards older people among nursing students and registered nurses in Sweden. *Nurse Education Today, 21*(3), 225–229.
Stewart, F., & Yermo, J. (2009). Pensions in Africa. *OECD Working Papers on Insurance and PrivatePensions*, No. 30, OECD publishing, © OECD. Retrieved July 5, 2011, from doi:10.1787/227444006716, http://www.oecd.org/dataoecd/41/6/42052117.pdf
Subedi, B. P. (2005). The aged and the marginal: Social geography of older people in Nepal. *The Himalayan Review, 35–36*, p1–p18.
Sundstrom, G. (2009). Demography of aging in the Nordic countries. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 91–111). New York: Springer.
Taeuber, I. B. (1956). Recent population development in Japan: Some facts and reflections. *Pacific Affairs, 29*(1), 21–36.
Takayama, N. (1992). *The greying of Japan: An economic perspective on public pensions*. Oxford: Oxford University Press.
Takayama, N. (1998). *The morning after in Japan: Its declining population, too generous pensions and a weakened economy*. Tokyo: Maruzen.
Takayama, N. (2003). Japan's Aging Problem and Macroeconomic Context. *Discussion Papers, No 188, Project on Intergenerational Equity Institute of Economic Research, Hitotsubashi University.*
Takayama, N. (2010). *Pension record-keeping problems in Japan*. Retrieved July 28, 2011, from http://www.ier.hit-u.ac.jp/pie/stage2/Japanese/d_p/dp2010/dp496/text.pdf

Taylor, S., & Field, S. (2007). *Sociology of health and health care*. Oxford: Blackwell.
Taylor, B., Mathers, J., Atfield, T., & Parry, J. (2011). What are the challenges to the big society in maintaining lay involvement in health improvement, and how can they be met? *Journal of Public Health, 33*(1), 5–10.
Thakur, S., Keen, M., Horvath, B., & Cerra, V. (2003). *Sweden's welfare state: Can the bumblebee keep flying?* Washington: International Monetary Fund.
The Times. (2010). *The big society*. Retrieved February 23, 2011, from http://www.timesonline.co.uk/tol/comment/leading_article/article7096805.ece
Thorslund, M. (1991). The increasing number of very old people will change the Swedish model of the welfare state. *Social Science and Medicine, 32*(4), 455–464.
Tosun, M. S. (2003). Population aging and economic growth: Political economy and open economy effects. *Economics Letter, 81*, 291–296.
Treas, J., & Batalova, J. (2009). Immigrants and aging. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 365–394). New York: Springer.
Uhlenberg, P. (2009). Introduction. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 1–4). New York: Springer.
UNFPA Nepal. (2008). Gender overview Retrieved January 25, 2009, from http://www.unfpane-pal.org/en/programmes/gender.php
United Nations. (n.d.). *Dag Hammarskjold,UNICEF (2010)*. Nepal Statistics Retrieved October, 25, 2010, from http://www.unicef.org/infobycountry/nepal_nepal_statistics.html
United Nations (n.d.). *Dag Hammarskjold*. Retrieved May 13, 2011, from http://www.un.org/Overview/SG/sg2bio.html
US Census Bureau. (2010). Retrieved December 13, 2010, from http://factfinder.census.gov, Retrieved May 13, 2011, from http://www.un.org/Overview/SG/sg2bio.html
Wacker, R. R., & Roberto, K. A. (2009). *Social policies for an aging population: An international comparison*. London: Sage.
Warnes, T. (2009). International retirement migration. In P. Uhlenberg (Ed.), *International handbook of population aging* (pp. 341–363). New York: Springer.
Wasserman, J., & Jones, E. (2003). *Population trends in Japan.* Retrieved December 12, 2003, from www.prcdc.org/summaries/japan/japan.html
Weissert, W. G., & Weissert, C. S. (2010). Why Major Health Reform Won't Solve Our Problems. *The Forum, 8*, 1, article 9. Retrieved January 13, 2011, from doi: 10.2202/1510-8884.1363, http://www.bepress.com/forum/vol8/iss1/art9
Wild, L., & Subedi, J. (2010). *Review of international assistance to political party and party system development: Case study report: Nepal*. London: Overseas Development Institute. Retrieved March 9, 2011, from http://www.odi.org.uk/resources/download/5537.pdf
Williamson, J. B., & Deitelbaum, C. (2005). Social security reform: Does partial privatisation make sense for China? *Journal of Aging Studies, 19*, 257–271.
Willmore, L. (2011). Retrieved July 5, 2011, from http://larrywillmore.net/blog/2011/02/12/universal-age-pensions-for-south-africa/
World Bank. (2010). Nepal Country overview available at www.worldbank.org
World Health Organisation. (2007). *Women, ageing, and health: A framework for action: Focus on gender*. Retrieved, from http://www.who.int/entity/aging/publications/Women-aging-health-lowres.pdf
World Health Organisation. (2011a). *Total commitments 2000–2009. Official Development Assistance*. Retrieved June 23, 2011, from http://www.who.int/gho/governance_aid_effectiveness/ODA_009.pdf
World Health Organisation. (2011b). *ODA for health. Commitment to recipient countries, 2009*. Retrieved June 23, 2011, from http://gamapserver.who.int/gho/interactive_charts/oda/commitments_total/atlas.html
Yashiro, N. (1997). Aging of the population in Japan and its implications to the other Asian Countries. *Journal of Asian Economics, 8*(2), 245–261.

Yu, G. (1987). *Spending the remaining years in ease, in women of China special series, new trends in Chinese marriage and the family* (pp. 209–213). Beijing: China International Book Trading Corporation.

Zimmer, Z., Kwong, J., Fang, X., Kaneda, T., & Tang, Z. (2007). Child coresidence among older adults in Beijing, China: Trends, determinants and transitions. In I. G. Cook & J. L. Powell (Eds.), *New perspectives on China and aging* (pp. 5–28). New York: Nova Science Publishers.

Index

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