



COVID-19 *and*
older people in
Asia Pacific
2020 in review



COVID-19 and older people in Asia Pacific: 2020 in review

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COVID-19 and older people in Asia Pacific: 2020 in review

As with the rest of the world, the COVID-19 pandemic dominated Asia Pacific in 2020. From early in the year, it became clear that age was a disturbing part of the story. The older population suffered more from the virus than any other age group, experiencing high rates of death and serious illness following infection. In some countries, nearly all deaths were among older age groups. The initial discussion of COVID-19's impacts on older people focused on these direct risks to health from the virus itself. But gradually it became clear that older people were also facing unique forms of indirect impact from the societal upheavals generated by the pandemic. The pandemic unleashed health care complications that were not directly caused by the virus, as well as challenges to older people's income, livelihoods, family relations, social connections and freedoms, as well as how they were perceived by society. The pandemic affected everyone, but how seriously each older person was impacted reflected the diversity of experience in later life and the inequalities within societies and between countries. This paper documents some of the key themes that emerged throughout the year and suggests critical gaps that 2021 will urgently need to address.



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This 2020 overview of the impact of COVID-19 on older persons in the Asia Pacific region is part of a series of reports coordinated by HelpAge International with financial support from UNFPA's Regional Office for Asia and the Pacific. The full set of regional and country reports from throughout the year, with references, can be found at <https://ageingasia.org/monitoring-covid-19-impact/>. Two separate briefs accompany this report and can be found on the same webpage: (1) Data gaps and ageing in the COVID-19 pandemic and (2) COVID-19, older adults and long-term care in Asia Pacific.

“Efforts to protect older persons should not overlook the many variations within this category, their incredible resilience and positivity, and the multiple roles they have in society, including as caregivers, volunteers and community leaders.”

UN Secretary-General's Policy Brief: The Impact of COVID-19 on older persons



Losing income

“We had to stop working. I know that these measures help to prevent COVID-19, but now we cannot buy what we want to eat.”

Mario Magpantay, 64, lives with his family in Manila, Philippines, and works as a driver.



Relying on assistance

“I haven't been able to go out since the outbreak. Fortunately, I received the government social subsidy.”

Nguyen Thi My, 67, lives alone in Ninh Binh, Vietnam. Because of a sight impairment, she counts on help and information from others.

Catching the virus

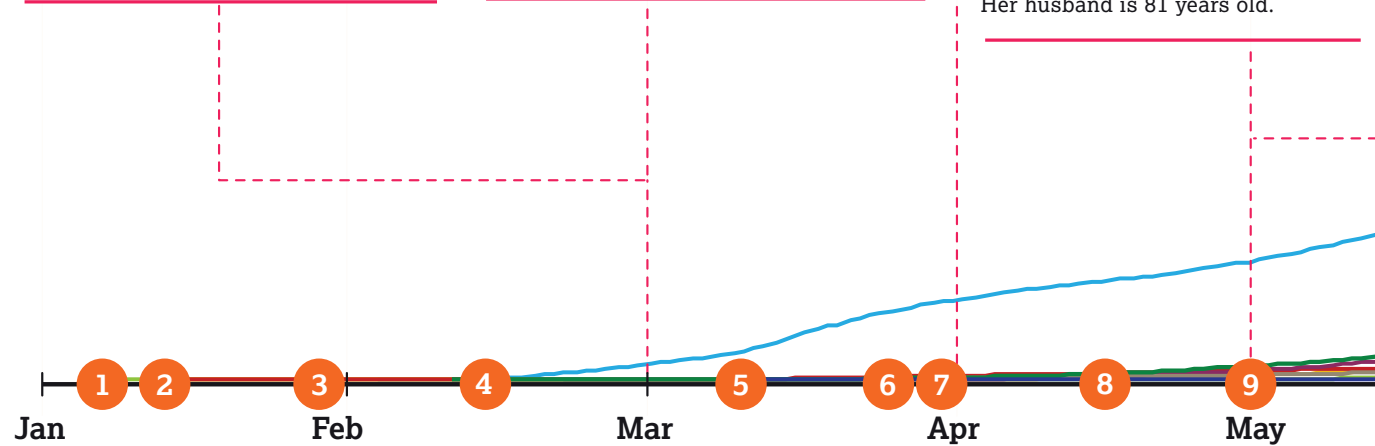
“After I tested positive for COVID-19, I couldn't earn income, and that made me feel tense.”

Muhammad Ali is 65 years old living with his family in Sindh Province, Pakistan.

Fearing COVID's impacts on family

“I have to go with my children and be a burden to them. I can't do the shopping by myself. And I am worried that I could catch Corona.”

Behjat, 67, lives in Tehran, Iran. Her husband is 81 years old.



- 1 China reports to WHO 44 pneumonia cases of unknown cause in Wuhan
- 2 Thailand reports first case outside of China
- 3 12 Asia Pacific countries have reported cases, WHO declares Public Health Emergency of International Concern
- 4 Early China study documents high mortality rates among older people

- 5 COVID-19 declared a pandemic by WHO, 23 Asia Pacific countries have confirmed cases
- 6 Asia Pacific governments have approved 100 social protection responses to the pandemic
- 7 Nearly all Asia Pacific country borders are closed to non-nationals



Doubting access to health services

“There are too many people living in the camps. How can we get treatment if my family members or I become infected?”

Salim Ullah, 69, lives in a refugee camp in Cox’s Bazar, Bangladesh.



Welcoming a pension top-up

“I will spend this for the medical fees of my wife and me. If we hadn’t received this payment, our children would have struggled to pay our expenses.”

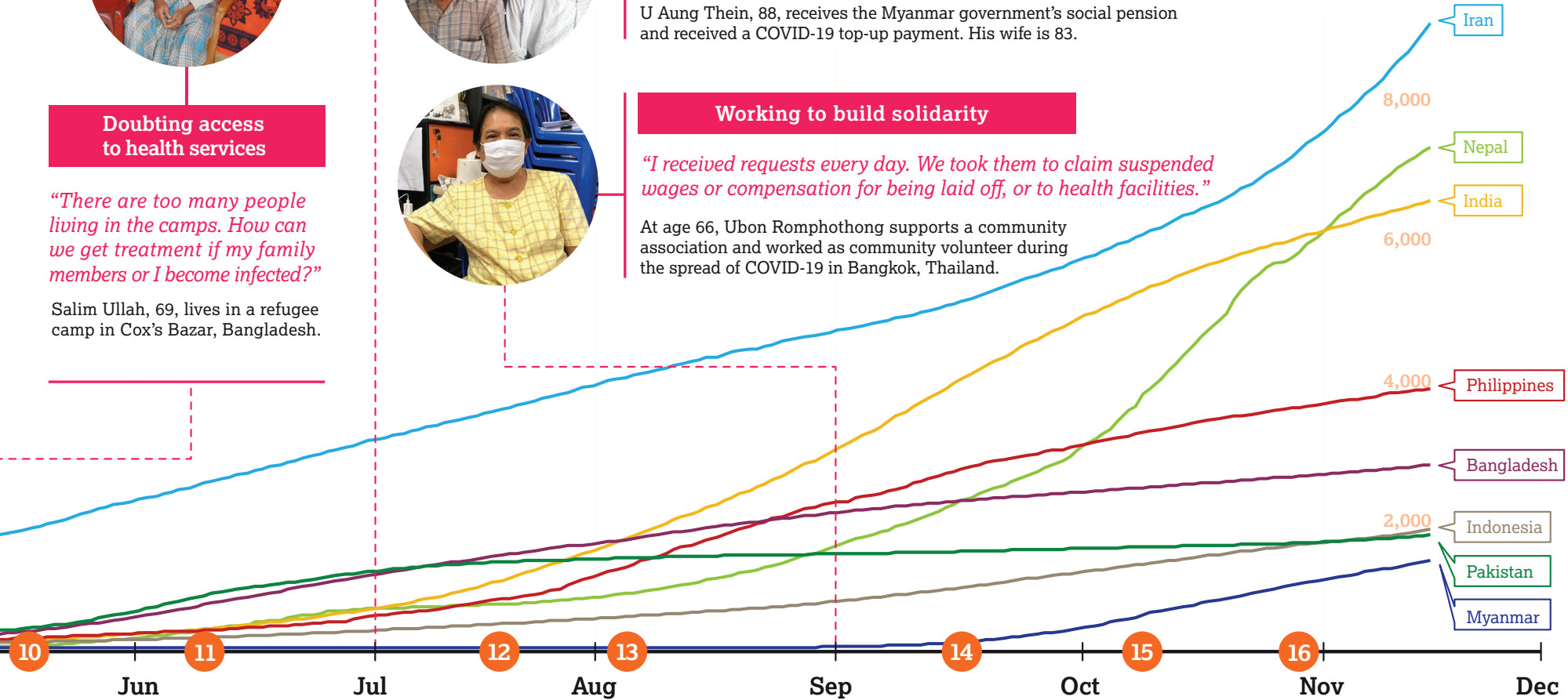
U Aung Thein, 88, receives the Myanmar government’s social pension and received a COVID-19 top-up payment. His wife is 83.



Working to build solidarity

“I received requests every day. We took them to claim suspended wages or compensation for being laid off, or to health facilities.”

At age 66, Ubon Romphothong supports a community association and worked as community volunteer during the spread of COVID-19 in Bangkok, Thailand.



- 8 Over 1.8 billion people living in 7 Asia Pacific countries are under severe lockdown
- 9 UN Secretary-General releases Policy Brief: The Impact of COVID-19 on Older persons
- 10 ADB estimates that within member states, 109-167 million jobs will be lost
- 11 India, Pakistan and Iran end lockdown at national level

- 12 India reaches 1 million cases, accounting for nearly half of cases in Asia
- 13 Asia Pacific governments have approved 300 social protection responses to the pandemic

- 14 ADB further reduces 2020 growth forecast for developing Asia, from 0.1% to -0.7%
- 15 World Bank estimates that up to 65 million people in Asia Pacific will be pushed into poverty by COVID-19
- 16 India reaches 8 million cases, accounting for 75% of all cases in Asia Pacific

Health and care

COVID-19 in Asia Pacific

Asia Pacific has done better than other regions in controlling COVID-19, but risk of exposure is very uneven. Asia Pacific accounts for only about 20 per cent of global COVID-19 cases and 17 per cent of global deaths, despite having more than 60 per cent of the world's population. As of November 2020, more than 75 per cent of the cases in Asia Pacific have been in India. Most of the rest have been in Iran, Bangladesh, Indonesia, Philippines, Pakistan and Nepal. A majority of countries in Asia Pacific have had no significant outbreak. Within countries the spread has also been uneven by region, city and even neighbourhood. Widespread outbreaks have occurred in informal settlements with high population density, where social distancing, appropriate sanitation and personal protective equipment (PPE) are less feasible to arrange. Household size is another factor influencing risk of contracting COVID-19: larger households are associated with greater risk of exposure.

COVID-19 has highlighted pervasive health and social inequalities both within and between countries. Lifecourse risks from the social determinants of health translate into higher rates of underlying health conditions at younger ages among poorer populations. These populations also face heightened threats from their socioeconomic and environmental situation. People living in

countries without universal social protection or health coverage often struggle to access and afford quality health care. Middle-income countries such as Thailand and Sri Lanka have shown that investment in universal health coverage and a whole-of-society approach to health over the years can yield impressive health outcomes during a pandemic.

COVID-19's direct toll on older people

Older people are at significantly heightened risk of severe health complications and death from COVID-19. See Figure 1. This risk is partly explained by higher prevalence of underlying health conditions by age. These conditions include hypertension, heart and lung problems, diabetes, cancer and dementia, which are more common in later life. However, even controlling for underlying conditions, some research suggests that age is the single biggest risk factor for mortality due to COVID-19, probably because immune systems weaken with age. Men are overrepresented in cases and deaths by age, most likely related to variations in risk factors and prevalence of underlying conditions.

Spotlight on Thailand

Confirmed cases: 3,977 (30 November 2020)
Population: 70 million
Confirmed deaths: 60
Test positivity rate: <1%
Universal Health Coverage: since 2002
No. of Village Health Volunteers (VHV) engaged in COVID-19 prevention and response: >1 million
Most VHVs are women and many are older women.

Sources: Thailand's 1 million village health volunteers – “unsung heroes” – are helping guard communities nationwide from COVID-19, World Health Organization, 28 August 2020; (2) Cumulative confirmed COVID-19 cases, Our World in Data, <https://ourworldindata.org/coronavirus> (accessed 30 November 2020)



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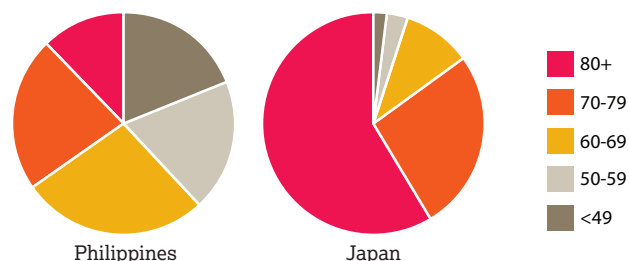
“Thailand is an excellent example that, with a whole-of-government, whole-of-society, comprehensive approach, this virus can be contained — even without a vaccine.”

Dr Tedros Adhanom Ghebreyesus, WHO Director-General

Older people account for the highest proportion of COVID-19 deaths in all countries, but younger people in poorer countries are more likely to die from it. Case fatality rates by age vary substantially by country, although such rates are an imperfect reflection of the likelihood of death after infection. Variations in case fatality rates between countries can be partly attributed to age profiles of the population. In countries with an older population profile in this region, only a small fraction of deaths has been among those under the age of 60 or even 70. But chances of survival are also affected by health care availability and quality – for example, when older or younger people require ventilation or other more intensive care. Environmental risks such as air pollution and poor living conditions at household and neighborhood level are also linked to severity of COVID-19 among patients.

Figure 1: Unlike the Philippines, most COVID-19 deaths in Japan are among those aged 80+

Percentage of COVID-19 deaths by age



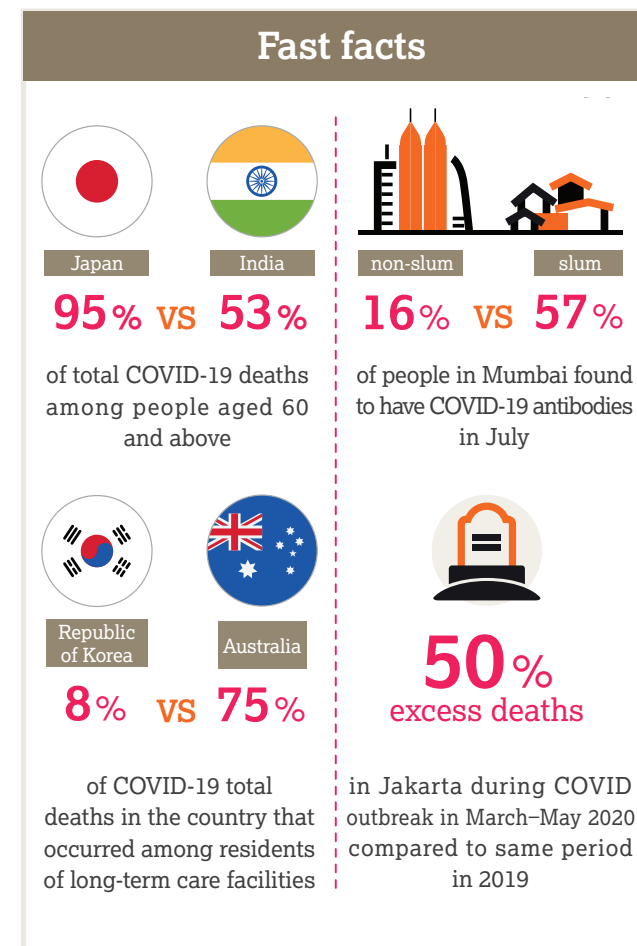
Source: Detailed case information COVID-19 tracker, Department of Health, Government of Philippines, <https://ncovtracker.doh.gov.ph/> (accessed 19 November 2020); and Patients profile of coronavirus disease (COVID-19) cases in Japan as of 30 October 2020, by age group. Statista, <https://www.statista.com/statistics/1105162/japan-patients-detail-novel-coronavirus-covid-19-cases-by-age-and-gender/> (accessed 20 November 2020)

COVID-19 and long-term care

One particularly high-risk group is those with care and support needs. First, prevalence of the underlying conditions associated with COVID-19 risk tends to be high among those who have care and support needs, as multimorbidity and frailty are related to the need for care. Many require personal support such as assistance with eating, bathing, dressing and hygiene and so cannot socially distance. People living with dementia may have difficulty understanding, remembering and/or carrying out important COVID-19 prevention steps. In Asia Pacific, the vast majority of people with care needs live at home with family, who provide support for them. Their risk of exposure is mainly based on ability to socially distance, living arrangements and presence of COVID-19 in their community. Almost no research or reporting has assessed COVID-19's impact on people receiving care informally. Lockdown measures disrupted home- and community-based care services, and the limited access to care and support created its own risks, beyond exposure to COVID-19.

The highest risk group are those living in long-term care facilities. A population already at very high risk of COVID-19 infection faces additional dangers from cohabitation in confined spaces, group meals and activities, and reliance on staff who provide personal care to multiple residents and may have difficulty travelling to the facility. Once COVID-19 enters a residential facility, it is difficult to control. Larger facilities and staff-sharing

between facilities increase these risks. In low- and middle-income countries in Asia Pacific, however, far less than one per cent of older people live in residential facilities.



Singapore and Japan have led the world in measures to protect people receiving community-based or residential care. In North America and Europe, between 40 per cent and 80+ per cent of all COVID deaths were linked with long-term care facilities. Meanwhile in Singapore and Japan, only 11 and 14 per cent of deaths respectively were linked with long-term care facilities. Among older people, 2.8 per cent in Singapore and 4.7 per cent in Japan live in long-term care facilities, but outbreaks within these facilities have been relatively rare. Long-term care facilities in these countries employed precautionary methods including introducing lockdown of facilities early on; following comprehensive safety procedures; providing PPE and training for staff; requiring universal regular COVID-19 testing for staff and residents; segregating staff into shift crews; reducing the number of staff in contact with residents; and quarantining any residents returning from a hospital stay. They closed community-based care centres, but in their place supported clients and their carers with home visits and online social activities, exercise programmes, and telehealth and telecare. All of this was possible because well-established, universal long-term care systems with strong governance and quality management were already in place.

Secondary health impacts of the pandemic on older people

The indirect impacts of the COVID-19 crisis on health have been far more commonly experienced in Asia Pacific than direct impact. Only 0.2 per cent of Asia's population has contracted COVID-19 so far, but almost everyone has been impacted by lockdowns, social distancing and economic slowdowns. Secondary impacts are wide reaching and affect the wider determinants of health. For example, the pandemic has touched social networks, household composition, migration, public services and support for income, housing and food security. Social isolation and stress have serious impacts on the physical, mental and cognitive health of older people. Yet evidence of these various impacts is still limited.

Some COVID-19 public health measures have had the unintended effect of reducing access to health services for issues of concern to older people.

These services include prevention and management of non-communicable diseases (NCDs), rehabilitation services, inpatient and outpatient hospital care, and semi-essential or non-essential health treatments. World Health Organization rapid assessments on disruption of services found that at least 85 per cent of countries in Asia Pacific experienced disruption of services for the prevention and treatment of NCDs. Many countries paused non-essential services, and a major decline was seen in healthcare utilisation across the board. These disruptions have increased preventable mortality from non-COVID-19 conditions. From

March to July, for example, Thailand recorded just 58 deaths from COVID-19, but 13,000 excess deaths above normal for this period. In India, where a stringent lockdown was put in place, studies show an uptick in deaths among dialysis patients unable to receive treatment and a large reduction of people with cardiac emergencies reaching hospitals in rural areas.

Social isolation and stress have serious impacts on the physical, mental and cognitive health of older people.

Research from Japan Gerontological Evaluation Study (JAGES) has previously shown that people who are socially isolated have an earlier onset of dementia and functional decline and higher rates of depressive symptoms. Rapid needs assessments carried out by the HelpAge network in seven Asian countries found that 58 per cent of respondents felt worried and anxious about the COVID-19 situation all or most of the time, and another 28 per cent felt that way sometimes. Physical distancing turned into social distancing for many older people, which creates health risks.

Loss of household income is causing or exacerbating negative health outcomes.

The pandemic's massive impact on household income has worrying implications for health. Access to sufficient, nutritious food is an essential building block of healthy ageing. The World Food Programme estimates that due to challenges such as the loss of income and increasing food prices, the number of people facing acute food insecurity will rise by 83 per cent to 49.6 million people in 2020, particularly in South Asia. As discussed in

the next section, most older people work in the informal sector without employment protections. Reduced incomes also impact ability to pay for health care costs and transport to health facilities.

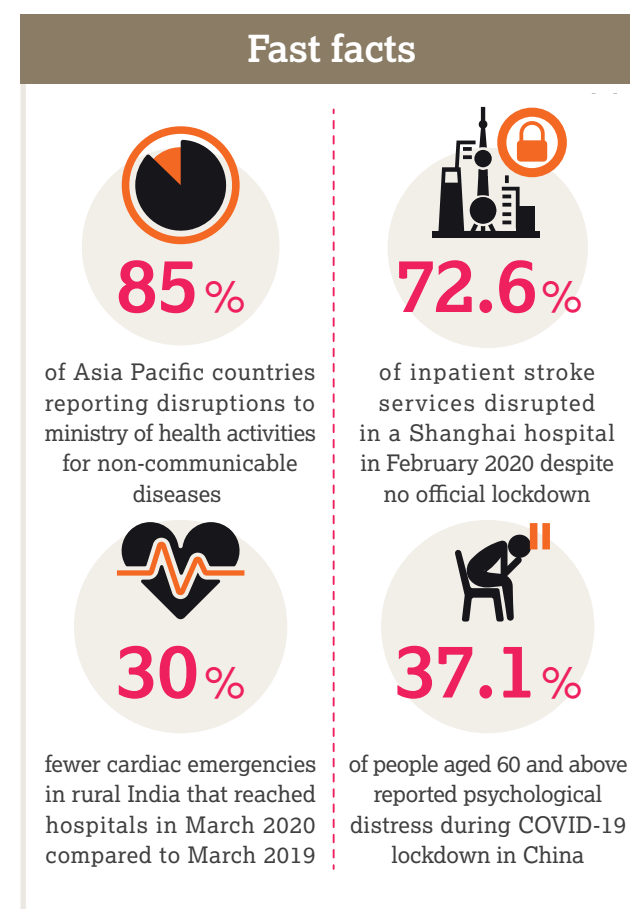
Only a handful of countries have expanded health insurance or free health services to support medical costs. Some countries have offered partly or fully subsidised COVID-19 tests or treatment, but this has been more common among countries with universal insurance schemes or free care at point of service. A few countries extended health insurance benefits. For example, Indonesia paid contributions to the national health insurance scheme for 30 million non-salaried workers. The Republic of Korea, the Philippines and Thailand reduced health insurance premiums for individuals who self-contribute.

Telehealth has been trialled and scaled up in many countries in an effort to bridge gaps in in-person care, but many older people may be left out. High-income countries scaled telehealth and telecare more easily, with more mature systems already in place. In middle-income countries such as India, Indonesia and Vietnam, the private sector market for telehealth has grown, but it mainly benefits those who can afford to pay out-of-pocket fees and have easy internet access. Thailand is continuing to expand the government telehealth programme started in 2019 for rural and remote areas. Even where telehealth becomes available and affordable, some older people will struggle to use the services, whether because of internet access

and skills or because of a hearing, sight or cognitive impairment. Advancements in telehealth may eventually reduce inequity in health care, but for the moment, the trends may be widening the gap.

Community support for hygiene, nutrition and care was a bright spot in a difficult year. Civil society organisations, community-based groups, religious groups and spontaneous neighbourly support have played important roles in protecting the health of people. Community associations led by older people or others distributed health information; made and distributed face masks, food and soap; and adjusted volunteer-based home care services so they could continue safely. Village health volunteers in Thailand and Silver Generation Ambassadors in Singapore supported older people living alone. Many older people were part of these community efforts, volunteering their time and donating to support others.

A coming challenge for governments will be to roll out safe and effective vaccines, ensuring ethical distribution. Late in 2020, a number of vaccine trials reported promising results. In September, the World Health Organization developed a values framework for the allocation of COVID-19 vaccines. The framework highlights that ethical distribution may entail prioritising high-risk groups. Other topics of discussion include vaccine access for low- and middle-income countries, and subsidised and accessible immunisations for vulnerable groups such as those who are housebound or living in informal settlements.



Social challenges

Globally, social isolation has been flagged as one of the key risks facing older people in the pandemic. Concerns about escalating social isolation in this period are intuitive. Older people are at greater risk than others of catching the virus, so they themselves or those around them (family, community or government) have sometimes taken special steps to limit their personal contact with others. Many older people were already in precarious social circumstances before COVID-19 appeared – for example, living in a care home, living alone or living as couple far away from their children. The pandemic has multiplied their challenges. As noted above, social isolation also has serious implications for mental health but also physical health.

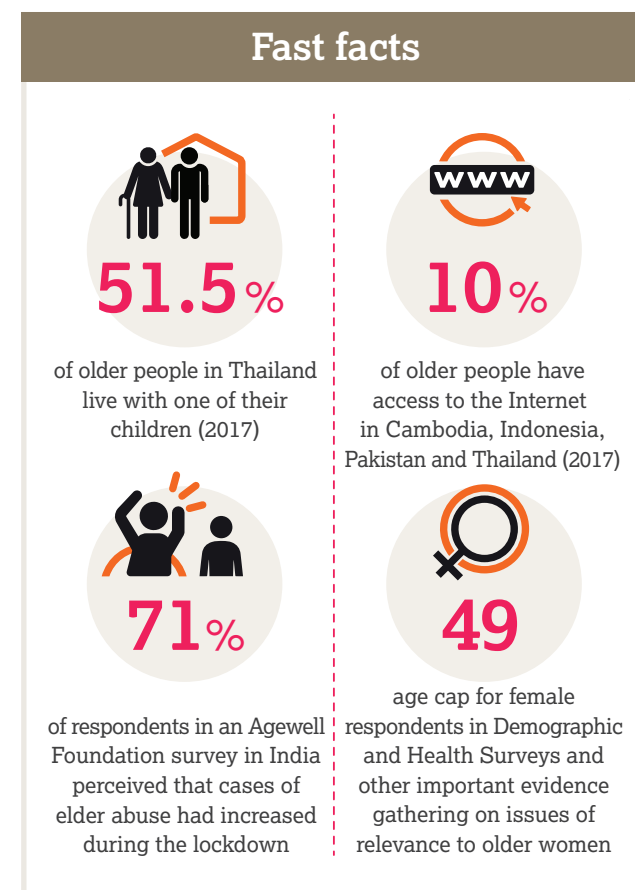
A major factor in older people's level of social isolation is their living arrangements. Compared to regions such as North America and Europe, older people in Asia, particularly in low- and middle-income countries, are more likely to live in larger households and less likely to live in residential care homes. That increases within-household risk of infection and changes the dynamics of social isolation. For instance, half of older people (age 60+) live in extended-family households in Asia Pacific, compared to just 7 per cent in North America, according to Pew Research figures. In India and Bangladesh, Pew found that only about 4 per cent of older people live alone. While socialising at care

homes has been severely restricted, in countries such as China, Indonesia and the Philippines no more than about 0.3 per cent of the population aged 60 or older lives in such institutions, according to World Population Ageing 2020 by UNDESA. In high-income countries such as Japan and Republic of Korea, however, living alone or in residential care facilities is much more common than in low- and middle-income countries. Thus, living arrangements vary substantially across the region. Those arrangements affect the nature and frequency of social interaction and intensity of social isolation.

Restrictions on older people's movements during lockdowns have constrained social interaction and also raised concerns about personal freedom. Some governments have imposed restrictions on movement by age. For example, both India and the Philippines have imposed restrictions requiring that older people “shall stay at home” or “remain in their residences at all times”, with some exceptions. Some of these restrictions are rather ambiguous legally. Anecdotal reports suggest that some families also forbid older household members from leaving the home because of the pandemic, although such informal practices are more difficult to document. In addition, in light of public warnings about the serious threat of COVID-19, many older people are concerned enough to remain at home and self-isolate.

Restrictions and messages based simply on age may reinforce an ageist “narrative of decline” and imply that older people are simply a “vulnerable

group”. Explicit displays of ageism such as those that have appeared in the international press during the pandemic appear to be less common in Asia. Instead, manifestations of ageism may be rooted in perceptions of older people, defined by chronological age, as helpless, frail, and unable to contribute to society. These messages may rest on the increasingly outdated assumption that older people are a small, dependent population group cared for



by family. These assumptions may be the foundation of government policies or COVID-19 responses.

Aware of older people's risk of isolation during the pandemic, many governments, civil society groups and individuals have looked for creative solutions. For example, state and municipal governments in India, Republic of Korea and elsewhere have tried to identify those most at risk – such as older people living alone – and mobilised public employees, volunteers or community associations to check on them regularly and deliver services at home. Where they exist, community-based organisations such as older people's associations have also tracked those who live alone or are at high risk, providing assistance, monitoring and friendship for people who feel cut off. Various forms of ICT including mobile phones are society's increasingly ubiquitous tools for overcoming distance and restrictions in face-to-face interaction. But on average, older people's usage of ICT is significantly lower than younger people's, and there is also a sharp gender divide.

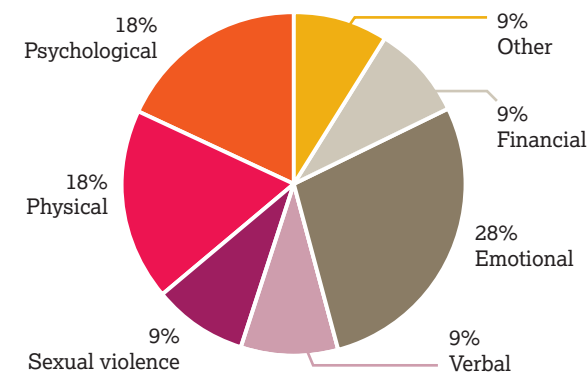
Social isolation also increases risks of violence, abuse and neglect against older women and men. Being confined at home in tense situations – with fewer opportunities to connect with people outside who might be able to assist – has heightened the threat of abuse. Such cases are difficult to document even in relatively normal periods. Past evidence, shows that violence and exploitation tend to increase during pandemics, particularly violence

against women. Some statistics already indicate that the COVID-19 pandemic has caused a rise in domestic violence around the world, although the situation of older people in particular is less clear. Surveys of older people in a number of countries indicate that they sense danger. For example, in an online survey of 5000 older people in India by Agewell Foundation in June, 71 per cent of respondents perceived that cases of elder abuse had increased during the lockdown. In HelpAge rapid assessments, most older people had similar worries (see Figure 2).

Lockdowns and other restrictions may increase unpaid duties at home, including grandchild care, particularly for older women. Globally, most care duties are generally carried out by women, and the related workloads and risks tend to rise during pandemics. Not only younger women but also older women typically provide informal care at home for children, older persons and household members with disabilities. Initial survey data from six countries in Asia conducted by UN Women found that women are taking on more unpaid work. During lockdown, sudden changes in living arrangements arising from employment disruptions, migration and school closures have intensified unpaid duties in many contexts.

The pandemic has multiplied the challenges of older people living in precarious circumstances such as those brought on by humanitarian crisis. Inequality across and within societies is widened in contexts such as displacement, conflict, natural

Figure 2: Types of abuse risks in the pandemic that most concern older respondents



Source: COVID-19 rapid needs assessment of older people: Asia Pacific. HelpAge, July 2020. Findings of rapid needs assessments carried out by the HelpAge network in seven countries of the region.

disaster and incarceration. For example, displacement in Myanmar's Rakhine State and crowded Rohingya refugee camps across the border in Bangladesh have left older people in a precarious situation, underserved, and often without a voice. Clear information about the virus may be limited, and internet access has sometimes been cut in areas affected by conflict, including Rakhine. Natural disasters may aggravate an already fraught pandemic situation for older people and complicate interventions. In India and Bangladesh, for example, the pandemic has coincided with floods during this year's monsoon.

Income security

Even before the pandemic, many older people struggled financially, and COVID-19 will make things worse. For income security, older people rely mainly on work, support from family and pensions. According to the World Bank, over half of people of all ages in South Asia and 7 per cent in East Asia and the Pacific lived on less than USD 3.20 a day before the COVID-19 crisis. Around 10 per cent of the East Asia and the Pacific total were aged 65 or older, and about 5 per cent in South Asia. While age-disaggregated poverty data in the pandemic is lacking, the loss of income from work and family and the limitations of pension systems mean that many older people will be among the 55 to 65 million people pushed into extreme poverty in Asia Pacific this year, as predicted by the World Bank (see Figure 3).

Older people's work

Older people in Asia Pacific work mainly in the informal sector, which provides little protection against income shocks and is being hit particularly hard by COVID-19. With limited pension coverage, older people in low- and middle-income countries rely on family support, savings and work to meet their needs. Before the pandemic, the International Labour Organization (ILO) estimates that 22 per cent of people aged 65 and older in Asia Pacific worked, rising to 40 per cent in the region's low-income countries. According to the

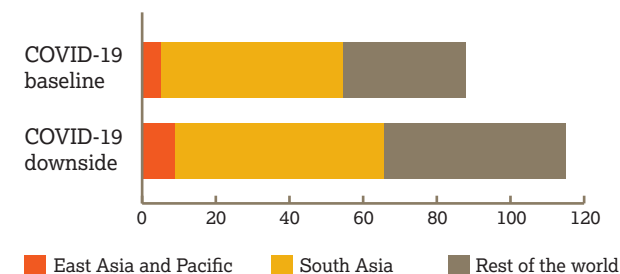
ILO, more than four-fifths of older people's work takes place in the informal economy. Informal employment tends to provide lower and more irregular incomes. For many, no work means no income. Furthermore, informal businesses and workers are often excluded from crisis-related financial assistance, and informal employment rarely provides social protection or health and safety benefits.

Loss of livelihoods and jobs caused by the pandemic impacts older people directly and indirectly. The impact on older people's income is a result of reduced income from their own work and reduced ability of family members to provide material and financial support. A national survey by HelpAge India in June 2020 found that the crisis has negatively impacted the livelihoods of 65 per cent of older people. In Japan, the greatest rise in unemployment between March and April 2020 was amongst those aged 65 and older.

Evidence from past economic crises suggests that older people can find it difficult to re-enter the labour market after spells of unemployment. Following the 2008 Great Recession, younger workers in Organisation for Economic Co-operation and Development (OECD) member states were more likely to lose employment, but older workers were less likely to find new work and experienced longer spells of unemployment. OECD evidence further suggests that older workers were more likely than younger workers to face a persistent decline in job quality after re-employment. Despite such


Figure 3: Many of the world's new poor will be in South Asia

Additional poor at the US\$1.90-a-day poverty line in 2020




Source: Poverty and shared prosperity 2020: Reversals of fortune, World Bank, 2020, <https://openknowledge.worldbank.org/bitstream/handle/10986/34496/9781464816024.pdf>

Fast facts




55-65m

people predicted to be pushed into extreme poverty in **Asia Pacific region** because of the pandemic




15%

average loss of working hours in the second quarter of 2020 in Asia Pacific



49-56m

people predicted to be pushed into extreme poverty in **South Asia subregion** because of the pandemic



82%

of people projected to be pushed into poverty by COVID-19 who are from middle-income countries

disadvantages, older workers are often forgotten in employment or economic recovery policies. Some countries limit such support to younger people: Vietnam's current employment promotion efforts, for instance, are limited to those younger than 59.

Family support and remittances

Family support is crucial but often inadequate and under further pressure during COVID-19. In Asia Pacific's low- and middle-income countries, most older people live with, or close to, other family members. Intra-family transfers of cash or goods are common. However, poverty and economic vulnerability mean many families have limited resources to share. Pre-COVID-19 research by HelpAge highlights the importance of support received from families but also points to the insufficiency of this support. While there is not yet much data on the impacts of COVID-19 on family transfers to older people, the loss of employment and livelihoods faced by many families is expected to lead to reductions in material support to older people. Witnessing the struggles of families, communities are showing solidarity. In many contexts, community groups and networks of volunteers are collecting and distributing food and material support to those in need, including older people and their families. Commonly distributed items are cooked meals, dry rations and hygiene packages.

Remittances from family members working abroad are projected to decline. These transfers are a crucial element of informal support systems in Asia Pacific. As the economic crisis threatens the livelihoods of millions of international migrants from Asia Pacific, remittances to the region are expected to drop by between 11 and 20 per cent in 2020. According to the Asian Development Bank, households of older persons or households with no income earner may face the biggest challenges. According to the Philippine Statistics Authority, 21 per cent of older people receive remittances, the largest proportion of any age group.

Pensions

The precarious nature of older people's work and family support during COVID-19 highlights the importance of pensions. According to the International Labour Organization, 55 per cent of older people in Asia Pacific receive a pension, though rates in South Asian countries are lower on average. As coverage of contributory pensions remains limited in most countries, tax-financed social pensions have been crucial to expand pension coverage. But according to HelpAge International's PensionWatch database, their average transfer value in the region is only 12 per cent of average income. Countries such as China and India (2 per cent) and Thailand (4 per cent) provide much less. COVID-19 makes this inadequacy apparent in many countries. In the Indian state of Odisha, for example, 40 per cent of social pension recipients spend their entire four-month payment in the first weeks after receipt.

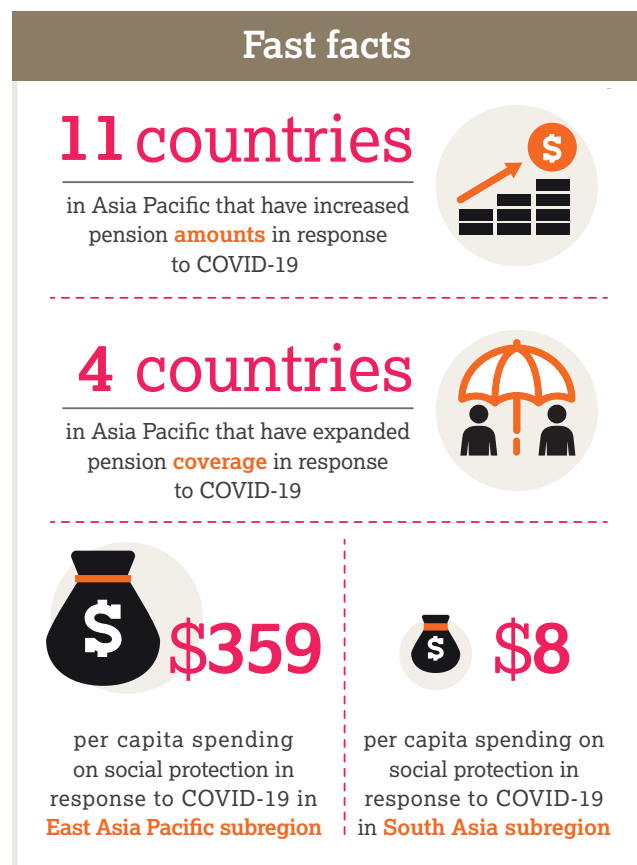


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Pensions tend to reflect gender imbalances in the labour market and disadvantage women, often leaving them financially dependent on others in later life. Traditionally pensions have been tied to formal employment status, while women are overrepresented in informal and unpaid work. Pension design often fails to protect women against lifecycle risks – including cycling in and out of the workforce throughout adulthood while balancing social expectations around family care and other uncompensated work. This reality is an added rationale for social pensions, which are not tied to employment history and can help address gaping gender disparities in income security.

Only 14 countries in Asia Pacific have adapted pension systems for older people as a COVID-19 response. Only Samoa has introduced a new social protection benefit specifically for older people, while Bangladesh, Mongolia, Sri Lanka have expanded the coverage of existing social pensions. Eleven countries in the region have increased pension benefits and five have introduced rules allowing those enrolled in funded pension schemes to

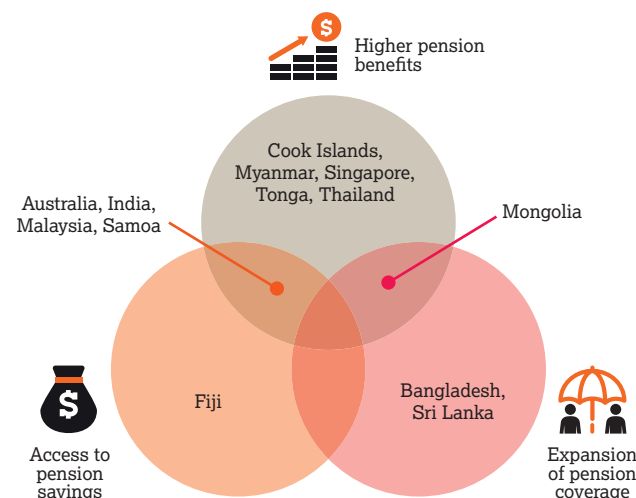
prematurely withdraw part of their funds, according to a mapping of social protection responses to COVID-19 by HelpAge International. See Figure 4, which categorises pension reforms (excluding other forms of social protection that older people may access).



Access to wider social protection benefits during COVID-19

Social protection has been an integral component of almost every government’s response to COVID-19. By October 2020, the World Bank counted 209 countries and territories that had announced a total of over 1,500 adaptations and expansions of their social protection systems to protect livelihoods, people’s wellbeing and national economies from the impact of the pandemic. See Figure 5. Countries are providing extra or higher social assistance transfers, scaling-up coverage through new schemes or expansions of existing ones, or adapting implementation systems to reduce risk for infection and improve access. Some these interventions target households while others are specifically designed for older people or other population groups.

Figure 4: Country efforts to improve pensions during COVID-19

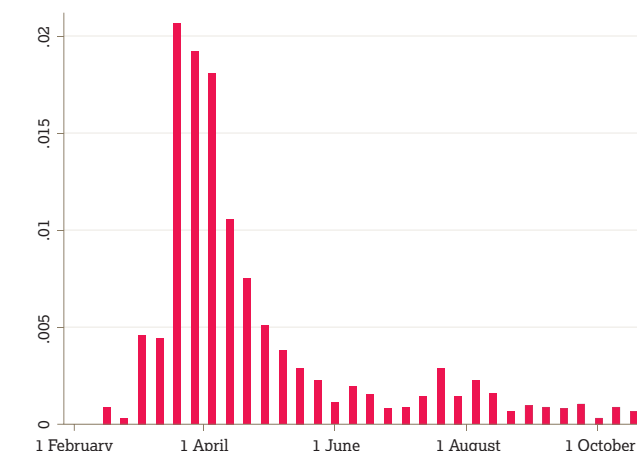


The World Bank estimates that during COVID-19, governments in East Asia and the Pacific provide cash transfers to more people than any other sub-region, increasing coverage from 19 per cent of the population before the crisis to 64 per cent in September 2020. In South Asia, coverage increased from 20 to 44 per cent, but the data does not include India, the country with the largest COVID-19 cash transfer (see Figure 6).

COVID-19 era cash transfers are relatively generous. In most countries, these cash transfers are temporary, with durations ranging from one to six months and with an average of three months. While typically short in duration, the size of these cash transfers is relatively generous, especially in contrast to pre-COVID-19 social protection for older

Figure 5: Most new social protection responses were announced early in the pandemic

Announced new social protection measures in Asia Pacific, by month

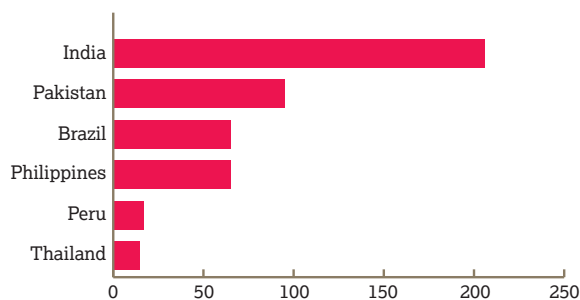


people. It is interesting to contrast social pensions and COVID-19 cash transfers. In Thailand, for instance, the THB 600 (USD 19) monthly minimum payment for the social pension is a mere 12 per cent of the country's monthly emergency cash transfer of THB 5,000 (USD 160).

Various constraints have excluded many older people from COVID-19 cash transfers in Asia Pacific. In principle, many older people should be eligible to access emergency cash transfers that are not targeted at particular groups but rather at broad segments of populations that have been made poorer by COVID-19. However, a survey by the HelpAge network in 18 countries worldwide, including India, Pakistan, Bangladesh, Philippines, Sri Lanka, Nepal, Vietnam and Myanmar, revealed a number of challenges for older women and men,

Figure 6: Some of the biggest cash transfer programmes are in Asia

World's 6 largest COVID-19 cash transfers, in millions of individuals



Source: Social protection and jobs responses to COVID-19: A real-time review of country measures "Living paper" version 13 (September 18 update), World Bank, 2020.

especially older people with disabilities, in accessing social protection during COVID-19.

Older people struggle with cash transfer registration and payment, particularly with digital systems. Digital registration and payment systems rely on internet access or mobile phone ownership and capacity to use. To be able to access programmes, many older people reportedly relied on neighbours and relatives for help, which in some cases opened opportunities for theft. Requirements for registration in person and the inconvenient location of pay-points also created access challenges for older people, especially those from rural areas or people with disabilities. Long queues at banks and welfare offices, lockdowns, lack of public transport, and fear of infection in places without physical distancing also discouraged older people from accessing benefits. Finally, the lack of a dedicated communication campaign targeted at older people and people with disabilities, as well as limited community involvement in outreach, left many unaware or confused about their eligibility and how to register.

The importance of universal social protection during a crisis

COVID-19 has demonstrated the value of universal social protection systems. This and previous crises have shown that countries with effective and universal social protection systems are better prepared to protect their citizens from socioeconomic crises. Such countries have the

institutional capacities and systems in place to scale up programmes quickly. Comprehensive systems also require less scaling up in the first place, as larger segments of the population are already covered and might require only increases in transfer levels. The Cook Islands, Mongolia, Myanmar, Samoa, Thailand and Tonga demonstrated how leveraging the infrastructure of universal social pension systems could rapidly provide additional support to older people. Since these social pensions are universal, and older people are already enrolled and understand the payment methods, they are effective in reaching most older people.

Countries without comprehensive systems, or that focus exclusively on the extreme poor, may suffer from delayed or ineffective responses.

These countries need to develop policies and interventions quickly in a crisis, often in an ad hoc way. In the Philippines, for instance, the scale of the pandemic pushed the government to go beyond, and largely bypass, the country's social protection system. Needing to rapidly develop a system from scratch, the country's social protection response has been plagued by confusion and delays. For example, older people have been excluded from the response because they are already entitled to a social pension. Yet the pension's monthly benefits are far below the level of the emergency cash transfer and, at the beginning of the lockdown, had not been paid in months.

Reflections

Recurring themes in 2020 from tracking the impact of COVID-19

Lack of evidence makes it difficult to understand the real situation of older people. Data and other evidence on the situation of older people in the COVID-19 era, particularly in low- and middle-income countries, are still very thin. This evidence gap is obvious across all domains and hinders an understanding of how the pandemic has changed lives. The lack of evidence also obscures the response options for governments and other actors. Of particular concern is the regular exclusion of older people from sampling, and from analysis and reporting that doesn't disaggregate findings by age. Until robust sex- and age-disaggregated research is conducted, much of what we presume about the pandemic's wider impacts on older women and men comes from extrapolation of pre-COVID-19 research, supplemented by smaller studies.

! Recommendation: Gather sex- and age-disaggregated data and other evidence about older people's situation in the pandemic.

We cannot generalise about older people in the pandemic. Older people are often lumped together as a vulnerable group in crises. Better data is needed to unpack the wide diversity in how older people have experienced the pandemic. That diversity is reflected in their (a) personal characteristics, for instance underlying health conditions, gender, and cumulative lifecourse advantage and disadvantage; (b) personal circumstances, such as living arrangements, COVID-19 safety practices of the family, and the presence or absence of household caregivers; (c) local environment, including community transmission rates, compliance with safeguards, and the strength of local civil society; and (d) national context, encompassing public policies, national systems, and societal attitudes. Depending on the mix of factors, an older person's experience during the pandemic may be relatively untroubled or severe or – more often – somewhere in between the extremes.

! Recommendation: Add nuance to statements warning of the pandemic's "risks to older persons", based purely on chronological age.



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Inequality has widened and shaped outcomes from the pandemic. Inequality is associated with the diversity of experience in later life. Already a defining socioeconomic trend of this century, inequality has shaped how individuals and places have been impacted by COVID-19. Disadvantaged groups are more likely to lose income, miss out on the public response, not be counted, and suffer and die from the virus. Those at the margins of society – such as refugee and displaced populations, informal workers and the destitute – may be hit hardest but receive little support. The pandemic is also accelerating those pre-existing inequalities, making the gaps between the richest and the rest of society wider, pushing millions, including large segments of older people, into poverty. “Build back better” must aim to reverse the trends that are taking hold and enable progress towards a fairer society.

! Recommendation: To avoid even wider inequalities post-pandemic, reimagine the future by investing in systems that can aggressively reduce inequalities in later life.



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Effective and inclusive state systems put countries in a better position to respond. Interventions that reduce inequality and support healthy and active ageing are already known, and the most important rely on governments as the critical actors. Strong national systems are the foundations for addressing inequality and ensuring no one is left behind. Well-regulated, person-centred services delivered through those systems have the potential to respond to the diversity of older people. Of most relevance for older people are health, long-term care and social protection systems. COVID-19 has shone a light on those systems’ quality, coverage and adequacy of benefits, and their flexibility in responding to crisis situations. Governments that had invested in strong systems over the years were able to move quickly, and universalism allowed them to be more inclusive and efficient. Universal health coverage, social protection floors and widening long-term care systems have demonstrated their value in the pandemic.

! Recommendation: Prioritise national systems that can deliver in a crisis and beyond, incorporating universal health coverage, long-term care and support, and a social protection floor for all.

The pandemic stimulated creative non-state responses, which strengthened solidarity. Non-state responses vary widely across societies, but they remain critical. In low- and middle-income countries in particular, they may fill gaps that limited government services leave behind. In most cases, families and households are the first line of response. Formal or informal community action is also important. In many places, community-based associations, religious groups, NGOs and volunteers stepped in creatively to address the needs of older people. Many leaders and volunteers of those groups are older people themselves. For example, one common community response across the region was food distribution: pop-up food pantries, cooked meals, or food packets. People also supported each other by distributing face masks, soap and hand sanitizer. Volunteers checked in on those living alone and continued to provide essential care services with extra precautions. In many countries, the private sector also made substantial donations of goods and services for the COVID-19 response.

! Recommendation: Promote national networks of local groups that strengthen community-based support in crises and intergenerational solidarity.

As in all aspects of life, gender shaped pandemic experiences and impacts. Individuals' COVID-19 experience has varied by both age and gender, although nuanced and sex-disaggregated evidence is still emerging. Men are overrepresented globally among COVID-19 cases and deaths. Social and behavioural factors related to gender are clearly influencing case and mortality rates. Women are less likely to have pensions and paid work, and therefore compared to men tend to be more financially dependent on others at older ages. On the other hand, women, including older women, take on more unpaid work than men, including grandchild care during pandemic school lockdowns and community volunteering. Older women are substantially more likely than older men to be widowed and to live alone, although men often have weaker social connections than women in later life. Both older men and older women fear a rise in violence, abuse and neglect during the pandemic, but the weakness of the evidence represents a societal betrayal.

! Recommendation: Raise the visibility and voice of older women in strategies on gender diversity and produce more nuanced analyses of the gendered impacts of COVID-19.

The pandemic may have widened a door for ageism. The pandemic has exposed the fine line between highlighting older people's social vulnerabilities and reinforcing ageist perceptions. A narrative of decline based simply on age may contribute to negative attitudes about later life, not only across society generally but specifically among older people themselves. Unconscious bias associated with ageism is not necessarily malicious; indeed, it is often rooted in language around protection, vulnerability and respect. Rather than as individuals with unique, personal needs and aspirations, older people are defined primarily as family dependents. As a result, they are left behind in data collection. Health conditions of older adults are low priority. Care needs are left to the family until the gaps become impossible to ignore. Income is assumed to be covered by family transfers or employment, which declines with age, partly because of the assumption that older people are no longer productive. Despite the fleeting virus-driven attention on older people because of the pandemic, we know little about them, and much of what we know is outdated.


! Recommendation: Analyse the perceptions of later life that drive pandemic responses and underpin national policies and services affecting older people.



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HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.

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