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ADVERT

# CHANGE IN TRADITIONAL ROLES FOR ELDERLY MEN AND WOMEN

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Jordan I. Kosberg – Juanita L. Garcia

## *Abstract*

*It is the purpose of this paper to present an overview of gender-related changes that have been occurring in some countries of the world that impact upon aging men and women. Following identification of the changes, the consequences on older people and their families will be addressed. In the final section, applied implications for education and community programme will be identified to assist countries in the preparation for the consequences anticipated to occur in the future, in different countries.*

## **INTRODUCTION**

Supported by cultural norms and religious dictates, women have been the major homemakers and caregivers in the family for dependent relatives, regardless of age. Men, on the other hand, have been expected to be economically responsible for the members of their families and act as major decision-makers. In their later years, elderly couples tend to maintain such traditional gender roles. The wife, generally younger than her husband, has looked after the home and cared for her husband. He, in turn, would attend to the male-oriented tasks that support his wife (such as providing transportation or controlling financial affairs) or socialized with other older men outside the home (such as in coffee houses or other public meeting places). In their later years, the elderly have expected their adult children or other family members to provide care for them. In some cultures it is a son who has major responsibilities, in others it is a daughter. Children have been expected to honour and obey their parents and all elders in the family. These gender and generational divisions across the lifespan remain strong in many countries of the world.

Yet, many countries are facing changes that will affect traditional gender-related roles that can, in turn, impact upon inter-generational relationships between the family and current and future cohorts of elderly men and women. It is expected that there will be new challenges for aging and aged men and women and the informal support systems (of family, friends, and

neighbours) that have traditionally provided care to older persons. Thus, there will also be challenges for governments to be aware of such changes and to begin planning for formal solutions for care to older persons as an alternative to traditional informal responsibilities. This paper seeks to address additional issues to those that had been discussed in an earlier article (Kosberg & Garcia, 1991) on social changes affecting family caregiving.

## **CONTEMPORARY CHANGES**

Over time and in different places, there have been many changes that have provided greater opportunities, but also greater challenges, for aging and aged men and women. These changes in gender-related values, behaviours, and preferences individually and collectively impact upon the quality of life for older persons now and in the future.

**Mobility.** Many countries exhibit dramatic population shifts resulting from in-country movements, emigration, and in-migration. Migration from rural to urban areas is rather common. People - often the young -- leave rural areas and go to more urbanized areas where economic opportunity, educational resources, and excitement exist. Urbanization has been seen as severely challenging traditional ways of life and values (Kosberg & Garcia, 1995). One of the consequences of movement of the young to urban areas is the growing proportion of older populations in rural areas lacking family support when needed. Over a decade ago,

Weeks (1992) suggested that even low levels of urbanization in the presence of declining mortality will result in the potential "abandonment of the elderly in the countryside" (p. 160).

Elderly persons, too, can move within countries, from colder climates to warmer ones, follow their adult children (and grandchildren), to urban areas where they may find needed supportive housing and social and health care services. Litwak and Longino (1987) tracked large groups of older Americans from northern areas of the country, where they had lived the greater part of their adult lives, to warmer southern states in their retirement years. Following widowhood or declining health or financial resources, it was found that many of these elderly persons returned up north to live in closer proximity to their adult children. Intra-country warfare, famine, and poverty can also result in individual and family mobility over to other adjoining countries. Given their greater longevity, in many cases older women are the ones who relocate.

Out-migration to other countries also seems to be occurring at an increasing rate, as individuals, again generally the younger and more able, pursue job opportunities or higher education or are assigned to foreign posts (i.e., the military, employment with a multinational company) or seek a better standard of living. So, too, can the political climate in a country force younger persons to relocate to other countries; for example, many young Anglophones in French-Canadian Quebec emigrated from the Province and prior to 1997, many Hong Kong citizens emigrated to Australia, the U.S., and Canada. Thus, whether individuals are fleeing adversity or are being attracted to "greener pastures," there is much inter-national mobility.

Older persons may also decide to move to other countries in their latter years. For example, in the U.S., older persons can move not only to warmer areas in the country (e.g., Florida, Arizona) but outside the country to areas with better climates or cheaper costs of living (e.g., Mexico, Guatemala); others move or return to their country of birth from where they had left (e.g., Ireland, St. Kitt, Israel). So, too, do elderly persons move to be closer to their children, such as elderly Chinese moving to Vancouver or San Francisco.

Here, again, it is generally older females who relocate, as a result of widowhood or poor health. In many instances, these elderly persons leave behind their homes, friends and neighbours, familiar and traditional ways of life, and resettle in a new land, with new customs, and new language.

**Cultural Changes.** Immigration from one country to another often results in the erosion of traditional values and norms as a result of assimilation and acculturation in the adopted land. Whether in Eastern or Western countries of the world, there have been tensions between not only native born and long-term residents, and those who are more recent immigrants, but tensions between family members representing different generations. Such tensions can result in intergenerational conflict and a blurring of the responsibility for elders in the family and between males and females in the family (Kosberg, 1992). For example, a Guatemalan daughter who has moved with her family to the U.S. may not want to inherit caregiving responsibilities for either younger siblings or older parents; a son living with his wife and children in Australia may not want to return to India to care for his widowed father, although tradition dictates that as the oldest son he has primary caregiving responsibility.

There seems to be a trend in most countries for smaller families. This results, in part, from the decision to limit the number of children and thus increase available resources for family members. Also, limiting the size of the family is related to rising costs of larger dwellings, the desire for dual employment of husbands and wives, policies discouraging larger family size, and an increased emphasis on consumption and materialism.

**Economic Forces.** Shifts in economic conditions within a country may result in changing circumstances, such as lower standards of living and more meagre government assistance. Economic fluctuations directly and indirectly affect families and their ability to care for older family members, as well as impact upon the ability of older persons to maintain independent living. The rise and fall of global economics create the need for emigration as nations fall on hard times. Thus, one finds shifts in populations around the world, as individuals and families search for new opportunities.

During a visit to Ukraine, Pope John Paul II urged citizens not to replace their former communism with materialism, as it would lead to large-scale emigration out of the country. Certainly, such out-migration of the mainly young would have profound ramifications for elderly persons.

Within some countries there has been the introduction of new economic philosophies that have, in some instances, resulted in new generations of affluent families who are better able to purchase care and services previously furnished by the family, the community, or the government (as in Russia and China). New-found affluence is believed to result in a reduction in the intergenerational interdependence of family members. As will be discussed, greater gender equity can result in more women being employed outside the home and thus less available to assume their traditional roles as caregivers.

**Changes in the Institution of Marriage.** As a result of population mobility and/or contact with those from diverse backgrounds, there appears to be an increase in marriages (or other such long-term relationships) between persons coming from different cultural backgrounds (whether different countries, racial groups, or religious backgrounds). Younger persons wish to select their own mates rather than to rely on arranged marriages. One of the results of such marriages of those from dissimilar backgrounds has been a decline in the commitment to traditional values for each of the partners, as each seeks to accommodate him or herself to values of the other or they seek to arrive at a "middle ground" between both sets of values (Kosberg, 1998).

Whereas in the past the marriage was most often a lifetime commitment, divorce, separation, serial marriages, long-term cohabitation without marriage, permanent relationships between homosexual partners, and blended families have all seriously challenged the definition and conceptualization of marriage and the family. The changing nature of marriage results, in part, from greater freedom experienced by women.

**Opportunities for Women Outside the Home.** Indeed, the most significant change in the world is the increased opportunity for females to pursue education,

jobs, and careers outside the home. Women who had traditionally been "tied" to (unpaid) work in the home are increasingly seeking opportunities outside the home. Of course, some women choose to remain at home to care for family members, and in some cultures they are not free to pursue opportunities outside the home. Some women seek outside employment as a result of economic necessity while others do so for reasons of self-fulfillment or social contributions to the community, the point being that these women have both the freedom and opportunities for this purpose.

When women do not remain in the home they are less available to care for elderly family members (such as parents, parent-in-laws, or spouses). Yet, pressures often exist for them to provide care back at home. In the U.S., for example, it has been found that many women must shift from full-time employment to part-time employment, or leave their paid employment altogether, as a result of caregiving needs at home (Brody, 1981).

**Reduction of Illiteracy.** One method by which disadvantaged populations have been kept "in their places" has been by keeping them illiterate and uneducated. This can be seen in some countries with regard to women, immigrants, and the poor. Such groups were not helped to break out of the poverty within which they were born. Also, there have been educational systems that perpetuated patterns where only male children or those children with privileged backgrounds received formal education. Such segregated systems are changing and in some areas of the world have really changed, reducing gender and social class disparities.

Literacy is perhaps a major mechanism by which females have left their traditional jobs in the home to seek education and then employment and if not becoming economically independent, less dependent upon the males in their families, whether fathers, husbands, or brothers. In an increasing number of countries, females are as literate as males and as prevalent in traditionally-male dominated occupations and professions (such as business owners and physicians). There is even concern in a number of countries when more women than men are seeking higher education (as in Cuba). While this move towards

equity is to be applauded, an increasing rate of marital breakups may result from women being less dependent upon their husbands. For future cohorts of older persons, there are real possibilities that older women will be as affluent as their husbands, if not more affluent.

**Return of Children.** The truism, "once a parent, always a parent," is nowhere seen more dramatically than when an adult child returns to the home of parents. This may result from a failure to secure employment following completion of education or from loss of employment. Besides such economic explanations, some adult children return to their parents as a result of adverse circumstances reflecting contemporary social, psychological, and familial forces. These circumstances can include divorce, spousal abuse, depression and other forms of mental health problems, health impairments that adversely affect the adult child's ability to function independently (such as AIDS, retardation, dementia), and a child's release from prison or other institutional settings with no alternative but to live with the parents. Sometimes adult children return with children of their own; sometimes it is grandchildren who come to their grandparents.

**Caring for Grandchildren.** A byproduct of such contemporary dynamics as AIDS, out migration, substance abuse, incarceration, and marital breakups is the growing phenomenon of grandparents caring for, if not rearing, their grandchildren. These grandparents are often referred to as "custodial grandparents." While such care has always existed, the increase in such responsibilities seems unrelated to socioeconomic status, urban/rural location, or age of grandparents. In the U.S., over 3 million minor children live with grandparents (AARP, 1995).

Custodial grandparents are more commonly grandmothers. The negative impact upon older grandparents can be great and affect their physical, emotional, social, and economic conditions.

There are special challenges for custodial grandparents caring for children having particular disabilities, such as HIV (Poindexter, 2002). There is some suggestion that caring for an adolescent grandchild with emotional and/or behavioural problems can place the grandparent

at some peril for elder abuse. In many instances, the grandparents are responsible for several grandchildren. Of course, coupled with concerns about raising grandchildren there often are concerns about the children's parents who may periodically visit their children.

## POTENTIAL CONSEQUENCES

Thus, there are many changes that may impact upon aging men and women; changes that challenge traditional gender relationships as well as intergenerational relationships. Women may not be at home to care for relatives, children may move distances away from aging parents, and economic changes may erode financial security of the elderly and reduce public support of less affluent populations. Changes may challenge traditional norms regarding gender roles and care for elderly relatives, leading to important consequences.

**Unavailability of Older Women as Caregivers.** As more women are seeking jobs and careers outside the home, they are less likely to be available to provide care to family members, whether a spouse, an adult child, or parents or in-laws. Changes in traditional gender-related role expectations, such as women not wishing to take on major caregiving family responsibility might result in their own guilt feeling, the anger of male members of the family, or humiliation for elderly parents. As mentioned, one of the incongruent consequences of social change is the fact that although women might share employment with males in the family, they do not enjoy equality in household chores. Further, caregiving responsibilities continue to be seen as a female responsibility, even in the face of social change.

**New Roles for Men.** Increasingly, however, men are finding themselves in new and unaccustomed roles. One new role is that of caregiver (Kramer & Thompson, 2002). Young married fathers are increasingly caring for their children as a result of gender equity that leads to shared parental responsibilities. Males, in some countries, are becoming "house-husbands," and their wives are the major wage earners. In cases of divorce, more men are being granted custody of their children or have equally shared parental responsibility.

Although in the case of males life span remains shorter than that of women, elderly married men may have caregiving responsibilities for “disabled” wives. Additionally, as a result of medical advances, specially-challenged children (i.e., mentally retarded, physically disabled) who in the past had died earlier now live past middle age, and it may be the older father who has major caregiving responsibilities. Finally, there is some suggestion that long-term relationships between older couples, are nowadays more likely to reflect gender equity. Such shared responsibilities are seen to result from the gradual elimination of boundaries between sex roles and a decreasing division of traditional male/female gender role household labour (Bogard & Spilka, 1996).

**Strain on Marital Relationships.** There is increased evidence of marital dissatisfaction, in general, and particularly as affecting older couples. Research has revealed that older wives caring for their husbands are more negative about their spouses and their marriages than are older husbands caring for their wives (Wallsten, S.S., 2000). There are several possible explanations. First, caring for the husband might represent the continuation of caregiving demands and burdens for the wife. Further, it may be that the majority of women's friends are widows with freedom and independence who are envied by the caregiving wives who might blame their husbands for their relatively restricted lives. Should the husband be either a complainer or overly dependent, or had not been a good mate, the wife's commitment to the caregiving role may be low. In contrast, caregiving husbands generally take on the caregiving role more willingly and are more reluctant to relinquish the caregiving role to others (or they may be reluctant to place their wives in institutions).

**Continued Gender Discrepancies.** While today more women are employed outside the home and pursue careers and seek economic independence, they are still at a disadvantage. There are salary disparities from most basic levels of employment to corporate executive levels. In terms of upward advancement (called “glass ceiling”) there remain problems. Recently at Walmart Stores in the U.S., the largest corporation in the country, female employees brought legal action against the company, claiming they faced discrimination in

administrative positions. Also, whether in developing or developed countries, it has been found that women do not receive equal compensation as men for comparable work.

**Hindrances to Family Care.** Given the combination of intra-country mobility and emigration, the increase in women employed outside the home, and changing values regarding family responsibility for elderly relatives, those from developing nations need to consider the possibility that the future might bring the likelihood that families will be unavailable or unwilling to care for older persons. Moreover, older persons, themselves, may increasingly wish to live independently. Indeed, in some settings (such as retirement communities, large cities), elderly persons seem more dependent upon age peers than on their families. Peer groups are generally composed of either older married couples or groups of older women. Older men, being fewer in number, less gregarious, and generally married, are less likely to be affiliated with peer groups of other older men. There has been increasing awareness of and concern regarding widowers -men who lose their wives as well as their confidants -- who are high risk for physical and emotional decline. These men are generally less responsive to community resources that are available to them in times of trouble (Kosberg & Kaye, 1997).

**Increased Tolerance for Diversity.** It is believed that individuals are becoming more tolerant of others having different backgrounds, lifestyles, and ways of life. If true, this is a result of population mobility and of exposure through the mass media to dissimilar individuals, and increasing opportunities for certain groups that have long been disadvantaged (e.g., women, immigrants, impoverished). While some might lament the “good old days,” or certain groups or governments might seek to curtail such trends, it is doubtful whether world-wide changes resulting in large-scale mobility can be deterred.

One aspect of increased tolerance is the reduction in gender-appropriate behaviour. Thus, men and women are being freed of their confining “yokes” of traditional norms that keep self-determination and self-realization within certain narrow gender-specific parameters. Women are becoming more assertive, competitive, and

self-reliant; men are more likely to express emotions, undertake nurturing roles, and are less tied to their jobs for self-validation.

Current cohorts of elderly men and women generally reflect the period and place within which they have been developed. Thus, they reflect more traditional gender specific roles and interests. However, it can be expected that future cohorts of older men and women around the world will be less encumbered by older conventions and traditions, and will reflect a greater desire for personal freedom within a relationship, family, and society. Such has already occurred in many countries and will certainly occur in the near future in many others.

#### **Unmarried Individuals and Childless Couples.**

Whether deliberate or not, there are many elderly persons who are not married (Hooyman & Kiyak, 1999). Also, with a combination of increased divorce rates and widowhood (especially for older women), there may well be an increase in the number of unmarried persons. Along with high rates of mobility and a smaller number of children, there may be no family members living in close proximity. So, too, for childless couples there may be few relatives anywhere. Accordingly, close friendship patterns or formal services will need to act as surrogate support systems for these older persons.

**Long-Distance Caregiving.** With continuing high rates of mobility for elderly persons and their families comes the need for providing care from a distance. This fact has been identified for military personnel (Roff, et al. 2003).

Such interaction can include traditional communications, such as letters and phone calls, as well as more contemporary forms of communications, such as computer-generated types (i.e., e-mail). Long distance caregiving can also include visits from adult children to their parents, or vice versa. In addition to transmission of warm feelings and support, such caregiving can involve periodic assessment of a parent's health condition. Should problems develop, often the adult child visits the parent or urges the parent to relocate to a closer location.

Of course, the distance of residence between parents and children is important, as are such things as the economic situation, pressing needs of parents or children, and quality of the relationship. It has also been found that there are gender differences in long-distance caregiving to an elderly parent, and it is expected that long-distance relationships between mothers and their daughters are more likely than those relationships involving male members of the family. In the U.S., long-distance caregiving has led to the development of private and sectarian care management services whereby families living great distances away from an elderly relative will contract with an agency in the same area as the parent to provide ongoing monitoring of the parent's condition and the mobilization of needed care and attention. Admittedly, this is a resource for the more affluent.

#### **EFFORTS TO PREPARE FOR EMERGING TRENDS**

**Education.** First and foremost is the need for educational efforts to prepare individuals, families, and societies for the contemporary dynamic changes occurring at different rates in the countries of the world. Whether these educational efforts result from governmental or private actions, there are many different areas upon which to focus.

**Gender Equity.** A reduction of traditional gender stereotyping, especially that which limits opportunities for women, has been occurring with great variation in many countries, and it would seem necessary to ensure support for such trends. We need to guard against gender distinctions that result in sexism that limits opportunities and affects the quality of life. Conflict and abuse can result from discrepancies in these matters as opposed to more enlightened views on personal relationships in a marriage or family, or within society.

**Skills and Knowledge for Women.** Many older couples maintain traditional gender specific divisions of labour in their families, whereby women may not have learned to drive a car, have not developed skills applied outside the home, and are unfamiliar with financial matters. Should her husband die, or divorce take place, the woman's loss will be exacerbated by loss of functions formerly undertaken by her husband. It can be expected

that younger cohorts of women, who have come to want and expect more equity with males in society, will be better prepared to be independent in their latter years, whether married or widowed. For older cohorts of women, however, education and training will need to be provided.

**Skills and Knowledge for Men.** As mentioned, cohorts of males are changing and have different notions for the meaning of masculinity. Increasingly, older men are becoming caregivers, whether for young children, adult children with special needs, elderly parents, or their wives or partners. Education and training is needed to prepare these men for such future responsibilities. Attitudes must also be addressed, as most men have not been habituated to attend to domestic chores or the emotional needs of others.

**Programmes and Services.** Education and training include efforts to prepare individuals for present and for future responsibilities. Often aging and aged persons are faced with adversities that result from the unexpected or unwanted events around them. Thus, there is a need for planning and provision of community resources that can assist elderly men and women in dealing with the conflicts and problems that they are currently facing. There may be the need for organised community services.

**Marital Counselling.** Greater attention will be needed for relationship counselling for couples from diverse cultural backgrounds with regard to caregiving for elderly parents and in-laws. This can result from such changing circumstances as step-parents, parents of partners in unmarried relationships, and grandparental rights of former in-laws with respect to visitation of one's children by a former marriage. So, too, will there be a need for assisting aging couples with cultural changes that can affect gender and intergenerational relationships.

**Intergenerational Interventions.** Aging and elderly couples may be in need of guidance regarding differences between their caregiving expectations (independence or dependence) and caregiving preferences of their adult children (to provide or not to provide care when needed). Possible discord between generations, resulting from cultural

adjustments and changing values, might be especially likely in the intergenerational relationships of immigrant groups. For example, this can happen when younger members of a recently-immigrated family become acculturated much faster than the older members of the family.

**Grandparent Assistance.** It is believed that until social and health crises in the world are controlled, the need for grandparents to rear grandchildren will continue. Such caregiving necessitates preparation and planning for grandparents. Certainly, those grandparents who are undertaking such tasks, perhaps for more than one grandchild, may be in special need of not only emotional support but, as importantly, provided help in way of respite and financial assistance. In the U.S. current housing for the elderly may increasingly include provisions for (grand)child care on the premises.

**Long-Distance Caregiving Mechanisms.** Peace of mind of an elderly parent, or an adult child, might be facilitated if plans can be made in advance for distant caregiving, if and when needed by an elderly parent living away from children. For those children who wish to be involved in caregiving from a distance there are several possibilities: a care manager where the parent lives, relocation to be closer to the parent, or relocation of the parent to be closer to an adult child. For elderly parents who do not believe they can rely on their children, or who do not want to, and/or those having an extensive informal support system (i.e., friends, neighbours, congregants), there will be the need to foresee the anticipated time when one cannot live independently and will need to rely on others for support and assistance. Thus, those living away from their adult children will need to assess the costs and consequences of long distance caregiving. For those without children motivated to provide care, or without any children, there will be the need to determine the supportive nature of the immediate social environment and make plans for the future.

## CONCLUSION

This paper has provided an overview of forces and changes known to be occurring in industrialized countries and possibly occurring in non-

industrialized ones. These present and future changes are believed to have consequences on younger and older family members. While such forces occur at different rates of speed, it is believed that with the "shrinking" of the world and greater interdependence of nations the "ripple effect" of cultural changes will impact upon all countries. It is important to anticipate

some of the intergenerational, intercultural, and inter-gender issues discussed in this paper. It is also important that nations consider planning for the education and community services that will assist elderly men and women, and their families, both to anticipate and to resolve problems resulting from the changes that they are or will be experiencing.

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# Economic and Financial Aspects of Ageing in Cyprus

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ELENI SERGIDES

## Introduction

### Geopolitical Situation of Cyprus

Cyprus, the third largest island in the Mediterranean Sea, stands at the crossroads of three continents - Europe, Asia and Africa. It has an area of 9,951 square kilometres, of which 1,733 are forested. It has a maximum length of 240 km from east to west and a maximum width of 100 km from north to south. The island-republic of Cyprus is situated in the northeastern part of the Mediterranean Sea, 33 degrees east and 35 degrees north of the Equator. It is located 75 km south of Turkey, 105 km west of Syria, 380 km north of Egypt and 380 km east of Rhodes (Greece). The Greek mainland is approximately 800 km to the west.

Cyprus is divided into three geological zones - the Pindaktylos or Kivrenia range to the north, the Troodos massif to the south, and the Mesaoria plain separating the two. It has an intense Mediterranean climate with mild, wet winters and hot, dry summers.

The population of Cyprus by the end of year 2002 was estimated at 802.5 thousands of whom 80.7% are Greek Cypriots, 11% are Turkish Cypriots and 8.3% foreigners residing in Cyprus. The density of the population is 86 persons/square km. The population does not include over 115,000 Turkish settlers illegally residing in the Turkish-occupied part of Cyprus.

The language of the Greek Cypriot community is Greek and the community adheres to the Autocephalous Greek Orthodox Church of Cyprus. The language of the Turkish Cypriot community is Turkish and the community adheres to Islam. English is widely spoken too, since Cyprus was under British rule until 1960, when it gained its independence.

Greek Cypriots and Turkish Cypriots were living together all over the island until the Turkish invasion

in 1974, which resulted in the occupation of 37% of the island by the Turkish troops and the separation of the Greek and Turkish population. Facts and figures reported in this paper refer to the Greek Cypriot population of the Republic of Cyprus at the present time.

The capital of the island is Nicosia with a population of 283,500 in the sector controlled by the government of the Republic of Cyprus. It is situated roughly in the centre of the island and is the seat of government as well as the main business centre. The 1974 Turkish invasion and occupation of 36% of the island's territory literally cut the capital in half.

While the political problem remains unsolved, the economy, based on the free enterprise system, has made a remarkable recovery, exceeding the pre-invasion levels. Cyprus is today a services centre (mainly banking and shipping) a major tourist destination and a telecommunications node. It is also classified among the high-income countries.

In February 2004, the United Nations achieved a breakthrough in its attempts to bring peace to the divided island of Cyprus, nearly a year after the process last collapsed. After decades of conflict and stalemate, the final push before Cyprus joins the EU in May 2004 appears to be working.

Cyprus has a standard of living that is even higher than some European Union member-states and the performance of its economy is good compared with that of most EU countries. In the past five years the annual rate of growth was estimated at 3.8%, while unemployment stood at 3.4% and inflation at 2.9%.

### Demographic Aspects

At the end of year 2002, the population of the government controlled area was estimated at 715,100 of which 69.1% live in the urban areas and 30.9% live in the rural areas. While the proportion of children aged between 0 and 14 has been

decreasing (was estimated at 20.9% at the end of 2002). the proportion of the elderly (aged 65 years and over) has been increasing and reached 11.8% of the population. It is estimated that by the end of year 2028 the proportion of the people aged 65 and over will be approximately 17.6% of the population. (Appendix 1).

The age structure of the population of Cyprus is close to that of more developed countries. Since Cyprus has not yet reached the stage of ageing experienced by developed countries, where fertility declined much earlier than in Cyprus, the proportion of the elderly is still lower. Moreover, the proportion of children below the age of 15 is fairly higher, as a result of the existing comparatively higher fertility rate.

The general improvement in the standard of living and, consequently, in the provision of health services has also contributed to a decrease in mortality at older ages. The life expectancy at birth is 76.1 for men and 81. for women. The fertility rate is 1.5, which is below the replacement level of 2.1 and compares favourably with that of most developed countries. (Appendix 2)

## **Societal Implications of Ageing**

### **The Family**

The most important institution that contributes towards people's physical, social and emotional survival and development has always been the family. Still today the Cypriot society has strong family ties and solidarity. Cyprus' society has experienced major socio-economic changes in the past twenty years which were intensified by the traumatic consequences of displacement of 1/3 of the population due to the 1974 Turkish invasion on the island.

In the later years, traditional values were challenged by many factors and led to the weakening of traditional family roles and social networks. Families and communities were split followed by new housing conditions, rapid urbanization, the development of tourism, the decline of agriculture and the so-called "economic miracle".

For the first time in recent years, while the Cypriot family has been in need of help to carry its duties,

older people have been faced with the threat of social exclusion. Increasingly, there is a shift from family to state responsibility on issues of care for family members.

### **Care Services and Community Services for Older People**

As a consequence of the social changes mentioned above, the government's policy for the elderly developed social services in order to maintain their human dignity and independent social functioning as well as strengthening their links to the family and community.

The provision of supportive services within the community is very important in order to enable elderly people to remain in their own familiar environment instead of being institutionalized. Such services provided by the department of social welfare are financial assistance, home-care, day-care and residential-care programmes.

#### **Financial Assistance**

Special benefits may be granted under the Public Assistance Law to purchase services such as accommodation, care or home help. Carers and helpers may be relatives, neighbours or other individuals or groups.

#### ***Individual Home-care Programme***

During the past few years, the home-care programme has been expanding because of its successful implementation throughout Cyprus. There are governmental, non-governmental, and (mostly) private home-cares. Through this programme, home-helpers employed and specially trained by the Social Insurance department, provide care to elderly people living at home, and services such as cleaning, cooking, shopping and transport for medical purposes. The main aim of these services is to support the elderly to stay in their own environment.

#### ***Day-Care Programme***

Day-care programmes have mostly been developed by the non-governmental sector. Some examples are the Trade Unions, the municipalities and the Church. Some of the government residential homes for the elderly are equipped to provide day-care services to non-residents. At the same time, community organisations operate day-care programmes for the elderly people and are provided with technical advice

and financial support, in the form of government grants, through the Grant-in-Aid Scheme administered by the department.

### ***Residential-Home Programme***

Before 1974 there were only 10 Residential Homes all over Cyprus and today there are 142. There are governmental, non-governmental and private Homes for the elderly. The family and supportive services within the community provide residential care for elderly people only in cases where particular needs cannot be met. Such care may be provided in government and community residential homes, which are relatively few in numbers because of the emphasis given to community care, or in private homes for the elderly.

Legislation administered by the department provided a means of guaranteeing a decent standard of living for residents of homes for the elderly. According to this legislation, non-governmental homes and institutions are registered and inspected by social workers in order to ensure adequate standards of operation, set by regulations.

### **Economic Implications**

#### **Social Insurance Scheme**

The first social insurance scheme in Cyprus was introduced in January 1957. All employed and self-employed persons were required to participate with the exception of certain categories of agricultural workers. Self-employed persons and those workers exempted from compulsory insurance were given the right to be insured voluntarily under certain conditions.

The social insurance scheme is financed through contributions paid by the employers, the insured persons and the state. In the case of employed persons, the contribution is 16.6%. (6.3% payable by the employer, 6.3% payable by the employee himself and 4% paid by the State. In the case of self-employment, 11,6% is paid by the selfemployed himself and 4% by the State. (Appendix 3 and 4)

The Social Insurance Scheme provides for the following benefits: Marriage grant, maternity grant, funeral grant, maternity allowance, sickness benefit, unemployment benefit, invalidity pension, old age pension, widow's pension, orphan's benefit, missing

persons allowance, injury benefit, disablement benefit and death benefit.

#### ***Old Age Pension***

The old age pension is payable at the age of 62 for men and women and at the age of 63 for women born before 1st of January 1935 and is not conditional on retirement from regular employment. Exceptionally, miners who have at least five years employment in a mine, are entitled to old age pension one month earlier than the normal pensionable age for every 5 months of work in a mine, on condition that they have retired from mine work. but in no case they can draw pension before the age of 58.

A person is entitled to old age pension if he/she has completed the age of 63, satisfies the relevant contribution conditions and has a weekly average of insurable earnings equal to 70% of the weekly amount of basic insurable earnings. A person who does not satisfy the contribution conditions at the age of 65 is allowed to continue the payment of contributions until the age of 68. After the age of 68, if he/she still does not satisfy the contribution conditions for the payment of old age pension, he/she is entitled to a grant, given that he/she has contributions for at least three years.

#### ***Widow's Pension***

The widow's pension is payable to the widow, and under certain conditions to the widower, of a person who on his/her death satisfied the contribution conditions for old age pension or was in receipt of old-age pension. In case of death caused by an accident, there is entitlement to widow's pension if the contribution conditions for funeral grant are satisfied.

#### **Social Pension Scheme**

The social pension is a non-contributory benefit which is payable to persons residing in Cyprus. It has been introduced on 01/05/1995 and its main purpose is to provide financial support to those people who reach the age of 65 and are not entitled to any benefit or pension from any other source. The cost of social pension is paid out of the General Revenue of the Republic of Cyprus (Appendix 5).

#### **Public Assistance**

The Department of Social Welfare is in charge of public assistance, which is responsible to ensure that

needy persons have a socially acceptable minimum standard of living. Public assistance may be provided in the form of money and/or services, depending on individual needs. Each year the department of social welfare reviews the rates for basic needs in order to meet the terms of the rising cost of living. Special needs may include a rent allowance, home care, medically prescribed diet allowance, day care, house equipment, house repairs as well as residential care.

### **Supplementary Pension Schemes**

Many employees in the private, government and semi-government sectors are covered by occupational schemes, besides the coverage by the social insurance scheme. Occupational schemes take the form of either provident funds or occupational pension schemes and they provide benefits in addition to those of the statutory social insurance schemes.

### **Other Benefits**

#### ***Social Card***

The Social card was first issued on 1st of January 2001 by the Ministry of Labour and Social Insurance with the co-operation of the co-ordinary body of the elderly in order to give the opportunity to all persons over 63 to participate in social and cultural activities. The social card entitles them to free travel on buses, both rural and urban, and reduced fares for travel on planes and ships. Other benefits include reduced hotel rates and cheaper medical tests. This benefit will cost the government £760,000 annually.

#### ***Family Assistance for the care of the elderly***

The above scheme was introduced in February 2001 and it provides financial assistance to families (up to CY£6000) for housing alterations or extensions in order to make possible the care of the elderly by the family and avoid institutionalisation.

#### ***Holiday Subsidisation***

The holiday subsidisation scheme supports the cost of holidays in Cyprus for persons over 63 years of age who are on welfare benefit.

#### ***Self-employment Scheme***

This scheme was introduced a year ago and its main objective is to keep persons over 63 years old actively involved in economic and productive activity. Grants are provided for the purchase of equipment and materials for activities such as

agriculture, stockbreeding, home-made sweets, ceramic work and writing books.

### **Health Care Expenditure**

Since the number of the elderly is growing in Cyprus, the demand for health care is increasing and it creates new service demands. There are three kinds of systems that provide health services and satisfy the medical needs of the population in Cyprus. There is the government health sector, the private health sector and a number of schemes covering specific sections of the population.

#### ***Government Health Sector***

This sector provides free health care through government facilities to those who are entitled. Officially, the groups covered by this scheme are government employees, individuals earning less than CY£6,000, households earning less than CY£10,000 annually and households with more than three children. Households with an income between CY£10,000 and CY£14,000 annually and individuals with an income between CY£6,000 and CY£9,000 are provided with health care at reduced fees.

The Government health scheme is funded out of general taxation. It has a broad range of services that includes visits to general physicians, specialist consultations, inpatient stays, medical care given abroad in specialities not offered in Cyprus and all drugs prescribed.

#### ***Private Health Sector***

The private health sector provides services to all the people who can afford to pay for their treatment. A large number of physicians in individual practice take over private medicine in the rural areas, in addition to several polyclinics that are established in the urban areas with a number of physicians offering a range of medical services.

#### ***Special Schemes***

A number of special schemes cover particular sections of the population (e.g. Trade Unions). A new National Health Scheme is under consideration, which will provide free health care at the time of delivery. It will be universal regarding population coverage, and it will be financed by contributions from the state, the employers, the employees, the self-employed, the pensioners and all those who have non-employment incomes. (Appendix 6)

## **Recommendations**

### **Educational Recommendations**

- Training programmes on technological changes and on new methods of work should be developed in order to help older people who choose to keep working, remain competitive and productive in the labour market.
- Educational programmes for the elderly including those who live in the rural communities or old people's homes.

### **Health Recommendations**

- Provide old people's residential homes with new equipment in order to offer rehabilitation services of high quality.
- There should be a compulsory module in geriatrics for the medicine students in order to have a general knowledge of geriatrics.
- Care services offering more specialised care for chronic and long-term illnesses should be developed.
- Improvement of the quality of health services by introducing specialised geriatric clinics and mobile units, especially in the rural areas.

### **Employment Recommendations**

- In order to prevent older people from feeling

useless and depressed, we should encourage them to continue working full-time or even part-time.

- In order to have an increase in economic growth and avoid social exclusion, efforts should be made to keep the elderly happy and productive in their work environment.
- Motivation of all kinds should be given to employers in order to keep the older people in the labour force.

### **Social Protection Services**

- There should be a further development in the involvement of non-governmental organisations in policy-making, implementation and delivery of services, since it has been proved more efficient in meeting people's needs in time, at local level.
- Government should consider the expansion of retirement age not only for social purposes but also to relieve the social security and other funds.
- There should be better co-ordination of all the services offered to the elderly.
- Social changes within the family structures together with the increase in life expectancy usually mean a higher demand for care services. Thus, policy makers need to focus on both the quantity and quality of such services.

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**Ministry of Labour and Social Insurance**  
**Nicosia, CYPRUS**

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## Appendix 1 – Population

	1992 (Census)	1995 (end)	1996 (end)	1997 (end)	1998 (end)	1999 (end)	2000 (end)	2001 (end)	2002 (end)
<b>Total population</b>	710.0	746.9	755.5	763.4	771.1	778.5	785.3	793.1	802.5
<b>Population gov. controlled area</b>	615.0	656.3	666.3	675.2	682.9	690.5	697.5	705.5	715.1
<b>Males</b>	306.4	324.8	392.2	333.0	336.3	339.7	342.7	346.2	350.6
<b>Females</b>	308.6	331.5	337.1	342.2	346.6	350.8	354.8	359.3	364.5
<b>Population Distribution (%)</b>									
<b>0-14 years</b>	25.4	24.6	24.3	23.8	23.4	22.8	22.3	21.5	20.9
<b>15-64 years</b>	63.6	64.3	64.6	65.0	65.5	66.0	66.4	66.8	67.3
<b>65 years &amp; over</b>	11.0	11.0	11.1	11.1	11.1	11.2	11.3	11.7	11.8
<b>Population Distribution by District (thousand)</b>									
<b>Nicosia</b>	249.6	264.6	268.0	271.0	273.4	275.8	277.9	280.3	283.5
<b>Ammochostos</b>	31.5	34.4	35.1	35.8	36.5	37.2	37.8	38.5	39.1
<b>Larnaca</b>	102.8	109.6	111.2	112.6	113.9	115.1	116.2	117.5	119.3
<b>Lemesos</b>	177.4	188.8	191.5	193.9	195.8	197.8	199.6	201.6	204.6
<b>Pafos</b>	53.7	58.9	60.4	61.9	63.3	64.7	66.1	67.6	68.6
<b>Share of urban population (%)</b>	67.7	68.1	68.2	68.4	68.5	68.7	68.8	69.0	69.1

<b>Population Projections, 1.1.2002 - 1.1.2052</b>											
	2002	2007	2012	2017	2022	2027	2032	2037	2042	2047	2052
<b>Females</b>											
0-4	21.634	19.451	19.956	19.765	18.631	17.852	16.509	15.408	14.811	14.430	13.948
5-9	26.113	22.221	19.841	20.345	20.074	19.122	18.144	16.804	15.704	15.108	14.727
10-14	26.155	25.831	22.821	20.421	20.704	20.435	19.483	18.808	17.167	16.088	15.473
15-19	27.085	25.861	27.417	23.291	20.773	21.057	20.789	19.839	18.964	17.526	16.428
20-24	26.507	28.309	27.903	28.245	23.910	21.397	21.682	21.415	20.488	19.494	18.156
25-29	26.074	28.771	30.167	29.988	29.356	25.030	22.521	22.807	22.542	21.597	20.625
30-34	26.116	28.623	30.883	31.864	30.644	30.605	28.289	23.786	24.073	23.810	22.867
35-39	27.343	28.273	30.405	32.291	32.901	31.689	31.653	27.349	24.855	25.144	24.602
40-44	27.277	29.056	29.663	31.506	33.067	33.702	32.500	32.470	28.184	28.702	28.991
45-49	23.363	28.427	29.982	30.392	31.994	33.575	34.196	33.008	32.967	28.730	26.260
50-54	22.040	24.020	26.877	30.264	30.566	32.157	33.736	34.364	33.196	33.189	28.966
55-59	18.016	22.318	24.180	28.891	30.184	30.476	32.074	33.654	34.294	33.161	33.157
60-64	16.134	18.071	22.215	23.965	26.536	29.655	30.174	31.778	33.366	34.033	32.623
65-69	13.844	15.857	17.704	21.691	23.396	27.871	29.204	29.570	31.190	32.602	33.470
70-74	11.852	13.126	15.040	16.914	20.624	22.333	25.671	28.035	28.479	30.134	31.712
75+	19.819	22.602	25.606	29.367	33.522	39.848	45.697	53.635	60.351	65.490	70.457
<b>Total</b>	<b>359.261</b>	<b>362.820</b>	<b>402.800</b>	<b>418.562</b>	<b>429.097</b>	<b>437.002</b>	<b>441.292</b>	<b>442.428</b>	<b>440.534</b>	<b>436.417</b>	<b>430.044</b>
<b>Males</b>											
0-4	22.448	20.860	21.094	20.914	19.907	18.972	17.453	16.287	15.652	15.246	14.739
5-9	27.423	23.045	21.057	21.489	21.207	20.202	19.169	17.751	16.586	15.952	15.546
10-14	27.970	28.201	23.694	21.576	21.877	21.597	20.594	19.562	18.144	16.979	16.345
15-19	28.722	28.680	28.789	24.166	21.926	22.231	21.984	20.953	19.921	18.505	17.341
20-24	27.121	29.682	29.466	29.405	24.623	22.366	22.702	22.426	21.426	20.399	18.957
25-29	23.901	28.647	30.924	30.439	30.104	25.346	23.131	23.436	23.162	22.168	21.143
30-34	23.159	25.572	30.001	31.972	31.196	30.866	29.132	23.927	24.231	23.958	22.990
35-39	25.332	24.526	26.883	30.847	32.567	31.800	31.477	25.765	24.569	24.872	24.600
40-44	26.139	26.310	25.324	27.279	31.229	32.948	32.193	31.675	27.192	25.009	25.310
45-49	23.179	26.704	26.741	25.633	27.435	31.360	33.075	32.334	32.019	27.378	25.210
50-54	21.467	23.410	26.770	26.710	25.525	27.315	31.191	32.886	32.156	31.846	27.260
55-59	17.266	21.383	23.159	26.397	26.276	25.154	25.925	30.718	32.372	31.660	31.352
60-64	15.281	16.984	20.853	22.558	25.597	25.542	24.510	26.240	29.500	31.498	30.810
65-69	12.154	14.603	16.174	19.762	21.390	24.343	24.373	23.432	25.070	28.536	30.047
70-74	9.572	10.997	13.209	14.665	17.979	19.566	22.373	22.457	21.596	23.095	26.270
75+	16.022	16.092	17.983	21.015	24.125	28.928	33.266	39.278	41.245	42.231	44.071
<b>Total</b>	<b>346.178</b>	<b>365.397</b>	<b>381.962</b>	<b>394.645</b>	<b>402.954</b>	<b>406.464</b>	<b>410.518</b>	<b>409.326</b>	<b>408.243</b>	<b>399.330</b>	<b>392.023</b>
<b>TOTAL</b>	<b>705.539</b>	<b>748.217</b>	<b>784.762</b>	<b>813.407</b>	<b>832.061</b>	<b>845.466</b>	<b>851.810</b>	<b>851.754</b>	<b>848.776</b>	<b>835.747</b>	<b>822.069</b>

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## Appendix 2 – Demography

	1990	1995	1996	1997	1998	1999	2000	2001	2002
<b><u>Population Change</u></b>									
<i>Annual mid-year population growth rate (%)</i>	2.1	1.8	1.6	1.4	1.3	1.1	1.0	1.1	1.4
<i>Natural Increase rate (per 1000 population)</i>	10.0	7.6	7.1	6.1	5.1	5.0	4.5	4.8	3.8
<i>Net migration (number)</i>	+8,708	6,000	5,300	4,800	4,200	4,200	3,960	4,650	6,885
<b><u>Fertility</u></b>									
<i>Live Births (number)</i>	10,622	9,869	9,638	9,275	8,879	8,505	8,447	8,167	7,883
<i>Crude Birth rate (per 1000 population)</i>	18.3	15.2	14.6	13.8	13.1	12.4	12.2	11.6	11.1
<i>Total Fertility Rate</i>	2.4	2.0	2.0	1.9	1.8	1.7	1.6	1.6	1.5
<b><u>Mortality</u></b>									
<i>Deaths (number)</i>	4,844	4,935	4,958	5,173	5,432	5,070	5,355	4,827	5,168
<i>Crude Death rate(per 1000 population)</i>	8.4	7.6	7.5	7.7	8.0	7.4	7.7	6.9	7.3
<i>Infant Mortality rate (per 1000 live births)</i>	11	8.5	8.3	8.0	7.0	6.0	5.6	4.9	4.7
<b><u>Marriages (number)</u></b>	5,607	6,669	5,761	7,187	7,738	9,080	9,282	10,57	10,28
<b><u>Divorces (number)</u></b>	348	757	725	851	852	1,193	1,182	1,197	1,320
	<b>1987/91</b>	<b>1994/95</b>		<b>1996/97</b>		<b>1998/99</b>		<b>2000/01</b>	
<b><u>Life expectancy at birth (years)</u></b>									
<i>Males</i>	74.1	75.3		75.0		75.3		76.1	
<i>Females</i>	78.6	79.8		80.0		80.4		81.0	

**Percentage distribution by age. 1.1.2002-1.1.2052**

Sex and Age	2002	2007	2012	2017	2022	2027	2032	2037	2042	2047	2052
<b>Females</b>											
0-14	20,56	17,89	15,57	14,47	13,89	13,14	12,27	11,46	10,82	10,45	10,27
15-64	66,77	68,63	69,94	69,32	68,04	66,26	64,72	63,38	61,93	60,12	58,19
65+	12,67	13,48	14,49	16,22	18,07	20,61	23,01	25,14	27,24	29,43	31,54
<b>Males</b>											
0-14	22,49	19,65	17,24	16,20	15,63	14,85	13,94	13,09	12,43	12,06	11,89
15-64	66,90	68,94	70,36	69,75	68,61	67,32	66,57	66,34	65,87	64,43	62,50
65+	10,62	11,41	12,40	14,05	15,76	17,83	19,49	20,56	21,69	23,50	25,61
<b>Total</b>											
0-14	21,51	18,75	16,38	15,31	14,73	13,97	13,07	12,25	11,59	11,22	11,04
15-64	66,83	68,78	70,15	69,53	68,32	66,77	65,61	64,81	63,82	62,18	60,25
65+	11,66	12,47	13,47	15,16	16,95	19,27	21,31	22,94	24,58	26,60	28,71

**Demographic Indicators of period**

	2002-2006	2007-2011	2012-2016	2017-2021	2022-2026	2027-2031	2032-2036	2037-2041	2042-2046	2047-2051
<b>Annual figures</b>										
Mid-period population	726,669	766,344	798,999	822,699	838,746	848,634	851,782	848,762	840,751	828,889
Births	7,960	8,181	8,123	7,741	7,334	6,777	6,321	6,073	5,914	5,715
Deaths	5,424	5,872	6,394	7,010	7,653	8,509	9,332	10,269	10,920	11,450
Net Migrants	+6,000	+5,000	+4,000	+3,000	+3,000	+3,000	+3,000	+3,000	+3,000	+3,000
<b>Rates per 1000 population</b>										
Birth rate	11,0	10,7	10,2	9,4	8,7	8,0	7,4	7,2	7,0	6,9
Death rate	7,5	7,7	8,0	8,5	9,1	10,0	11,0	12,1	13,0	13,8
Natural increase rate	3,5	3,0	2,2	0,9	-0,4	-2,0	-3,5	-4,9	-6,0	-6,9
Net migration rate	8,3	6,5	5,0	3,6	3,6	3,5	3,5	3,5	3,6	3,6
Growth rate	11,7	9,5	7,2	4,5	3,2	1,5	0,0	-1,4	-2,4	-3,3

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## Projection Assumptions, 1.1.2002 - 1.1.2052

	2002-2006	2007-2011	2012-2016	2017-2021	2022-2026	2027-2031	2032-2036	2037-2041	2042-2046	2047-2051
<b>Fertility</b>										
Total Fertility Rate	1,45	1,40	1,35	1,30	1,30	1,30	1,30	1,30	1,30	1,30
<b>Mortality</b>										
Life expectancy at birth										
Females	81,3	81,8	82,3	82,8	83,3	83,7	84,1	84,5	84,9	85,0
Males	76,4	76,9	77,4	77,9	78,4	78,8	79,0	79,0	79,0	79,0
<b>Migration</b>										
Annual net migration	+6.000	+5.000	+4.000	+3.000	+3.000	+3.000	+3.000	+3.000	+3.000	+3.000

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### Appendix 3 – Income from Contributions, Interest, Rents and Fines

<i>Year</i>	<i>Income of the Social Insurance Fund (£)</i>
1990	175.602.089
1991	191.492.616
1992	217.505.693
1993	260.090.862
1994	294.687.558
1995	316.437.110
1996	346.347.248
1997	371.960.847
1998	401.058.500
1999	424.436.968
2000	454.875.412
2001	501.444.639

### Appendix 4 – Total Expenditure including Administrative Express

<i>Year</i>	<i>Total Expenditure (£)</i>	<i>Total Expenditure as % of GDP*</i>
1990	92.974.175	4.1
1991	105.168.268	3.9
1992	112.758.559	3.6
1993	136.843.961	4.2
1994	153.044.375	4.2
1995	170.223.940	4.3
1996	191.280.523	4.6
1997	211.144.451	4.9
1998	223.924.673	4.8
1999	242.528.778	4.9
2000	273.600.461	5.0

\* GDP is at current market prices. It is pointed out that the GDP indicates only the expenditure of the Social Insurance Fund.

## Appendix 5 – Pension Payments

<b>Year</b>	<b>Old Age Pension (£)</b>	<b>Widow's Pension (£)</b>	<b>Invalidity Pension (£)</b>	<b>Orphan's Benefit (£)</b>
<b>1990</b>	52,328,726	18,954,127	4,329,321	286,666
<b>1991</b>	56,991,640	20,556,612	4,930,081	339,267
<b>1992</b>	62,996,068	22,787,248	5,764,154	395,723
<b>1993</b>	79,319,650	25,693,178	5,893,448	462,214
<b>1994</b>	87,550,158	27,884,499	6,866,934	534,354
<b>1995</b>	97,564,985	30,676,375	7,966,862	629,560
<b>1996</b>	109,119,753	34,137,313	9,605,771	750,450
<b>1997</b>	118,444,395	36,507,058	10,891,378	857,236
<b>1998</b>	127,573,401	38,466,999	11,939,549	935,978
<b>1999</b>	141,609,856	41,693,691	12,578,290	1,038,064
<b>2000</b>	156,887,446	45,409,874	14,272,136	1,126,991
<b>2001</b>	170,380,738	48,990,804	16,021,849	1,246,122

## Appendix 6 – Health

	1990	1995	1996	1997	1998	1999	2000	2001
<b><u>Persons per</u></b>								
<i>Doctor</i>	483	405	402	398	394	390	385	381
<i>Dentist</i>	1,354	1,198	1,187	1,170	1,157	1,136	1,121	1,106
<i>Nurse</i>	234	231	232	231	231	233	237	237
<i>Hospital beds</i>	170	197	202	215	221	223	220	229
<i>Hospital beds (per nurse)</i>	1.8	1.6	1.6	1.4	1.4	1.4	1.4	1.4
<i>Hospital beds (number)</i>	3,405	3,298	3,273	3,114	3,078	3,072	3,147	3,068
<b><u>Government</u></b>								
<b><u>General Hospitals</u></b>								
<i>Bed Occupancy rate (%)</i>	74.4	80.8	79.7	78.9	79.0	77.6	81.4	80.1
<i>Average length of patients stay (days)</i>	6.8	6.3	6.2	6.0	6.0	5.8	5.9	6.0
<i>In-patient (number of discharges)</i>	41,924	50,185	51,604	53,097	53,536	54,457	56,338	54,93
<b><u>Health Personnel</u></b>								
<b><u>(number)</u></b>								
<i>Medical</i>	1,199	1,607	1,645	1,685	1,721	1,762	1,800	1,839
<i>Dentist</i>	428	543	557	573	587	604	619	634
<i>Nursing</i>	2,478	2,821	2,850	2,901	2,937	2,950	2,931	2,963
<b><u>Total Expenditure on Health Services</u></b>								
<b><u>(£million)</u></b>								
<i>As % of GDP</i>	4.5	5.0	5.7	6.1	5.8	5.8	5.9	6.1

## Appendix 7 – Country Organisations Working in the Field of Ageing

### Governmental Organisation

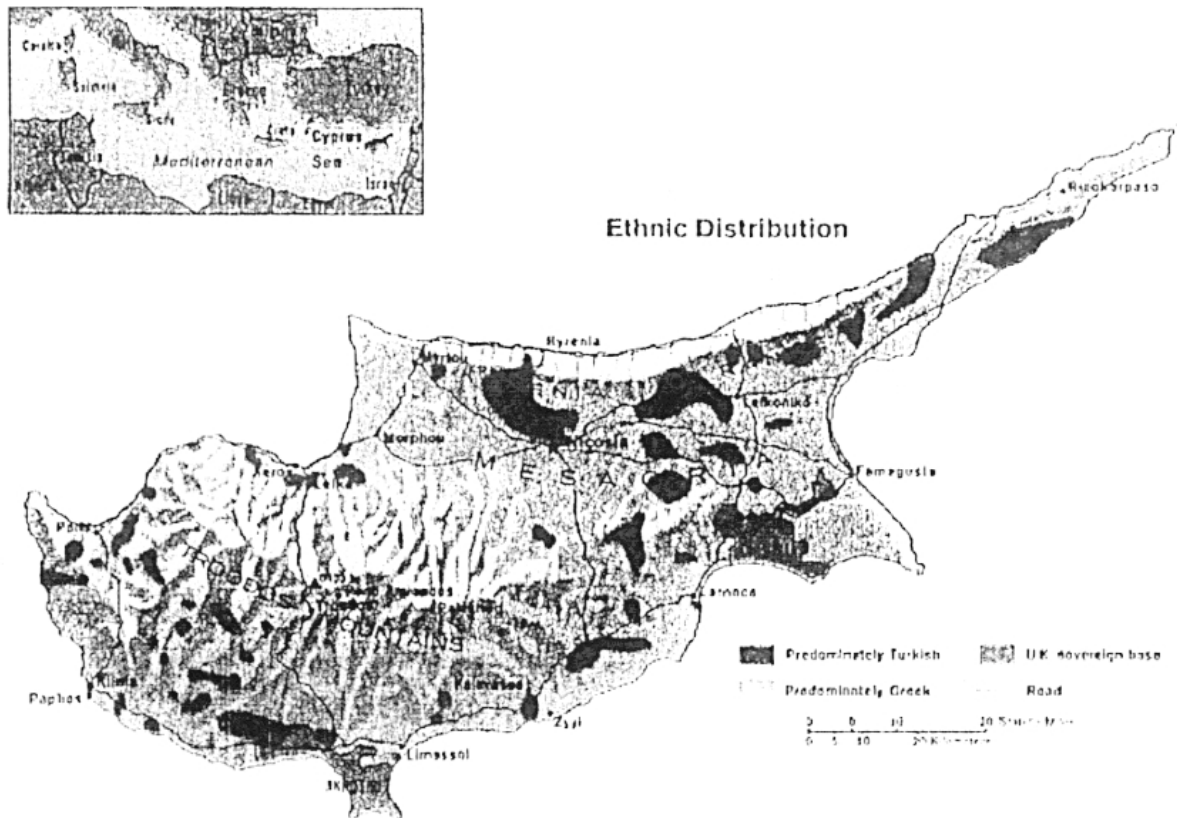
- Ministry of Labour and Social Insurance
  - (a) Department of Social Insurance
  - (b) Department of Social Welfare Services
- Ministry of Education
- Ministry of Health
- Co-ordinary Body for the Elderly (1995)
- Advisory Body on Policy Making for the Elderly (2000)

### Non-Governmental Organisation

- Pancyprian Welfare Council

- Pancyprian Federation of Elderly Welfare Clubs
- District Associations of Elderly Welfare
- P.A.S.Y.D.Y. (Trade Union) Pensioner Branch
- Pensioner's Pancyprian Union S.E.K. (Trade Union)
- Union of Cypriot Pensioners P.E.O. (Trade Union)
- District Welfare Councils
- Councils of Community Welfare
- Senior Citizens Organisations

Photo 1



*A Society for All ages*

SAGE 乐龄

**The 7th International Federation on Ageing (IFA) Global Conference  
5-8 September 2004, Singapore**

*Hosted by Singapore Action Group of Elders (SAGE)*

**Conference Theme : "Global Ageing: Sustaining Development"**

In April 2002, there was an unprecedented collective effort by UN member countries and NGOs to address ageing issues. The United Nations 2nd World Assembly on Ageing, First World NGO Forum and the Valencia Forum were held in Madrid and Valencia, Spain. Action plans were drawn up for countries to implement. 2 and a half years later, in 2004, the 7th IFA Global Conference in Singapore will be an ideal platform to share your research findings, programmes and services to advance the cause of seniors with an international audience.

# EARLY INITIAL ASSESSMENT OF PERSONS WITH DEMENTIA

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STEPHEN ABELA

Demographic trends show an ever-increasing world population resulting from decreased infant mortality and improved life expectancy.<sup>1</sup> With increased survival beyond 65 years of age, the percentage of elderly within populations is reaching levels of 13-14%. These proportions have already been reached in developing countries to date, however developing countries are expected to face these demographic changes in the forthcoming decades. Many studies have shown that the prevalence of dementia rises sharply with increasing age, doubling every five-year increase in age. Thus, dementia is a growing worldwide concern.

Over the last two decades, several advances have been made in the understanding of the pathological mechanisms that result in the clinical syndrome of dementia. Several investigative tools have also become available to help establish a firmer diagnosis. Newer treatments have been developed to improve cognitive function and ameliorate the symptoms and to improve the functional abilities of people with dementia. Yet, despite these developments, a comprehensive dementia assessment rests undoubtedly on the initial assessment of patients presenting with symptoms of memory loss or confusion.

In 2002, as part of the World Alzheimer's Day campaign, Alzheimer's Disease International presented the theme "Old age or disease? Recognising Dementia"<sup>2</sup>. The underlying message was that dementia and memory problems are not a normal part of ageing, this still being unfortunately a common misconception. Recognising the symptoms of dementia is the first step towards receiving a diagnosis and help. The family doctor plays an important role at this point, and can offer initial assessment and support while referring to specialist services as required. In general practice, screening questionnaires such as the Abbreviated Mental Test Score<sup>3</sup> or the Folstein's "Mini Mental State Examination" can be used to detect cognitive impairment and to identify patients requiring a more detailed examination.

Referral to specialist services may then be required and is especially important when trying to distinguish between the different types of dementias. Specialists involved in the assessment of patients with dementia include old age psychiatrists, geriatricians and neurologists. Old age psychiatrists usually become involved especially when patients exhibit behavioural problems, depressive or psychotic symptoms. Geriatricians deal more with elderly patients having multiple medical problems or those requiring multi-disciplinary intervention. Neurologists will be especially called to assess patients with abnormal neurological signs such as lateralising signs or evidence of Parkinsonism. The initial assessment of patients with memory impairment and confusion involves taking a full medical history and performing a detailed physical examination, blood investigation and imaging. In fact these requirements are set in diagnostic criteria, such as the DSM-IV criteria<sup>5</sup> by the American Psychiatric Association, which stipulates that secondary causes of dementia must be excluded. A list of potentially treatable secondary causes of dementia can be seen in Table 1. A series of blood investigations required to exclude these possibilities<sup>6</sup> is listed in Table 2.

Making a proper diagnosis in dementia is not only concerned with the consideration of dementia as the single diagnosis but also entails the exclusion of other conditions that may present in a similar way. The confusion of delirium for example, may initially be mistaken as resulting from dementia unless the acute onset, fluctuation and the presence of visual hallucinations are taken into consideration. The importance of recognising delirium cannot be overemphasized in view of the high mortality associated with the condition

**Table 1: Secondary Causes of Dementia**

<p><i>Deficiency States</i> eg. Vitamins B12, folic acid, B1</p> <p><i>Infections</i> Syphilis HIV</p> <p><i>Toxins</i> Drugs Alcohol Heavy Metals</p>	<p><i>Endocrine Disorders</i> Hyper and Hypoparathyroidism Cushing's syndrome Addison's disease Hyper and Hypothyroidism</p> <p><i>Other</i> Intracranial Tumour Depression (pseudodementia) Subdural haematoma Normal Pressure Hydrocephalus</p>
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**Table 2: Blood Investigations for Dementia**

<p><i>FBC</i> (particularly for Hg and MCV)</p> <p>ESR Thyroid Function Test Vitamin B12 &amp; folate Urea, Electrolytes and Creatinine</p>	<p>Liver Function Test, Proteins and Albumin</p> <p>Calcium and Phosphate Random Blood Glucose Urinalysis VDRL</p>
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if prompt treatment is not instituted<sup>7</sup>. Other psychiatric conditions that may present in a similar way to dementia include major depression and schizophrenia.

An important group of conditions that need ruling out are the space occupying lesions within the brain. Brain tumours (primary or secondary) usually present and progress over a shorter course and impaired alertness may be a prominent feature. Sub-dural haematomas may present not so differently and may include hemiparesis and a history of previous head trauma. Treatment and prognosis in these situations will be very different from that of dementia due to Alzheimer's disease or due to vascular causes. Imaging investigations such as CT brain scanning or MRI will identify space-occupying lesions, or other abnormalities such as the dilated ventricles of normal pressure hydrocephalus, or the changes of cerebral infarction or haemorrhage.

Since there is no cure for dementia, one may argue that there is no purpose in diagnosing the condition. There are however several good reasons why it is important to make a definite diagnosis. Firstly, a firm diagnosis will establish the prognostic implications that result from a diagnosis of dementia. Very often, persons with dementia recognise that there is a problem and want to know more about their condition. People have a right to know about the illness, even if this entails bad news, and they have a right to access more information about the condition and its treatment. Knowledge of the diagnosis will give an opportunity to discuss outlook and to organise practical arrangements. Further advice given to patients and their carers by occupational therapists may include help on how to remember things, recommendations for activities of daily living, home adaptations and environmental safety and the encouragement to lead an active lifestyle.

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The assessment of patients by geriatricians may provide an opportunity to screen for underlying unrecognised problems, which if treated could improve cognitive function<sup>8</sup>. Hearing problems may result from cerumen impaction or could be resolved by using a hearing aid. Visual problems are common and may even be associated with falls. Polypharmacy is another problem that can be addressed at the initial assessment. Psychoactive drugs may be inappropriately prescribed, especially in elderly residents of nursing homes<sup>9</sup> and their use may be associated with an increased rate of cognitive decline<sup>10</sup>.

The availability of acetyl cholinesterase inhibitors<sup>11</sup> and more recently the NMDA receptor antagonist memantine<sup>12</sup> as specific symptomatic treatment has brought hope to the management of dementia. These medications confer improvement of cognitive function and functional abilities and may delay the need for institutional care. Other alternative therapies available include ginkgo biloba and nootropics. The treatment of depressive symptoms with antidepressants (especially with selective serotonin re-uptake inhibitors) and of behavioural symptoms with psychoactive drugs (especially with atypical neuroleptic drugs) is also part of the management of the condition. Other treatment is indicated depending on the type of dementia. For example, vascular dementia will include the control of hypertension and the use of antiplatelet drugs such as aspirin. Vitamin E can be given in Alzheimer's disease to slow progression by conferring protection from injury by free radicals to nerve cells<sup>13</sup>. Lewy Body Disease is becoming increasingly recognised due to better awareness of the condition<sup>14</sup>. Important indicators for this condition include the features of Parkinsonism, the early occurrence of visual hallucinations and the fluctuation in cognitive status. Lewy body disease patients do not tolerate neuroleptic drugs, which should be avoided. Acetyl cholinesterase inhibitors have been shown to be very effective in treating this condition.

On a final note, the setting up of specialised memory clinics, which are nowadays considered to be important constituents of hospital-based services<sup>15</sup>, should be commended. Memory clinics facilitate the development of a structured assessment and enable professionals from various disciplines to team up and collaborate in the assessment and care of these patients. Physicians and psychiatrists can jointly carry out the initial assessment as described previously while other team members can become involved depending on the requirements. Neuropsychologists are commonly involved in carrying out detailed assessments on patients with dementia and in giving their opinion regarding the interpretation of neuropsychological tests. Patients who can benefit most by attending memory clinics would be those presenting with early dementia or those with milder cognitive impairment. Memory clinics may also serve as a centre where monitoring and control of anti-dementia treatment can be effected.

In conclusion, the importance of recognising the early symptoms of dementia and of carrying out a detailed initial assessment cannot be stressed. Although no definite cure is yet available, much can be done to improve the quality of life of patients and their family.

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## MERCK INSTITUTE FELLOWSHIPS



The International Institute on Ageing, United Nations – Malta has received a grant from the Merck Institute of Ageing and Health, Washington D. C. for the years 2003 and 2004 for Training Programmes, which are held in Malta. These funds support the educational activities of 8 Fellows from developing countries participating in the Short Training Programmes in Social Gerontology, Economic and Financial Aspects of Ageing, Geriatrics and Demographic Aspects of Ageing as well as 2 Diplomates participating in the 9-month Postgraduate Diploma Course in Gerontology and Geriatrics at the European Centre for Gerontology, University of Malta.

Applications for the above Fellowships will be received by Professor Frederick F. Fenech, Director of the International Institute on Ageing, United Nations – Malta, 117, St. Paul Street, Valletta VLT 07, Malta, e-mail [ffen@inia.org.mt](mailto:ffen@inia.org.mt).

The closing date of applications can be obtained from the Institute's website, [www.inia.org.mt](http://www.inia.org.mt).



# INIA'S ACTIVITIES 2004



5th – 6th May	Fifth Board Meeting, (MALTA).
10th – 21st May	International Short Training Programme in <b>Geriatrics</b> , (MALTA).
31st May - 9th June	Short Training Programme in <b>Gerontology</b> in collaboration with the China National Committee on Ageing, (CNCA), (MALTA)
5th - 8th September	International Federation on Ageing (IFA) 7th Global Conference, ' <b>Global Ageing: Sustaining Development</b> ', (SINGAPORE)
6th – 17th September	International Short Training Programme in <b>Demographic Aspects of Population Ageing and its Implications for Socio-Economic, Policies and Plans</b> , (MALTA).
Oct. 2004 – June 2005	International <b>Post Graduate Diploma in Gerontology and Geriatrics (Dip.Ger)</b> European Centre of Gerontology and Geriatrics, (University of Malta), (MALTA).
13th – 16th October	Conference on " <b>Medicines Management in Older Persons</b> " organised by the International Institute on Ageing-United Nations, (Malta), in association with the University of Malta – Department of Pharmacy, Zammit Clapp Hospital for the Aged, Parliamentary Secretariat for the Care of the Elderly – Ministry of Social Policy and the European Society of Clinical Pharmacy, SIG Geriatrics, (MALTA)
1st - 12th November	In-Situ Training Programme in <b>Gerontology</b> in collaboration with the Singapore Action Group of Elders (SAGE), (SINGAPORE).
5th - 12th December	In-Situ Training Programme in <b>Gerontology</b> in collaboration with the Beijing Civil Affairs Bureau (BCAB), Beijing, (CHINA).
14th - 21st December	In-Situ Training Programme in <b>Gerontology</b> in collaboration with the Zhejiang Working Committee on Ageing (ZWCA), Hangzhou, (CHINA).

## **International Short Training Programme in Social Gerontology and International Short Training Programme in Economics and Financial Aspects on Ageing**



The International Institute on Ageing, United Nations, Malta (INIA), in collaboration with the United Nations Fund for Population Affairs (UNFPA), organised an **International Short Programme on Social Gerontology**, between 9 - 20 February 2004.

This multi-disciplinary Programme was attended by 18 participants hailing from Armenia, Cameroon, China, Cyprus, India, Jamaica, Malta, Nigeria, Papua New Guinea, Romania, Russia, South Africa,

and Uganda. It provided a broad and up-to-date understanding of the complex and far-reaching consequences of mass longevity. Participants were helped to evolve and implement appropriate policies that will ensure for older persons, a high quality of life in their own society.

Apart from local tutors, International tutors invited to participate in the teaching were Professor Toni Antonucci, Programme Director and Research Scientist, at the Institute of Social Research, and Professor of Psychology at the University of Michigan, USA and Professor P. V. Ramamurti from Sri Venkateswara University India.

Another programme organised by INIA in collaboration with UNFPA was the **Programme in Economic and Financial Aspects of Ageing** held between 1 - 12 March 2004.

The programme was designed to make policymakers aware of the enormous and far-reaching consequences stemming from mass survival to old age both for individuals and for society as a whole. The 14 participants hailing from China, Cyprus, Malta, Nigeria, Romania, South Africa, Uganda and Yemen, were able to discuss current situations in the developing countries.

Apart from local experts, International tutors invited to lecture were Dr. Robert Clark, Professor of Business Management and Economics, North Carolina State University, USA and Dr. Raja Gopal Dhar Chakraborti, Professor in the Department of South and Southeast Asian Studies, Calcutta University, India.

The programmes, were co-ordinated by Professor Joseph Troisi, INIA's Deputy Director and opened by the Hon. Dr. Francis Agius, Parliamentary Secretary at the Ministry of Social Policy.

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# INTERNATIONAL DIARY 2004

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JUNE 6 - 9 – VIENNA, AUSTRIA

World Conference on Injury Prevention and Safety.

Information:

E-mail: [safety/2004@sickerleben.at](mailto:safety/2004@sickerleben.at)

JUNE 19 -21 – SIGTUNA, SWEDEN

11th International Research Seminar of FISS  
Issues in Social Security

Information:

E-Mail: [1g11@york.ac.uk](mailto:1g11@york.ac.uk)

JULY 21-25 – ORLANDO, FLORIDA, USA

2nd International Conference on Politics and Information Systems: Technologies and Applications (PISTA'04)

Information:

Website: <http://www.confinf.org/Pista04>

AUGUST 3 - 7 – LONDON, ONTARIO, CANADA

World Congress on Ageing and Physical activity  
“Research to Action for an Ageing Society”

Information:

Website: [http://www.ca/actage/wcapa/en/  
program-objectives.htm](http://www.ca/actage/wcapa/en/program-objectives.htm)

SEPTEMBER 5 - 8 SINGAPORE

International Federation on Ageing 7th Global Conference – Global Ageing: Sustaining Development.

Information:

Website: [www.7ifaconference.com](http://www.7ifaconference.com)

SEPTEMBER 12 - 18 BEIJING, CHINA

International Social Security Association (ISSA)  
28th General Assembly

OCTOBER 15 - 17 – KYOTO, JAPAN

International Conference on Alzheimer Disease  
“Dementia Care in an Ageing Society”

Information:

Website: [www.alzheimer.or.jp](http://www.alzheimer.or.jp).

DECEMBER 2 - 3 – CARDIFF, U.K.

Final Scientific Conference on Dignity and Older Europeans

Information:

E-mail: [doe-project@cf.ac.uk](mailto:doe-project@cf.ac.uk)

### **The Editor Invites:**

All readers and users of BOLD to send him critical comments and suggestions.

### **The Editor Appeals:**

We need regular inflow of your best, most colourful and significant photographs relevant to our Ageing themes to feature on the front cover of future issues of BOLD.

### **Copy Deadline:**

The next issue of BOLD will be published in August 2004  
for which copy deadline is 30 June 2004.

Proposals for articles or letters, information, news bulletins and conference details may be addressed to:

**The Editor, International Institute on Ageing,  
United Nations – Malta,  
117, St. Paul's Street, Valletta VLT 07, Malta**