

# AGEING IN EMERGING MARKETS





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# PREFACE

This report is based on conclusions reached at a symposium on *Ageing in Emerging Markets* organized by the Emerging Markets Symposium (EMS) at Green Templeton College, Oxford in January 2015.

The EMS is grateful for corrections and suggestions on the draft report from Sir George Alleyne, Yasser Bhatti, Peter Bourne, Lia Daichman, Mary Daly, Cynthia Egan, Irina Fedorenko, Kenneth Fleming, Dian Gomes, Michael Hodin, Morné Oosthuizen, Alexandre Sidorenko and Fernando Torres Gil. The EMS is particularly grateful to Stuart Basten, Sir John Grimley Evans and Alexandre Kalache for their exceptionally generous gifts of advice, knowledge, patience and time. The report does not necessarily reflect the views or opinions of any individual participant in the symposium. The EMS is accountable for errors of omission, commission or interpretation.

Figures 5, 6, 7, 17, 18 and 19 are from a lecture given at the symposium on *Ageing in Emerging Markets* on 17th January, 2015 by Stuart Basten published on the EMS website ([ems.gtc.ox.ac.uk](http://ems.gtc.ox.ac.uk)). Figure 11 is from a lecture at the symposium on *Maternal and Child Health and Nutrition in Emerging Markets* on 8th January 2014 by Steven Kennedy (also published on the EMS website). Figure 3 is taken from the *Analytical Framework* prepared for the symposium on *Ageing in Emerging Markets* by Katharine Knight (links available on the EMS website).

The Chatham House Rule (nothing said is attributed to individuals or organizations) is rigorously observed at all EMS symposia. Accordingly, statements attributed to participants in the symposium on *Ageing in Emerging Markets* are published rather than oral statements.



# THE EMERGING MARKETS SYMPOSIUM

The demographic, economic, cultural, technological and political changes that have transformed global communities, nation states and individual lives in the last half century will be followed by faster and vaster changes in the next one. Some of those who read this report will be alive to see them. Many of the fifty leaders from government, business, civil society and academe who met in Oxford in January 2015 to reach the conclusions on which it is based will not.

Brazil, China, India, Indonesia, Mexico, Russia, South Africa, Turkey and smaller countries in Africa, Asia, Europe and the Americas we call emerging markets are culturally, politically and in other ways remarkably different. But since the 1980s they have:

- Achieved relatively strong and sustained economic growth;
- Made significant progress in reducing income poverty, fertility, infant mortality, communicable diseases and illiteracy;
- Developed distinct but relatively stable polities with relatively effective governance, judicial and financial systems that, among other things, have encouraged domestic and foreign investment;
- Developed sufficiently large populations, economies and markets and sufficient external influence to become significant or dominant players in regional and/or global geopolitics; and
- Been faced with challenges and opportunities associated with demographic, economic, social, technological and spatial change.

With more than 50% of the world's people and roughly half its economy, emerging markets expect, and are expected, to be powerful actors on the world stage in the 21st century. But their prospects for sustained growth, social cohesion and political stability are partially clouded by eroding competitive advantages, environmental degradation, weaknesses in national, local and corporate governance and unresolved issues of human welfare. These challenges have confronted and are still confronting wealthy countries. Emerging markets must confront them under greater pressure on compressed schedules with fewer resources and weaker institutions.

Issues of human welfare are the soft underbelly of emerging market economies. Some of them have bet on government interventions to address the social, economic and political consequences of the rapid growth of older populations. Some have launched innovations to deliver healthcare to previously neglected urban and rural populations. Some have focussed on expanding free or subsidized primary and secondary education. Some have used fiscal and legislative tools to attack economic and social discrimination. Some have created public-private sector initiatives. Most have sought long-term change through combinations of macro policies and sectoral interventions.

The Emerging Markets Symposium (EMS) was created in 2008 as an academic initiative of Green Templeton College (GTC), the newest college in the University of Oxford and one of its seven graduate colleges. The EMS is an expression of GTC's commitment to promote understanding of the issues of managing human welfare in the modern world and the flow of ideas across traditional disciplinary and professional boundaries. From the outset the EMS has been most generously sponsored by the C&C Alpha Group.

The creation of the EMS was anchored in the premises that: (1) Unresolved issues of human welfare are critical constraints to growth, cohesion and stability in emerging markets; (2) Existing international forums did not reflect the complexity and urgency of these issues; (3) The College had the capacity and ambition to address them, the convening power to bring together leading figures from the public, private and voluntary sectors and the means to promote changes in policies and practices in governments, multilateral institutions, national and international corporations and civil society.

Topics considered by the EMS are selected by a Steering Committee chaired by Shaukat Aziz, former Prime Minister of Pakistan (see page 52). The Committee's decisions are based on its judgements about:

- The ripeness, timeliness and urgency of issues;
- How (if at all) they are being addressed in other forums;
- The capacity of the EMS to tackle them; and
- The assumptions that economic, social and political outcomes are influenced by:
  - The quality of governance, intra-government coordination and cooperation between government, business, civil society and individual actions
  - Policies and interventions in health, healthcare, social care, nutrition, education, the environment, infrastructure, housing and urban development in the context of the human life-course

The six symposia completed since 2008 have focused on: Health and Healthcare (2009) Urbanization, Urban Health and Human Security (2011); Tertiary Education (2012); Gender Inequality (2013); Maternal and Child Health and Nutrition (2014); and Ageing (2015). The next, (2016) will be on Young People and the Future of Emerging Markets.

After each symposium the EMS works with the press, media and participants to produce articles, op-ed columns, letters for print and on-line publication, radio and television interviews and discussions. Reports on the first five symposia were published on the EMS website ([ems.gtc.ox.ac.uk](http://ems.gtc.ox.ac.uk)). This report is the first to be published in print and on line. It will be launched in eight countries and will be sent to Heads of Government, businesses, multilateral institutions and major voluntary organizations.



# SUMMARY AND CONCLUSIONS

*There is more to old age than ageing*

## INTRODUCTION

The rise of emerging markets in the last half century has been associated with violent shifts in the tectonic plates of demography, economics and geography. There will be larger shifts in the next half century as emerging markets are transformed by the megatrends of globalization, urbanization, digitization, climatization, ideological conflict... and longevity.

The United Nations anticipates that between 2010 and 2050, declining fertility and infant mortality and rising longevity will drive the proportion of the total population aged over 65 from 7% to 20% in Brazil; 8% to 24% in China; 13% to 26% in Russia; and 5% to 12% in India. Challenges and opportunities associated with population ageing are not unique to emerging markets. But like those associated with epidemiological transitions and urbanization, they have been so compressed that some transitions spread over 150 years in high income countries will happen in just 25 years in emerging markets.

This report describes the outcomes of a 2015 symposium on *Ageing in Emerging Markets* convened by the Emerging Markets Symposium at Green Templeton College, Oxford. It focusses on the causes and consequences of rising longevity in the largest and most successful emerging markets; explains why they must wake up to the realities of getting older; assesses the economic and social and health implications of population ageing; and relates ageing associated issues to the economic cultural and political diversity of emerging markets.

Emerging market economies have made limited progress in planning for longevity. Many rely on outdated or imported policies. Few have acknowledged the consequences of demographic transformation. Few have calibrated social and economic policies with realistic assumptions about life expectancy. Even fewer have yet recognised that rising longevity is also a triumph of civilization, a challenge to the ingenuity and vision of managers and leaders and an economic, social and political opportunity.

The scope and scale of necessary adjustments in attitudes, mindsets, understandings, behaviours, policies and practises are such that, irrespective of contrasting political and economic systems, governments, the private sector, civil society and individuals in emerging markets must play leading roles in the last act of life.

## FINDINGS

The main finding of the symposium was that whereas it is fashionable to see rising longevity in emerging markets as a looming threat, it is also an opportunity to learn from the high income countries that have squandered the potential economic contributions of older people and failed to capture their knowledge, experience, productivity and capacity to help create more cohesive societies and nurture their polities.

Conventional thinking about longevity in emerging markets tends to focus on: (i) The impacts of declining fertility on the size of the labour force and of a consequently shrinking younger population to support a rapidly growing older population; (ii) Potential resentment on the part of younger people for whom older people are a burden; (iii) The cost of income transfers to older people with nothing else to live on; and (iv) The rising costs of healthcare for older people. In short, longevity is often seen as a threat to economic growth, social cohesion and even political stability. Scanning the horizon, many people see the clouds but miss the silver lining.

## THREE CLOUDS...

Nobody should underestimate the magnitude, complexity and urgency of health and economic and social welfare problems associated with longevity in emerging markets:

### Health

The growth of multimorbidities, disabilities, chronic diseases, dementia and other age associated conditions could overwhelm public and private healthcare systems in emerging markets. These countries need to improve their capacity to care for older people by: developing holistic ('womb to tomb') perspectives on human health; recognizing that human life-chances, including the chances of healthy ageing, are strongly influenced by maternal and child nutrition and health in the 1000 days after conception; promoting healthy lifestyles to eliminate the causes of premature death through (among other means) taxation and education; creating physical and social environments adapted to age-related physical and mental frailties; coordinating health related policies and plans across jurisdictional boundaries within governments; and exploiting innovative applications of new technologies.

There are many demands for improvements in prevention, diagnosis and care and hard pressed health systems may find it impossible to prioritize healthcare for older people. Yet there are few excuses for the facts that: (i) Healthcare professionals in most emerging markets typically receive little or no training or education in the health of older people; (ii) Specialist services (e.g. dementia, psychiatric disorders, disabilities) are neither integrated nor coordinated; and (iii) Policies that affect the health and well-being of older people (e.g. road crossing safety) that lie outside the purview of health policy are rarely coordinated

### Economic Welfare

Depending, in part, on demographic profiles, large scale old age poverty is a very real prospect in many emerging markets. In those with relatively well-established contributory or non-contributory pension schemes for formal sector workers, pensions may not cover basic needs. Those without formal sector pension systems cannot meet the needs of current generations of older people. And in emerging markets where unregulated, untaxed informal sector employment (82% cent of total employment in South Asia, 65% in East and South-East Asia excluding China, 51% in Latin America and 10% in Eastern Europe and Central Asia), dwarfs formal sector employment, workers who cannot work may face financial ruin in the absence of government income transfers, family financial support or sufficient financial savings to meet their needs in old age.

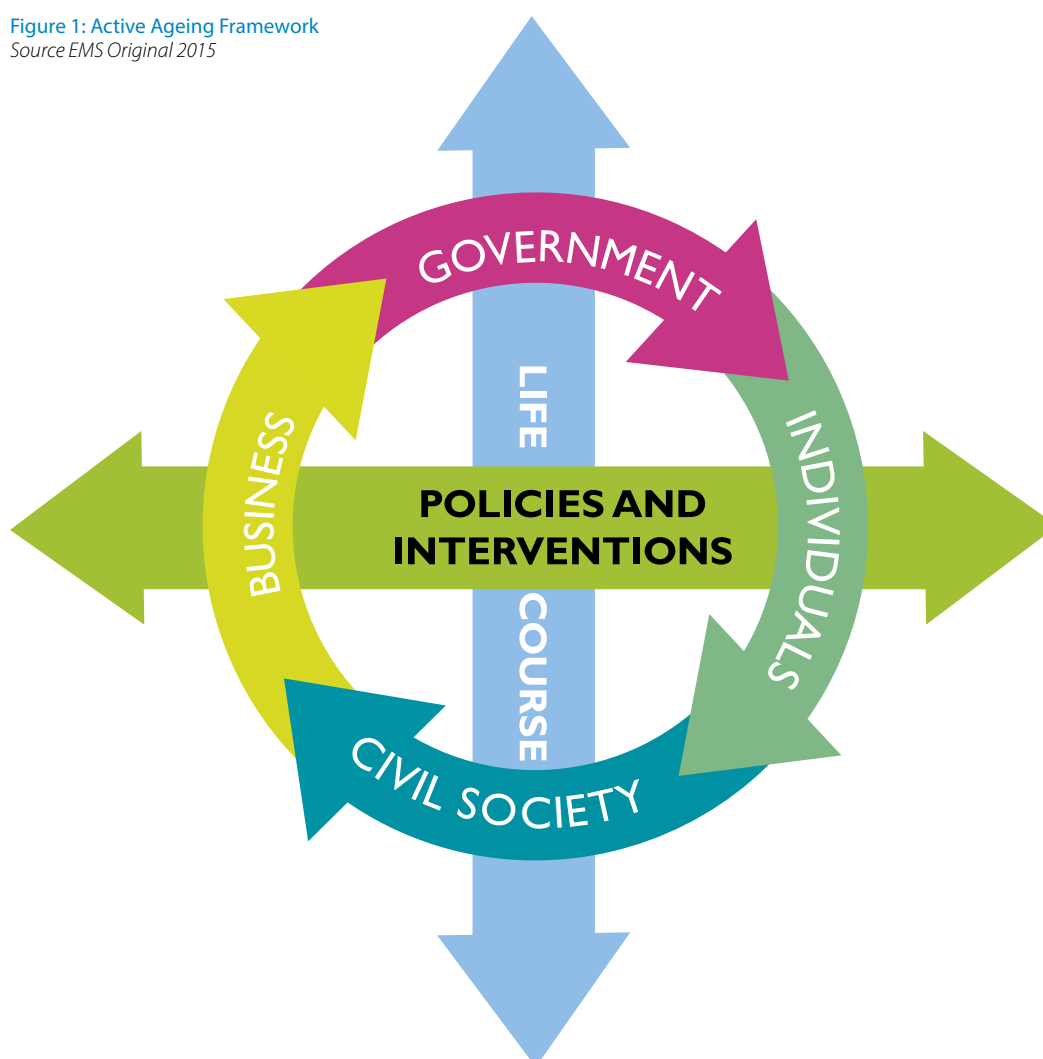
## Social Welfare

Physical and cognitive disabilities, personal isolation, the absence of age-friendly environments and products, lack of lifetime education, ageism, abuse, violence and income poverty combine for a bleak old age for many people. The hardships are exacerbated by diminished family capacities and commitments to provide social care for parents and other older people: partly because internal and external migration, labour mobility and urbanization have resulted in the spatial fragmentation of families; partly because younger members of fragmented families have other priorities; and partly because traditional family values must compete with individualistic and material values. Whereas, in most high income countries, governments and civil society organizations have taken up some of the slack, most emerging markets lack alternative solutions and where social care exists it is rarely coordinated, much less integrated, with healthcare.

## ... AND A SILVER LINING?

From one end of the telescope these appear to be 'wicked problems'<sup>1</sup> that defy solutions. From the other end emerging markets could see opportunities to adopt and adapt the concept of *active ageing* first proposed by WHO<sup>2</sup> in 2002. The concept offers a framework for simultaneously enhancing the quality of older lives and benefitting economies and societies. Being less burdened by tradition, convention and constraints to change, emerging markets may be better placed to make it work than most other countries.

Figure 1: Active Ageing Framework  
Source EMS Original 2015



The concept of active ageing is anchored in three premises:

- Decisions that affect the lives of older people are made by the public and private sectors, civil society and individuals.
- Decisions about health, education, work, retirement, financial security, personal security and other factors that affect opportunities for economic, social, cultural and spiritual participation by older people, should be taken in the context of related decisions (i.e. *horizontally* coordinated).
- Decisions about health, education and employment should also be taken in the context of life course perspectives (i.e. *vertically* coordinated).

The lynchpin of active ageing is coordinated action by government, business, civil society and individuals to address the disjunction between rules that govern retirement and the cognitive and physical capacities, aspirations and ambitions of older men and women in emerging markets.

Existing retirement regimes in formal sectors of emerging market economies are incompatible with healthy, productive ageing. They deprive economies of experienced workers, tax revenues and demand for goods and services. They rob individuals of the financial, social, psychological and reputational benefits of extended working lives. And they create unsustainable burdens on public sector finances. Although benefits will be smaller in countries with large informal economies, existing rules and mindsets that make it impossible for emerging markets to capture the dividends of active ageing must be replaced by flexible arrangements that allow and encourage older people to continue working, pay taxes, consume goods and services and retire when they wish. Emerging markets should not delay action until half their populations are having 100th birthdays and current regimes become risible anachronisms.

## RECOMMENDATIONS

The magnitude, complexity and urgency of issues associated with population ageing in emerging markets demand actions by national governments, private sectors, civil society organizations, academe, individuals and international organizations to encourage and enable people to capture life course opportunities for health, learning, participation and security that enhance their prospects for active, productive, creative ageing.

### WHAT SHOULD GOVERNMENTS DO?

#### Recommendation 1: National Ageing Policies

Emerging markets should adopt rights-based *National Ageing Policies*. The policies should be anchored in: (1) Coordinated sectoral policies (health, education, employment, retirement, financial security, personal security and social care) that affect the quality of life, employability and productivity of older people; and (2) Holistic frameworks that ensure policies that affect the well-being of older people are conceived in life course perspectives that promote the seamless integration of older people in the economic, social, cultural and spiritual lives of emerging markets.

**Background:** *Many emerging market governments lack policy frameworks for coordinating actions that affect the welfare of older people. Those that do not should create them. Those that do should ensure they are anchored in realistic demographic, economic, cultural and political assumptions.*

#### Recommendation 2: The Formal Economy

- Subject to exceptions (e.g. for people with disabilities or public service workers), people employed in the *formal sector* of an emerging market economy who are eligible for contributory or non-contributory pensions could retire about 15 years below the age of average life expectancy (i.e. if average life expectancy in an emerging market were 75, minimum retirement age would be 60).
- Employees could retire from employment in the formal sector at a time of their choosing beyond a defined minimum age.
- Employees retiring at the minimum age would receive reduced inflation-adjusted, pensions
- Employees retiring at older ages would receive larger, pro-rated pensions up to a maximum age, determined by average prospective longevity.
- The minimum age of retirement and the maximum size of pension would be subject to periodic adjustment in light of changes in expected longevity

**Background:** *There are growing disjunctions between longevity and the age of retirement for formal sector workers in emerging markets. As a result, many people will spend more time retired than working. The disjunctions will become increasingly anomalous and the viability of social security systems will be increasingly threatened as longevity increases. The above recommendations would contribute to equitable and sustainable outcomes for emerging markets with relatively large formal sectors and contributory or non-contributory pension systems by: (i) Permitting older people who reach retirement age to continue to work, contribute to economic output and to effective demand and pay taxes whilst drawing pensions; (ii) Enabling older people to contribute to their own health and reduce healthcare costs by remaining physically and cognitively active; (iii) Allowing older people to enjoy non-financial (social, reputational, psychological) benefits of work; (iv) Offsetting labour force reductions associated with declining fertility rates; (v) Allowing employers to benefit from the knowledge and experience of older workers (as mentors and in other roles); and (vi) Accommodate the special needs of older workers associated with cognitive and physical decline.*

### Recommendation 3: The Informal Economy

National Ageing Policies should:

- Minimize destitution among older people who work/have worked in the informal economy, are ineligible for pensions and are financially vulnerable, through inflation adjusted, need-based, publicly funded income transfers.

**Background:** *Some emerging markets with large populations of income poor older people could face ethical, economic, social and/or political crises. Fiscal constraints and competing priorities could make it difficult or impossible for some governments to shoulder the cost in which case innovative and culturally appropriate joint ventures with business and civil society organizations could offer partial solutions. In contemplating action, emerging market governments should take account of models developed in emerging markets that have pioneered successful programmes.*

### Recommendation 4: Health and Healthcare for Older People

National Ageing Policies should incorporate explicit health and healthcare objectives including:

- The prevention and treatment of chronic and infectious diseases, dementia, psychological disorders disabilities and multimorbidities.
- The adoption of life course perspectives in health policy and action reflecting the importance of events in earlier life (childhood, adolescence, young adulthood) on elder health.
- The coordination of health and healthcare policies with policies in other sectors that directly or indirectly influence the health of older people.
- The coordination and integration of primary health care and care provided by specialized providers (e.g. psychiatrists, orthopaedists).
- The provision of specialized care for disabled people of all ages.
- The coordination of healthcare provided by different providers (e.g. cardiologists, internists, neurologists, gerontologists) ideally through single points of delivery.
- Ensuring that older patients and their carers play explicit roles in healthcare decisions and processes.
- Integration of healthcare and social care.
- The incorporation of ageing-associated health and healthcare in the education and training of non-specialized healthcare providers.
- Ensuring the effective and creative use of information technology (e.g. telemedicine) in healthcare delivery throughout the life course with particular attention to older age.
- The prevention of accidents through the creation of people-friendly environments (e.g. safe road crossings, easy-to-open food packaging) that promote the personal safety of older people, particularly those with disabilities.

**Background:** *Huge challenges to the health and healthcare of older people in most emerging markets have been created by rapid demographic and epidemiological transitions. Health and healthcare have a direct influence on many age-associated economic and social issues and should be the bedrocks of national ageing policies.*

## Recommendation 5: Ageing in Society

National Ageing Policies should seek to improve intergenerational understanding, empathy and mutuality and help society adjust to ageing populations by:

- Enacting laws to control abusive and antisocial behaviour against older people (particularly older women) modelled on those designed to curb other forms of antisocial, and discriminatory behaviour.
- Developing education programmes that help children and adults understand the realities of life for older people, particularly the poorest old.
- Encouraging schools and community organizations to offer physical and other help to older people (e.g. through home visits by children and school visits by older people).
- Developing education programmes for older people including lifelong learning, computer skills and preparation for retirement.
- Developing specialized advisory services to help older people understand available options and cope with life in old age.
- Developing innovative, sustainable and socially, economically, financially and culturally appropriate social care systems in societies where the principle and practice of kin based care for older people has weakened, atrophied or no longer exists.
- Encouraging and/or partnering corporate initiatives that provide parental care for employees.
- Coordinating social care and healthcare systems (e.g. by expanding the roles of healthcare extension worker to include social care).

**Background:** *Massive urbanization, external migration, technological change and the erosion of communal solidarity by individualistic values have created increasing generational tensions, weakened filial obligations and are contributing to the growth of ageism and elder abuse in some emerging markets. These trends militate against social cohesion and as the relative and absolute numbers of older people continue to grow, are likely to be exacerbated. The size, scale and distribution of older populations also represent growing and exacting needs for long term care. The practical answers for most emerging markets will be differentiated solutions to different economic groups.*

## WHAT SHOULD THE PRIVATE SECTOR DO?

Corporate and other businesses in emerging markets should contribute to the resolution of ageing-associated issues in two ways: First, by urging governments to develop and detail national ageing policies and, secondly, by taking independent or joint initiatives in partnership with government, other businesses and/or civil society organizations.

## Recommendation 6: Initiatives Affecting Older Workers

Businesses in emerging markets, acting alone or with other businesses should capture the experience and knowledge and address the needs of older people by:

- (For example) creating or enabling flexible work schedules, part-time positions, job-sharing arrangements, flexible benefits, seasonal employment, compressed workweeks, expanded or reduced shifts, voluntary demotions, job rotation, job redesign, continued education and development, active recruitment of older workers and accommodating those with physical or cognitive limitations.
- Collaborating with government and civil society through education initiatives to increase awareness and understanding of social issues that affect older people.

- Collaborating with government to implement changes in retirement laws that allow employees to retire at times of their choosing within fixed parameters (subject to periodic adjustment) on terms and conditions that encourage older workers to continue working in the same or other enterprises.
- Developing regulated and inspected care homes.
- Developing and partially funding residential and day-care facilities for older people with limited means as businesses or joint government/business ventures.
- Ensuring they are aware of and understand employees' elder care as well as child care responsibilities.
- Providing counselling and advice to employees with elder care responsibilities.
- Adopting flexible leave policies for employees with elder care responsibilities.
- Developing day-care facilities for parents of employees along the lines of existing childcare facilities.

**Background:** *As some far sighted emerging market businesses have realized, business initiatives that support the familial responsibilities of employees are good for employees, good for business and good for society. They are good for business because they contribute to productivity, loyalty and retention, enhance corporate image and reputation and show business can do well by doing good. Too few employers – and this goes for wealthy countries too – take active interests in the lives of employees. As labour forces shrink with declining fertility and numbers of employees with elder care responsibilities grow, it is likely more businesses will find it profitable to ease employees childcare and elder care burdens.*

## WHAT SHOULD CIVIL SOCIETY DO?

### Recommendation 7: Civil Society Initiatives to Benefit Older People

Recognizing all generalizations on potential roles of civil society are conditioned by the distinctive values, traditions and norms of each emerging market, there are opportunities for:

- Joint (government, business, civil society) initiatives that improve understanding of the circumstances and needs of older people, fight ageism and control elder abuse.
- Civil society initiatives that help older people, particularly those with disabilities, manage their everyday lives.
- Civil society initiatives to relieve the burden of social isolation among older people.
- National and international campaigns to persuade governments, businesses, multilateral institutions and international organizations to take action on ageing issues.

**Background:** *Civil society organizations and institutions enjoy more degrees of freedom to express their views, to be protagonists for change and to empower older people than their counterparts in other sectors. Secular and religious civil society organizations have long played vital roles on behalf of older people in emerging market communities. Additional initiatives could be encouraged by ensuring these organizations actively participate in the development of national ageing policies.*



## WHAT SHOULD ACADEME DO?

### Recommendation 8: Research

Universities and other academic institutions in emerging markets and wealthy countries should rise to the challenge of providing or strengthening the empirical foundations for actions that affect the health and economic and social well-being of older people in emerging markets.

The following list is a sample of relevant research topics.

- National ageing policies and strategies
- Pension policies
- Retirement and longevity
- Financial security in the informal sector
- Who should care for the old and poor?
- Elder care in the workplace
- Experience with integrated healthcare and social care
- The effect of legal sanctions on elder abuse
- Education and training in health and healthcare for non-specialist healthcare providers
- Experience with coordinating policies that affect health outcomes.

**Background:** *Emerging markets are littered with the remnants of well-intended and seemingly sound projects that turned out to be based on inadequate or insufficient evidence. In many cases research could be done in the context of pilot projects which would in almost all cases precede large-scale implementation.*

## WHAT SHOULD INTERNATIONAL ORGANIZATIONS DO?

### Recommendation 9: Ageing and the Sustainable Development Goals

Emerging market (and other) governments should urge the United Nations to include ageing issues in the Sustainable Development Goals (SDGs).

**Background:** *Despite the endorsement of the Secretary General of the United Nations and prolonged and arduous efforts by UN bodies (e.g. UNFPA) and NGOs (e.g. Help Age International) there is no commitment to refer to the welfare and potential economic and social contributions of ageing populations in the SDGs. Some pressure has been applied. It can and should be increased.*

### Recommendation 10: Rights of Older Persons

The United Nations should consider a convention on the rights of older persons.

**Background:** *The human rights of children, women and other vulnerable groups are protected by international law. The rights of older persons are not. In 2011, the Secretary General of the United Nations commented that international obligations to older persons were implicit in, for example, the UN Covenant on Economic, Social and Cultural Rights, the UN Covenant on Civil and Political Rights, the UN Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of Persons with Disabilities. However, he also noted that “explicit references to older persons in binding international human rights instruments are scarce”. Although there are distinctly different views on the proposal for adopting such a convention, the United Nations should thoroughly consider the benefits of adopting it as many emerging market societies lack legal frameworks to respond to rapid population ageing.*

# THE REPORT

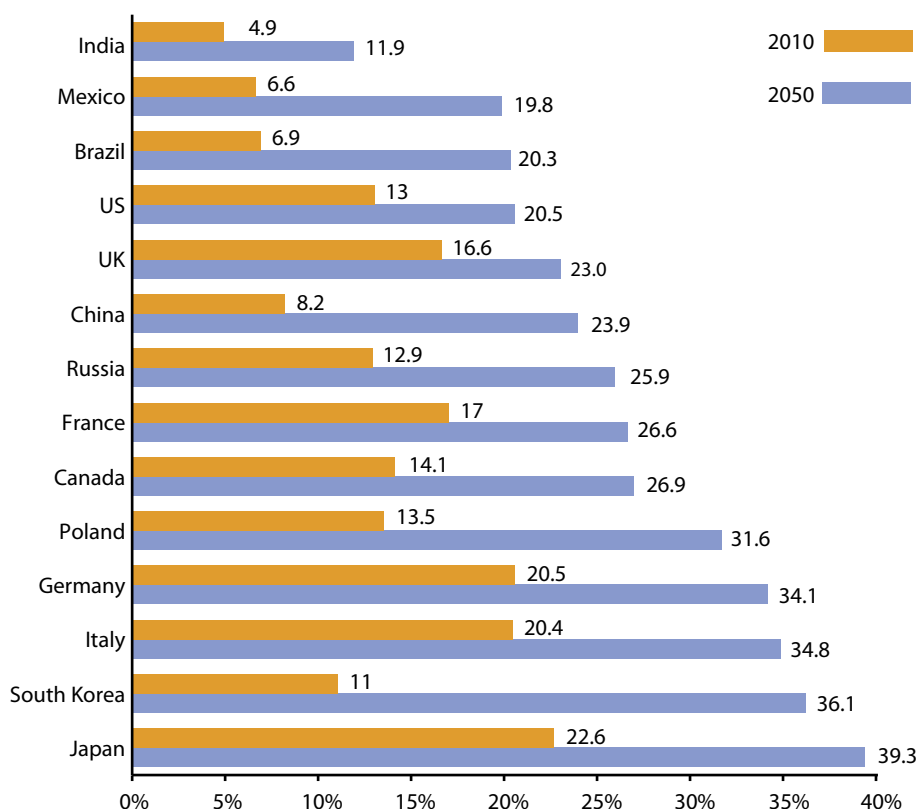
On 15th -18th January 2015, fifty participants from twenty countries (see page 51) convened at Egrove Park, Oxford to consider ageing-associated challenges and opportunities in emerging markets. This report elaborates and expands on conclusions reached in three days of conversation and subsequent consultations among participants. It has four parts. The first outlines the dynamics of increased longevity and other demographic changes in emerging markets. The second describes generic health challenges for older people and opportunities to address them. The third considers generic economic challenges facing older people and how they could be managed. The fourth describes social challenges and how they could be tackled.

## DEMOGRAPHY AND DESTINY REVISITED

Demographic change in emerging markets in the last 50 years has been breathtaking. In the next 50 it will heart-stopping. By the middle of the 21st century, differential shifts in fertility and mortality will re-draw the population map of the world. Other countries will follow the pattern now seen in Japan and in some European countries which, as a consequence of low birth rates are experiencing depopulation and undergoing profound structural transformations, and will soon have more old people than young people and far more old people than in the 20th century. This transformation is unprecedented in human history.

Figure 2: Persons aged 65 and over as % of population, 2010–2050

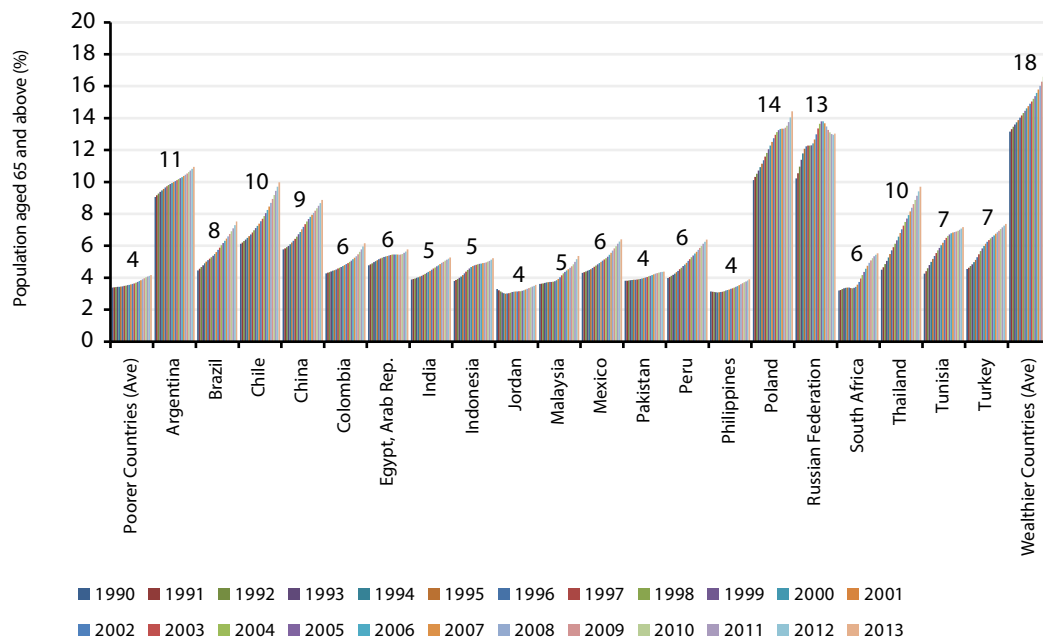
Source: World Population Prospects 2010



Until quite recently it was widely assumed global population would increase from five billion in 1980 to twenty billion in 2050. There is now consensus that declining fertility and infant mortality and increasing longevity mean it will stabilize around 10 billion by mid-century<sup>3</sup>. The demographic transition has been sharpest in emerging markets where total fertility rates (TFRs) have fallen rapidly. In 1950, almost all countries we now call emerging markets had TFRs above five (most above six)<sup>4</sup>. Today, only Jordan, Pakistan and Philippines have rates above three. Several, including China, Thailand and ten states in India have TFRs below the net replacement rate of 2.1. Lower rates of infant and child mortality and higher survival rates beyond age 65 are not in themselves causes for celebration. The demographic transition – although its benefits have been neither universally nor equitably distributed – has nonetheless been a triumph of civilization.

Figure 3: Population aged over 65 years in 20 emerging markets

Source: The World Bank 2014



## POPULATION AGEING

Since the 1950s changes in fertility and in longevity have generated very large absolute increases in populations aged 65 and over. The trend accelerated after 1970 and quickened through the 1980s and '90s (see Figure 3 for comparisons between 20 emerging markets).

Figure 4: Age and gender profiles for six emerging markets

Source: United Nations 2010

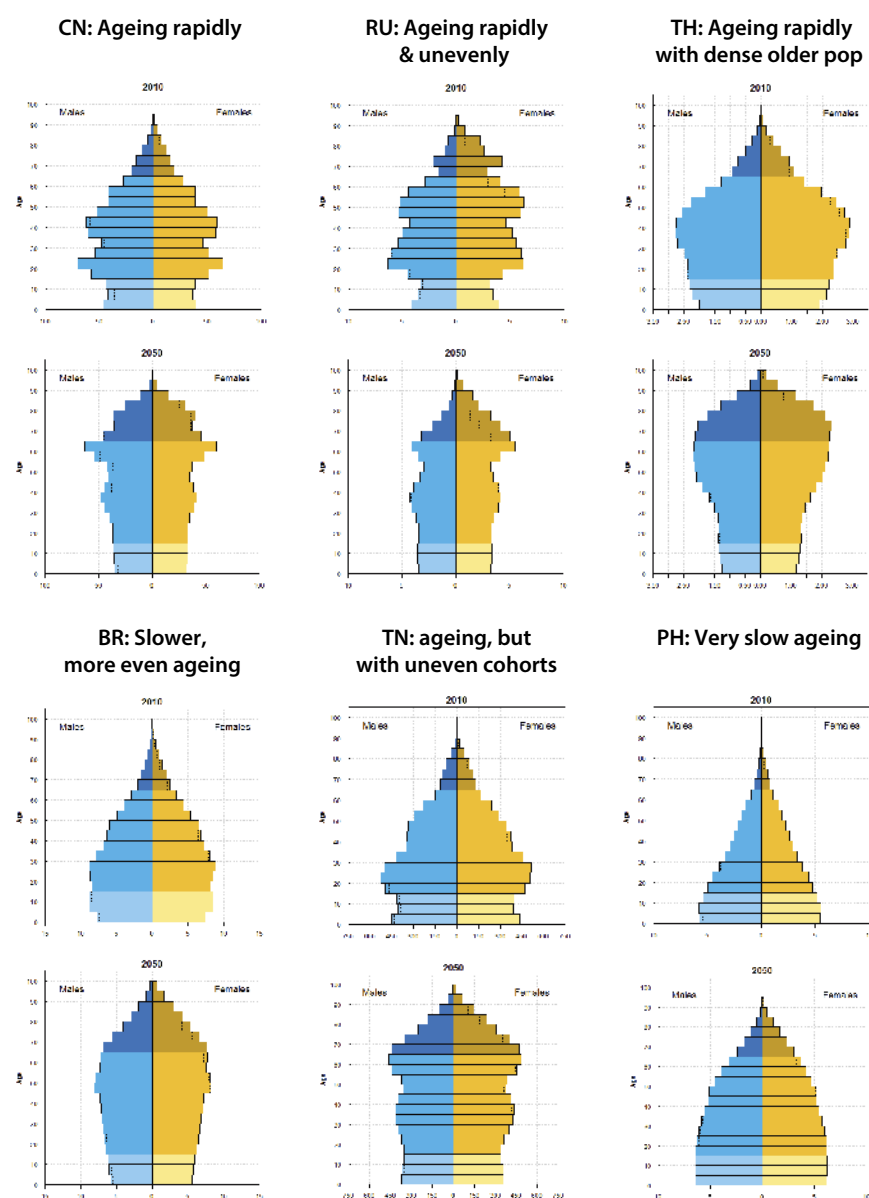


Figure 4 shows comparative age and gender profiles for three emerging markets where ageing has been rapid (China, Russia, Thailand) and three where it has been slower (Brazil, Tunisia, Philippines).

Even larger changes have occurred in Old Age Dependency Ratios (OADRs)<sup>5</sup> in emerging markets. Except for Argentina (0.20), Poland (0.24) and Russia (0.20), emerging market<sup>6</sup> OADRs are currently under 0.17 (i.e. everyone aged 20-64 is 'supporting' fewer than 0.17 people aged over 65). This contrasts with OADRs of 0.39 in Japan; 0.30 - 0.35 in Germany, Italy, Sweden and Greece; 0.10-0.15 (in ascending order) in South Africa, Egypt, Colombia, Peru, Mexico, Tunisia, Turkey, Brazil and China; and between 0.07 and less than 0.1 (in ascending order) in Jordan, the Philippines, Pakistan, Indonesia, Malaysia and India (see Figure 5).

By 2150, OADRs in emerging markets in Latin America are expected to rise to between 0.39 (Peru) and 0.56 (Chile). In the Middle East and North Africa, OADRs in Tunisia and Turkey are expected to rise to 0.53 and 0.45 respectively, while increases of more than 150% are projected in Egypt and Jordan. Elsewhere, Russia and Poland are likely to rise to 0.40 and 0.62, while South Africa's OADR is expected to double. In Asia, rapid increases in OADRs are expected in Malaysia (0.37) China (0.54) and Thailand (0.65) which will be similar to OADRs in Germany and Singapore. Forecasts for other Asian countries are between 0.20 and 0.29.

Although the OADR is an established metric of dependency it has two major weaknesses.

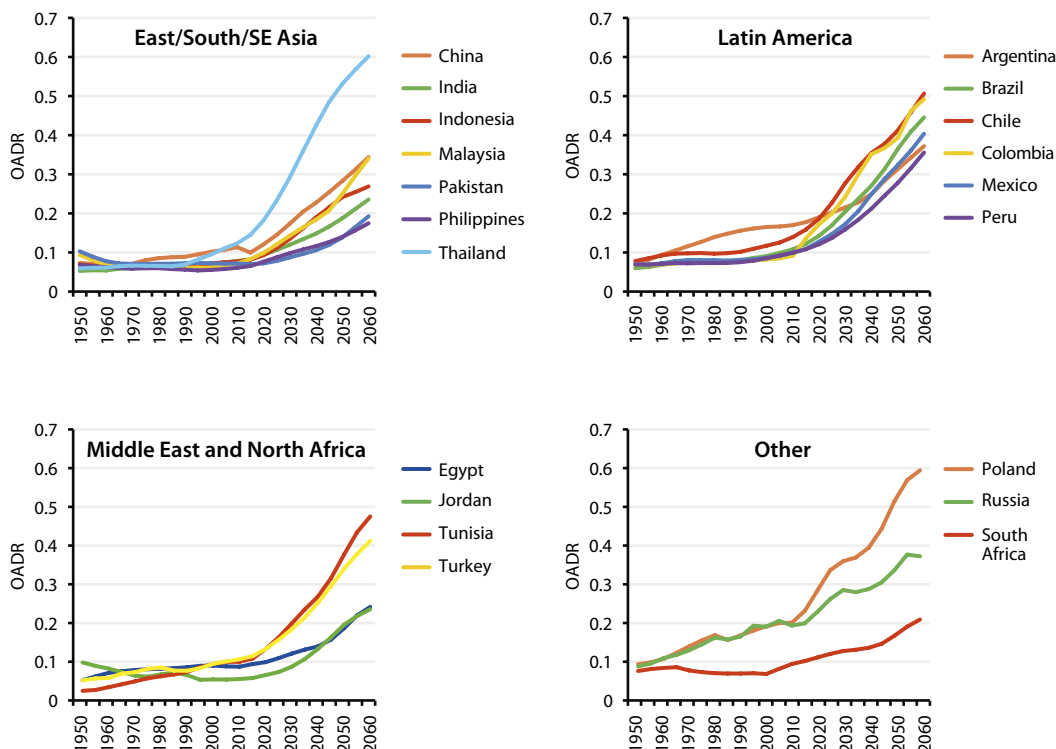
First, it assumes a fixed threshold for 'old age' notwithstanding the history and promise of changes in life expectancy and the facts that:

- As a consequence of modernization and urbanization, longevity is increasing at stunning rates, adding decades to 20th century levels.
- The age of 65 was a rather meaningless boundary when it was introduced in Germany in the early 20th century<sup>7</sup>. It became more meaningless in the late 20th century when popular conventions defined 60 as the new 50 and 80 as the new 70. It will become totally meaningless when centenarians become common. In some emerging markets it is already too low, in others still too high.
- It is often emotively portrayed as a 'threat', a 'ticking time bomb' or 'an express train hurtling towards demographic disaster'.
- Dependency will become an increasingly fuzzy concept as the future becomes the present, working lives are extended, distinctions between pensionable age, retirement age and old age become increasingly arbitrary and the OADR is revealed as "a male-orientated, wealthy-country construct of dubious empirical validity"<sup>8</sup>.

*"Our current maximum lifespan, of over 100, was well-established by historical times... What has changed since those times is not an increase in the maximum lifetime of our species but the proportion of a population that reaches anywhere near it."*

**Sir John Grimley Evans, 'Human Ageing' EMS, 2015**

Figure 5: Old age dependency ratios (65+/20-64)  
Source: Stuart Basten 2015



*Developed countries first became rich and then became old. Countries like Brazil are getting older faster while still struggling with development challenges*

**Alexandre Kalache,**  
EMS Presentation,  
2015

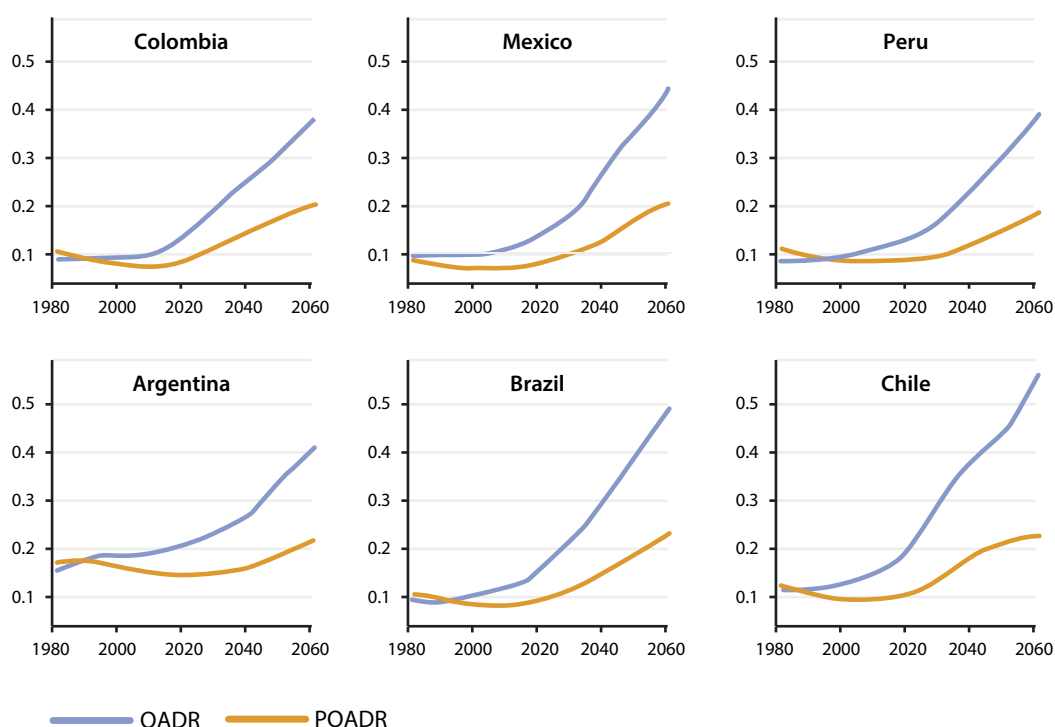
- The growing literature on the validity of the OADR in wealthy countries emphasizes the need to distinguish between such factors as pension eligibility, gender, labour market exit, changing labour force patterns, increased (healthy) life expectancy and differential expenditure (e.g. on health and social care) among over 65s. It also suggests there are positive associations between declining disability and financial and educational advantage (Manton and Gu (2001)).<sup>9</sup>

Second, the concept of chronological age is less valuable than the concept of *prospective* age which is to say years left vs. years lived. If the age of dependency is the age beyond which, on average, the physical and cognitive effects of ageing hinder and ultimately impede the ability to work and/or lead an independent life on the same terms as the rest of the population, a plausible interpretation is that, with variations within and between emerging markets and over time, the age of dependency starts about 15 years below the age of average life expectancy (see Figure 6 which shows OADRs and POADRs in six countries in Latin America).

The shortcomings of the OADR are more pertinent in emerging markets than in wealthy countries. Many older people in emerging markets (particularly in Asia) lack pension income either because structured (mandatory or optional) systems do not exist or because they work in informal labour markets and therefore do not pay taxes and have no pension rights. Some emerging markets (e.g. Chile, China, India) have however begun to develop policies to address the needs of low income workers.

The Prospective Old Age Dependency Ratio (POADR) assumes prospective age is a dynamic variable that varies within age cohorts and between emerging markets and other countries. It is a more suitable policy tool for 21st century policy makers than the OADR. It is grounded in the here and now. It is adaptable to future demographic and economic changes. It is relatively equitable. And because it is flexible it will inform a rational discourse on ageing for the indefinite future. It is by no means perfect because it ignores differential mortality and ill-health and is very weak at determining denominators. It is nonetheless an improvement over arbitrary definitions anchored in the 19th century.

Figure 6: Comparing OADR and POADR (Latin America)  $RLE_{15}$   
Source: Stuart Basten 2015



## AGEING IN EMERGING MARKETS

Until the late 20th century population ageing (the % age of old to young in a country) did not become a major policy issue in emerging markets. But as median ages have risen, it has become a significant, though uneven, challenge. Whereas Western Europe transitioned from being relatively young to being relatively old in 150 years, emerging markets in Asia and Latin America will make similar transitions in about 25 years.

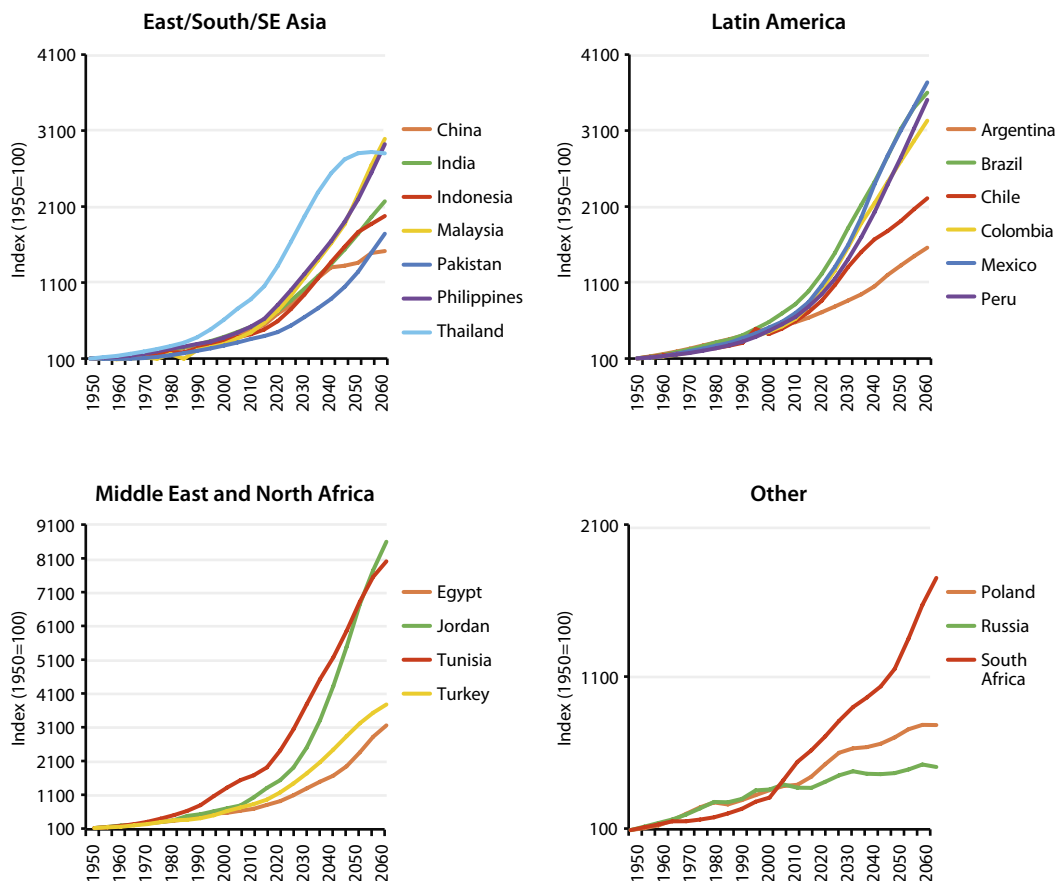
The recent demographic histories, like their recent economic and urban histories, of most emerging markets are, for the most part, histories of compression and accelerated change. But there are important differences (see Figure 7) in its consequences. Despite such differences, almost all emerging markets need to rethink population ageing, and recognize that older populations are far from homogenous; that problems and opportunities for the younger old and older old are very different; and that ageing populations offer both challenges and possibilities.

*Chronological age is not a precise marker for the changes that accompany ageing. There are dramatic variations in health status, participation and levels of independence among older people of the same age.*

**WHO 2002**

Figure 7: Population size over 65 (indexed, 1950=100)

Source: Stuart Basten 2015

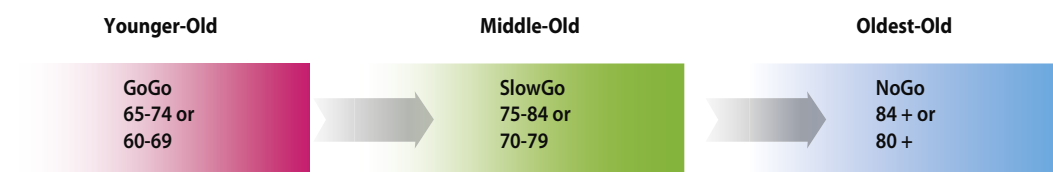


The symposium agreed that:

- Ageing is defined by diminishing adaptability to challenges from external or internal environments as reactions become slower, less sensitive, less accurate and less well sustained.
- These challenges will hit older people with different degrees of severity, in different combinations, at different chronological ages (although many people will die without experiencing them). Individuals age at different rates as a function of life course health, work-related wear and tear on minds and bodies, education, lifestyle choices, physical, cultural, social and emotional environments and heritable and other attributes and will reach old age in variable states of health and with differentiated energy levels, ambitions and prospects for longevity.
- These contrasts, originally identified in wealthy countries, have increasingly important implications for ageing-associated policies and strategies in emerging markets.
- Efforts to stereotype the characteristics of older people are generally misleading because biological age cohorts cannot be matched to chronological cohorts. This casts doubt on distinctions such as those shown in Figure 8.
- It is more useful to focus on the conditions of healthy, productive, satisfying and *active ageing* (ideally ending in a quick death) as measures of successful longevity.

Figure 8: Example of stylized 'Stages of Ageing'

Source: EMS Original 2015



Sir John Grimley Evans comments that: "As people age their capacity and desire for independent (autonomous) living may be gradually or abruptly abridged by declining physical and/or cognitive powers and the need for cooperative living arrangements (e.g. with family members) and towards the end of life may leave them totally dependent on family or institutional care."<sup>10</sup>

Figure 9:

Source: EMS Original

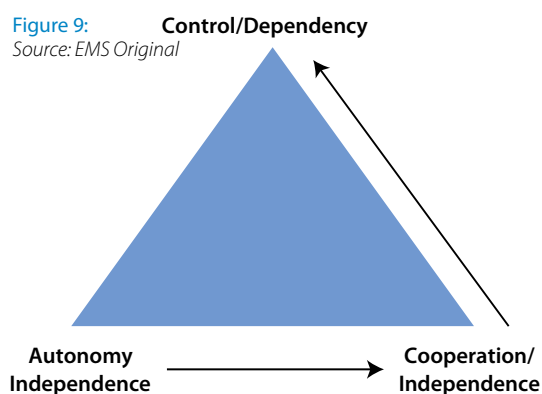
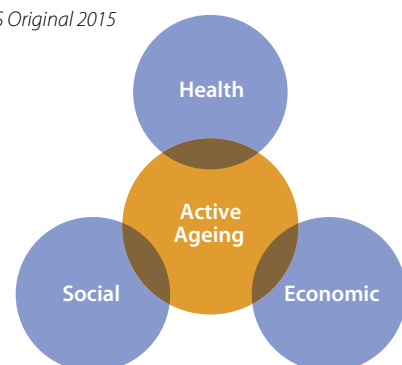


Figure 10:

Source: EMS Original 2015



Assuming the three constituent elements of human behaviour are control, autonomy and cooperation, Figure 9 suggests that ageing is associated with the (gradual or abrupt) loss of autonomy and independence leading to the need for cooperative living arrangements (e.g. family homes, sheltered or group housing) and increased reliance on others and, in many cases to complete loss of independence and control (e.g. nursing home, hospice, hospital).



The quality of life in old age is influenced by numerous factors, many of which (e.g. climate, environmental risk, culture, violence and warfare) may be *sui generis*. Allowing for those differences, active ageing is driven by health, economic and social determinants (Figure 10). By way of illustration consider the prospects of four individuals as they look forward to the rest of their lives. Their stories/cases are compilations drawn from authentic situations: while the people themselves are fictitious, the places they live in and their contrasting circumstances are real:

*Andres Gomez is 61. He owns a steel import company in Bogota, Colombia founded by his grandfather in 1950. He joined the company after graduating from the Universidad de Los Andes in 1978 and became CEO in 2005 when his father retired to his farm on the River Tequendama. Andres has no plans to retire although he thinks he might ease off a bit as his daughter takes a bigger role. But he is not in a hurry. He is fit, healthy, spends weekends at the Bogota Country Club, at his farm or visiting his parents. He says he is financially unsinkable and is optimistic about the country, the company, his family and his life. He has no idea how long he will live, never thinks about death and believes he has earned the right to spend the rest of his life as he pleases.*

*Andres is optimistic about the future. He has had excellent health and dental care throughout his life and will continue to have it. He understands the imperatives of healthy diets and healthy exercise. He knows what is going on in the world, travels frequently on business and pleasure, reads a lot, works the Internet and is familiar with current research on healthy ageing. He has developed both the knowledge and the means to stand a good chance of living an active life for years to come.*

*Akbar Lakhani, aged (he thinks) about 50, lives in Sukkur, Pakistan. He is a net-fisherman on the Indus. His catch provides a small but fairly regular income except when the river floods, which it does at least once a year. His wooden boat is old and leaky but serves its purpose – for the time being. He cannot afford an outboard motor but never goes far and says he does not need one. He has never had a paid job. He works for himself, which means, in effect, he has no economic status, does not pay taxes and receives no benefits other than subsidized education and some healthcare for his wife, three surviving children and himself. Having been poor all his life he has no expectations of anything but work until he is no longer able to manage his boat and his catch. He knows his economic future is bleak but that has been true of his whole life*

*Akbar does not know life handed him a raw deal. In fact he knows very little about anything other than the world of the city, the riverbank, his boat and his small and vulnerable house. Nor does he know he has done well to stay alive for 50 years. He is not in good health, suffers from aching joints and although he does not know it, has a weak heart that will soon kill him.*

*Nur Dhia Mawaddah, 60, has been teaching in the Cameron Highlands, Malaysia, for 35 years and has been a head teacher since 2003. Having reached the mandatory age she will retire this year but has no intention of retiring from life. She has spent parts of the last several years considering her options and has decided to develop a portfolio of old and new activities. They include a part time role (paid) as a mentor to primary school heads in Pahang Province; one day a week as a teaching assistant (unpaid) in another school; volunteering for one half day a week as a visitor in a juvenile detention facility; and spending the rest of her time in her garden. She has a full government pension, which, given that her house is paid for, will be adequate. She views the future as a time to give, a time to learn and a time to remain active.*

*Nur is not highly educated but her two years at the Teachers College in Kuala Lumpur gave her an adequate grounding that has served her well in her professional and personal lives. She has not read much about ageing but has an intuitive understanding of the problems and opportunities associated with getting older. She knows that her chances of living long and living well depend on her past, present and future health, nutrition, financial security and physical environment. It is likely her future life will be reasonably prosperous and happy.*

*“Ageing, in the sense of senescence rather than maturation, is characterized by a progressive lack of adaptability of an individual organism as time passes. An organism’s functional reserves diminish; the homeostatic mechanisms on which its ability to respond adaptively to challenges from the external or internal environment become less sensitive, less accurate, slower, and less well sustained. Sooner or later the organism encounters a situation it cannot deal with and it dies. For aged humans this final challenge might be an infection, a cancer, a blocked artery, an accident or perhaps less-than-best medical attention. A rising age-associated risk of death is therefore the hallmark of senescence*

**Sir John Grimley Evans op cit**

Ludmilla Semnovich is 59 and lives in the historic city of Suzdal, 130 miles northeast of Moscow. She worked as a chamber maid in one of the city's small hotels having had a variety of menial jobs since she finished a fragmented education at fourteen. Her husband died five years ago. She has two children, one in Suzdal whom she sees every day, the other in Moscow who comes home from time to time. She retired in 2005 at the age of 55. She has a modest state pension but it is stretched thin and she has decided to move in with her daughter's family where she will help look after her grandchildren while her daughter works – as a hotel chambermaid. She says her life has been hard; much of the time she feels very tired and has little energy. Her future years, which may not be many, will not be very active.

*Ludmilla has had a miserable life but does not feel frustrated because she knows she could not have changed her past. She missed no opportunities because there were none. She took no wrong turnings because there no forks in the road. For however long she has left, she will live from day to day, enjoying her time with her daughter and grandchildren. She is in fairly good but not robust health, has fading eyes and muted hearing but smiles quite often. She has no idea what active ageing might be. If asked she might say it sounds nice but is not for her.*

The circumstances and prospects of two men and two women of similar ages in four emerging markets on four continents validates the concept of active ageing while emphasizing it is not for everyone. It also confirms the importance of:

- Initial advantage (Figure 11, taken from the report on the 2014 EMS *Symposium on Maternal and Child Health and Nutrition*), contrasts the prospects of two infants in a footrace; it is also a metaphor for unequal life chances and contrasting outcomes
- Life course health and nutrition
- Lifetime education
- Favourable lifetime (or even sometime) physical, social and cultural environments.
- Economic security including social security and pensions.

Figure 11

Source: Report on Maternal and Child Health and Nutrition, EMS 2014)



# HEALTH AND HEALTHCARE CHALLENGES AND OPPORTUNITIES

## CHALLENGES

Most healthcare systems in emerging markets provide fragmented care with high transaction costs, perverse payment incentives, inadequate emphasis on prevention, inefficient use of high order skills, insufficient use of low and middle order skills and inappropriate training for medical practitioners. These conditions give rise to far from trivial challenges associated with infectious and chronic diseases, dementia, emotional disorders, disability, medical education and attitudes towards the relative priority of healthcare for older people.

### Epidemiological Transitions

Except for deaths caused by predation, malnutrition, suicide, homicide, starvation, dehydration, and accidents, death is caused by disease and mostly occurs in old age. In today's wealthy countries, epidemiological transitions<sup>11</sup> are well advanced and chronic diseases have largely displaced infectious diseases as leading causes of death. In emerging markets where epidemiological and demographic transitions started later, deaths are increasingly attributable to chronic and degenerative diseases that can strike anyone, anywhere, at any stage of life but are particularly associated with older populations. But death and disability (e.g. associated with malaria) attributable to infectious diseases will continue to exist as long as significant populations remain poor, badly housed, badly fed and badly protected from environmental hazards.

### The Metabolic Syndrome

Economic development typically leads to improvements in population health, due primarily to better sanitation, housing, nutrition, and education. Benefits from access to medical care become apparent later when necessary and accessible substructure has been put in place. Increased food calorie intake, following migration or economic development, can, however, lead in some people to increased morbidity and mortality by inducing the "metabolic syndrome" of central obesity, high blood pressure, high blood glucose, and disordered blood lipids. The syndrome is associated with high risk of cardiovascular disease and diabetes. Two situations in particular increase the risk of metabolic syndrome. Both are associated with economic development:

First, population groups that have lived through periods of famine are thought to accumulate, through natural selection, so-called "thrifty genes"<sup>12</sup> that promote the laying down of fat during times of plenty allowing individuals to survive subsequent periods of starvation (individuals without such genes will either wastefully burn off excess calories or simply not have the appetite to eat them). Peoples thought to exemplify the thrifty gene effect include Pima Indians in the US, South Asians in South Africa and the UK and Polynesians in New Zealand. It is now suspected that in addition to natural selection of actual genes, changes in epigenetic control of gene expression - "thrifty phenotype" - may contribute to the genesis of the metabolic syndrome.

*"Last scene of all  
That ends this strange,  
eventful, history  
Is second childishness  
and mere oblivion,  
Sans eyes, sans teeth,  
sans everything"*

**William  
Shakespeare  
As You Like it,  
Act 2 Scene 7**

Second, fetuses of pregnant women suffering nutritional deficiencies also undergo changes in epigenetic control of the relevant genes so that such children are liable to the metabolic syndrome if they later find themselves in a calorie-rich world. The effect of this intra-uterine “metabolic switch” was first detected in a link between cardiovascular disease in the economically and socially developing UK and geographical patterns of poverty in the preceding generation of mothers<sup>13</sup>. Here is one contributor to social class differences in morbidity and mortality.

A mechanism that matches a developing child’s metabolism to its likely subsequent environment confers survival value that will have been encouraged by natural selection. A more obvious effect of such “intra-uterine programming” is on patterns of growth and notably the lower birthweight of children of nutritionally disadvantaged mothers. Overfeeding to compensate for low birth weight can lead to the metabolic syndrome. The 1,000 days of human life from conception to age two are critical to the physical and cognitive development of children and adults; how long and how well you live has a lot to do with how well (and how long) you were at birth. Healthy mothers in roughly comparable circumstances around the world, should have similarly sized (healthy) babies *irrespective of race or ethnicity*<sup>14</sup>. Parental lifestyle decisions (e.g. about alcohol, tobacco and drug use) have important and often irreversible impacts on the adult health of their children.

### Multimorbidity

Older populations in emerging markets, like their wealthy country counterparts, are characteristically prone to multiple morbidities. The growing prevalence of multimorbidities has numerous implications for the design, delivery and integration of primary and secondary healthcare for older people. Some emerging markets have developed innovative approaches such as nurse-led clinics for asthma, diabetes and cardiovascular disease. But there is a widely felt need for better understanding of the aetiology of disease and how health services should be organised to provide continuity and co-ordination of care in resource-constrained and institution-weak environments. There is also an urgent need to address nutrition-related issues associated with morbid obesity, diabetes and cardiovascular and other diseases in older adults.

## DEMENTIA

*“Alzheimer’s is poised to become the fiscal nightmare of the 21st century”*

**Michael Hodin, The Fiscal Times, 2013**

A new case of dementia is reported somewhere in the world every seven seconds<sup>15</sup>. It is increasingly likely the victim will be 65 or over and will live in an emerging market. China (where ageing individuals with living family members must, by law, be cared for by their families), now has more cases of dementia than any other country in the world. In other emerging markets the frequency varies but is increasing everywhere<sup>16</sup>. It is rising fastest in populations over 65 although individuals may develop familial, or early onset Alzheimer’s, as early as their 30s and 40s<sup>17</sup>. Few emerging markets are equipped to manage dementia on an epic scale but current projections suggest they will have to do so.

## PSYCHOLOGICAL DISORDERS

Clinical Depression is neither a normal nor an inevitable part of ageing, although evidence from emerging markets and wealthy countries confirms it is increasingly prevalent among older adults and is often associated with *medical* (chronic diseases, failing eyesight, loss of hearing, skin deterioration that may be linked to social isolation and depression), *circumstantial* (deaths of friends and family members, inability to participate in cherished activities) and/or *external* (e.g. financial) events. There is also evidence that age-associated physical and chemical changes (e.g. lower concentrations of folate in the blood and nervous systems) may increase risks of depression, mental impairment and dementia; that mortality rates for older people suffering from depression and isolation are higher than for those who are satisfied with their lives; and that depression in ageing populations is usually associated with multiple causes including chronic disease.

The relative priorities of chronic diseases, dementia and emotional disorders vary between emerging markets but the prevalence of multimorbidities and evidence of causal relationships between diseases amplifies the need for vertically integrated (over time) and horizontally integrated (between types of disease and specialisms) least cost healthcare. This need was recognized in the 2009 symposium on *Health and Healthcare* and was recognized again in the context of health and healthcare for older people in 2015.

## DISABILITY

Ageing in the sense of senescence is associated with increased risks of physical or cognitive impairment (loss or reduction of physiological, psychological or anatomical structures and functions); disability (diminished capacity to match actions to intentions or wishes) or handicap (the social consequences of ecological gaps between human impulses and physical or social environments). These outcomes are functions of complex physiological changes. The central nervous system slows down; vision and hearing deteriorate; bones become brittle; and neural processes change but do not necessarily limit the capability of older people to do what they want to do or what is expected of them. Some older people can do things as well as or better than younger counterparts or competitors. Others begin to deteriorate long before they become chronologically 'old'.

The nature and severity of functional deterioration varies in light of education, knowledge, experience, life-style choices and preventative and therapeutic interventions through the life course. Its consequences also vary as a function of the availability and continuity of physical or other support and assistance during senescence; the use of compensatory technology to attenuate the consequences of impairment; and the extent to which an individual has multiple impairments, disabilities or handicaps.

Most wealthy countries have measures that permit impaired, disabled and handicapped individuals of all ages to access schools, restaurants, clinics, theatres and other buildings; participate in social and economic activities on modified if not equal terms; safely open packaged products; and safely use public transport are a work in progress. Some have made less progress than others but most have made more progress than emerging markets. This is consistent with the fact that emerging markets have fewer resources and may also have other priorities. It is also consistent with the facts that inequalities of all kinds (ethnic, gender, racial, financial, economic, cultural, social, political) are widely tolerated and accepted in emerging markets and that the concept of a sharing society has taken root in very few. However, as ageing populations grow, the absolute and relative numbers of physically and cognitively impaired, disabled and handicapped older populations will grow too.

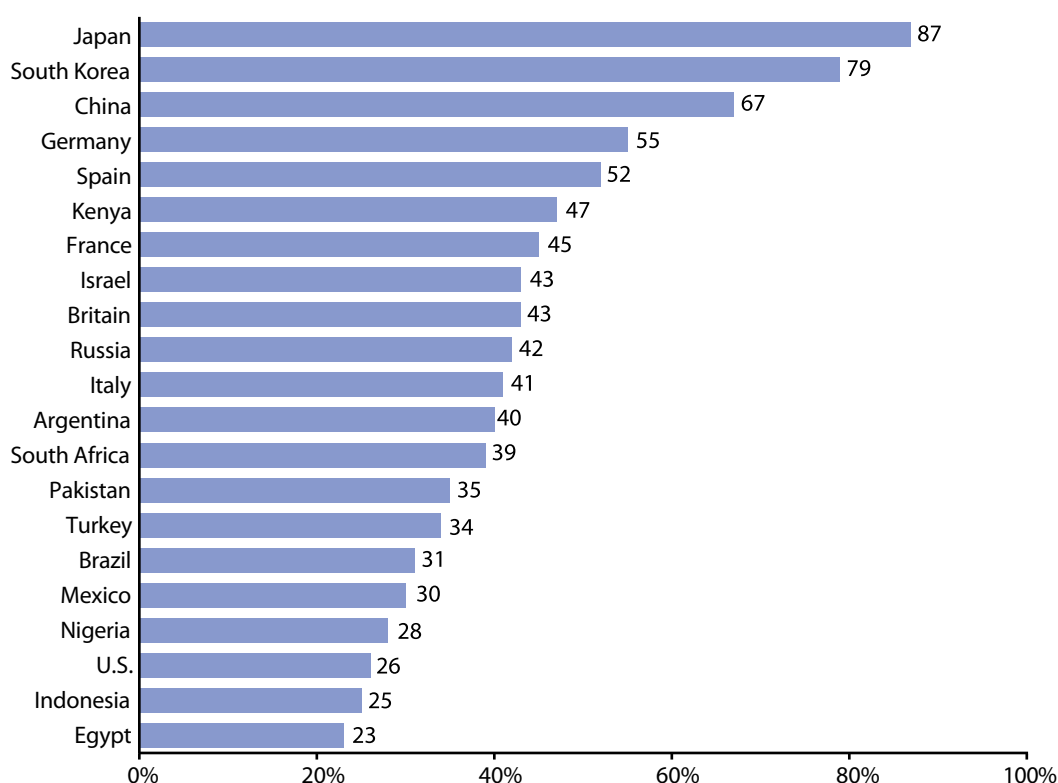
## EDUCATION

Previous EMS symposia<sup>18</sup> have highlighted the need to broaden the education and training of medical professionals in public health, urban health and maternal and child health. This symposium highlighted the need to equip selected (mainly general practice, primary care) physicians, assistants and nurses with at least minimal skills to recognize, diagnose and treat age-related conditions, including age-specific morbidities and chronic illnesses. Many emerging markets will face the generic challenge of accommodating competing claims on training resources while recognizing that the healthcare needs of older people will gradually outweigh those of younger populations.

*"And yet health professionals (in Brazil) continue to be trained for the 21st century learning next to nothing about ageing and health care in old age",*

**Alexandre Kalache,**  
EMS Presentation,  
2015

Figure 12: 'Is aging a problem in your country'?  
 % People who described growing number of older people as major problem.  
 Source: Pew Research Center 2014"



## ATTITUDES

Recent survey data<sup>19</sup> confirm that attitudes towards the priority of healthcare for older people are broadly correlated with the expected relative and absolute size of ageing populations.

In emerging markets with relatively young populations (e.g. Egypt, Indonesia) there is less implicit concern about the needs of older people (and implicitly their healthcare) than in emerging markets with large ageing populations (notably China and to a smaller extent Russia, Argentina and South Africa. (See Figure 12).

The battle over the relative priorities of healthcare for different age cohorts will not be fought in isolation but as part of a bigger battle over the perceived value of older people in emerging market societies. In societies where traditional values seem to be surviving globalization and urbanization, respect and concern for older people has also survived; that may not be so elsewhere.

## ENVIRONMENTS

For many people, physical and cognitive degeneration are gradual processes that may begin at relatively early ages (e.g. early onset dementia). Wealthy countries offer examples of how the consequences of progressive impairment (e.g. sight, hearing, mobility, strength) can be attenuated. Although few have addressed, much less resolved, all the problems arising, their experience suggests cost effective solutions that emerging markets could emulate (e.g. audible road crossing signs, reserved parking bays, easy-to-open food packaging) that reduce the risks of accidents and enhance the quality of life for older people.



## OPPORTUNITIES

Whereas China provides basic healthcare care to older populations, the older poor, like the younger poor, lie beyond the reach of healthcare systems in other emerging markets (e.g. India, Malaysia, Peru) because: (i) The scope and scale of demand exceeds the supply of available financial and human healthcare resources; (ii) The needs of ageing populations, like those of the poor, have relatively low priority; (iii) Medical professionals are not well trained to recognize and understand dementia, multimorbidities, emotional disorders related to environmental circumstances and intergenerational relationships, chronic diseases prevalent in older populations or to enable patients to play active roles in their own healthcare.

The evidence suggests that healthcare for older people in emerging markets could be improved by: (i) Emphasizing coordination and integration; (ii) Improving training and education for medical practitioners; (iii) Making more intensive use of information technology to meet the healthcare needs of elderly patients; and (iv) Taking steps to create people-friendly environments, particularly in urban areas.

## JOINED-UP HEALTHCARE

Previous EMS symposia (2009, 2011, 2014) have pointed to the need for emerging markets to pay more attention to coordination and integration when planning and delivering healthcare of all kinds to people of all ages. This symposium focused on five aspects of joined-up healthcare for older people: integrated life course perspectives; intersectoral coordination between ministries and departments whose activities directly or indirectly affect health; integrated delivery of specialized healthcare services; the integration of healthcare and social care; and the integration of patients in healthcare decisions.

### Life Course Perspectives

Healthcare policies in emerging markets should be grounded in *life course perspectives* that link human health from *in utero* beginnings through old age; acknowledge that nutritional deficiencies in early life may lead to permanent and irreversible disadvantages and to many of the health problems that compromise the quality of life of older people; and recognize that simple measures in adult life (e.g. good nutrition, clean environment, exercise) can prevent, or at the very least forestall, many of the health problems that compromise the quality of life of older people.<sup>20</sup>

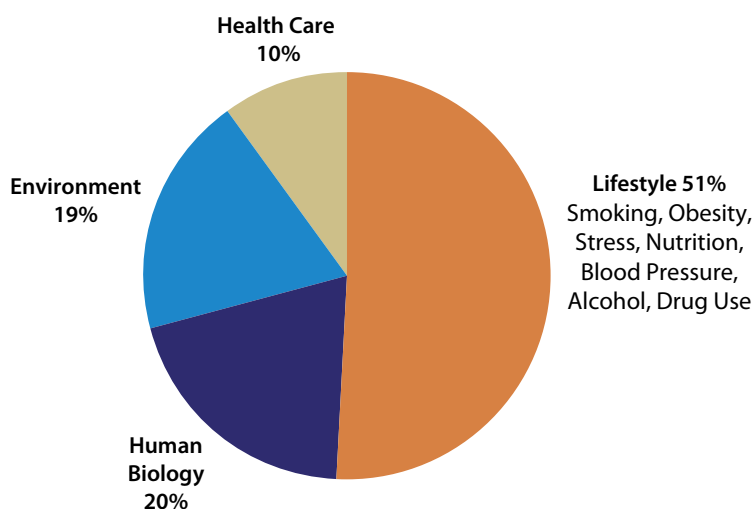
#### International best practice suggests successful integrated health and care systems have:

- Strong clinical leadership
- Data driven processes
- Multi-disciplinary teams
- Strong investment in preventative services
- Proactive assessment and care planning
- Effective care co-ordination in crises
- Seamless transfer between settings
- Single electronic care records with patient access
- Integrated commissioning and provisioning
- Integrated physical and mental health services
- Consistent incentives across system

## Sectoral Coordination

Given compelling cross-cultural evidence that health outcomes are largely determined by factors other than healthcare, health strategies for older people in emerging markets should emphasize *coordination* between government departments and jurisdictions that directly or indirectly influence health outcomes and affect longevity. Sir Michael Marmot told his audience in a lecture at the symposium on *Urbanization, Health and Human Security* in 2011, “*Every Minister is a Minister of Health*” and Figure 13 shows healthcare plays a relatively minor role in determining health outcomes.

Figure 13: Social determinants of health  
Source: WHO 2009



## Integrated Healthcare

*Integrated personal healthcare* offers potential benefits at all ages and particular benefits to older populations with multiple morbidities and complex needs and pathologies. As emerging market populations live longer and chronic diseases become more prevalent, integrated healthcare delivered through collaborating teams of specialists, each of whom knows what others are doing, will become an increasingly attractive option. Although existing systems in emerging markets have diverse objectives, priorities, styles, metrics and rigidities, they are generally less tradition-bound and more open to innovation than older systems in wealthier countries. Pioneering applications of telemedicine and other technologies in India and other emerging markets in Asia and Latin America offer persuasive evidence of what can be done.

## Integrated Healthcare and Social Care

Many wealthy countries have struggled to overcome practical constraints to the integration of healthcare and social care and to overcome resistance to coordinated action. Emerging markets face those problems too and, given the generally embryonic nature of their social care services, will have even greater difficulties in capturing the advantages of integration.

Yet *integrated health care and social care* offers substantial benefits, including more efficient use of scarce resources, holistic approaches and improved patient experiences. The experience of wealthier countries suggests integration should be driven through clinical engagement and based on local initiatives rather than nationwide policies, although national policy frameworks help avoid undue variations in outcomes. The political scope for integrated care will vary between emerging markets but variations would not preclude coordinated pilot schemes which would in any case be needed to test alternative models.



## Integrating the Patient

There are opportunities to integrate patients in healthcare decisions by emphasizing *patient* responsibilities (e.g. for lifestyle choices, monitoring personal and family health and acquiring minimal levels of health knowledge) and providing appropriate education through healthcare extension agents. Successful innovative approaches (including some from poorer countries e.g. Myanmar) offer examples that could be adapted and adopted in emerging markets. The need for patient participation is likely to be sharpened as the debate on doctor-assisted dying (not discussed at the symposium) now largely confined to wealthy countries, spreads to emerging markets where it may raise more general questions about roles and responsibilities.

## EDUCATION AND TRAINING

Three recommendations of the 2009 EMS symposium on *Health and Healthcare* have peculiar relevance to older people. One is that emerging markets should emulate countries (e.g. India) where non-traditional health-workers are trained and remotely supervised by senior professionals using state of the art information and communications technologies to diagnose, treat and monitor infectious and chronic conditions. A second is that emerging markets should create incentives to persuade medical professionals to work for limited periods among older people in marginal areas. A third is that medical schools and other institutions (including foreign institutions where emerging market medical professionals are trained and educated) should equip doctors with knowledge, skills and experience needed to care for older people.

## INFORMATION TECHNOLOGY

Personal computers, mobile phones, tablets and other devices have transformed many aspects of life in the wealthy world. In emerging markets mobile telephones are rapidly penetrating urban and rural communities and although Internet use is growing more slowly the digital divide is shrinking. As in wealthier countries, today's older generations were in their middle years when information technology began to change economies and societies and their reticence to embrace it may be at least partly explained by generational differences, learning difficulties and skepticism about potential benefits. Emerging markets have however set the pace in capturing the advantages of telemedicine for older people and there is ample opportunity to expand the scope of technology supported health (and social) care on their behalf.

## AGE-FRIENDLY ENVIRONMENTS

The symposium agreed there are many ways in which emerging markets can be made safer, more convenient and more reassuring and less frustrating and intimidating for older people. The role of governments is to create public environments for people with minor mobility, vision, and hearing problems; create industry standards for access to and activities within public buildings and public housing including sites and services projects in poor communities; encourage industry to design age friendly products and packaging; and encourage employers to design age friendly workplaces.

*An age-friendly world... is a place that enables people of all ages to actively participate in community activities; that treats everyone with respect, regardless of their age; that makes it easy to stay connected to those around you; that helps people stay healthy and active even at the oldest ages; and that helps those who can no longer look after themselves to live with dignity and enjoyment.... Many barriers persist: poorly designed buildings, lack of transportation that prevents older people accessing the places they want to visit, but many barriers result simply from the way we think about ageing and the way we view and treat older people.*

**Adapted from Age Friendly World, WHO, 2015**

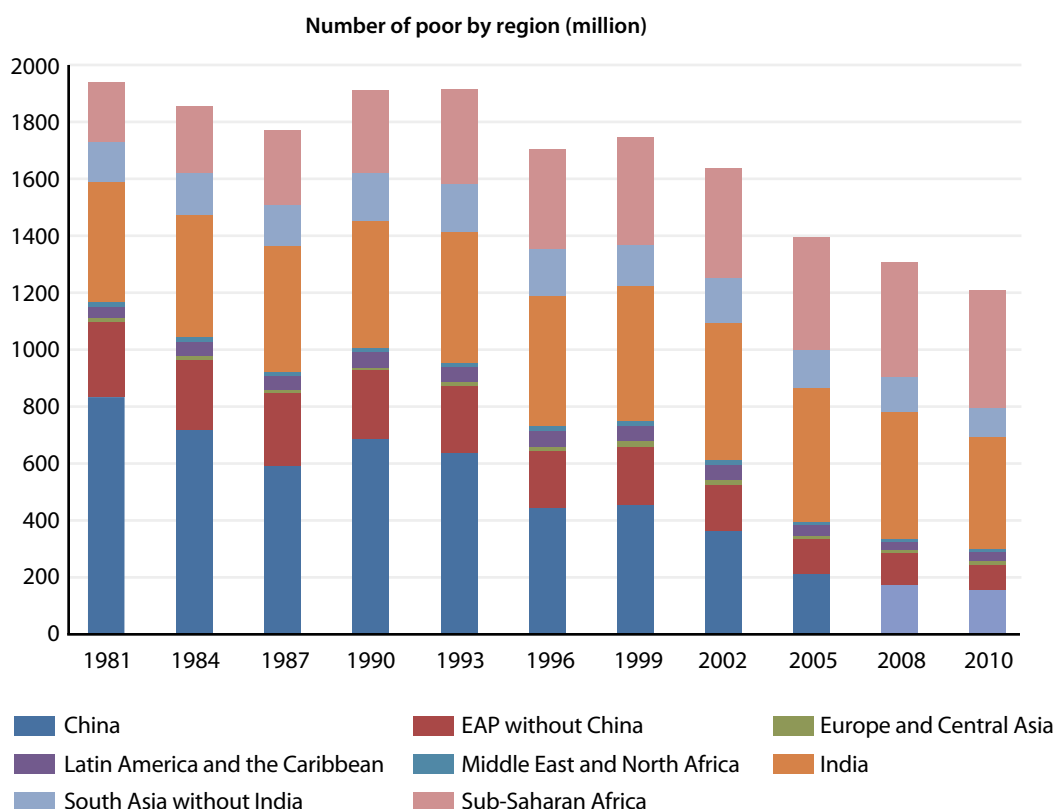
# ECONOMIC CHALLENGES AND OPPORTUNITIES

## CHALLENGES

In the last thirty five years, sustained economic growth has permitted most emerging markets to reduce income poverty (in some cases massively), enable large numbers of people to graduate from being relatively poor to being relatively well off and allow the relatively rich to become even richer. The less good news is that emerging markets continue to dominate the global distribution of absolute income poverty. These changes, coupled with demographic changes, have created a raft of historically unfamiliar challenges for emerging market governments and societies. None of them are more acute or more potentially divisive than those associated with population ageing. The outstanding issues are the prospect of large concentrations of absolutely and relatively poor and indigent older people in cities and rural areas, the increasingly urgent need to realign laws that govern retirement from the labour force with changing demographic realities, the dominance of the informal sector and the inadequacies of social security systems.

Figure 14: Absolute poverty in emerging markets

Source: World Bank 2013



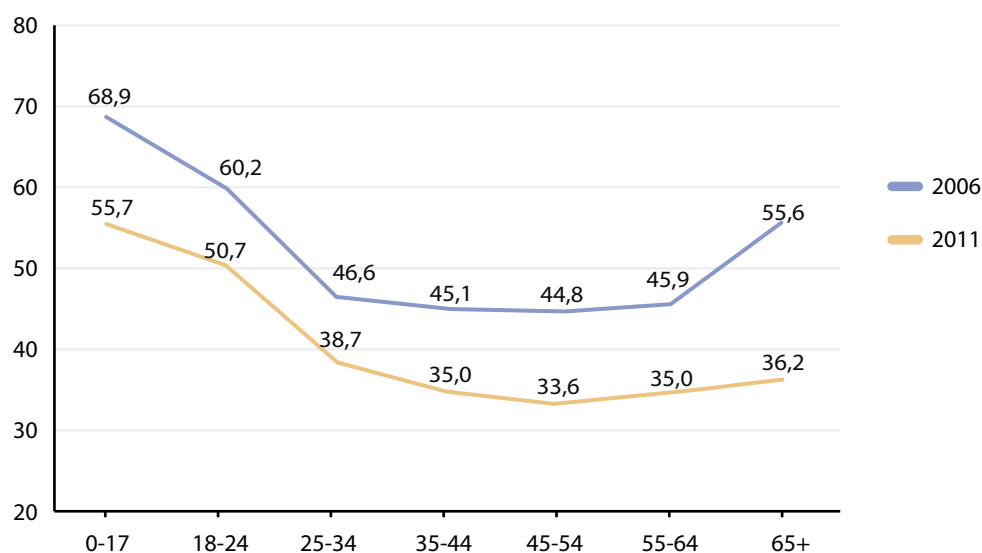
## OLD AGE POVERTY

Between 1981 and 2010 the prevalence of extreme (or absolute) poverty (defined by the UN as daily *per capita* income under \$1.25 in 2005 prices)<sup>21</sup> fell from 81% to 16% in China, from 17% to 8% in Brazil and from 60% to 42% in India. The contrast is greatest in rural areas. East Asia saw the most dramatic reduction in extreme poverty, China alone accounting for most of the decline. In 2011, just over 80 % of the extremely poor lived in South Asia (399 million) and Sub-Saharan Africa (415 million) with 161 million in East Asia and fewer than 50 million in Latin America and the Caribbean, the Middle East and North Africa, and Eastern Europe and Central Asia combined (see Figure 14).

Disaggregated data are less reassuring. In India, in 2010, one in three people over 60 had incomes below the UN poverty threshold. In China the corresponding proportion was one in four. In South Africa the age-poverty relationship is 'U' shaped and although there has been some improvement in recent years (see Figure 15) the oldest old are at greater risk of income poverty than younger adult age cohorts.

Figure 15: % of age cohorts with incomes below South African absolute poverty line 2006-2011

Source: Statistics South Africa, 2014



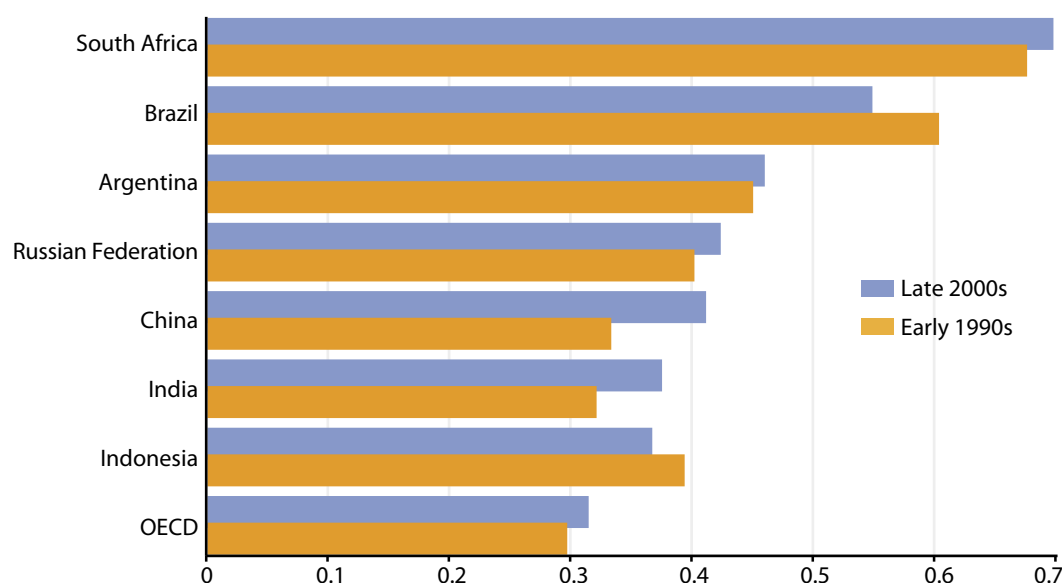
## INCOME INEQUALITY

The ghost of inequality has stalked every EMS symposium and ran a seamless course through this one. In most emerging markets the overall decline in income *poverty* since 1980 has been roughly paralleled by growing overall income *inequality* (see Figure 16). There have been similar trends in some wealthy countries.

If recent trends in income levels and income distribution in emerging markets are sustained, the numbers of older people living in extreme and relative poverty will create social and moral hazards and (if the old and poor find a voice or acquire powerful champions) political hazards too. The acid test is likely to come in India which, by mid-century, may be the world's most populous nation and have the largest number of poor people.

Figure 16: Change in inequality levels, early 1990s versus late 2000s<sup>1</sup>  
Gini coefficient of household income<sup>2</sup>

Source: OECD 2011



1. Figures for the early 1990s generally refer to 1993, whereas figures for the late 2000s generally refer to 2008.

2. Gini coefficients are based on equivalised incomes for OECD countries and per capita incomes for all EEs except India and Indonesia for which per capita consumption was used.

## RETIREMENT

If current retirement ages in emerging markets (see Figure 17 where pensionable age is a surrogate for retirement age) remain unchanged, increasing numbers of people will spend more time retired than they spent working. As life expectancy has increased, the health of ageing populations has improved and the cognitive and physical capacities of older people have become more durable, formal retirement ages have remained frozen. Yet the popular fallacy that people who live beyond a certain age are no longer fit for (or wish to) work has endured. Whereas male life expectancy in many emerging markets is expected to increase by up to five years between 1990 and 2030, very few emerging markets have followed the example of the European countries that have increased statutory retirement ages (although even there the changes have been modest).

Figure 17: Pensionable ages in selected EMs

Source: Stuart Basten 2015

AGE	MALE	FEMALE
65	Argentina, Brazil, Chile, Mexico, Peru, Poland	Mexico, Peru
62	Colombia	
60	China, Egypt, Jordan, Pakistan, Philippines, Russia, South Africa, Tunisia, Turkey	Argentina, Brazil, Chile, Egypt, Philippines, Poland, South Africa,
58	India	India, Turkey
57		Colombia
55	Indonesia, Malaysia, Thailand	China, Indonesia, Jordan, Malaysia, Pakistan, Russia, Thailand

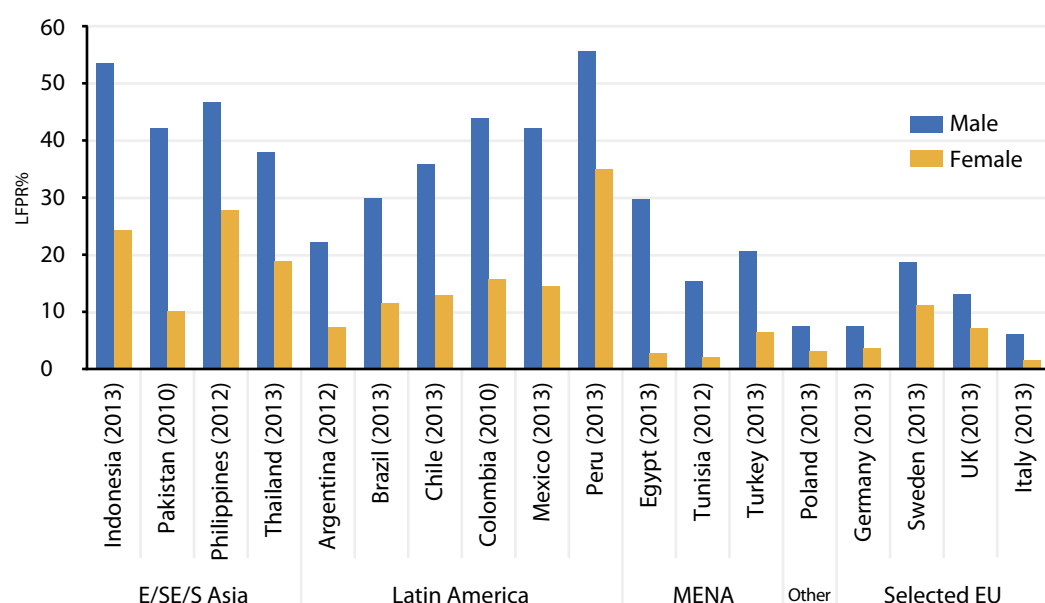
The symposium found that current definitions do not fit the facts. And not just in emerging markets. For example the official retirement age in Germany has not changed since it was decided in 1916 that men were too old to work at 65. That decision and subsequent decisions around the world created a fixed boundary between the world of work and the world of what comes next.

Whilst finding current arrangements anomalous the symposium agreed that emerging markets face more difficulties managing retirement ages than wealthier countries because their labour forces are more diverse, the informal sector is huge and there are much larger issues of poverty and inequality. As a result, in many but not all emerging markets, the phenomenon of rising average longevity conceals contrasts between older people who:

- Are relatively prosperous, healthy and expect to live in to their 80s or beyond and, like the fictitious Andres Gomez (see page 23) may wish to continue working beyond the 'normal' retirement age because work is a source of validation, reputation and social participation.
- Benefitted from economic growth in the 1980s and 90s, have relatively positive financial circumstances, health and prospective lifespans and (like the fictitious Nur Dhia Mawaddah see page 23) may wish to continue to work part time for financial and/or other reasons.
- Are relatively unhealthy, have relatively short prospective lifespans and, like the fictitious Ludmilla Semnovich (see page 24) continue to work part time because her pension is inadequate.
- Like the fictitious Akbar Lakhani (see page 23) continue to work because they must.

Figure 18: Labour force participation rates, aged 65-70

Source: Stuart Basten 2015/ILOSTAT, 2013



The symposium recognized that in wealthy countries, and increasingly (but not to the same extent) in emerging markets, rates of wear and tear have been diminished by technology based capital-labour substitution (in agriculture, mining, manufacturing and services), health and safety regulations, minimum wage legislation and other measures, and that, as a result, some manual as well as non-manual workers now reach the finish line with wind in their sails.

It also recognized that because poverty and income inequality are far greater and the informal sector is far larger in emerging markets than in wealthy countries, it is unrealistic to imagine that, for some time to come, labour market reforms that may be feasible in say, France or Australia will be feasible in say, Colombia or Sri Lanka. It is nonetheless true (and consistent with sharp economic contrasts between wealthy countries and emerging markets) that many older people contribute to the economy because they have no choice, not because they want to: Figure 18 shows higher participation rates in emerging markets than in wealthy countries, particularly for males although females often contribute through such activities as childcare.

*"Age 65 is generally set as the threshold of old age because it is at this time of life that the rates for sickness and death begin to show a marked increase over those of the earlier years", Rubinow (1916)*

*In 1936 The First Railroad Retirement Act in the USA referred to the "Commonplace fact that physical ability, mental alertness and cooperativeness tend to fail after a man is 65"*

*In the 1940s, Beveridge, Ostler and Hoffmann argued that "Retirement age should be 65 as workers after this age lacked 'mental elasticity' and 'adaptability to technological change' (Costa 1998)*

**Source: Basten and Scherbov (2015)**

*Instead of forcing older workers to retire, or firing them, BMW tinkered with an assembly line in an auto plant, staffing it so the average age of workers became 47. It also made 70 small changes to reduce the chance of errors and risk of physical strain. Productivity rose 7%.*

**Anderson LB (2013) 'How frames present BMW as embracing an aging workforce. Public Relations Review 39: 484-90.**

## THE INFORMAL SECTOR

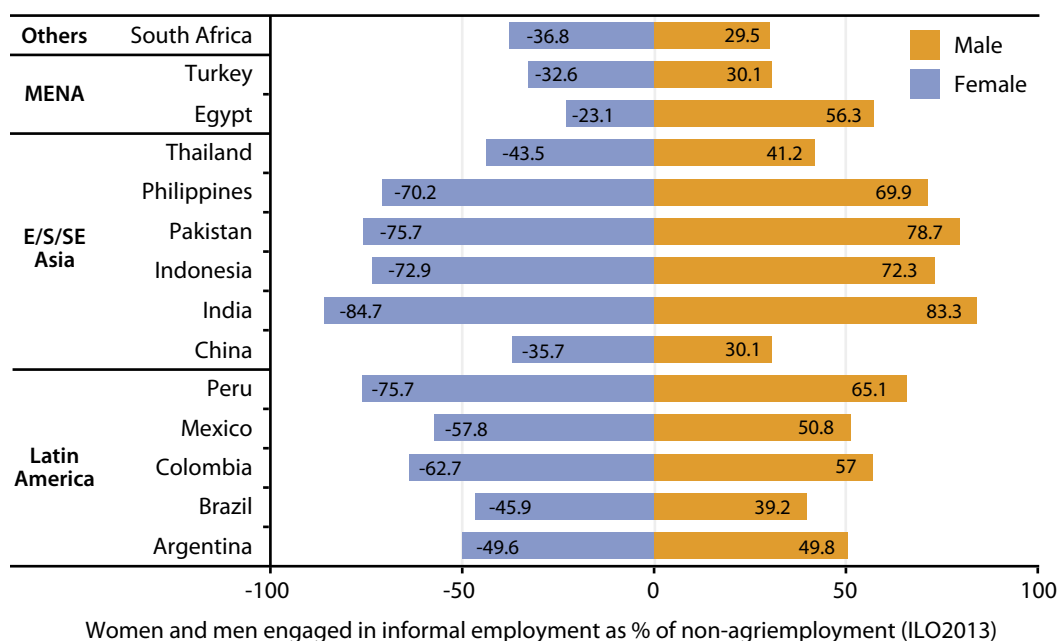
A large (in some cases very large) proportion of economic activity in emerging markets is in the informal sector. It is unregulated, untaxed and in many ways separate from the formal economy. In a stylized form, it is a man selling lottery tickets on a street corner in Lima, five women sewing garments for piece work wages in a Kolkata sweatshop, a family assembling Christmas crackers in Sri Lanka, a woman selling farm produce on a Russian roadside.

Through the late 20th century, the informal sector was often characterized (and sometimes chastised) for what it lacked: regulated wages, health and safety inspections, job security, health benefits, pensions. And it was often assumed it would disappear as economies matured. When that did not happen as expected, the *formalization* theory was temporarily replaced by an *informalization* theory that argued the growth of informal employment was driven by globalization until that theory was, in turn, confronted by evidence of persistent informality in emerging markets with fast growing economies.

Recent ILO data on non-agricultural employment shows the informal economy accounts for 82% cent of total employment in South Asia, 65% in East and South-East Asia (excluding China), 51% in Latin America and 10% in Eastern Europe and Central Asia. These regional averages include poorer countries as well as emerging markets and conceal wide inter-country variations (e.g. 42% in Thailand vs 83.5% in India) and significant gender gaps. But overall, the informal sector is much larger than commonly supposed.

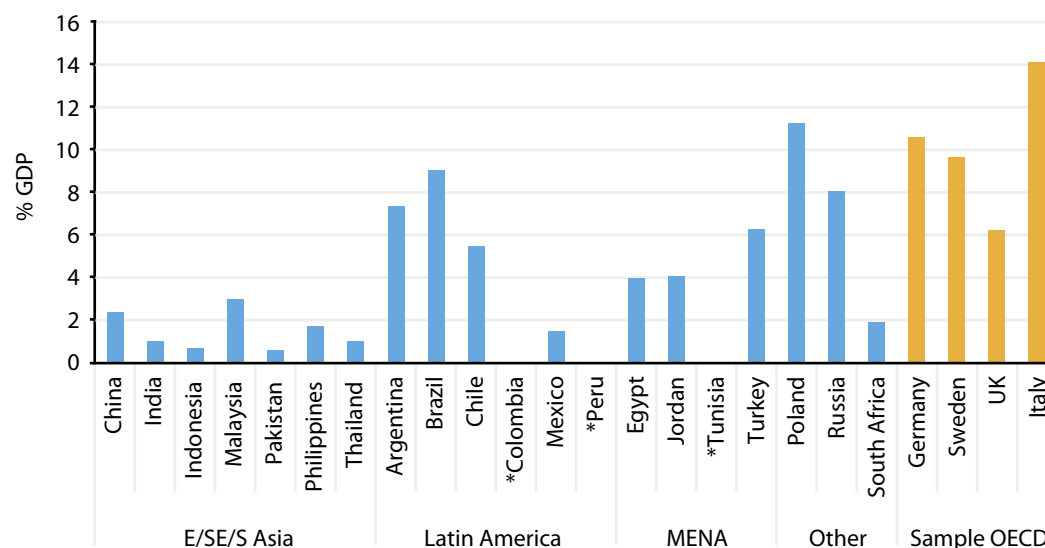
Figure 19: Informal employment in EMs

Source: Staurat Basten 2015/ILO2013



As suggested above, informal employment has been typified as low-paid work in homes, small sweatshops and street corners. In reality, although mean informal wages are lower than mean formal wages in emerging markets, the continuum of informal wages overlaps with the continuum of formal wages. Moreover, wage employment can be both formal *and* informal (e.g. employees in a firm in an emerging market in Eastern Europe, might receive declared *and* undeclared or "envelope" wages). The informal sector is heterogenous, complex and *sui generis* but is likely to become a major issue as emerging markets consider the question of how to provide financial security for ageing populations (see Figure 19).

Figure 20: Public pension expenditure (% GDP 2010)  
Source IMF 2012)



## SOCIAL SECURITY

From ancient origins<sup>22</sup> in Iraq through Bismarck's ambitious interventions in late 19th century Prussia<sup>23</sup>, pension schemes have been grounded in motives ranging from moral obligation to enlightened self-interest. Existing arrangements in emerging markets vary enormously in scope, scale, cost and long term sustainability, and the extent to which, if at all, they provide safety nets for the poor. Schemes include: (i) Mandated, unfunded, publicly managed, defined benefit systems; (ii) Mandated, funded, privately managed, defined-contribution systems; (iii) Voluntary savings systems; and (iv) Poverty alleviation systems.

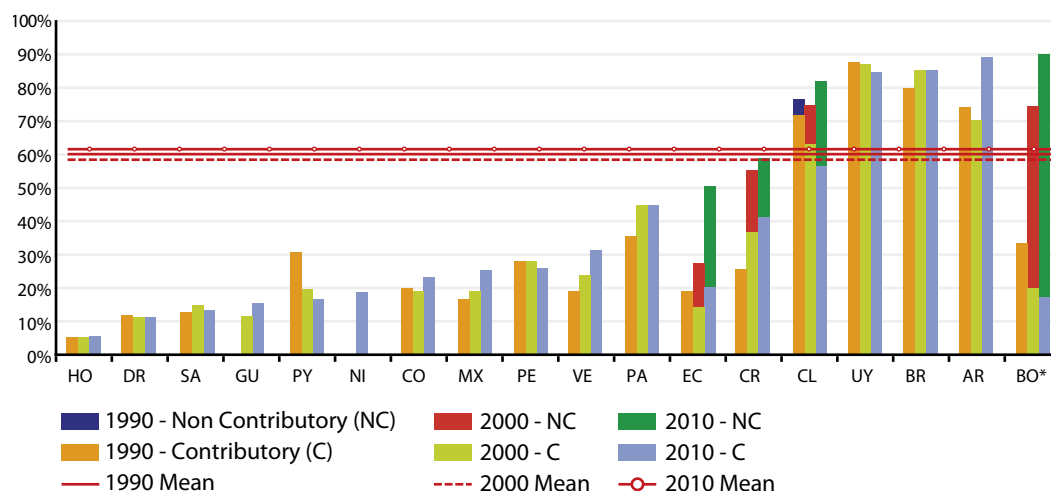
They all have two weaknesses. First, most of them exclude the informal sector, which, in some emerging markets, means they do not cover most of the working population. Second, they are ill equipped to manage the growing needs of those who are, in principle, covered but in fact are covered inadequately.

Public expenditure on pensions provides only a partial picture of the cost of existing schemes but reveals relatively modest expenditures in most emerging markets (the main exceptions being Poland, Brazil, Argentina, Russia, Turkey and Chile) by comparison with wealthy countries (Figure 20) where the long run affordability and sustainability of many schemes, most created in the early or mid-20th century, have been reappraised (in some cases agonizingly) in the context of the 2009 recession. Similar but generally less urgent questions have been raised in emerging markets, in some of which, as a result, future benefits and eligibility criteria have been altered.

In China, where economic growth and urbanization have been associated with weakening family ties and rapid population ageing, the main challenge has been to increase coverage. In the late 1990s, China's state enterprise based, cradle-to-grave, system was replaced by a public pay-as-you-go system initially limited to urban areas. By 2009 less than 30% of China's adults had been covered, partly because mandatorily funded accounts had been used for other pension payments by local governments. Urban coverage has since increased to 50% although rural areas, with locally administered systems still lag with 9%.

Figure 21: % age of the economically active population contributing to pension systems

Source IMF 2012

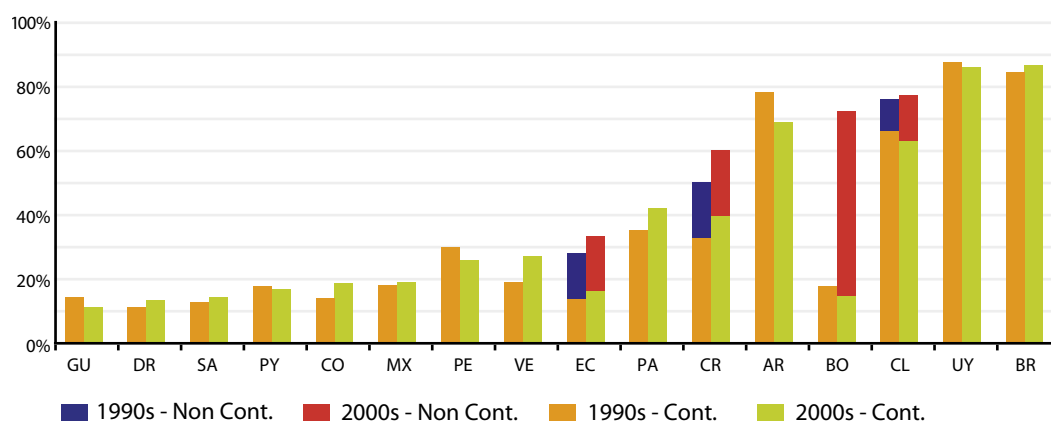


India has a highly fragmented pension system with a limited safety net, schemes for public servants and two mandatory schemes for private employees (from which employers can opt out and establish company funds). There are also voluntary occupational schemes and a public provident fund for voluntary savings. Except for the last, these schemes exclusively cover the formal workforce (around 12% of the population) which in 2011 meant 26 million people as compared with 433 million in the informal sector (including daily wage labourers and others). Recent reforms have included a new Direct Contribution scheme for public servants, (replacing the old Defined Benefit scheme that will also be open to the informal sector).

In the 1990s macroeconomic pressures and labour market issues prompted many Latin American countries to (i) Restrict access to pension benefits (through parametric reforms) and (ii) Following the trend initiated by Chile in 1981, expand the role of the private sector in pension administration. More recently, the focus has been on increased coverage through social or non- contributory schemes and reduced access to contributory schemes (see Figure 21).

Figure 22: Pension coverage (%) for Latin American countries for people aged 65 and over

Source: World Bank 2006



Coverage of older people remains low in emerging markets in this region except in Argentina, Chile and Brazil where coverage exceeds 60 % (Figure 22) although in Argentina coverage fell from 77 % in 1995 to 65 % in 2004. While coverage is generally limited to contributory schemes in countries with relatively low participation, non-contributory benefits are important in some of the countries with high coverage. Argentina has small non-contributory benefits that cover people over 70 who do not qualify for contributory benefits. In Brazil, a large quasi-non-contributory system covers rural workers. Mexico has some non-contributory schemes at the subnational level.



## OPPORTUNITIES

No aspect of longevity in emerging markets generates higher temperatures than financial security. Whilst strong filial ties persist in some places, they are weakening in others and traditional assumptions about reciprocal childcare and elder care (parent raises child, child tends parent) are less sure than they were. Accordingly, emerging markets must find answers to some neuralgic questions: (i). How should they approach the prospect of growing numbers of older people with minimal financial security and others who are only a bit better off? (ii). How should they deal with the demographic truth that (in most emerging markets) increasing numbers of people will live in retirement for many years? (iii). How should they respond to growing numbers of people (in both the informal and low wage formal sector) for whom retirement is an abstract idea because they must continue working? (iv). How can they create and manage equitable, adequate and sustainable pension policies for the formal sector?

## THE POOR AND POOREST OLD

Not all emerging markets face the prospect of large and growing numbers of extremely poor and potentially indigent older people: Some (e.g. Russia) because they have distinctive demographic profiles; some (e.g. Brazil) because the poorest old already receive income transfers<sup>24</sup>; others because many of the poorest and neediest do not reach old age and, if they do, have short lifespans. But in some emerging markets, growing numbers of poor old people could pose economic and ethical challenges that could be addressed through income transfers, institutionalized solutions or refusals to intervene on the grounds that older people should be cared for by their families and/or that states cannot afford the financial burdens.

The symposium concluded that emerging markets should, in principle, consider the costs and benefits of subventions to older people whose (biological) age means they cannot work. The subventions would include:

- Transfer payments to the poorest old who are financially and materially vulnerable and do not qualify for pensions. These transfers would be based on verified needs (i.e. would not be universal entitlements).
- Transfer supplements (based on verified needs) to those whose pensions are inadequate to satisfy basic needs and maintain human dignity.

The subventions would be financed from general revenues. Recognizing potential resistance, governments could build public support through targeted education campaigns building on lessons learned in countries (e.g. Brazil) that have already adopted similar measures.

## MOVING THE GOALPOSTS

From an individual perspective there is an important distinction in emerging markets (there is a much smaller one in wealthy countries) between:

- An older person working in the *informal* economy, who is not affected by formal retirement rules, is ineligible for a pension and continues to work because s/he *must* until becoming unfit to work and eligible for a subvention; and
- An older person who works in the *formal* economy, is subject to formal retirement rules and is eligible for a pension but wants to work to supplement his/her pension and/or for other reasons.

The contrast implies that in emerging markets with very large informal economies (e.g. India) the costs of subventions would be overwhelming although, in practice, it would be attenuated by massive contrasts in the prospective lifespans of the poor and the better off; there is ample evidence that the poor die younger.

In the formal economy, the extension of working lives would help reconcile the growing disjunction between current retirement ages (and the duration of working lives) and prospective life spans. Allowing individuals to retire at a time of their choosing would help: (i) Minimize cuts in replacement rates (the ratio of the average pension to average wage); (ii) Compensate for labour deficits associated with declining fertility rates; and (iii) Leverage the experience of older workers to benefit themselves, younger workers (through mentoring), employers and communities; (iv) Allow older workers to obtain the non-financial (social, communal, personal health) benefits of work, and remain active in economy and society.

The symposium endorsed the notion that emerging markets should review and, as necessary, revise existing formal retirement and pension systems with several principles in mind:

- People should be allowed to retire at an age of their choosing beyond a threshold age linked to average prospective life spans for men and women.
- The threshold age should be periodically reviewed (rather than automatically indexed) and, if necessary, updated.
- Pension payments should be indexed to inflation.
- Allowing for special cases (e.g. people with disabilities and some public service workers and military personnel), pension payments at the threshold stage would be calculated to discourage early retirement. Those retiring later would receive progressively larger payments up to the age of (say) 75.
- People drawing pensions would be allowed to work for pay in other activities.
- Because the productivity of older workers may decline as a function of diminished (age-related) physical or cognitive abilities, reduced wages and salaries should be negotiated.
- Older workers should pay income tax on their earnings, offsetting the costs of pensions.

In reviewing and revising pension systems, emerging markets should also ask if they are: Compatible with national macroeconomic and fiscal environments; national economic priorities; the capabilities and competencies of existing institutions; plausible demographic and economic futures; the interests of central and local governments; the relative priority of pensions vis-à-vis competing uses for fiscal resources; realistic assumptions about financial literacy; and the wishes of individuals to smooth consumption and manage the risk of outliving their savings.

# SOCIAL CHALLENGES AND OPPORTUNITIES

## CHALLENGES

The consequences of financial poverty and economic inequality for many older people in emerging markets are exacerbated by the facts that their rights, privileges, power and social conditions are diminished in comparison with those of wealthier older and younger people. Six interdependent social challenges stand out: education inequality, gender inequality, urban-rural inequality, ageism, abuse and isolation.

### EDUCATION INEQUALITY

Unequal access to lifetime education is a critical example of how and why social inequality adversely affects social cohesion within ageing populations and between older and younger populations. Older people who have enjoyed the initial advantages of secondary and tertiary education also enjoy enduring and cumulative advantages. They tend to live longer, have higher lifetime earnings, greater material comfort, better nutrition, more living children, fewer disabilities and more autonomy than those with less education. Having started in pole position, they are equipped to stay ahead of the field and to reach old age with the curiosity, technological proficiency and learning habits of a lifetime that allow them to make the most of their older years. Education also allows older people to continue to participate in economic activities as long as they wish, usually for financial reward but sometimes for the satisfaction of using their capabilities in the partial use of their powers in unpaid or partially paid activities.

Contrasts between the educationally advantaged and disadvantaged are more obvious in emerging markets than elsewhere and to a large extent, parallel contrasts in income, wealth, health, material conditions and the quality of life. The best educated are most often the most adaptable, the most versatile and the most likely to acquire new skills. They also run less risk of cognitive decline. The differences are growing and as longevity increases will become more significant. But the most important questions, for both emerging markets and wealthy countries are: as life expectancy approaches 100, how is it possible to justify stopping formal education at the age of 16 or 26; how can education be extended through the lifespan; and how can those who started life with little education find ways to compensate?

*'The problems of elderly women are exacerbated by a lifetime of gender based discrimination, often stemming from deep-rooted cultural and social bias. It is compounded by other forms of discrimination based on class, caste, disability, illiteracy, unemployment and marital status'*

**Indian National Policy on Senior Citizens, 2011**

### GENDER INEQUALITY

The 2013 EMS symposium concluded that gender inequality is rooted in bigotry, bias and the morally indefensible belief that females are intrinsically inferior to males. The 2015 symposium focussed on the fact that while gender inequality is pernicious at all stages of the female life course it is particularly pernicious among older women. The traditional status of older women in many emerging markets has been disrupted by social and spatial change. As the ties that bound families together have frayed, poor old women have become an increasingly large and vulnerable but decreasingly visible cohort.

Many women in emerging markets reach old age with fewer financial assets than men of equivalent age because: they lacked autonomy; barriers to entry often made it impossible for them to work continuously or full-time earlier in their lives; if they found work in the formal economy they typically earned less than men; they were less likely to have benefitted from secondary and tertiary education and as a result earned less than younger women; and/or if they worked in the informal economy did not acquire pension benefits. As a result, although, on average, women in emerging markets live longer than men, they are more likely to be poor, less educated, less employable and more vulnerable to social isolation than men of equivalent age.

## SPATIAL INEQUALITY

Ageing populations in both wealthy countries and emerging markets are often physically and socially segregated from the rest of society. In traditional societies, generations were often mingled, lived in the same places or communities and were involved in the lives of families and friends. Since the early 20th century in most wealthy countries and in the last half century (or less) in most emerging markets, families have been spatially fragmented, emotional bonds have been weakened and concepts of mutuality and filial responsibility have been stretched to and beyond breaking point.

Nothing distinguishes emerging markets from the rest of the world more than the convergence of economic, demographic, epidemiological and spatial transitions since the 1950s. And nothing encapsulates the scale, speed and inequality of economic and social transformation more than the rapid and explosive growth of cities and megacities, particularly in Asia and Latin America.

In wealthy countries, urban and rural changes, changes in labour force participation, demographic changes (family size and composition, longevity) and health changes have gradually removed the option of family care for ageing generations and replaced it with nursing homes, retirement communities and other arrangements. Privileged ageing populations in emerging market cities have comparable options. For others, chaotic, polluted, urban and peri-urban settlements may offer greater deprivation, isolation and exposure to a broader range of health and social hazards than anywhere on earth save perhaps the most depopulated and isolated rural areas. In China, the locus of birth, life and work has largely determined the level and even existence of retirement benefits, although the Government is now committed to reducing the urban-rural welfare gap.

Income differentials are typically reflected in geographically segmented high, middle and low income areas where the urban poor, including the ageing poor, inhabit *barrios*, *favelas*, townships and slums with primitive housing, pirated, if any utilities and few if any services. Although circumstances and conditions vary enormously, a third of the populations of most emerging market cities, including large numbers of older people, may live in conditions that are incompatible with health and human dignity.

Demographic concentration makes cities vulnerable to epidemics, social disorders and natural disasters. But, for older people and younger people alike, the city is both the problem and the potential solution because its disadvantages are offset by the advantages of agglomeration. These include economies of scale, operation and specialization for building low income housing; constructing and maintaining water supply, sewerage, and other health-relevant infrastructure; and developing and running hospitals, clinics and other facilities. In principle, the old as well as the young should benefit. In practice older people are unlikely to be the highest priorities.

## AGEISM

Words used in intergenerational discourses on ageing are often harmless but imprecise ('senior citizens', 'retirees', 'elders', 'mature', 'seasoned' and even 'unyoung'). Others ('decrepit', 'doddering', 'senile', 'mossy', 'geriatric', 'fossilized') are pejorative and may reveal hardening attitudes towards older people. Because history shows that semantic precepts and prohibitions can be cultural signposts, emerging markets should consider using public media and education campaigns as well as legal measures to change hearts, minds and mindsets.

Casual or systematic discrimination against older people on the basis of age, like racism and sexism is based on myths rather than evidence. But unlike racism and sexism, it shelters in the shadow of the fact that, as they approach the end of life most people find their physical and cognitive capabilities are impaired.

The 'othering' of older people distances younger generations from older generations who may be demonized as people in decline who consume inequitable shares of scarce resources, erode social solidarity, propagate fear of ageing and belittle age-associated wisdom, particularly in societies that have adopted individualistic values.

Some demographic facts are inconvenient truths and some demographic myths prejudice rational debate on ageing much as, in some countries, other myths have prejudiced rational debate on international migration. Leaders in emerging markets must therefore persuade their communities to rethink attitudes, assumptions and prejudices about ageing, including, *inter alia*, relationships between chronological age and the capacity for productive work, the true costs of health and social care for ageing populations, financial transfers from younger to older populations and the relationship between retirement age and pension eligibility.

In many wealthy countries youth unemployment, resentment at having to support older generations and growing awareness that younger generations may be less well off than their predecessors have become sources of niggling and sometimes active discontent. In emerging markets intergenerational tensions have been exacerbated by urbanization and there is evidence of a growing trend of intergenerational violence towards older people. This may shock those who assume traditional values of respect and deference (e.g. in some Asian and Latin American societies) have survived social transformation. Emerging markets should recognize the potential implications of intergenerational tensions and should use social and public media and other means to promote mutual understanding and develop new mindsets.

## ELDER ABUSE

Elder abuse lives in the dark. It occurs everywhere. It includes physical, psychological, emotional, sexual and financial abuse and intentional or unintentional neglect. Its underreported existence in emerging markets is disputed by people who prefer to think it does not happen and it is often dismissed as a private matter. Hard data are hard to find but thanks to the *International Network for the Prevention of Elder Abuse* and other organizations it is an increasingly publicized even if a mostly invisible and inaudible phenomenon.

*"Elder Abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, resentment which causes harm or distress to an older person".*

**Toronto Declaration,  
WHO, 2002**

## ISOLATION

In wealthy countries more than one third of older people live alone. In emerging markets, the proportion is higher and as ageing populations grow, social isolation, like impairment and disability, is likely to become an historic challenge.

Isolation in older people is often associated with the loss of a spouse, partner, close friends or family members; impaired mobility and mental acuity; loss of hearing and vision; and a raft of age related and unrelated diseases, including emotional and mental disorders. In emerging markets, particularly in cities where physical separation, social barriers, restrictions and conventions may be strongest, it is also a function of absolute and relative income poverty. The correlation between income poverty and isolation is imprecise: not all poor people are isolated and not all isolated people are poor; the consequences of spatial separation can be attenuated by technology; and intergenerational anger about the share of goods and services consumed by ageing populations who contribute little or nothing to the economy can be moderated by information, education and legislation.

Some emerging markets inhibit internal migration of older people (e.g. internal passport controls in Russia and China) or seek to compensate for spatial separation by requiring children to visit parents (e.g. in China parents can sue children for non-compliance). They may wish to reconsider policies and practices (including mandatory retirement) that contribute to social isolation; consider the fact that women live longer than men and are more likely to experience isolation; and assess the benefits of active ageing initiatives.

## OPPORTUNITIES

The main opportunities to address social issues associated with ageing lie in legal action, public education and social care initiatives.

## LEGAL INITIATIVES

Most emerging markets now have laws that prohibit racial and gender discrimination, defend the rights of children and other vulnerable groups and at least in theory, protect individuals from predatory behaviour. Similar but generally better established measures exist in wealthier countries although none are perfect and many, at least in some respects, are inadequate. Yet few wealthy countries or emerging markets have comparable protections for older people or address the phenomenon of elder abuse.

This anomaly should be addressed as a matter of principle and to provide a context for educational measures that address ageing-associated issues. Allowing for cultural and juridical variations and bearing in mind the fact that countries that once sanctioned certain forms of elder abuse no longer do so, all emerging markets should consider legislation that would outlaw all forms of elder abuse and define the consequences of violations.

Older people should also be protected against age discrimination in the labour market and in financial markets, although in emerging markets with dominant informal sectors, very large numbers of older people will remain unprotected.

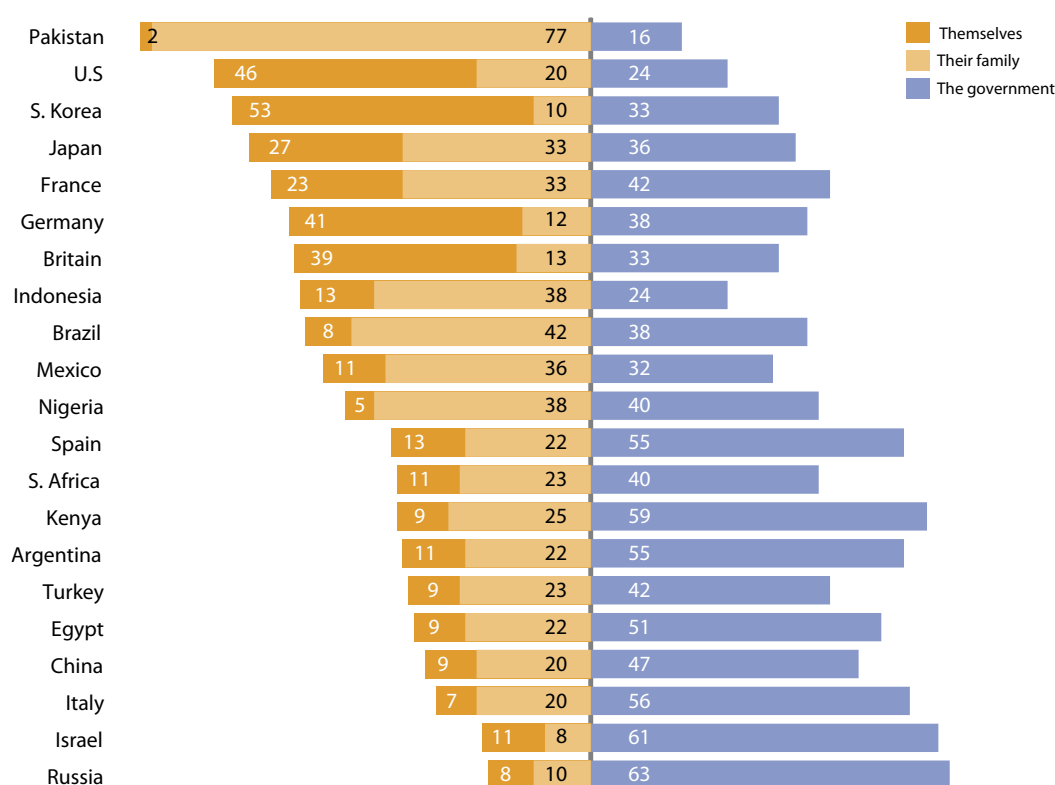
## EDUCATION INITIATIVES

Partly because differences in educational opportunity and attainment lie at the heart of contrasting life experiences and inequalities, partly because the quality of life for older people is intimately associated with lifetime education and partly because education initiatives can benefit at least some of those who were disadvantaged in childhood, education programmes and projects sponsored by government, the private sector and civil society can make a difference. Budget limitations mean they are unlikely to become priorities in emerging markets because funds for education rightly go first to children. It would in any case be naïve to suppose they would appeal to everyone but the success of initiatives such as the *Education for the Elderly Programme* at the Universidad Nacional de la Provincia del Noroeste (Argentina) demonstrate the scope for imaginative action.

Education initiatives can also help children and adults understand that cruel and disrespectful behavior towards older people is wrong if not illegal. Emerging markets can learn from precedents elsewhere (e.g. Canada) that sensitize children to the facts that verbal and physical abuse violates the rights of older people. Training in the use of appropriate language to describe older people may be appropriate - from the early years onwards - to help avoid explicit or implicit discrimination against older people in general and older women in particular. And schools and other community organizations should emulate programmes of physical and other practical assistance to older people through home visits by children and school visits by older people.

And governments can collaborate with business and civil society to increase awareness and understanding of social issues that affect older people. Programmes that exist throughout the world to provide opportunities for children and adults to engage with older people in their homes or elsewhere could be replicated in emerging markets and could alleviate the pain of social isolation.

Figure 23: Who should bear the greatest responsibility for the elderly? (%)  
Source: Pew Research Center 2014



*A Canadian curriculum to prevent elder abuse*

*Health Canada developed a two-part educational project on elder abuse for children and young people. The project is intended to make children aware of and sensitive to old age and what it entails, and to create opportunities for young people to foster relationships across generations. In so doing, it is hoped that children and young people will develop greater respect for the elderly and will be much less inclined, now and in the future, to mistreat them. The first part of the project is an interactive story-telling kit for children aged 3--7 years. A formal school curriculum is at the core of the second part of the project, developed after extensive consultations with a range of people --- including teachers, youth workers, religious leaders, health care providers, young people, those working with the elderly and older people themselves.*

**World Report on Violence and Health, WHO, 2002**

## CARE INITIATIVES

Figure 23 suggests that, in contrast to a third or more of the people surveyed in wealthy countries, (e.g. Germany, UK, US), few people in emerging markets think old people should bear primary responsibility for their own care. They are more likely to point to the family (Brazil, Indonesia, Pakistan, Turkey) or government (China, Russia). The degree to which respondents think older people should be responsible for their own care is affected by perceived (and actual) empowerment although other evidence suggests there may be a tendency for some respondents to give idealised (what ought to be) rather than realistic (what actually is) answers.

Government care for ageing populations has a short history in most emerging markets, in some none. In this sphere more than others, cultural and institutional differences override emerging market commonalities. China has sought, with mixed success, to place the burden on families. In other emerging markets, parental relations have become sources of tension. Children who cannot (or will not) get home often have difficulties absorbing the costs of paid care at a time when their main priorities are their immediate families and many hope central or local governments will assume the costs. But the constraints are severe. First, organizing frameworks (public or private) for social care are weak or missing. Second, they are inadequately funded. Third, even if they are funded, there is a shortage of qualified caregivers.

No emerging market offers a plausible model for long term care. None has developed coherent policies for care, found a corruption-free way to regulate it or decided on proper roles for the public, private and voluntary sectors. And none has made significant inroads on the challenging question of how to integrate health and social care, although some countries (e.g. India) have made progress in integrating healthcare and social care to the point they are almost synonymous.

The symposium recommended that:

- Governments should consider working with the private and voluntary sectors to raise awareness of growing needs for long term care, and help families to close gaps between real and ideal situations created by social and spatial processes they cannot control. Possibilities include elder care grants or soft loans similar to those that might be envisaged for childcare support.
- Although in many countries cultural barriers may be definitive, governments should call on enterprises engaged in building and running private sector care homes to develop separate low cost facilities for the oldest poor who cannot live independently as gestures of corporate social responsibility. The development of (largely unregulated) private care homes in some emerging markets (e.g. India) that are effectively reserved for the well-off should offer significant opportunities.
- Governments should encourage and/or partner corporate initiatives that provide parental care alongside systems that provide child care for the children of employees.
- Governments should add social care to the responsibilities of low cost health extension agents, thereby integrating social care and health care.
- Expand Healthcare systems to include social care.





# END NOTES

- 1 Wicked' problems, are complex and seemingly intractable problems that defy resolution. They are hard to recognize, understand, and define. Information about them is often incomplete and scattered. Criteria for solutions may be contradictory. And efforts to resolve one such problem may create others. Solutions are invariably non-linear and demand complementary knowledge, multi-sectoral (public, private, voluntary) perspectives and multidisciplinary cooperation. Richey suggests that "Wicked problems are ill-defined, ambiguous and associated with strong moral, political and professional issues. Since they are strongly stakeholder dependent, there is often little consensus about what the problem is, let alone how to resolve it. Furthermore, wicked problems won't keep still: they are sets of complex, interacting issues evolving in a dynamic social context. Often, new forms of wicked problems emerge as a result of trying to understand and solve one of them". 'Wicked Problems: Modelling Social Messes with Morphological Analysis' Tom Ritchey 2005 (revised 2013), Swedish Morphological Society
- 2 *Active Ageing: A Policy Framework*, WHO, 2002
- 3 Sarah Harper, *The World Today*, April-May 2013
- 4 Argentina, Poland and Russia were exceptions
- 5 A standard tool for measuring relationships between 'working age' and 'old' or 'mature' populations, in which the 65+ population is the numerator and those aged 20-64 the denominator. People over 65 are 'old' and 'dependent' on those aged 20-64
- 6 i.e. the 20 countries included in the EMS list of emerging markets.
- 7 When Bismarck introduced pensionable age in Prussia in 1889 he set the bar at 70. It was changed to 65 in 1916.
- 8 Basten, Stuart and Sherbov, Sergei, Paper for EMS Symposium on Ageing in Emerging Markets, 2015
- 9 Manton, Kenneth G., and Xi Liang Gu (2001). "Changes in the Prevalence of Chronic Disability in the United States Black and Nonblack Population Above Age 65 from 1982 to 1999." Proceedings, National Academy of Sciences, 2001
- 10 Sir John Grimley Evans 'Preface to Symposium on Ageing in Emerging Markets' Green Templeton College, Oxford, January 2015
- 11 The epidemiological transition describes the shift from infectious diseases (e.g. tuberculosis, diarrhoea and enteritis, pneumonia) to chronic diseases (e.g. cancer, stroke, diabetes) as major causes of death
- 12 Neel JV (1962). "Diabetes Mellitus: A "Thrifty" Genotype Rendered Detrimental by "Progress"?". *Am. J. Hum. Genet.* 14: 353-62
- 13 Barker, D. J. P., ed. (1992). *Fetal and infant origins of adult disease*. London: British Medical Journal.
- 14 See José Villar et al, *International standards for newborn weight, length, and head circumference by gestational age and sex: the Newborn Cross-Sectional Study of the INTERGROWTH-21st Project* The Lancet, 2014 Sep 6
- 15 In the USA where the cost of dementia care will soon exceed the joint costs of treating cardiac disease and cancer, Alzheimer's has been described as the 'fiscal nightmare of the 21st century. In the European Union dementia cases increased from 4.9 to 6.3 million between 2004 and 2010
- 16 Specific research on links between Alzheimers and emerging market environments is sparse although there is evidence that delays in the onset of cognitive decline is linked to education.
- 17 For Alzheimer's disease, the incidence among people age 85 years and older is about 14 times that among people aged 65 to 69 years. Another study found that beginning at age 65, the risk of Alzheimer's disease increased by 23 % per additional year of age. While age is of course a risk factor that cannot be controlled, lifestyle changes and diet can be controlled and evidence is increasing that good practises may help decrease the risk of Alzheimer's.
- 18 Symposium on Health and Healthcare in Emerging Markets (2009), Symposium on Urbanization, Health and Human Security (2011)

- 19 *Attitudes About Aging: A Global Perspective*.  
Pew Research Center 2014
- 20 See '*Towards a Canadian Model of  
Integrated Healthcare*', Leatt, Pink and  
Guerriere, Healthcare Papers, 2000
- 21 i.e. the UN standard definition of  
absolute poverty
- 22 Some sources trace state funded pensions  
to the 6th century caliphate of Umar ibn al-  
Khattāb, others that they began during the  
Abbasid Caliphate in the 8th century. State  
pensions were introduced in early Islamic  
law as forms of *Zakat* (one of the five Pillars  
of Islam). Taxes financed income transfers  
to the poor, the elderly, orphans, widows,  
and disabled.
- 23 Followed by non-contributory 'old age  
pensions' in New Zealand (1898) and  
Britain (1908)
- 24 '*Cash Transfers and the Well-being of Older  
People in Brazil*', Peter Lloyd-Sherlock, Joao  
Saboia and Baruch Ramirez-Rodriguez,  
Development and Change 2014

# FIGURE SOURCES

Fig 1: "Source EMS Original 2015"

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Fig 3: "Source: The World Bank 2014" (Reference: Health, Nutrition and Population Statistics. The World Bank. Updated 11th July 2014 <http://data.worldbank.org/data-catalog/health-nutrition-and-population-statistics>)

Fig 4: "Source: United Nations, 2010" (Reference: World Population Prospects, United Nations Department of Economic and Social Affairs (2009, updated 2012): <http://esa.un.org/wpp/>)

Fig 5: "Source: Stuart Basten 2015" (Reference: Prepared for EMS Symposium on Ageing in Emerging Markets, January 2015)

Fig 6: "Source: Stuart Basten 2015" (Reference: Prepared for EMS Symposium on Ageing in Emerging Markets, January 2015)

Fig 7: "Source: Stuart Basten 2015" (Reference: Prepared for EMS Symposium on Ageing in Emerging Markets, January 2015)

Fig 8: "Source: EMS Original 2015"

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Fig 11: "Report on Maternal and Child Health and Nutrition, EMS 2014"

Fig 12: "Source: Pew Research Center 2014" (Reference: Attitudes About Aging: A Global Perspective. Pew Research Center, January 30, 2014)

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Fig 15: "Source: Statistics South Africa, 2014 (Reference: Poverty Trends in South Africa 2006-2011, Statistics South Africa, 2014)"

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Fig 17: "Source: Stuart Basten 2015" (Reference: Prepared for EMS Symposium on Ageing in Emerging Markets, January 2015)

Fig 18: "Source: Stuart Basten 2015/ILOSTAT, 2013" (Reference: Prepared for EMS Symposium on Ageing in Emerging Markets, January 2015 based on data from ILOSTAT)

Fig 19: "Source: Stuart Basten 2015/ILOSTAT, 2013" (Reference: Prepared for EMS Symposium on Ageing in Emerging Markets, January 2015 based on data from ILOSTAT)

Fig 20: "Source IMF 2012" (Reference: International Monetary Fund, Occasional Paper 275, 2012)

Fig 21: "Source: "World Bank, 2012" (Reference: Pension Coverage in Latin America Trends and Determinants, Rofman and Oliveri, World Bank 2012)

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