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ADVERT



ECONOMIC SECURITY FOR OLDER WOMEN IN INDIA

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Traditional roles have always offered a lower position to women, especially on matters concerned with finance and financial transactions, and it is this tradition that places women in financial destitution in old age. Financial problems that women face in old age are multiple in nature especially due to (i) insufficiency of economic resources (ii) conditions attached with social security entitlements and (iii) poor employment history. These factors lead them to a financially deprived state. Women, the carers of the family - caring for parents/grandparents, caring for husband, children and grand children - are themselves often not cared for in old age.

Due to demographic factors - age difference from spouse and higher longevity - women tend to live as widows in their old age and live without assistance of spouse. The number of years a woman lives as a widow varies with an average of 12 years (Nayar 1999). A survey of widows - who have had at least two years of widowhood - held in Kerala state revealed that a higher proportion of older women live more than 10 years as widows. Widowhood influences the economic status of older women because widowed women lose the opportunity to benefit from their spouse's earnings. Currently, married women are in a better financial position especially because their men are considered as the earners and supporters traditionally.

This paper explains various means by which an older woman could keep herself in financial health. Not only do these means enable elderly woman for a better sustenance, but also they help the elderly woman to support younger generations.

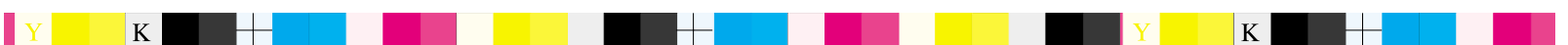
Economic Dependence in Old Age

As the proportion of older women with personal financial means remains low, the proportion with

economic independence also remains low. Most older women depend largely on others for their day-to-day expenses. The National Sample Survey (Government of India, 1998) showed that nine out of ten older women in India are financially dependent on others - either partially or fully. As compared to the situation that prevailed in 1986-87 (Government of India, 1991), the situation has improved slightly. The higher levels of economic dependency among older women arise due to the following factors

- Women's caring role in the family
- Male dominance in property and family assets
- Traditional social values and prejudices that restrict women's participation in paid labour
- Women's participation in low paid jobs
- Women's higher participation in agriculture (or family business)
- Women's higher contribution to their family expenses and lesser monetary savings

On the basis of financial capability older women could be classified into (i) those with cash (ii) those with only assets and (iii) those with neither cash nor assets (Radha Devi et al., 2002). Older women with cash are considered as economically better off and having financial freedom. Older women with immovable assets receive respect and consideration from other members of the family; but they have less financial freedom. The other category of older women - lacking finance - depends on others (spouse, children, grandchildren, relatives etc.) for their day to day expenses.



Sources of finance for old age

The financial status of older women varies widely from individual to individual. The sources of finance for old age are earnings, properties and assets, pensions and social security benefits.

Earnings

Only a small proportion of older women have earnings (through work participation). In comparison with older men. The percentages of older women who have earnings were 12 in urban and 23 in rural areas in 1983 (as per NSSO report). The corresponding percentages among males were 51 and 66 respectively. There was no substantive increase over a ten-year period (Government of India, 1997). Widowed older women are worse off than their currently married counterparts.

Possession of properties and financial assets

Important financial resources for old age security are property and assets. Property refers to immovable assets whereas financial assets refer to movable assets. Examples of immovable assets are agricultural land, residential houses, residential plots etc. Savings, vehicles, household articles etc., are movable assets. Properties offer financial security in two ways (i) as the income from property adds to the older women's financial condition, she will have the liberty to spend that income for her welfare and (ii) possession of property prompts her children to provide better care in her old age, with the hope of "better the care, more the share". Savings provide financial freedom whereas ownership of household assets provides better status in the family.

However, the numbers of older women who possess properties or assets are low (Government of India, 1991 and 1998). Among those who possess properties, a majority give up the task of its management in old age. This puts them in a financial destitution. Older women who do not manage the properties are more or less equivalent to those without properties or assets. For an older woman to make financial benefits, she needs to retain control over her properties or assets.

The surveys of NSSO showed that only half of the older women in India possess properties or assets. Yearly data show a declining proportion of older women having properties, which could be because of the transition from agriculture to regular employment. But older women with financial assets are also in decline. There is not much difference between rural and urban older women in this respect. This shows clearly that older women are in serious financial destitution in both rural and urban areas. This declining proportion of older women having properties over the last nine years (1986-87 to 1995-96) reveals poor financial planning for old age.

Retirement Benefits

Retirement benefits forms an important source of finance for older women. Retirement pensions and other benefits (including insurance, provident fund, gratuity etc.) provide economic security to a great extent. But the proportion of older women having any retirement benefits remains low; their proportion is higher in urban areas as compared with of rural areas.

Social Security Benefits

Social security pensions, even though meagre in amount, create a sense of financial security for older women who benefit through old age pension, widow's pension, agricultural pension and pension for informal sector workers - the usual social security pensions. However the proportion of older women who benefit from these schemes remains low.

It is clear that very many older women of today live in a poor financial situation. This is mainly because of their poor professional skills. These women have come through without proper financial planning for old age. So, the challenge of today is assisting women with more remunerative employment and cultivating saving habits in order to produce financial reserves for old age.

Social Security in the Organised Sector

Older women who had been in Government sector



employment receive benefits on retirement. The benefits may be contributory or non-contributory. The contributory benefit is the provident fund. Under this scheme both the employee and the employer make contributions at a prescribed percentage of the employee's monthly emoluments. All employers (in the modern sector) are obliged to implement the provident fund scheme.

The non-contributory scheme includes a pension. An employee benefitting under the pension scheme receives a monthly payment as pension. The amount of pension is decided according to the length of service and the last salary drawn.

The minimum period of service needed for a full pension is 33 years. Those with less than 33 years of service receive a reduced pension according to the years of service. Those who retire before completing a minimum ten years of service are not eligible for pension. They receive other benefits, such as the service gratuity offered to an employee for rendering continuous service for a minimum period of five years. This is applicable in case of superannuation, retirement, resignation, death or disablement.

Social Security in the Unorganised Sector

The unorganized sector in India exists on relatively low wages and insecurity due to the absence of a comprehensive social security system. Some of the states have introduced social security schemes for certain sections of the unorganized sector workers. Examples are the Sanjay Gandhi Niradhar Yojana implemented in Maharashtra and the pensions for informal workers in effect in the state of Kerala.

An important move in the direction of social assistance in old age has been the introduction of Old Age Pension through the National Social Assistance Programme in 1995. This is a centrally sponsored programme with full assistance of Central Government to states and union territories. This scheme provides a pension to the destitute older persons. Older women having little or no regular means of subsistence from their own source of income or through financial support from family members are eligible.

Measures for Improvement

Promoting welfare of older women is a concern of society. Social security measures on the part of Government provide economic security to some extent. Such public sponsored schemes are proved to be unsustainable due to the increasing longevity and destitution. Western nations that followed welfare state ideology are finding difficulty as to maintain social security provisions. Their failure was attributed to the higher importance given to concepts of ageism, paternalism, humanitarianism, segregation and welfare gap.

Ageism is the negative image of a person formed only on the basis of age. With this approach older women get mistreated and discriminated. Paternalism refers to provision of goods and services to older women considering them as destitute. Humanitarianism considers the inabilities of older women and provides services. All such concepts led to considering old persons especially older women as dependents and destitute. This led to segregating them. The western nations adopted institutionalization as the cheapest solution. At institutions they lead a life of loneliness and worthlessness. This approach of providing a welfare measures resulted in a welfare gap due to increased longevity; that is, the duration for providing welfare measures increased noticeably. Due to reduction in the number of earning members, the resources have reduced.

Strategies to meet the economic challenges of ageing are changing all over the world. The United Nations (1983) directed countries to offer social security and social programmes to older women. They recommend governments to facilitate older persons (older women's) participation in the economic life of society through

- Measures in collaboration with employers and workers' organizations for ensuring continuation of older workers (older women) in employment.
- Measures to eliminate discrimination against older workers (older women) in the labour market through education. Older workers (older women) should enjoy equal access to orientation, training and placement facilities and services.
- Measures to assist older women to return to



employment by creating new possibilities and training and retraining, and

- Measures to be taken against lowering the retirement age.

Satisfactory working conditions and work environment that consider the characteristics of older women should be incorporated in the work setting. A smooth transition from working life to retirement should be ensured through pre-retirement courses and lightening the workload during the last years of working life.

The second World Assembly on Ageing (2002) emphasized the need to strengthen research in line with promoting the welfare of older persons (older women), with planned strategies to open up opportunities for economic activities for older people (older women) particularly in rural areas.

The US Department of Health and Human Services (1999) also pointed out the need of assisting older women to return to employment through new opportunities and training and retraining. This will help older women who live below the poverty line and who depend on social security benefits.

The pension reform strategies introduced as a response to budgetary pressures in the European region include

- Raising the legal age at retirement
- Introducing flexibility in retirement viz., gradual or partial retirement (allowing a combination of pension and income from work)
- Extension of contribution period of pensions by altering the methods for financing pensions
- Curtailment of pre or early retirement policies
- Reduction in the levels of pension and
- Encouraging more fixed pension systems through funded financing.

Keeping in mind the experiences of ageing countries and the situations prevailing in India, there is scope for adopting strategies to meet the economic challenges of older women. The strategies should include

- Encouraging older women's earning activities
- Valuing older women's economic and non-economic contributions to the household
- Improving intra familial relationship between older women and younger generations
- Promoting the concept of filial responsibility
- Encouraging children to care for the older mother through family benefits
- Encouraging women to make use of retirement and old age benefit schemes proposed by insurance companies, which will ensure security in the future cohorts of older women.

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INIA'S ACTIVITIES 2005

7th - 18th February

International Short Training Programme in **SOCIAL GERONTOLOGY**, (MALTA)

9th - 18th February

43rd Session of the Commission for Social Development, **New York** (UNITED STATES OF AMERICA)

28th February - 11th March

International Short Training Programme in **ECONOMIC AND FINANCIAL ASPECTS OF AGEING**, (MALTA)

3rd - 4th March

Conference on **POPULATION AND DEVELOPMENT CO-OPERATION**, organised by the German UNA and the Protestant Development Service, **Bonn**, (GERMANY)

21st - 30th March

In-Situ Training Programme in **GERONTOLOGY AND GERIATRICS** in collaboration with The St. Petersburg School of Public Health, **St. Petersburg** (RUSSIA)

7th - 8th April

Council of Europe Conference on **DEMOGRAPHIC CHALLENGES FOR SOCIAL COHESION**, organised by the European Population Committee in collaboration with the Parliamentary Assembly and the Congress of Local and Regional Authorities, **Strasbourg**.

21st - 22nd April

TRACER STUDY ADVISORY MEETING in collaboration with the United Nations Population Fund (UNFPA), (MALTA)

17th - 18th May

UN Economic Commission for Europe (UNECE) **TASK FORCE MEETING**, (MALTA)

19th - 21st May

Workshop on **'CARE PROVISION IN AGEING SOCIETIES: WHAT ARE THE POLICY CHALLENGES AND HOW TO ADDRESS THEM'** organised by the UN Economic Commission for Europe (UNECE) and the International Institute on Ageing (INIA), MALTA.

16th - 27th May

International Short Training Programme in **GERIATRICS**, (MALTA)

21st - 30th May

Short Training Programme in **SOCIAL AND HEALTH ASPECTS OF AGEING** in collaboration with the Beijing Civil Affairs Bureau (BCAB), (MALTA)

26th - 30th June

International Association of Gerontology (IAG) **WORLD CONGRESS OF GERONTOLOGY**, Rio de Janeiro, (BRAZIL)

September

In-Situ Training Programme in **GERONTOLOGY** in collaboration with the Singapore Action Group of Elders (SAGE), (SINGAPORE)



OLDER WOMEN IN INDIA: A Case of Multiple Jeopardies

ANUPAMA DATTA

Introduction

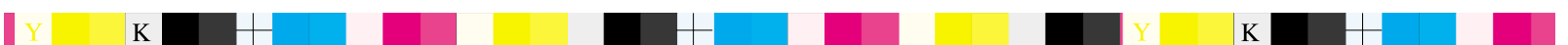
To be a woman in a man's world is quite an unenviable position, more so for women in India. The irony of their fate is that the very family in which they are born do not hesitate to kill them even in the foetal stage, ignoring their basic needs for growth and development and treating them as burdens that should be offloaded at the earliest. The family into which an Indian woman marries is based on exploitation of her labour because of "duty towards family". She has not only to play the role of wife and mother and daughter-in-law but also carry the major responsibility of care giving to the old, sick and others. As most women are younger than their husbands and outlive them and as their status is dependant on the husband, in his absence it degrades further. In the year 2002 the sex ratio (men per 100 women) for the 60+ population is 91/100 and it reduces to 81 in the age group of the 80+ population. In the age group of 60+, 75% of the men are currently married as compared to 42 women in the same age category. (Ref: www.un.org/esa/population/publications/ageing/graph.pdf) Therefore, most of these women make a heavy emotional investment in their sons who are expected to take care of them when they grow old and frail. But how fruitful does this investment prove to be is anybody's guess.

Elderly women are particularly at risk in Indian society because most of them live in the shadow of the males throughout their lives – father, husband, son or male relatives like nephew, brother, uncle. In most cases they do not earn money and even when they do, their employment is often guided by family considerations, so most of them take up casual employment or are under employed and they also shoulder family responsibilities. Moreover, their earnings are managed by the male counterpart, so for all practical purposes they have no knowledge

of how to use them. The labour force participation also tells the same tale of a disadvantaged position with 59% of men as compared to 18% women being included in the labour force in the 60+ age group. It is easy to defraud such women as their world view, in most cases, is limited to family and kin-group matters. This also applies to ownership of property. Most of the women do not own property and even when they own it they do not manage it. They are completely dependant on the male members of the family for fulfilment of all their basic needs. They cannot even go to the local doctor without a male relative accompanying them, even when they are fit to move around. With age this dependence increases.

Besides, elderly women face specific health problems: they are prone to arthritis, osteoporosis and hypertension, cervical and breast cancer, anaemia, dementia and most of all depression. In one study, it was revealed that 93% of older women were suffering from depression. In the same study, it was found that about 88% of the elderly women were suffering from multiple geriatric problems and this increased their dependence on other, with 23% being completely dependant whereas 60% were partially dependant on their care givers.* The challenge in such cases is doubled by the fact that women generally tend to underplay their health problems. They do not consult doctors unless the symptoms become obvious. In some cases they neglect their health due to pre-occupation with taking care of the husband. Illiteracy and lack of awareness make matters worse. Those who visit the medical facilities generally go to the primary health centres

*Vijay Kumar, S.: *Elderly Women in Rural India: Need for Health Policy Intervention*; in Lecture Series in Geriatrics; Bhatla, P.C. (ed.); National Institute of Primary Health Care; New Delhi; 2000; pp-274-277.



or hakims. The social emphasis on sacrifice by the mother and wife leads to nutritional deficiencies in women, which could create major health risks in old age.

Problems faced by Older Women

As already stated women are at a clear disadvantage in our society. The problems that elderly women in any country face are more or less the same—health, economic, emotional, abuse and crime. The order of importance may vary according to the class to which the elderly women belong. The rich educated women may be economically self-sufficient but could be facing problems of emotional insecurity and physical vulnerability. Even these women are open to threats of crime and fraud by their own relatives or children; single elderly women are particularly vulnerable. Imagine a situation where there is a very old woman living alone and has to depend on two young servants, or a land lady who has a rogue tenant. She would be a very "attractive" target for the miscreant as she would be too weak to resist before help reaches her or somebody even notices the crime. This would certainly embolden the miscreants. There are cases where children take advantage of the frailty of the mother and fraudulently use her assets or property as she would be too weak to call police or apply to the court.

The higher middle class professionally qualified women, who worked as doctors, teachers, lecturers during their young years and were retired at the mandatory age of 58/60 years are also economically secure and have well settled children. They may have some health problems that could be looked after and possibly only minor irritants but they may have a big emotional gap in their lives. The family members may be so busy with their own affairs that may have no time to talk to them or take them to the doctor/friend. They do not have any substantial role to play in their own house as the grandchildren are taken care of by professionals and the household chores are performed by paid help. They have nothing meaningful in life to do. So they feel useless, ennuis sets in and many of them face psychological problems due to this status and role loss.

The majority of the women in that age group are uneducated housewives, who have lived in the shadow of their husbands all their lives. Their identity and existence revolves around the family. But as their children grow up and marry, their position and status in the family deteriorates even further. The elderly lady loses her status in the family due to assertion of rights by the daughter-in-law to manage the household according to her choices. Differences of opinion on seemingly minor matters like observance of a religious taboo on food, etc might become irreconcilable. Such situations are mostly found in lower-middle class families where the economic condition of the elderly is not so sound and they are partly dependant on their children.

Being an elderly woman without resources is bad enough but some are unfortunate enough to be widows; in that situation they are most of the time at the mercy of the adult children. Their health and other needs become secondary to the needs of other members of the household. Nobody wants to "waste" time or money on taking them to a doctor; the widow is most often accused of blowing things out of proportion, being too touchy about minor things in life, too adamant to adapt to the needs of changing times. Such women tend to suppress their real urgent health and nutritional needs and at times face severe depression. Mrs X, who was widowed at the age of 30 years, raised her three children by running a small shop in the neighbourhood. Today both her sons are well placed but treat her like a burden. The elder son donates money to local bodies in the name of his deceased father but does not even talk to his mother. So she is completely dependant on her younger son, who may not say anything overtly but does resent her presence in his house.

Many elderly women find themselves forlorn in the world after that they have done their job as home-makers. Their children immigrate to cities or foreign countries and the old women have to take care of their husbands in their ripe old age, with only friends, relatives or neighbours to fall back on for help. Their life is not only devoid of the joys of grandparent hood but also emotional support of their own children. The stress of care giving in old age could tell on their own health, which more often than not



they neglect. Mrs G had five children, all well settled in life but all of them lived separately. Her husband had enough money to see them through their old age. Unfortunately, her husband fell ill and was bed-ridden for 8 long years. Mrs G had to take care of him single handed. The children were only willing to shell out money to employ servants and professional help, which Mrs G refused. Needless to say that today she is a disillusioned person who is suffering from severe depression. However, to find meaning in life she has started educating poor girls in the neighbourhood .

This brings us to another very major issue in the lives of older women, the role of care giving to an ailing spouse over long periods of time. In worse cases the elderly woman has no family member to support her either due to emigration of children or any other reason. This has many implications for the health of women. This not only challenges their physical capacity but also brings tremendous stress on mind which could lead to serious psychological problems. Such women are anxious about loss of husband, or at times about what would happen to them if the same fate befalls them? Who will take care of them?

Policy Intervention

In the section entitled Principal Areas of Intervention and Action Strategies, the National Policy on Older Persons released by the Government of India in the year 1999 acknowledges and addresses concerns of elderly women. The Policy states that in India in the year 1991, there were four times as many widows as compared to widowers; It acknowledges the vulnerability of single older women as few persons are willing to take care of non-linear relatives and of destitute widows. It is sensitive to the fact that Older Persons, particularly women, become soft targets for criminals and also become victims of fraudulent dealings and of physical and emotional abuse within the household by family members, who could force them to part with their ownership rights. The widow's rights of inheritance, occupancy and disposal are at times violated by her own children and relatives. It therefore makes a commitment to introduce special provisions in IPC to protect older

persons from domestic violence, and machinery will be provided to attend to all such cases promptly. It also promises to review tenancy legislation so that the rights of occupancy of older persons are restored speedily. (*National Policy on Older Persons; Ministry of Social Justice and Empowerment; GOI; 1999; New Delhi*)

Concrete steps that could be taken

In order to address the issues of economic insecurity of elderly women, rather than outright welfare support Government should adopt a rational approach that is a right mix of enterprise and welfare. Women in the age group of 60-75 years who are willing to work should be encouraged to form cooperatives and earn their living. NGOs could assist such women to develop their skills and get credit on reasonable terms from some micro credit scheme. Volunteers should be selected from students pursuing business management to teach marketing skills to these women. However, the toughest challenge would be to convince these older women that they still have the potential to learn new skills and start an enterprise. So, again, the NGOs and social workers could be entrusted with this task as they have better communication skills to deal with hardened attitudes. Those who are incapacitated or very old may be considered for outright help and given money so that the family does not treat them as a burden.

This approach of encouraging enterprise will not only help older women financially but also give them an opportunity to develop sorority with fellow women workers, which could lessen their dependence on their own family. A fellow worker could take an ailing older woman to a local doctor, they would be able to talk to each other about their problems and probable solutions. Solving each other's problems may lessen the feeling of uselessness in them.

Care should be taken to simplify administrative procedures so that these illiterate women are able to take advantage of these schemes. NGOs should also work together to give wide publicity to these schemes.



The curriculum for geriatrics and gerontology for medical / paramedical and support services faculties should be sensitive to the health and nutrition concerns of women. The medical fraternity should be able to address the specific health concerns of older women, NGO's, PHC staff should be encouraged to spread awareness among women about these issues and also stress the importance of healthy ageing. This is very important as women tend to neglect health, especially older women, who have no one to take care of them.

Security concerns of older women are of particular importance as they may not be able to deal with such situations adequately. There should be a change in the IPC keeping in mind the disabilities that older women face. Moreover there should be collaboration between NGOs and local police to prevent such crimes whether perpetrated by family or outsiders. NGOs could run a helpline and inform the local police about any such reported crimes or harassment or abuse. The police and volunteers should also carry out a regular round of the identified families of the areas where older persons, particularly women, live. Delhi police has introduced such a scheme of regular visits by policemen in the identified houses of senior citizens on a limited basis. The beat officers in the area have been directed to make a list of senior citizens and help ensure a secure environment for them. Under the plan the local SHO will visit them every first Saturday of the month and the beat constable will visit once a week on Sunday. The Delhi police have listed so far 3,325 senior citizens living alone under the scheme and claims are made

that over 3,200 have been visited by the police. The beat constables have been instructed to maintain close contacts with the senior citizens' neighbours and the local resident welfare associations, and ensure that a proper verification of their servants and drivers has been done. The police will provide the older people with the address and telephone numbers of NGOs they can call in emergency. The south district has launched "Police at your Doorstep", in which the senior officers meet older people during their morning wafks. The Delhi Police will soon start a helpline for senior citizens living alone.

Steps taken by Government, NGOs and security agencies go a long way in reducing threats to older women, but the family still remains the most important institution in an Indian woman's life. She nurtures her family with all her capacity throughout her 'productive years' in the hope that when she gets old and frail these very members will take care of her. However, in the context of industrialization the family has undergone some changes, its structure and functions are no longer the same. But it would not be practical to advise older women to sever all their ties with the family and expect nothing out of their children. Therefore one needs to work on the policies and programmes that support families to take care of older women. Counselling of both, the young and the old to adjust to each others' needs and life styles should be imparted and new methods of conflict management should be taught to the people so that they live in their own families without becoming a nuisance to each other.

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AGEING IN NIGERIA: Blessing or Curse?

MARTIN MAKINWA

In Nigeria, ageing is a sensitive and seriously regarded issue. The elderly members of our society are highly revered, respected and often held in great esteem. They are often seen as the custodians of knowledge due to their experience in life. Sociologically, they are seen as the organizers of the society, and as people through whom inter-generational beliefs and traditions/customs are transferred to the younger generations. The aged in traditional African societies enjoyed privileges that include seniority positions in clans and kinship groups because of their age (United Nations, 1994). In summary, they are the arbiters in the society in which they live.

Demographically, the categorization of people on the basis of ageing varies from one place to the other.

But for the purpose of this paper, people aged 65 years and above are considered. The major criterion considered for choosing age 65 years is that at this age, in Nigeria, one is expected to have retired from economic activities and been a dependant in line with the tradition of caring for the aged by close relatives like wives and children, and by the extended family members through multi-generational living arrangements (Hashimoto, 1991).

The findings of the 1991 population census in Nigeria indicate that there were close to 3 million aged people of 65 years and above in the country. This constitutes 3.37% of the total population of 88.9 million (Table 1). Of these data, more than 2 million people were in the rural areas while the remaining 0.8 million were in the urban centres.

Table 1: Rural - Urban Distribution of Aged Population Nigeria (1991)

Age Group	Rural Population (65+ percentage)		Urban Population (65+ percentage)	
	Population	Percentage	Population	Percentage
65-69	525,887	0.9	238,053	0.7
70-74	649,851	1.1	236,451	0.7
75-79	249,935	0.4	101,888	0.3
80-84	357,066	0.6	123,620	0.4
85+	310,528	0.5	114,461	0.4
Total	2,093,267		814,473	

Source: NPC, 1998: 1991 Population Analytical Report

Tables 2 (a-d) show the projected figures of the aged population from 1991 to 2010 based on their sex classification using the medium variant method.



Table 2a: Sex Distribution of Aged Population Nigeria (1991)

Age Group	Males	Females
65-69	406,640	238,053
70-74	492,186	236,451
75-79	195,455	101,888
80-84	488,644	123,620
Total	1,582,925	1,324,915

Source: NPC, 1998: 1991 Population Analytical Report

Table 2c: Sex Distribution of (Projected) Aged Population Nigeria (2005)

Age Group	Males	Females
65-69	789,498	577,112
70-74	533,336	471,292
75-79	330,100	317,891
80-84	249,100	242,731
Total	1,902,034	1,609,026

Source: NPC, 1998: 1991 Population Analytical Report

One of the reasons for the expected increase in the population is that Nigeria is demographically a young nation. There is also a steady decline in fertility at the national level with the southern part of Nigeria contributing significantly to this decline. Total Fertility Rate in 1991 was 5.89 (NPC, 1998) while the National Demographic and Health Survey of 2003 found the TFR to have fallen to 5.7 (NPC, 2004). The decline is expected to continue. There has been some remarkable improvement in the health sector thus decreasing the mortality rate across all the ages. Kinsella (2001) corroborates the increase thus '75% of the world's net gain of elderly individuals, from July 1999 to July 2000 (615,000 people monthly), occurred in developing countries'.

Table 2b: Sex Distribution of Aged Population Nigeria (2000)

Age Group	Males	Females
65-69	675,255	238,053
70-74	480,325	236,451
75-79	297,081	101,888
80-84	249,328	123,620
Total	1,701,989	1,539,613

Source: NPC, 1998: 1991 Population Analytical Report

Table 2d: Sex Distribution of (Projected) Aged Population Nigeria (2010)

Age Group	Males	Females
65-69	992,148	917,845
70-74	628,852	566,303
75-79	370,974	337,967
80-84	272,323	274,494
Total	2,264,297	2,096,609

Source: NPC, 1998: 1991 Population Analytical Report

The United Nations report states, inter alia, that 'persons aged 60 years and over, who presently constitute about 5% of Africa's total population, will grow more rapidly than the other age groups to the extent that by 2050, their share of the total population will be 12% (U.N. 2000). The implication of this statement applies specially to Nigeria as Nigeria is Africa's most populous nation, and the tenth most populous in the world. The crux of the matter now is that of the fate of the aged people in Nigeria.

Fate of the Aged

The aged people in Nigeria are not finding it rosy at all. Table 1 shows that more than 2 million people



representing 72% of the aged population are in the rural areas. By world standards not all the urban centres in Nigeria have the amenities that standard urban centres should have. In the rural areas, the dwellers lack almost all the basic social and economic amenities. These amenities, which include good schools, motorable roads, medical centres, electricity, telephone service, etc are lacking in virtually all the rural areas. Besides, most of the rural dwellers are engaged in a monotonous economic practice; that is, agriculture. Interestingly, the aged are the people feeding the children, the young and all the able bodied people. Yet their needs are not being adequately considered let alone being met.

In Nigeria, literacy level is still low. The findings of the 1991 population census were that altogether, 82% of the literate population were under age 35 years, and barely 6% were aged 50 years and above. The distribution of the literate people declines as age increases (NPC, 1998). The overall literacy rates (sexes combined) were about 48% for the rural population and 72% for the urban population. The corresponding rates for the males were 57% in the rural areas, while the rates for the female population (38% and 64% respectively) were below the national average.

Most of the elderly people in Nigeria are experiencing a hard life coupled with the fact that they lack the basic education which could have given them some opportunity to free themselves from the shackles of poverty. One can imagine what it means to live in the rural areas without the basic needs of life including education. It is a pitiable experience! This lack of education affects the people's health (reproductive health inclusive) greatly.

In Nigeria, the retirement age is 60 years for both males and females in the public service sector. But the majority of the people are still economically active well beyond this age. For example, in the rural areas, where literacy level is very low, there is nothing like retirement age. People continue being economically active until they can no longer perform. The aged people in the rural areas are mainly engaged in agriculture and artisanship. These are very tasking professions that demand a lot of

physical energy; and there is no good medical arrangement for these people either by the government or the community. A country profile by the Congress Library, U.S.A. has this to say about the plight of the older people in Nigeria: "Nigeria has no social security system. Less than one percent of the people older than 60 years received pensions... there is some evidence that the traditional practice of caring for parents was beginning to erode under harsh conditions of scarcity in urban areas". People in the public service sector continue to manipulate their ages so that they will not attain the retirement age quickly. This is why some of them *'die in active service'*.

The 'fear of the unknown' associated with a very bleak future has culminated in the entrenchment of corruption in the social and economic system of Nigeria. "Basically, the problem we have with the aged or the plight of the aged is the fact that there is no provision to take care of them in their old age. What we have is a programme or policy that takes care of people after their employment years. But it is not everybody that works in the formal sector, so that leaves quite a number of people uncatered for by the government which then has the excuse that the extended family should take care of the aged" (Abbah and Mabo, 2004).

As presented by the Nigeria National Population Commission in its monograph on the elderly, it was concluded that, in Nigeria, the rates of labour force participation among the elderly are the highest of any significant population group. Although elderly men have higher participation rates than elderly females, a significant percentage of the latter continue to participate in the labour force well beyond due time. Most of the elderly who were in the labour force were in current employment, there was virtually no unemployment among the elderly. It is significant to note that in this country, the greatest contribution to agricultural production is by the elderly population. Only very few of the young were engaged in agriculture (NPC, 2004).

What next?

In Africa, we treasure old age. Individuals strive to



honour, support and care for the aged because of the respect accorded them and the blessings from them, which Africans believe, have divine approval.

The problem of taking care of the aged is not that of individuals only, but that of the state, in general, and communities, in particular. According to Abbah and Mabo, "the traditional African culture has provisions for how old people should be taken care of. When a man or woman has attained old age, their children and extended family members provide for them. This value, however, is becoming a thing of the past. Unfortunately the aged have to fend for their needs. They have to secure their own accommodation, take care of their feeding, clothing and health needs. As a result of this development, the aged now face their gray days with palpable fear of abandonment and of being stripped of their barest comfort. In addition to all these, the national economic policies are not helping to alleviate the suffering of the aged. This is due to the cost of living which keeps on rising as a result of continuous increase in the pump price of petroleum products with its associated multiplier effects. This has added to the problems of the aged as some of them continue to take care of their unemployed/retrenched adolescents and youths including those with HIV/AIDS infection!

Any hope?

In 1982, the first African Conference on Ageing was held in Nigeria. At a conference in Nairobi, Kenya in December, 2001, the African Union, representing 53 member states, adopted a framework on ageing in Africa. Recognizing the effect of Africa's rapidly

increasing population of the elderly and the issues affecting the lives of the elderly, the member states called for:

- Legislation requiring adult children to promote support for their ageing parents although traditional family support structures are still strong, cases of abuse and neglect are rife.
- Integrating a gender dimension into policies and programmes relating to older people, and,
- Recognizing that HIV/AIDS and other epidemics affect older people in multiple ways.

In line with such declarations, Nigeria has now adopted a national policy on the care and well-being of the elderly in Nigeria. The goal of the policy is: "the substantial enhancement of the dignity, quality of life and overall well-being of the elderly in Nigeria, in particular, their economic security, their physical mental and emotional health, their social participation, integration and sense of belonging, and their personal welfare in all other aspects (NPC, 2004).

It is expected that the Federal Government of Nigeria will adopt these policies to improve the quality of life of the elderly in the society. This is necessary so that ageing in Nigeria will be a blessing and not a curse. The fact that the aged have not yet reached the point of crisis allows African governments in general, and the Nigerian government in particular, a period of time to plan for their integration (Mba, 2001).

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THE ELDERLY OF INDONESIA

Current policy and programmes

NUGROHO ABIKUSNO

Summary

Objectives: To inform related stakeholders on current policy and programme development for the older population in Indonesia.

Method: Compilation of various primary and secondary data on policy and programme development.

Results: Older persons are defined as those men or women of age 60 years and above. The current life expectancy for the Indonesian population is 68 years. It will be the same number as the under five years population in the next decade and double its current number in the next two decades. Highlights in policy on older persons are (1) The enactment of Law 13 in 1998 on Older Persons Welfare; (2) National Plan of Action for Older Person Welfare Guidelines in 2003; and (3) Presidential Decree on the formation of the National Regional Commissions on Ageing in 2004. Presently, older persons programme development is focused on community-based home care and older person empowerment in the rural areas. The main focus of these programmes is on poor and neglected older persons; the majority are older females. The pilot study is being conducted by an older person NGO, Yayasan Emong Lansia, in cooperation with various government and non-government stakeholders both national and international with funding from the Republic of Korea through ASEAN. This project has cooperated with the National Training Centre on Ageing that has trained 40 volunteers as home helpers or home companions of 40 poor neglected older persons living in the community of Tegal Alur sub-district, west Jakarta. These older persons, were selected from 400 living in this community. Volunteers were trained from community social workers, women groups, and youth Red Cross members. The training was a 4-day course followed by fieldwork, and their main tasks were to provide older persons with companionship, personal care, house services, personal activities, and referral services. Another main programme was Older Person Empowerment coordinated by the Coordinating Minister's office for People Welfare. A pilot study was conducted in Jakarta that covered a substantial number of older persons in Indonesia and had developed community-based programmes at the grass-roots level. The main function of these older person groups was providing services in health, socialization, supplementary feeding, exercise, and economic productive activities.

Introduction

The older population is defined as those women and men aged 60 years and above; they constitute 7% of the total population in a circumscribed area. There are 8 provinces in Indonesia with an aged structured population; in fact, Indonesia has an older population of 7.18%. The aged structured population provinces

according to the National Plan of Action (2003) are 1) Jogjakarta (12.48%), 2) East Java (9.36%), 3) Central Java (9.26%), 4) Bali (8.77%), 5) West Sumatra (8.08%), 6) North Sulawesi (7.64%), 7) West Java (7.09%), and 8) South Sulawesi (6.98%).

The trend in population growth of Indonesia within the first decade of the new millennium will show an older population equal to or exceeding the under five children population. Within the next two decades of the new millennium, the older population will double its present number (around 20 million) and

• Presented at the 1st National Seminar on Research Indonesia Private Medical School Council (MFKSI), Jakarta, September 11th, 2004.



of the third version of the NPA, the coordinating minister facilitated by the RI Minister of Social Affairs formed a national task force consisting of representatives from related government sectors, NGOs, and academia with the task of revising the existing NPA, drafting the Presidential decree on the National and Regional Commission on Ageing. The presidential decree was issued in 2004. The RI government regulation on supporting older person welfare was issued in October 2004. The members of the National Commission for Older persons have been nominated by related government agencies and NGOs that represent government, public, academic and private sectors.

NPA-related programmes

In anticipation of the issuance on the Presidential decree of the members of the National Commission on Ageing, the national task force has been involved in two major programmes related to the NPA namely 1) Community-based home care, and 2) Older person empowerment at the grass roots level.

Community-based home care

Community-based home care in Indonesia is supported by the Republic of Korea through the ASEAN project on home care in 9 countries of ASEAN within a span of 3 years. The first year will be conducted in three countries namely 1) Indonesia, 2) Philippines, and 3) Vietnam. In Indonesia this project has been awarded to YEL (Yayasan Emong Lansia) a national NGO that is concerned with poor and disadvantaged older persons living in the community. InResAge Jakarta provided technical assistance in grant proposal development and presentation. It is also a member of the advisory council of this project together with other members representing government sectors and NGOs. YEL also cooperated with the National Training Centre for Ageing coordinated by the National Alzheimer Association in Cibubur, West Java to provide training for volunteers recruited for this project. The project objective was to determine whether there was a difference between service provided by home helper volunteers of this project compared to those provided by the existing community-based home

care providers in the study area. The study area was Tegal Alur sub-district in West Jakarta considered as one of the poorest areas in Jakarta metropolitan area. This area was unanimously approved by all stakeholders at the first National community-based home care seminar held by YEL at the RI Ministry of Social Affairs in Jakarta. This district was also selected because it was supported by a network of potential volunteers, a local health centre and hospital that could provide referral services of poor, disadvantaged older persons.

There were 40 volunteers recruited as home helpers that were trained at the training centre. These volunteers were recruited from 1) community social workers, 2) family planning and older person family guidance field workers, 3) youth Red Cross members and 4) women organizations. The latter proved to be the most dedicated volunteers in their respective communities. Criteria for recruitment were personal experience and professional experience with older persons. They attended a four-day course and were trained in 1) companionship, 2) personal care, 3) house services, 4) personal services and 5) referral services. After the course, the volunteers were evaluated on their capability to provide the above services as home helper and they had to agree to participate in the project for 1 year until the time when the project will be evaluated. The advantage the home helpers would get out of the project is that they would have experience as home helpers as stated by the certificate they received, and they would have expertise should they decide to further their career professionally in providing services for older persons.

In Tegal Alur sub-district, West Jakarta, a survey was done on poor, disadvantaged older persons. Out of a total number of 400 older persons, there were 40 who were selected because they desperately needed to be assisted by the home helpers. The older person home helper pair would be monitored and evaluated at intervals of 3, 6 and 12 months. The results could be compared either to their baseline data that consists of parameters measuring 1) ADL, 2) IADL, 3) life satisfaction, and 4) level of depression, or to a cohort of older persons who have been participating in an existing communitybased



home care programme (PUSAKA) in the same area. The object of this evaluation is to see whether there are any differences between the two cohorts related to their quality of life.

Older Person Empowerment

Another programme related to the NPA is that coordinated by the Coordinating minister's office for People Welfare focused on empowering older persons at the grassroots level. The model used for empowering older persons is Jogjakarta community older person programme activities. These activities have been in existence because 1) Jogjakarta has the highest older population in Indonesia (12.48% and above), and 2) many innovative programmes related to the older population have been initiated in Jogjakarta such as older person health posts (posyandu lansia) which were formerly designed for providing nutritional services for small children. In these posts activities related to older persons such as health, nutrition and promotion of healthy lifestyles have been routinely conducted.

A qualitative study was done on informants representing older person managers of older person grassroots group in Jogjakarta. The results of the study showed that groups were organized by older persons themselves. Initially the activities were self-funded. They were mostly retirees concerned with the welfare of other older people in their immediate community. Thus within the older person groups there was cross-subsidy provided by older persons of upper middle class to their peers of middle lower class. Eventually they would receive funding externally from social services, provided that their organization has been officially registered and eligible for social funding by the local government agency.

The activities of these grassroots older person groups

varied depending on their needs and group capacity. The activities of such groups consisted of 1) health maintenance, routine medical checkups and regular group exercise usually in the mornings provided by the local health service and a certified trainer, 2) recreational and socialization activities, 3) morality and religious activities, 4) economic productive activities for those members who still need income for their daily livelihood, and 5) savings and loan cooperatives mainly for, house repair, grand child's school tuition, and burial costs of deceased members.

Conclusion

Indonesia in the future will be the fourth most populous aged society in the world after China, India and the United States. In a relatively short span of time namely not more than a decade it has built the foundation for a healthy and prosperous aged society in the future. The development of policy and programmes for the older population in Indonesia has achieved its present state through:

- 1) A core coalition of stakeholders representing related government agencies, NGOs, and academia.
- 2) A favorable response from the RI government in the implementation of the universal goals on Ageing as stated in the Second World Summit on Ageing in Madrid, and the Shanghai Regional Implementation Strategies declared in 2002.
- 3) The positive support from international government and private organizations related to Ageing such as UNFPA and HelpAge International in the form of funding, expertise and networking.
- 4) Finally, older persons themselves were proactively involved in the efforts to promote their own political, social and cultural as well as economic welfare.

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Capacity Building and Manpower Training in Elderly Healthcare

GERALD C. H. KOH

In 2001, a paper by Anneli Milen was presented at the WHO "Forum for Senior Policy Makers and Managers of Health Systems", where the concept and practice of capacity building was discussed.¹ This landmark WHO paper provides us with a framework to discuss capacity building for elderly healthcare from an international perspective.

For effective **capacity building**, a fundamental question is how **capacity** is defined. While there are a multitude of projects and programmes on capacity building which are based on different concepts, assumptions and expectations, one of the most widely used definitions, applied to the field of elderly healthcare, defines capacity as "an ability to perform appropriate functions effectively, efficiently and sustainably and hence contribute to defined mission, policies and strategic objectives."

For decades, capacity building was seen as assistance to local organizations primarily by providing funding and equipment, increasing accountability and strengthening technical skills. However, there has been a growing recognition amongst international and local organisations that while technical assistance and financial input are often vital for improving capacity, they are insufficient, as organizations also need to define their vision and design effective strategies that are adapted to local context, broad in scope and cognizant of their stage of development.²

The new definition of capacity building emphasizes the continuing process of strengthening of abilities to:

1. Perform core functions, solve problems, define and achieve objectives and
2. Understand and deal with their development needs at different levels and dimensions in a sustainable manner.

The core competencies required for capacity building consist of:

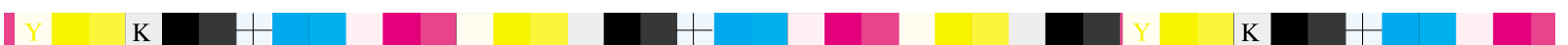
1. Analyzing the local environment;
2. Identifying real needs and key issues;
3. Formulating realistic strategies that build on what already exists;
4. Implementing actions;
5. Ensuring and monitoring performance;
6. Adjusting courses of action and acquiring new knowledge and skills to meet constantly evolving challenges.

It is also important to realize that capacity building is broader than an organizational level as it includes an emphasis on the overall system, environment and context within which individuals and organizations operate and interact. Capacity building is a continual process of improvement and not a one-time event. It is essentially an internal process based on local ownership and national self-reliance which may only be enhanced by outside assistance. Capacity building needs to be built on what already exists and utilize and strengthen existing capacities, instead of starting from scratch. In our fast changing globalising world, capacity building should also include a capacity to cope with constant change. It should also involve a more integrated and holistic approach based on genuine partnership rather than a traditionally sectoralised way of thinking. Capacity building takes years and requires a long-term commitment from all involved.

Capacity building programmes need to be examined in a wider context of interlinked levels and dimensions.

Levels of Capacity Development

Capacity building can occur at three levels: systems level, organization level and individual level.



1. The systems level includes the economic, political and social milieu in which governments carry out their activities.
2. The organization level refers to the set of organizations, including the private sector and NGOs, which involve formal and informal networks of people and flow of information, collaboration and cooperation.
3. The individual level focuses on how people in an organization are trained and their current technical, professional, managerial, communication and networking knowledge and skills. It also involves attracting people to the organization, utilization of their knowledge and skills and retention of talent.

Dimensions of Capacity Development

The concept of capacity building should also be conceptualized along 4 paired dimensions:

1. Human vs institutional capabilities: Both are needed for good performance of staff. If the organization where people work has major weaknesses such as no clear vision, weak practices and management, staff is unlikely to perform well regardless of knowledge and skills.
2. Planning vs implementation capabilities: Although distinct, both are interdependent and call for strong links between policies, programmes and implementation.
3. Micro vs macro dimensions: Capacities required at the micro level (eg. the need for more trained healthcare personnel) may be different from macro level (eg. the need for policymakers to be trained in policymaking).
4. Cognitive vs practice dimensions: This points to the need for considering capacity building at the hardware and heartware levels. The practical provision of elderly healthcare needs to be combined with an underlying sound understanding of gerontological principles, paradigms and ideology.

I have outlined broad principles on healthcare capacity building so far because recent literature has shown that it is not possible to develop model programmes that can fit into every situation, be it in a developed or developing country. Capacity is context specific and capacity constraints are related to particular factors in particular environment in a particular time. Hence, capacity building programmes have to be tailored to the situation.

The Facets of Elderly Healthcare Manpower Training

Older persons are characterized by their heterogeneity and complexity in health and social needs. Healthcare providers involved in elderly healthcare need to be specially trained to meet these needs and they often have to work within multi-disciplinary teams because no one member is able to meet all the healthcare needs of older persons.

Hence, firstly, training of health manpower needs to be broad-based to match the wide spectrum of medical conditions and geriatric syndromes. Secondly, training should also be inter-disciplinary, that is, although each member of the multi-disciplinary team has core skills and knowledge in one discipline, they should also possess basic knowledge of other team members. For example, a doctor may be the expert in medical problems in older persons, but he should also be knowledgeable of the role and skills of other members of his multi-disciplinary team. This team approach to elderly healthcare is termed inter-disciplinary care as opposed to multi-disciplinary care where there is no emphasis on each team member knowing a little about his team member's area of expertise.

Providers of elderly healthcare also need to be familiar with the roles and limitations of different elderly healthcare settings. For example, elderly may be found in various settings such as their own homes, nursing homes, day care centres, day rehabilitation center, geriatric rehabilitation hospitals and hospices. To ensure appropriate placement of older persons with special healthcare needs, providers need to understand the role, capabilities and limitations of each setting.



Elderly healthcare providers also tend to be well trained in geriatrics, the medical aspect of gerontology. However, they often lack training in social gerontological principles that form the foundation paradigms and philosophy of geriatric care and help guide healthcare providers to administer older patient-centred healthcare.

It is a common tendency for governments to invest in building geriatric expertise in acute hospital settings and neglect investing adequately in the community setting where geriatric care is most needed and accessible, because ill elderly persons often have problems getting to tertiary healthcare centres.

It is also another common problem of governments to focus on training doctors but neglect the training of other members of the multidisciplinary team. Often this is done under the mistaken belief that doctors can end up becoming trainers of nurses, therapists and social workers.

Challenges to Elderly Health Manpower Training

Manpower training in elderly healthcare faces many challenges. Common limitations are financial and time constraints. This is a common problem for developing countries. Fortunately for Singapore, our government has provided elderly step-down community care providers with funding through the Health Manpower Development Programme for Step-Down Care (HMDPSC). The funding is not limited to doctors but to all members of the interdisciplinary team, recognizing the important role of each team member.

The lack of expertise is another common problem. In developing countries which often lack geriatric expertise, the solution is to sponsor elderly healthcare personnel to go for overseas training to learn about geriatric healthcare according to their profession. However, while they return to their sponsoring institutions to provide geriatric services, they are often not given opportunities to transmit what they have learned to other healthcare providers. Investment in training trainers to exploit the multiplier effect of disseminating geriatric expertise

is the most cost-efficient way of boosting manpower skill and numbers. Sending staff for training without allowing them to transmit their knowledge to others is unsound and wasteful. In Singapore, many of our geriatricians working in tertiary hospitals are sent overseas for post-graduate training. In turn, the Framework for Integrated Care for the Elderly (FICE), created by the Ministry of Health, provides funds and incentives for community elderly care institutions to acquire geriatric expertise from tertiary institutions to build the skills and knowledge base of step-down care facilities.

As mentioned, training and development of elderly healthcare manpower is often initially limited to doctors. Even in countries that manage to focus on the training of main professions, that is, doctors, nurses, social workers, physiotherapists and occupational therapists, the allied health professions are still neglected. Allied health professionals include the speech therapist, dietician, podiatrist, optometrist, prosthodontist, oral hygienist, audiologist and case manager.

However, perhaps the most common limitation is a lack of commitment of policymakers in supporting manpower development in elderly healthcare. Governments need to recognize that older persons have complex needs that require special skills and expertise. They also need to view healthcare as a resource for older persons to fully realize their potential as equal citizens and allocate sufficient resources to build manpower in this area.

Conclusion

Key factors for successful capacity building include meeting real needs, building local ownership and self reliance, practicing genuine partnership, understanding local contexts and broad systems and having a long-term commitment of partners. Manpower training is an important component of capacity building in elderly healthcare and faces similar challenges. In particular, it needs to focus on broad-based, inter-disciplinary, multisetting training with an emphasis on community elderly care. To achieve this vision, commitment and partnership among all stakeholders is needed.



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Advancing Advance Directives

PIERRE MALLIA

Introduction

Making an Advance Directive is becoming an important way of controlling one's own medical personal decisions and participation in treatment. As the term implies it means giving a directive (to your medical team) in advance. This is basically a document (signed or otherwise) which the person draws up when still mentally competent and given to a person who has power of attorney, usually the family doctor or a trusted relative. It is then given to the medical team taking care of the patient when the time comes so it will enable them to know what wishes the patient has regarding his or her treatment. An Advance Directive can even be given by word of mouth, but written and signed documents are always more useful and helpful for obvious reasons. It is thus also called a 'living will' or testament.

One has to distinguish between these Advance Directives and what usually occurs in many situations - the substituted judgment. In a Substitute Judgement close relatives are helped to make a judgment on behalf of the patient which seems to them to be in the patient's best interest. But 'best interest' judgments are not always easy. They carry a moral burden - if the medical team think it appropriate to issue a *Do Not Resuscitate* order, then one would have to decide and balance this suggestion of what the medical team think is in the best interests of the patient and knowing (or not knowing) whether the patient wished for everything possible to be done. Available resources may also affect these kind of decisions. In many countries living wills are less favoured, even among the medical community. Although they are not legally binding they are becoming more and more popular in Europe and are considered as included within the "Patient's Bill of Rights" in the United States. This article will analyse some of the problems of Advance Directives, then it will consider a local situation and argue that one

needs to be aware and adaptive of local circumstances in any country. Finally guidelines are described on how doctors close to the person can help in this End-of-Life decision.

Advance Directives

Advance Directives were developed in the United States in the sixties (Vollmann, 2001, p. 161). The idea was that competent individuals could make written provisions in advance for refusal of certain medical interventions should an illness or accident render them incompetent of exercising self-determined wishes. Since it is analogous to the last will it is also termed 'living will'. However, since it is difficult to determine exact situations or to foresee the treatment in a given situation, an individual can also make provision for a 'power of attorney'. This is a trusted person (such as a close friend, a relative or even the family physician) who is given the power to make decisions on the patient's behalf. Therefore the patient has a means to be more flexible in difficult situations, the power of attorney acting not strictly speaking in the best interests of the patient as the medical term would have it, but acting on how the patient probably would have chosen. This means the person is usually someone who needs to enjoy considerable trust and possibly know the way the patient thinks and would behave.

Advance Directives are more and more common in many European countries. However often they are not legally binding. Nevertheless patients do have a recognised means of expressing their wishes, and questions of 'authenticity', (Ibid., p. 162) have largely been overcome or over-ridden. A patient has a right to make a decision, especially regarding refusal of treatment, no matter how 'unreasonable' that decision is or whether better treatment is available. This is true also for patients with early stage dementia who still retain personal self-determination. However



they must be informed at an early stage of their disorder and its character. The holder of a 'power of attorney', conversely can act for a patient, even if ignorant of his or her conditions (a patient has a right not to know), and assess what in an eventuality he or she would desire.

Problems with the living will

There has been a philosophical debate, put forward by Parfit (Ibid., p. 165) as to whether the "identity" of a person with dementia is still that of the person before the condition sets in. Does a change in 'personality' mean that 'identity has changed'? The argument is largely refuted on the basis that one cannot argue that since there is no mental continuity then the personal identity is non-existent. If we were to accept such an argument then even wills and testaments that a person writes years ahead to express wishes when he or she dies should be refused. Since we respect the wishes, even legally, of a person when he / she is dead, we must respect the wishes when the person is no longer competent of making decisions. The question of identity is resolved not through conscious experience but through the phenomenological reality of the human being, who maintains an identity even when dead.

A more real problem arises should a person in late stage dementia, having written an advance directive well before, change his or her position (Welie, 2001, p. 176). During a lucid interval, the patient may express a wish that 'all that is necessary be done', after having, for example, refused procedures like resuscitation or advance life support at all costs. Can a person with dementia, certified non-competent to make decisions, effect a choice which practically over-rides the decision made when competent and lucid? What position does the holder of the power of attorney have here? Do the judgments of the attorney take precedence of the present wishes of the patient? In these circumstance the patient cannot be construed as a 'black box' (Ibid., p. 179). The attorney cannot rely on what was said in the past; rather, and with the help of the medical team, a judgement is made on what the patient would have consented to under the *present* conditions in the present time. This is indeed making a substituted

judgement, and some courts have even ruled against it, as determining what a patient would have decided is not only legal fiction but fallacious. Welie, in fact argues that substituted judgments are nothing more than 'best interests' judgements (Ibid., p. 179). This poses the problem of whether 'best interests' judgments, as explained above, reflect the patient's wishes or not. Welie thus argues that living wills should not be used in opposition to best interest judgments, but rather as a complement to them (Ibid., p. 181). Whilst admitting that he goes contrary to popular judgment, Welie concludes therefore that best interest decisions should trump over substituted judgments and living wills. Be that as it may, this brings us to the exhausted arguments of whether the principle of respect for autonomy should trump over principle of beneficence or vice-versa. I have argued that this can only be done if beneficence is seen as the phenomenon of the doctor-patient relationship and respect for autonomy as a manifestation of that phenomenon - a manifestation made in the light of enlightenment, of freedom of choice and the phenomena of libertarian societies (Mallia, 1998; Mallia & Ten Have, 2003). It is not a question therefore of beneficence trumping over beneficence but rather of beneficence, in today's understanding, as including a respect for autonomy. This then, by Jos Welie, is a clear application of that rule. Contrary to Welie, we must not see this as applying a best interest judgment (for the patient's good) to trump over his or her personal autonomy, but rather that medical practice must always consider the patient's good, even if irrational wishes are expressed, and "best interest" must include in the equation these irrational wishes.

Local Scenario (Malta)

I will now briefly tackle a local scenario to show and argue that Advance Directives can be used to advantage to overcome problematic areas in the local situation of health care provision which may affect other areas of patients' lives. Advance Directives have largely been used to determine and express refusal of treatment, as we have seen. But what about expressing wishes of another nature? Malta has a unique primary health care system which is two-tiered. The family doctor is usually a private doctor.



But patients can also attend health centres for primary care attention. There is no continuity in these centres, however, and contact with the same doctor is not therefore provided. For an Advance Directive to be useful in this local situation the patient must have recourse to a private GP. Thankfully these are very accessible and inexpensive. However, patients are not registered with private Gps, as these are not under any state regulation. This means that as a patient may 'shop around' between doctors, relatives or friends may bring in a private doctor other than the patient's. There is no way this new doctor would know if the patient has started to suffer from dementia. This situation may arise simply because the helper wants to be helpful or to have the word of a doctor *he or she* trusts, but may create complications when relatives want elderly people to sign wills and testaments. A notary would usually require certification by a doctor confirming that the patient is competent. The patient may be in an interval of lucidity when the 'new' doctor sees him or her, or conversely the patient may be too afraid to disappoint, or be seen to disappoint a relative. Relatives in this way can abuse both doctor and patient, leaving the door open to having a will drawn up under subtle coercion, undue persuasion, or duress.

An Advance Directive drawn up in front of a *chosen* doctor who is given power of attorney can easily be a solution to this problem, the patient expressing that any certification of mental state can only be done by the said doctor or a doctor/specialist chosen by him. Naturally such an act would need the support of local law and preferably such a sensitive issue should be dealt with by a public notary. When I first tried using this resource, the notary expressed concern whether in fact it is legal. It is the duty of the medical profession to bring forward such problematic areas that their patients may face. Many elderly people allow themselves to be examined by a doctor that a daughter bring in; such doctor will be acting in good faith. But when it comes to

asserting mental competence, unless the doctor has known the patient for some time, there is no way of knowing whether another doctor may be more competent in this situation. It is the duty of medical organizations to lobby governments to validate legally such advance directive with proper legal consideration and insight, to be drawn up. Working towards an international approach to advance directives is now imperative (Fenech, 2003, p. 233).

Helping families with End-of-Life decision

Because advance directives are not yet widely adopted, end-of-life decisions for a patient without medical decision-making capacity are regularly discussed between the patient's physician and the family (Lang & Quill, 2004, p. 719). In the light of what has been argued, it is important to try and establish not merely what is good for the patient as this can be very subject to circumstance. What the patient would probably have decided in these circumstances, rather, is the more appropriate approach. Of course certain decisions, such as whether the patient would have wanted termination of life, cannot be acceded to unless the legislature of the country would allow it, and even under these circumstances it may be problematic. But controversy apart, there are many end-of-life decisions which should be discussed with the relatives. These include, whether to use advanced life support systems, discussion of Do-Not-Resuscitate orders, and also termination of treatment. It is important that relatives understand that decisions may not be absolute and may be reversed should the patient's situation improve. More importantly it is the responsibility of the medical team to record all discussions and ensure with nursing staff for proper communication of orders should professionals who may not know the patient take over. The opportunity can also be taken to inform the relatives of advance directives and their nature for future use.

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INTERNATIONAL DIARY 2005

January

CICRED - The Impact of Mortality as Both a Determinant and a Consequence of Poverty and Hunger: A Contribution to Achieving the First Millennium Development Goal (Eradicate Extreme Poverty and Hunger)

January 30th - 31st – Pune, INDIA

Expert Group Meeting on Asian Medicine & Longevity (CASP)

February 9 -18 New York, USA

43rd Session - Commission for Social Development
Website: <http://www.un.org/esa/socdev>

March 3 - 4 Bonn, Germany

Conference on Population and Development Cooperation

May 7th - 8th, London, U.K.

2nd Anti-Ageing Conference London (AACL)
Website: <http://www.antiageingconference.com>

June 26 - 30 - Rio de Janeiro, Brazil

World Congress of Gerontology (IAG)
Website: www.acceventos.com.br

June 27 - 29 Trondheim, Norway

Sixth International Conference - Creative Solutions for an Ageing Society: Sharing the Wisdom
Website: www.iahsa.net

29th September- 1st October St. Gallen, Switzerland

1st World Ageing & Generations Conference
Website: <http://viva50plus.org>
E-Mail: [http://viva50plus.org](mailto:viva50plus.org)

30th September - 2nd October Ljubljana, Slovenia

XVIII International EURAG Congress 2005
Website: www.eurag.europa.org

November 17 - 20 - THESSALONIKI, GREECE

2nd International Congress on Brain and Behaviour
Information: <http://www.psvchiatry.gr/intro-brain2-erg.html>



ADVERT



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, 2004 and 2005 for Training Programmes, which are held in Malta. These funds support the educational activities of 8 Fellows from developing countries participating in the Short Taining Programmes in Social Gerontology, Economic and Financial Aspects of Ageing, Geriatrics and Demographic Aspects of Ageing as well as 2 participants 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.

The closing date of applications can be obtained from the Institute's website, www.inia.org.mt.

