Ageing, Intergenerational Equity and Solidarity

A background paper by the Alliance for Longevity in the Asia-Pacific Region (ALAP) for the Joint Expert Group Meeting (UNDESA- UNESCAP) on Older Persons and Intergenerational Solidarity, 10-11 October 2023, Bangkok

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1.0 Preamble: What is ALAP?

The Alliance on Longevity in Asia-Pacific (ALAP), formed in August 2022, is a new regional coalition of organizations working on ageing and longevity. The Alliance aims to contribute to improving the well-being of older people in Asia-Pacific in two main ways: (1) By fostering mutual learning through sharing knowledge, experience, and best practices across the region; and (2) Undertaking joint action towards a limited number of multi-country priorities related to ageing. It currently is comprised of Civil Society Organisations working on ageing and longevity in Bangladesh, India, Nepal, Cambodia, Viet Nam, Philippines, Thailand, Singapore and Indonesia.

2.0 Why is life-course based approach to policy and systems planning important and how does an inter-generational perspective fit into this?
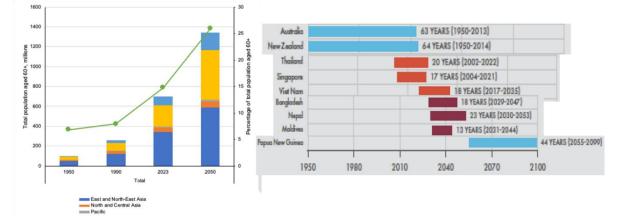
2.1 A life-course based approach to policy and systems planning is needed to build a 21st century society that is based on human longevity

Asia and the Pacific is home to 4.7 billion people or 60 per cent of the world's population. About 67 per cent of the population is of working age (15-64 years), about 22 per cent are children and youth (0-14 years) and about another 11 per cent are older persons (65 years or over). By 2050, the share of the older population will have increased to 21 per cent.

When we consider the context of rapid ageing, especially in the Asia-Pacific region (figures 1a and b), we see that many currently developing countries are becoming aged societies at a much more rapid pace compared to more developed countries that had much longer lead times before going from a young to an aged society. Where Australia had 63 years to graduate from an ageing society (7% of the total population 65+) to an aged society (14% of total population 65+), countries such as the Maldives are projected to make this transition in a mere 13 years (figure 1b)

- Number and share of people aged 60 years or over in the Asia and Pacific region and sub regions, 1950, 1990, 2022, 2030 and 2050. United Nations, Economic and Social Commission for Asia and the Pacific (ESCAP) (2022). Asia-Pacific Report on Population Ageing 2022: Trends, policies and good practices regarding older persons and population ageing (ST/ESCAP/3041)

- Time required to move from an "ageing society" (7% of population 65+) to an "aged society" (14%). United Nations, Economic and Social Commission for Asia and the Pacific (ESCAP) (2022). Asia-Pacific Report on Population Ageing 2022: Trends, policies and good practices regarding older persons and population ageing (ST/ESCAP/3041)

Figures 1 a (left) and b (right).

This success of global developmental policies and agendas has resulted in an unprecedented population boom, previously unseen and unmatched in all of human history. There were a mere billion people on the planet as recently as the turn of the 19th century, and in the preceding 123 years we have added **seven** billion souls to this planet. The global population, in absolute numbers, continues to rise because of longer life expectancies, even though birth rates have more than halved since 1950 (Ritchie et. al., 2023). The UN projects that world population will peak at 9.7 billion in 2050, and peak at nearly 10.4 billion in the mid-2080s (UN 2004, 2023). By 2100, life expectancy is expected to vary across countries from 66 to 97 years, and by 2300 from 87 to 106 years (UN 2004,2023).

In other words, many children born since 2010 in more developed countries can reasonably expect to be alive by the end of the 21st century. A developed Asia-Pacific country such as Singapore, therefore, needs to plan for a 100-year life course as par for its citizens, and take this course of development to be part of its policies and city development strategies. Only then can this type of life span be genuinely lived with meaning, dignity and purpose, right to the end-of-life.

This calls for a life-course based approach to policy planning and systems development especially in health, care, economics and social supports for ageing populations.

Figure 2 explores the importance of life course-based systems planning. This figure demonstrates the cumulative gains from 2000 – 2015 in terms of years of life expectancy gained from better management of different burdens of disease in three countries.
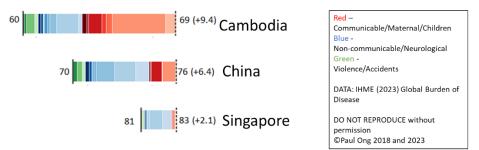
The reds represent communicable/maternal/child health issues (MCH), blues and violets are noncommunicable diseases (NCDs) and neurological conditions like dementias; and the greens, represent deaths from accidents and violence.

Three countries are represented here- Cambodia transitioning from low- to lower-middle income status. China as an upper middle-income and Singapore as a high-income country.

Figure 2

Life expectancy gains (from improvements in major disease burdens) in MDG era 2000 - 2015

In a country like Cambodia, there is a large burden in maternal, child health and communicable diseases issues, and as they are addressed better, significant gains in overall life expectancies become possible. In this case, 9.4 years were gained in the MDG era (2000 – 2015).

In a country like China, there is a shift towards NCDs, while there are still residual MCH and communicable diseases issues to be dealt with. Life expectancy gains are harder to obtain with health burdens related to older age groups and in this period, China gained the equivalent of 6.4 years.

In a country like Singapore, nearly all of its entire burden of disease is due to later life related chronic/life-style diseases. Better management of NCDs led to a life expectancy gain of just 2.1 years over the 15 years. Deaths in Singapore tend to peak in older ages, in the 80s.

Thus, figure 2 demonstrated how this basket of countries formed a ladder of progressive challenges (and thus of health systems and long-term social care developmental challenges) that must be faced up to, as countries first develop their systems to deal with communicable diseases and the ravages of maternal and childhood disorders. Then, the issues of citizens dying still too young, as a result of challenges from non-communicable/life-style driven diseases are the next things to be addressed, even as the challenges from communicable diseases, maternal and childhood diseases remain.

Finally, being successful in tackling these issues means that a country comes into possession of an increasingly long-lived population. Life expectancy gains slow, as MCH and communicable diseases are successfully managed to their lowest possible rates with accompanying decreases in fertility. Alongside the completion of these simpler wins for the health system comes the more complicated tasks of increasing healthy life expectancy, and increasing active life-span for those citizens without full health expectancy, and thus, the overall life span. Based on current global circumstances, this suggests pushing for peak rates of dying when people fall into their late 80s and beyond.

As traditional NCDs such as cardio-vascular diseases, cancer, diabetes and respiratory diseases become better managed and prevented, current profiles suggest that neurological illnesses become increasingly dominant in longer lived societies. For many of these conditions, there are as yet no cure nor effective, or well-established preventative solutions. This is where long-term care (LTC) becomes much needed.

The description above, depicts the 20th century model of health and social care systems development as each stage of the demographic and epidemiological transition is tackled, only as it arises.

This is a highly inefficient way of designing and/or planning a health system in the 21st century. The concept of managing a health system and its development and disease burden in a linear fashion, first MCH and communicable diseases, then NCDs, then dealing with population ageing and LTC is outdated, wasteful of resources and quite unnecessary when so much data on diseases burdens and its correlation to development already exist.

Therefore, imagine a 5-year old in Cambodia in 2015, then becoming middle-aged in a more developed Cambodia in 2055, and then growing old in Cambodia as a developed nation in 2085, similar to Singapore today. It is one and the same person. It only makes sense for a country like Cambodia to ensure that all through a citizen's life course, the appropriate services are available for this person. The young of today are the elders of tomorrow.

Health systems in Asia in the 21st century therefore, must plan ahead even as they tackle or mop up the issues that arise as a result of communicable diseases, maternal and childhood disorders. Analyses such as the one presented in this position paper should allow us the opportunity to reflect on how we might "leapfrog" development, and the key to this is to ensure that health systems and policies are planned from a life-course informed and from a multi-generational/intergenerational perspective. This is one method that could avoid the problems of broken, fragmentary and disconnected health and social care systems, as a country develops and ages.

2.2 Intergenerational equity is a key component to a life-course based approach to policy and planning

UN (DESA) defines of Inter-generational equity as: "The principle of intergenerational equity holds that, to promote prosperity and quality of life for all, institutions should construct administrative acts that balance the short-term needs of today's generation with the longer-term needs of future generations." (2023).

Fairness between generations is embedded in the concept of sustainable development – essential to SDGs 2030. The concept of "intergenerational equity" is likely to be played out in a single person's life-time, as discussed in figure 2 above.

With longevity, multiple generations will inhabit the same living space and social context and will need equal allocation of resources since each age group's population size is broadly equal. This creates unique demands on systems of services delivery, for health, education or social protection, never seen before in history (figure 3)
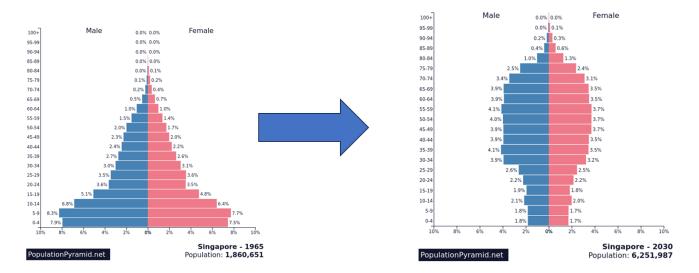
Figure 3

Figure 3 illustrates what Marc Friedman from encore.org called the evolution in humanity's history of the most "age diverse" society humankind has ever created. Each age-group now exists in nearly equal proportions, something that has never happened in human history. Therefore, national development and planning needs to allocate resources across this diverse spectrum of people, co-existing at the same time, and all needing equal amounts of resources, but for different stages of life and personal development. For example, as discussed in figure 2, a health and care system suited to a longevity, need to focus not just on the maternal and child health arena, but must already have in place the shape and structures necessary to support NCDs and long-term care of elderly people.

2.3 Practical areas that could define the need for intergenerational equity and solidarity approaches to enable longevity societies to be practical, meaningful and equitable societies

In the context of a longevity-based society predicated on a 100-year life span, there are many issues that affect intergenerational relationships that need to be addressed. Table 1 suggests what some of these issues might be.

Table 1. Some areas that a longevity society will have to address that are inter- or cross generational and which will require the fostering of good and clear intergenerational understanding and collaboration

- o Age-inclusive employment and livelihoods opportunities
- o Life-long learning for all
- o Adequate social protection and social health protection
- o Health and care needs/services for older adults and children in a joined-up health and social care system
- o Work-life balance across the life course
- o Addressing cultural issues: e.g., filial piety pressures
- o Social cohesion and inclusion for whole society
- o Gender and gender equality
- o Communications and mutual respect of age diversity
- o Cooperation and collaboration

WeWork collapsed in November 2023. This was an industry that rose from 2010 – 2019 to a business with peak valuation of USD$47 billion in 2019, before subsiding into bankruptcy in Nov. 2023, with a value of less than $50 million. The "Tom Tom" in-car navigator devices surged from 2006 but largely

disappeared as standalone devices by the mid-2010s as the smartphone rendered these devices obsolete.

Therefore, the context and boom-bust cycles of work and industry are rapidly changing. Massive and hugely valuable transitional industries rise and fall with the equivalence of the life-span of a Mayfly, when set within the context of historical time. By comparison, the US steel industry rose after the American Civil war (circa 1865) and began its trajectory of decline from the mid-1980s onwards.

It is likely therefore that a child born today in 2023, will have a 100-year life span AND multiple careers in the space of his/her life-time.

Taken from this perspective, a life-course based approach to work, employment, education and skills will be needed. The idea that a college education which ends in your 20s will decide your socio-economic potential and relevancy to work and employment to the end-of-life is increasingly unlikely to hold true. Education initiatives and investments are as needed for the older as well as for the young person. Education is required, in this longevity landscape, right across the life course. Education has become intergenerational, and is not merely important for the young, and there must be intergenerational equity in access to education.

The concept of retirement at 60 or 65 and then doing nothing but leisure till 100, seems implausible when pensions and savings are expected to sustain oneself for up to 40 years post-work, in a wildly and widely challenging economic and technological environment. As an example of intergenerational equity in this situation, we should not be expecting to simply increase tax burdens on the young in order to support the old – this would not be sustainable.

Therefore, the notion of inter-generational competition for jobs, that of youth vs the older or mature worker for work, makes little sense in this complex landscape. The context we are entering will call for significant re-thinking around jobs, education and skills re-design, and where careers will look extremely different to the world of today. The economy of tomorrow is only just revealing itself. The opportunities and landscape for older and mature workers and older and mature consumers of products, technology and services is only just being glimpsed. The economy in the next 20-30 years will bear very little resemblance to the national economies of today.

Progressively, people are having fewer children and at later ages, especially in upper- and high-income countries. It seems increasingly unfair that the burden of care for the old should fall simply on those who are younger. Progressively more and more people will have to deal with responsibilities for both not yet fully independent children and older relatives simultaneously.

Thus, with smaller families, and with more older people living in ever increasing numbers of single households, social compacts between generations will need to be renegotiated. For example, the actual practice and application of filial piety (Thang, 2011; Visaria and Chan, 2018; Sreeja & Dommaraju, 2023). This takes into account cross-cutting trends, for example, such as mass migration/mobility for work/employment, making it less likely that multi-generation households are feasible or can be maintained easily.

Women and especially younger women bear the brunt of care work – much of it informally and not remunerated. With lower fertility and the right to education, the traditional context of caregiving needs to be renegotiated between the genders, between the younger and the elder, and with the government, in order to realise a care system that delivers quality of care, quality of life, as well as equity between genders and between the generations. All of this needs to be supported by States' policies and services.

3.0 A society that creates quality of life in longevity is one where inter-generational collaboration and cooperation are the norm and therefore, must be community-based

We argue that suitable health and social system redesign for the 21st century, in the face of many societies becoming filled with people living longer and longer lives, needs to become demand-led rather than remain solely supply-driven.

Chronic disease management, for example, requires patients and their families to actively manage their own health and health care on a daily basis. Rather than becoming a passive recipient of medical care, people need to be empowered to maintain and promote their own health, understand and comply with medical advice, and work in partnership with health care providers.

These concepts are the basis of WHO's integrated person-centered care approaches, in which people co-lead or actively contribute to care planning, collective action, and health promotion for the benefit of individuals and the community.

A community-based approach is crucial and this is community that must be inclusive of all age groups, and therefore, inter-generational. Without community development, activation of whole populations that are capable of peer-supporting within and between generations, and who also become interested and have the self-caring skills to manage their own health (and who also thus, become the community peer monitors for their frailer or more vulnerable neighbours), would be very hard to achieve.

Figure 4a describes an unsustainable model for healthy ageing, where the expectation is that the health system will sort everything out for the end user.

A lack of ability to deploy good health seeking behaviours is prevalent globally. Large-scale health literacy surveys in developed countries have already established that the rates of limited health literacy in these populations is still around a third (36%) (Cutilli and Bennett 2009) to nearly half of the population (47%)(Consortium HE 2012). A survey of nearly 14,000 Swedes aged 18-80 discovered that nearly a third of Southern Swedish men and women, lacked belief in the possibility that they could influence their own health (Lindstrom 2006).

Figure 4b suggests the context where health promotion activities are undertaken through community-based partnerships that can result in increased empowerment and skilling of the end-user so that self-awareness, maintenance and management of health are facilitated. This shifts the frame of engagement from that of "passive" consumption of health care towards a more sustainable, pro-active and engaged relationship with the health services, where the most primary level of long-term and primary care resides with the community instead of the local health centres. In the best-case scenarios, there is also knowledge and skill within and between the generations to manage a child, mother or older person, as the need arises. This would be a truly activated intergenerational community for health.
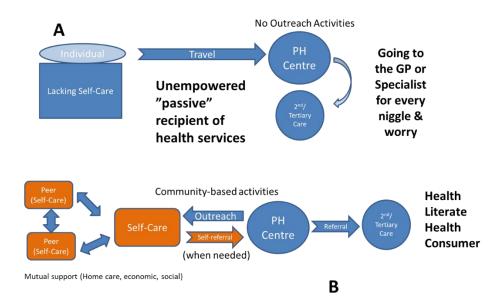
Figure 4a The individual as a "passive" recipient of health care. This may be linked to circumstances where the health system itself is not engaged with communities. This means that the health system takes on all of the burdens of self-management and self maintenance, especially when health literacy is poor.

Figure 4b A "two-way" dynamic is established with the health system. This raises the ability (e.g., through community health deveopment programs) of individuals of all ages to self-manage their health, visiting the health centre only when essential. In addition, community-based activities can activate groups of people of all ages into becoming effective peer supporters for each other, so that there is the ability in all families to manage mother, child and older person.

This is a form of "empowerment" and in this context, it may be conceptualised as achieving personal control, as well as realising behaviours to realise control for health(Shearer 2009). This notion of empowerment fits the National Cancer Institute (USA)'s definition of self-efficacy (for health) which they defined as where "a personal sense of control facilitates a change of health behaviour. Self-efficacy pertains to a sense of control over one's environment and behaviour. Self-efficacy beliefs are cognitions that determine whether health behaviour change will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles and failures."(Schwarzer 2014)

A community-based care service or program for the elderly has been defined by the WHO as that blend of health and social services provided to an individual or family in his/her place of residence for the purpose of promoting, maintaining or restoring health or else minimising the effects of illness and disability (WHO 2004, 2018). These services are usually designed to help older people remain independent and in their own homes. They can include senior centres, transportation, delivered meals or community meals, visiting nurses or home health aides, adult day care and homemaking services. Community-based care programmes also refer to those activities of long-term care that do not primarily occur in institutional settings. This holistic approach, thus, enables older adults to access a wide range of services in a more comprehensive way within a single point of access that is managed from within the community.

In a sense, the broad base of community-based initiatives suggests that everything works towards the well-being of any person and therefore, an organised community of people can become a powerful resource for health, with the ability to intervene holistically in various different aspects, and

at different stages of a person's life challenges, young or old, many of which could also impact health (e.g., financial insecurity). The organisations themselves may be more responsive than any service or local authority in tailoring resources to the needs of a person. It is crucial that case coordination between different sectors and stakeholders is part of the role that is fulfilled by these types of activated and organised communities(Austin et al. 2006, Hebert et al. 2010, Powell et al. 2012).

A strong and organised community is also one that has strong interactive links with the formal health services and thus, can work to link remote and often scarce services with a community (see figure 6)
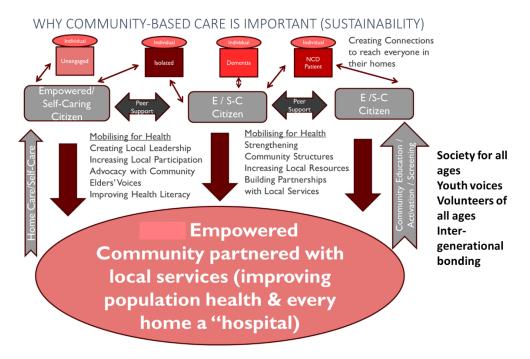

FIGURE 6 The empowered community of all ages: Formal health and social care systems interaction with the community and all of its people. This diagram also describes how peers (inter- and within generations) provide support to each other. It also describes the factors required for the empowerment of a community for health.

4.0 Discussion

Healthy Intergenerational relationships in a functional society, require both concepts of inter-generational equity and solidarity to become part of nationally realised life-course based policy making and systems planning.

Figure 2 illustrated how the relationships between young and old is not a situation where one group's needs should be set off against the other. The example of the 5-year old boy in Cambodia from 2015, becoming a respected senior in 2085, illustrates the principle that the young of today are the elders of tomorrow. Intergenerational equity and solidarity need to be understood in this light.

Life-course based policy making and systems planning, acknowledges that we are not merely making policy for individual vulnerable groups at different points of the life-cycle, but rather looking at the perspectives of a whole population need from the point of view that we are all one people who are young and who also, if conditions are right, have the chance to grow old with dignity and meaning.

A longevity and genuinely intergenerational society is one that knows how to foster interactions and cooperation across the whole diversity of age groupings, and knows how to share resources across the generations. Therefore, community-based activities and the empowerment and activation of communities to peer-support across and within generations is very important. This kind of activated community possesses enhanced awareness of diversity, but which is also very aware of

commonalities and similarities. This is a community that also focusses and builds on mutual strengths rather than fixating on weaknesses or divisions.

Therefore, joined up policy making that is intergenerationally equitable, but which also engenders solidarity, will focus on common challenges that have to be faced in order to build a functional society based on longevity for the 21st Century. This starts with all countries understanding and practicing joined up life-course based policy and systems planning to plan their national development.

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