AARP®

Achieving equitable healthy aging in low- and middle-income countries

The Aging Readiness & Competitiveness Report 4.0

Data and analysis by

ECONOMIST IMPACT

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About the report

This report was written by Economist Impact with support from AARP. The findings are based on an extensive literature review, interviews with subject-matter experts and older adults, and data analysis conducted by Economist Impact between January and October 2022.

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Economist Impact created the graphs in this report based on data retrieved from the indicated sources, as well as its own analysis when needed. Reusing these graphs is welcome on the condition of a proper citation of this report.

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About the cover: The illustration demonstrates the dual journey that individuals and communities around the globe embark upon toward healthy aging. An easier path is depicted on the left, whereas an incomplete path on the right—as a consequence of inequities—presents challenges that must be overcome.

Disclaimer: The views expressed in this report may not necessarily reflect those of AARP.

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Key definitions

Aging inequity: For the purpose of this report, aging inequity refers to unfair differences experienced throughout the life course that culminate in greater disparity in older age *within a country.*

Equality vs. equity: Equality is a state of affairs—i.e., being equal, especially in status, rights, and opportunities.[i] Equity is a process in pursuit of "the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically, or by other dimensions of inequality."[ii]

Inequities vs. inequalities vs. disparities: Inequities is the opposite of equity, implying unfair and unjust differences. Inequalities is the opposite of equality, referring to measurable differences of some sort.[iii] Inequalities and disparities are used interchangeably in this report.

Equitable healthy aging means that all individuals have a fair and just opportunity to optimize health and wellbeing at all life stages and fulfill their health potential to age well. Achieving equitable healthy aging requires a **life-course approach**, in other words, reducing or eliminating the social and structural disparities people experience *throughout their lifetime.*

Marginalized/disadvantaged/vulnerable groups: These terms are used interchangeably in this report, following the World Health Organization's definition, to mean "people, who due to factors usually considered outside their control, do not have the same opportunities as other more fortunate groups in society."[iv] *We recognize that terminology continues to evolve; however, there is not universal agreement on terminology. Thus we chose to utilize these terms as defined above because they are widely recognized and currently utilized by the WHO. In addition, while these terms can be viewed as reinforcing hierarchies among different groups of people that can perpetuate inequities, that is not our intent in this report.*

Informal economy vs. informal employment is defined as all economic activities by workers and economic units that are—in law or in practice—not covered or insufficiently covered by formal arrangements. People working in the informal economy are in informal employment, or "informal workers" who do not have secure employment contracts, workers' benefits, or social protection.[v]

How do we define "older adults"? The age threshold applied to define "older adults" and "older populations" varies across countries and is sometimes adjusted according to average life expectancy or statutory retirement ages. In this report, for comparative simplification, we benchmark older age at 65 and over when describing relevant statistics, unless otherwise specified due to data availability. However, we recognize that any metric lacking regional specificity is inherently flawed.

How do we define "country groups"? Country groups are defined based on the World Bank's income group classifications, which take gross national income per capita as the main indicator of a country's development status.[vi] In this report, we compare country groups on various dimensions and indicators for the purpose of illustration rather than generalization, acknowledging the heterogeneity of countries within an income group. We are aware that while a country's lower income level can be one of many contributing factors to the disparities experienced by its population, increasing income does not guarantee reduced disparities.

i UN Department of Economic and Social Affairs. "Concepts of inequality. Development issues no. 1." 2015. Available at: https://www.un.org/en/development/desa/policy/wess/wess_dev_issues/dsp_policy_01.pdf.
ii WHO. Health equity. 2010. https://www.who.int/health-topics/health-equity#tab=tab_1
iii WHO. Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook. 2016. Available at: https://www.who.int/publications/i/item/9789241511391
iv WHO. Glossary of terms used for Health Impact Assessment (HIA). Available at: https://www.who.int/publications/m/item/glossary-of-terms-used-for-health-impact-assessment-hia
v International Labour Organization. Available at: https://www.ilo.org/global/topics/wages/minimum-wages/beneficiaries/WCMS_436492/lang--en/index.htm
vi World Bank Country and Lending Groups. Available at: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups

Executive summary

Aging inequity—the cumulative effect of inequalities experienced throughout a person's lifespan—is becoming an increasingly urgent issue in low- and middle-income countries (LMICs). These countries are driving an unprecedented global wave of demographic aging. Between 2022 and 2050, LMICs will account for 85% of the population growth of people aged 65 and over worldwide, and by 2050 roughly four out of five older adults will live in these countries. Meanwhile, persistent and unfair differences experienced by older adults—which are often based on demographic and socio-economic factors—pose a major roadblock to these countries' promotion of healthy aging and pursuit of sustained economic and social development.

This presents an immediate need to tackle aging inequity in LMICs. However, a significant knowledge gap exists in understanding the challenges and efforts around aging in these countries, which is preventing effective action. The fourth iteration of the Aging Readiness and Competitiveness initiative (ARC 4.0) aims to remedy these gaps, identify and amplify solutions and leading practices, and contribute to the global endeavor to achieve equitable healthy aging.

As shown in this report, aging inequity tends to be more acute in LMICs than in high-income countries (HICs). For example, gender-based disparities in education, labor force participation, and pension coverage overall are larger in LMICs. While rural-urban gaps in access to social protection and healthcare are a common challenge for most HICs and LMICs alike, in the latter their impact on older adults is compounded by the under-development of social protection systems. LMICs also tend to face a larger rural-urban divide in educational attainment than HICs.

A variety of economic, policy, and societal challenges hinder equitable healthy aging in LMICs. Large informal economies, where people are employed in jobs without access to adequate income and employment benefits, pose a structural barrier to equal access to economic opportunity and social benefits. Underdeveloped public institutions fail to extend universal access to social protection, healthcare, and education.

In addition, a lack of policy imperative to legally enshrine the rights of older adults leads to insufficient action on the part of governments to tackle aging inequity. Strains on informal, familial networks of care—due to urbanization, declines in birth rates, and other social shifts—further exacerbate the problem. These challenges are not unique to LMICs but tend to be more pronounced due to lower levels of economic development, more limited fiscal capacity, and ongoing rapid urbanization, among other factors.

Governments, businesses, and civil society in LMICs have started to act, employing innovative practices that have had some initial success in addressing aging inequity. This report highlights some of the pioneering and leading solutions and profiles 14 select programs in the Appendix. Examining these efforts reveals key takeaways that are relevant and useful for the ongoing global endeavor to achieve equitable healthy aging, not only in LMICs but also in HICs:

- **Equitable healthy aging is achievable—even in a society with a large informal economy and limited institutional capacity—but this requires sustained commitment from governments.** Governments play a central role in enhancing national legislation on protecting equal rights, building physical and institutional infrastructure, and implementing aging-related policies. As a result, their commitment is essential for combating aging inequity at both the national and local levels. For example, thanks to sustained political and financial commitment, some LMICs, including Colombia, India, Thailand, and Vietnam, have made remarkable progress on expanding pension and/or healthcare coverage over the past several decades. In Sumapaz, Colombia, the local government's funding of the Comprehensive Care Model for Rural Health for more than two decades has improved local access to high-quality healthcare, benefiting older adults in rural communities.

- **Action that targets intersecting segments of gender, race and ethnicity, ability, geography, and socio-economic status among older adults can effectively improve their livelihoods and wellbeing, reducing inequities.** The heterogeneity of disparities experienced by older adults across different intersecting segments requires targeted efforts to meet their specific needs. Governments, businesses, and civil society have led innovative programs that provide support and empowerment to specific groups of disadvantaged older adults. Successful examples include the Bangladeshi national government's cash-transfer programs, which focus on older women living in poverty, and Someone Somewhere, a social enterprise in Mexico that partners with older artisans in indigenous communities to promote traditional textiles while generating income.
- **Community-centered approaches can effectively reach underserved groups among older adults, and cross-sector collaboration is key to their design and implementation.** The success of community-centered programs lies in the ability to tailor them to local situations while tapping into existing networks of support. Innovative practices have yielded initial success in places where stakeholders collaborate across sectors. This is demonstrated in the success of the Older People's Associations in Vietnam and Bangladesh, which are a proven model to facilitate mutual support among older adults and reduce poverty and inequality. In Malawi, the Kaundu Community-based Health Insurance program mobilizes community volunteers, village leaders, and local health centers to oversee the operation and manage health insurance payments, reducing out-of-pocket health expenditure as well as health inequities among older adults in a rural region.
- **Adopting a life-course approach is imperative to reduce aging inequity in the long term, because supporting today's younger generations empowers tomorrow's older populations.** Inequalities accumulate throughout a person's life course. Therefore, mitigating inequities among older adults requires effective intervention to reduce disparities in earlier stages of life. Some innovative programs have focused on economically empowering younger generations, particularly women. For example, Mission Shakti in India works with community organizations to develop income-generating activities, provide financial services, and build professional skills for women, showing the potential to reduce gender inequities among future older populations. Other programs adopt life-course interventions to improve the health outcomes of current and future older populations. One successful example is the National Health Extension Program in Ethiopia, which aims to mitigate rural-urban health inequities by increasing the provision of high-quality healthcare services in rural areas.
- **A lack of aging-related data is hampering solutions to tackle aging inequity; immediate action is needed to conduct more robust data collection.** While demographics and socio-economic status have significant impacts on aging inequity, disaggregated data at the intersection of these factors are scarce globally. This lack of data leaves stakeholders with limited knowledge on how to best create avenues for equitable healthy aging. Nationally collected data need to be inclusive of the older population and consistently disaggregated by demographic and socio-economic factors as a foundation for other collection efforts. India's first Longitudinal Ageing Study in 2017-19 provides an encouraging example of such an effort. Region- and community-specific qualitative research (such as that conducted through focus groups and interviews) can enhance the understanding of older adults' needs that are innately tied to physical locality and unique lived experiences.

Addressing aging inequity in both LMICs and HICs is essential to achieving the goals set out in the UN's Decade of Healthy Ageing (2021-30). With increasing global momentum toward supporting healthy aging, a crucial opportunity exists to raise awareness and prompt action from policymakers, the private sector, non-governmental organizations, community organizations, and individuals. All stakeholders can and should play a role, taking concerted actions toward the collective goal of achieving equitable, healthy aging.

I. Introduction

Low- and middle-income countries (LMICs)* are driving an unprecedented global wave of demographic aging. Between 2022 and 2050 this group will account for 85% of the population growth of people aged 65 and over worldwide, and by 2050 1.2 billion older adults will live in these countries.[1] Coupled with this dramatic demographic shift is persistent aging inequity–unfair differences experienced throughout the life course that culminate in greater disparities in older age–which poses a major roadblock to countries' pursuit of sustained economic and social development. To achieve the goals set out in the UN's Decade of Healthy Ageing (2021-30), it is imperative for international organizations, governments, businesses, and civil society to step up their efforts to address aging inequity in LMICs through a life-course approach. However, significant knowledge gaps prevent effective action. The fourth iteration of the Aging Readiness and Competitiveness initiative (ARC 4.0) aims to remedy these gaps and contribute to the global endeavor to achieve equitable healthy aging.

According to the *Global Longevity Economy® Outlook* report, in LMICs the 50-plus population (both at home and abroad) on average contributed 35% of local GDP in 2020 and is expected to contribute 41% by 2050.

A. Rapid population aging in LMICs

The world is undergoing a dramatic demographic shift: In 2018, for the first time in history, people aged 65 and over outnumbered those under five years old. By 2050, this population will double in size from 2022, with one in six people 65 years or older.[2]

This rapid growth will predominantly be driven by demographic shifts in LMICs. Between 2022 and 2050, the 65 and over population in LMICs will grow over 2.5 times faster than in high-income countries (HICs). By 2050, 77% of people aged 65 and over will live in LMICs (Figure 1-a). Among LMICs, Sub-Saharan African countries will experience the fastest growth, while Asian countries will contribute to over 70% of the global increase of the older population (Figure 1-b).[3] Significant increases in life expectancy–or the duration that an individual can expect to live–have contributed to this demographic shift, although longevity in these regions remains lower than in HICs.[4] In addition, falling birth rates are also contributing to the rising proportion of older people in LMICs.[5]

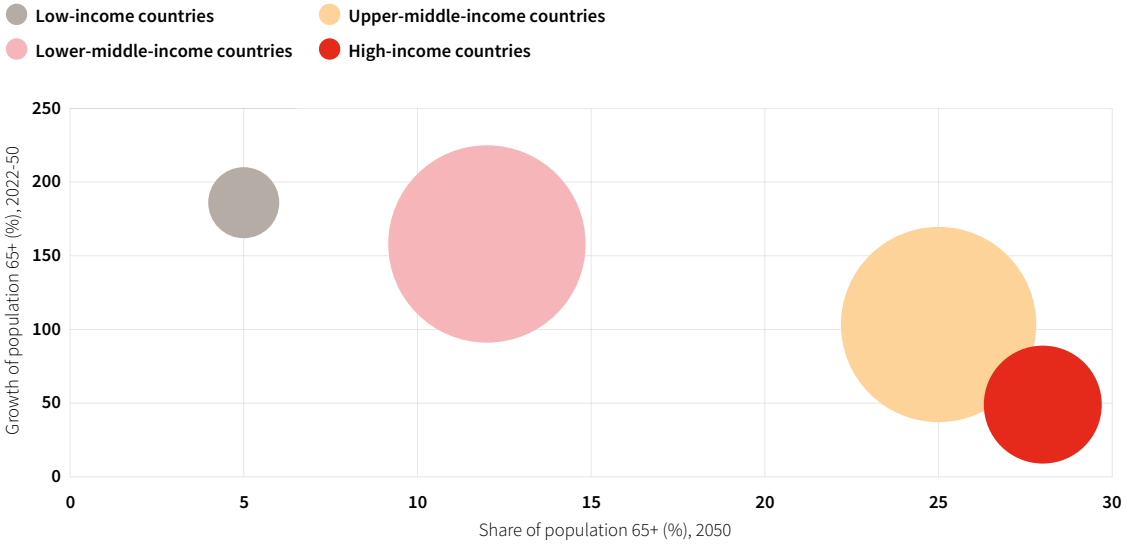
The implications of demographic aging for LMICs are twofold. First, LMICs are facing an opportunity to unlock the hidden potential among older adults. For example, the *Global Longevity Economy® Outlook* report released by AARP in 2022, with analysis conducted by Economist Impact, reveals that the population aged 50 and older contributed US$45 trillion to, or 34% of, global GDP through consumer spending in 2020, which will more than double to US$118 trillion in 2050.[6,7] In the LMICs featured in the same study, which totaled 33 out of the 76 economies analyzed, the 50-plus population (both at home and abroad) on average contributed 35% of local GDP in 2020. This same group will contribute an estimated 41% by 2050.

Second, growing older populations also drive the impetus for societies to strengthen institutional systems that provide social protection and health services for all older adults as well as building age-friendly communities that enable people to live longer, healthier, and more productive lives. Such efforts are not only essential for cultivating an inclusive society, but they also help to achieve sustainable economic prosperity. Population aging is often associated with shrinking labor forces that, in turn, slow down economic growth. However, some empirical analysis shows that this dampening effect on GDP can be avoided through policy interventions supporting healthy and active aging.[8]

* Country groups are defined based on the World Bank's income group classifications (see **Key definitions**). In this report, we compare country groups on various dimensions and indicators for the purpose of illustration rather than generalization, acknowledging the heterogeneity of countries within an income group. We are aware that while a country's lower income level can be one of many contributing factors to the disparities experienced by its population, increasing income does not guarantee reduced disparities.

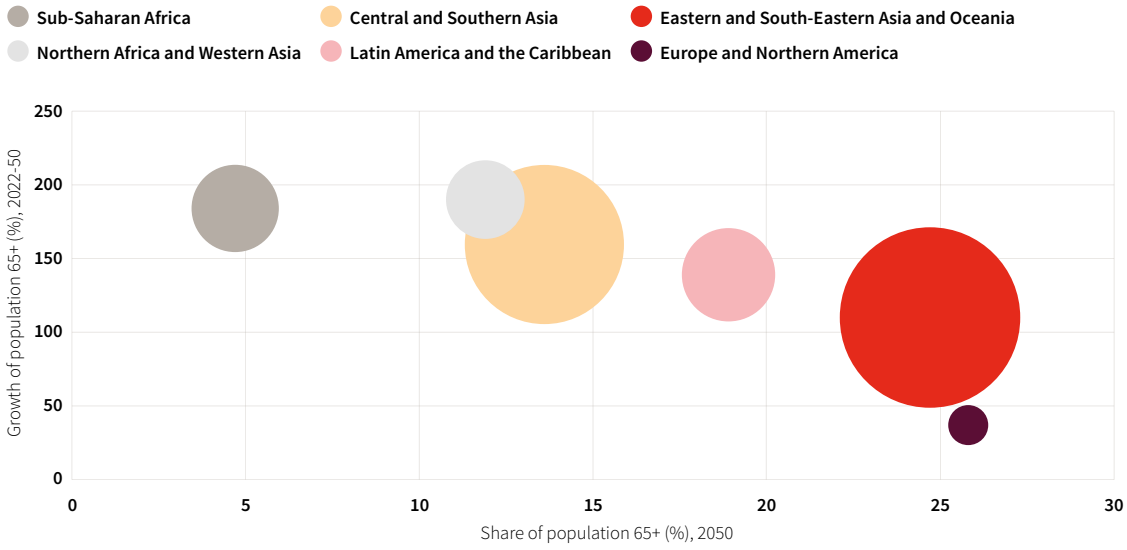
Figure 1. LMICs will drive rapid demographic aging in the coming decades. Among LMICs, Sub-Saharan African countries will experience the fastest growth, while Asian countries will contribute to over 70% of the global increase of the older population.

a) Percentage of population aged 65 and over in 2050; growth rate (%) and size increase (in thousands) of population aged 65 and over between 2022 and 2050; by country income level



Bubble size = Increase in population aged 65+ (thousands), 2022-50

b) Percentage of population aged 65 and over in 2050; growth rate (%) and size increase (in thousands) of population aged 65 and over between 2022 and 2050 among LMICs; by region



Bubble size = Increase in population aged 65+ (thousands), 2022-50

Sources: World Population Prospects 2022, UN Department of Economic and Social Affairs, Economist Impact.

Notes: 1) Country groups are defined based on the World Bank's income group classifications, which are updated annually. For example, for the 2023 fiscal year, low-income countries are defined as those with a gross national income (GNI) per capita of US$1,085 or less in 2021; lower-middle-income countries are those with a GNI per capita between US$1,086 and US$4,255; upper-middle-income countries are those with a GNI per capita between US$4,256 and US$13,205; and high-income countries are those with a GNI per capita of $13,205 or more; and 2) Economist Impact created this and other graphs in this report based on data retrieved from the indicated sources, as well as its own analysis when needed. Reusing these graphs is welcome on the condition of a proper citation of this report.

B. LMICs face an acute challenge in tackling aging inequity

Aging inequity manifests potently in unfair differences among older adults related to gender, race and ethnicity, ability, place of residence (rural and urban), and socio-economic status (see **Key definitions**). As in HICs, a major challenge that LMICs must address is ensuring that all older adults have access to healthcare and other social services. The COVID-19 pandemic has further exacerbated existing inequalities (Box 1).

As an OECD study underscores, inequalities experienced by individuals later in life are largely a consequence of different socio-economic outcomes built up throughout their lives.[9] Therefore, tackling aging inequity requires taking actions to not only target unfair differences among older adults but also to eliminate them earlier in people's lifespans. Working toward this end is also instrumental in mitigating inequalities within a society, preventing broader social and economic losses (Box 2).

While aging inequity is a common issue for countries at different income levels, it tends to be more acute in LMICs thanks to large informal economies, constrained financial capacity, insufficient public institutions, and a lack of political will for implementing robust aging policy. The challenge is compounded by the rapid increase in the number of older adults in LMICs who are unprepared for older age.[10]

"The challenge of aging inequity is more acute and urgent in countries of lower income levels. This is particularly the case for those with the highest levels of income inequality, due to their greater fiscal constraints and lack of preparedness of their social protection systems," says Irene Hofman, CEO of IDB Lab, the Inter-American Development Bank Group's innovation laboratory.[11]

> "The challenge of aging inequity is more acute and urgent in countries of lower income levels. This is particularly the case for those with the highest levels of inequality, due to their greater fiscal constraints and lack of preparedness of their social protection systems."
>
> **Irene Hofman**
>
> CEO, IDB Lab (the Inter-American Development Bank Group's innovation laboratory)

Box 1: The COVID-19 pandemic exacerbated inequalities among older adults

The COVID-19 pandemic exacerbated existing income and health inequalities among older adults in both high-income countries (HICs) and low- and middle-income countries (LMICs)[12]. Countries with lower income levels will struggle with particularly weak recoveries that will be felt strongly by their most marginalized populations.[13] In particular, the economic fallout during the pandemic has threatened the livelihood of workers in the informal economy (see **Key definitions**), where 78% of global working adults aged 65 and over are employed. Most of these workers live in LMICs and many have limited or no access to social protection or entitlement to employment benefits.[14]

The weaker public institutions in LMICs—such as underfunded healthcare systems—were unequipped for the pandemic, which has had significant ramifications on older adults. These healthcare systems, which lack the capacity to function effectively during a crisis, leave the poorest people without access to basic care. Even before the pandemic, as many as half of older adults in some LMICs had no access to essential health services.[15]

C. Achieving equitable healthy aging aligns with international commitments

The international community has made relatively slow progress over the past decades in proactively reducing aging inequity. The one exception is the landmark 2002 Madrid International Plan of Action on Aging (MIPAA).[16] However, the MIPAA is non-binding, meaning that reporting on its implementation is "voluntary and often sporadic."[17]

In recent years, calls to address these gaps indicate some forward momentum.[18,19] The UN's 2030 Agenda for Sustainable Development calls for the Sustainable Development Goals (SDGs) to be met across all segments of society. As aging cuts across the goals on poverty eradication, good health, reduced inequalities, and gender equality, among others, older persons are recognized as "the active agents of societal development in order to achieve truly transformative, inclusive and sustainable development outcomes."[20]

Among its guiding principles, the Plan of Action for the UN's Decade of Healthy Ageing (2021-2030) highlights "inclusiveness" and "equity," which are aimed at ensuring equal, just opportunities for all segments of society—irrespective of age, gender, ethnicity, ability, location, or other social categories—to access healthcare, education, employment, and financing, among other enablers of healthy aging.[21]

With the 20th anniversary of MIPAA in 2022, policymakers, alongside stakeholders from civil society and scientific researchers, have affirmed their commitment to promoting active and healthy aging. The emphasis is on tackling inequalities among older people and mitigating cumulative inequalities over a person's life course.[22,23]

Reducing aging inequity in LMICs aligns with current international efforts and guidelines. Although it requires a comprehensive understanding of countries' current states, challenges, and efforts, a significant knowledge gap exists. This is in part due to the relatively young populations in many LMICs, which leads to a lack of national attention on the subject of aging and aging inequity.

Box 2: The imperative of eliminating inequalities

Eliminating inequalities, both in older age and over the life course, is essential for helping people to fulfill their potential and live healthy, productive lives in older age. More broadly, it also prevents social and economic losses–and recent history provides an extreme case of how these factors can play out. The COVID-19 pandemic demonstrated how inequality leads to devastating health and social impacts. For example, according to a study by Oxfam, if Latinx* and Black people in the U.S. had a COVID-related death rate as low as that of White people, close to 22,000 Latinx and Black people who died in the first year of the pandemic would still be alive. The same study also found that if women and men globally had been equally represented in the employment sectors negatively affected by the pandemic–rather than women being overrepresented–112 million women would no longer be at high risk of losing their income or jobs.[25]

Inequalities can stifle economic growth, resulting in suffering for an entire society. Empirical analysis by the OECD indicates that increases in income inequality in 19 OECD countries between 1985 and 2005 led to a nearly 5-percentage-point loss in cumulative growth from 1990-2010 in these countries.[26] A 2018 World Bank study estimates that gender inequality in earnings could lead to losses in wealth estimated at US$160 trillion worldwide, or twice the value of global GDP.[27] A report released by AARP in 2021 with analysis conducted by Economist Impact reveals that racial disparities in life expectancy could cost the U.S. economy US$1.6 trillion and over 10 million jobs in 2030 alone.[28]

D. Provoking action and amplifying solutions will lead to less aging inequity

Considering the urgent need to tackle aging inequity in LMICs and the wide knowledge gap that exists, the Aging Readiness and Competitiveness (ARC) initiative has developed its fourth iteration (ARC 4.0) in order to contribute to a better understanding of this important issue, draw greater attention to the experiences of older adults, and provoke discussion and, most importantly, collective action.

First launched in 2017, the ARC initiative seeks to provoke new thinking about the role of older adults in communities and economies, and prompt innovative stakeholder action to enable more active, engaged, and productive older populations. The third and most recent iteration of the initiative, ARC 3.0, expanded upon existing knowledge and insights by highlighting best practices and programs driving improved healthcare and wellness,[24] which are essential to an individual's experience of older age.

However, health outcomes and socio-economic status–including education, employment, and income–are inextricably intertwined through an individual's life course, and disadvantages and disparities in these areas often reinforce each other. ARC 4.0, therefore, focuses on aging inequity in LMICs and how inequalities accumulate across the life course based on gender, race and ethnicity, places of residence (urban and rural), and other social and economic factors. It also highlights solutions and leading practices to combat aging inequity in LMICs (including 14 select innovative solutions profiled in the Appendix).

The research approach included an extensive literature review, interviews with subject-matter experts and older adults, data analysis, and case studies. To better understand the factors that enable and combat aging inequity, we explored 10 rapidly aging LMICs: Bolivia, Colombia, Ethiopia, Ghana, India, Jamaica, Malawi, Nigeria, Thailand, and Vietnam. Countries were selected to represent different regions, stages of development, population composition and aging experiences, as well as those that have not been featured in previous iterations of the ARC. For each country, we evaluated its ecosystem for achieving equitable healthy aging and summarized the analysis in a one-pager infographic, which will be published separately.

While ARC 4.0 focuses on LMICs, it serves as a valuable resource for stakeholders in HICs. HICs share many of the same inequity issues as LMICs, although to a lesser extent overall. As such, they can also benefit from the solutions and leading practices apparent in LMICs, with some adaption and culturally sensitive policymaking.

This ARC 4.0 report concludes with a set of recommended actions that stakeholders from both LMICs and HICs can take to address aging inequity in the coming decades. With time, this research effort will help fill knowledge gaps and promote solutions and good practices to achieve equitable healthy aging around the world.

* Oxfam explained its use of the term "Latinx" in the cited report: "The term 'Hispanic'… has historically centered Spanish colonization and whiteness, and is widely perceived as erasing the indigenous and African heritage of the geographical lands of Latin America. Instead, Oxfam uses the gender non-binary identifier 'Latinx' which attempts to create an inclusive collective identity, while also interrogating the ways people are historically positioned."

II. The state of play: aging inequities in LMICs

Inequity exists at the intersection of demographic factors, such as age, gender, race and ethnicity, and socio-economic status, which is influenced by education, employment, and income. These factors intertwine and interact with each other, and with an individual's state of health, collectively compounding the disadvantages and disparities experienced throughout a person's lifespan.

Aging inequity is often more severe in LMICs than in HICs. For example, gender-based disparities in education, labor force participation, and pension coverage overall are larger in LMICs. Moreover, while rural-urban gaps in access to social protection and healthcare are a common challenge in both HICs and LMICs, their impact on older adults in LMICs is compounded by the under-development of social protection systems.

Innovative and pioneering programs have emerged in LMICs to provide support and empower disadvantaged* older adults, such as elderly women in rural areas. Some programs also target marginalized communities, such as indigenous groups. However, a lack of aging-related data is hindering more widespread effective action.

A. Gender disparities prevent equitable healthy aging

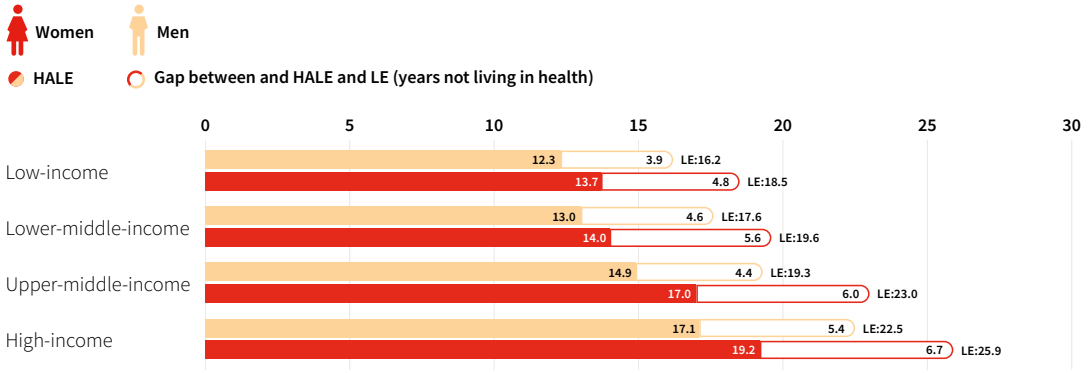
Gender influences all aspects of the aging process, leading to the disparities experienced by older women and men. As Professor Sarah Harper, Director and Clore Professor of Gerontology at the University of Oxford, asserts, "Gender is without any doubt one of the most important variable impacting inequity in aging."[29] While gender inequities have been a common challenge across countries, wider gender gaps in access to educational and employment opportunities as well as social protection in LMICs mean that women there face a greater risk of inequity throughout their life course.

Gender inequity in older age

Women tend to live longer than men (also known as the "feminization of aging") and in more years of poor health (Figure 2), yet they are more likely to face a lack of access to social and healthcare support in older age. Non-communicable diseases, already an enormous and rapidly increasing structural burden in LMICs, hit older women harder due to the cumulative impact of pregnancy and childbirth.[30] Because women tend to live longer than men, older women frequently do not have partners to help care for them.

Figure 2. Across countries of different income levels, women live longer than men but in more years of poor health in later life.

Healthy life expectancy (HALE) and life expectancy (LE) at age 60 (years), women versus men, by country income level, 2019



Sources: World Health Organization Global Health Observatory, Economist Impact.
Note: LE at age 60 is the average number of years that a person of 60 years old can expect to live. HALE at age 60 is the average number of years that a person at age 60 can expect to live in full health.

* The terms of "disadvantaged groups", "marginalized groups", and "vulnerable groups" are used interchangeably in this report, following the World Health Organization's definition (see **Key definitions**). We recognize that terminology continues to evolve; however, there is not universal agreement on terminology. Thus we chose to utilize these terms as defined above because they are widely recognized and currently utilized by the WHO. In addition, while these terms can be viewed as reinforcing hierarchies among different groups of people that can perpetuate inequities, that is not our intent in this report.

Moreover, their lower levels of labor force participation and structurally enforced unpaid domestic and caregiving responsibilities tend to limit the accumulation of wealth over their lives. As a result, they are more likely to be at risk of poverty in older age.[31]

Existing literature on the 10 deep-dive countries covered in this report, combined with expert interviews, reveal some of the significant disparities that women face in LMICs. For example, in Malawi, 34% of women over 60 years of age are married, compared with 85% of men, meaning that many fewer women have the material, social, or emotional support as well as personal care that a spouse can provide.[32] In Vietnam, where the gap between the lifespan of women and men (i.e., a differential of over 5 years in life expectancy at birth, with 22.0 years for women and 16.9 years for men) is among the largest in the Association of Southeast Asian Nations (ASEAN), older women are more financially dependent, have lower literacy and education levels, and suffer a greater incidence of morbidity and disability than older men.[33]

Inequalities accumulate over the life course

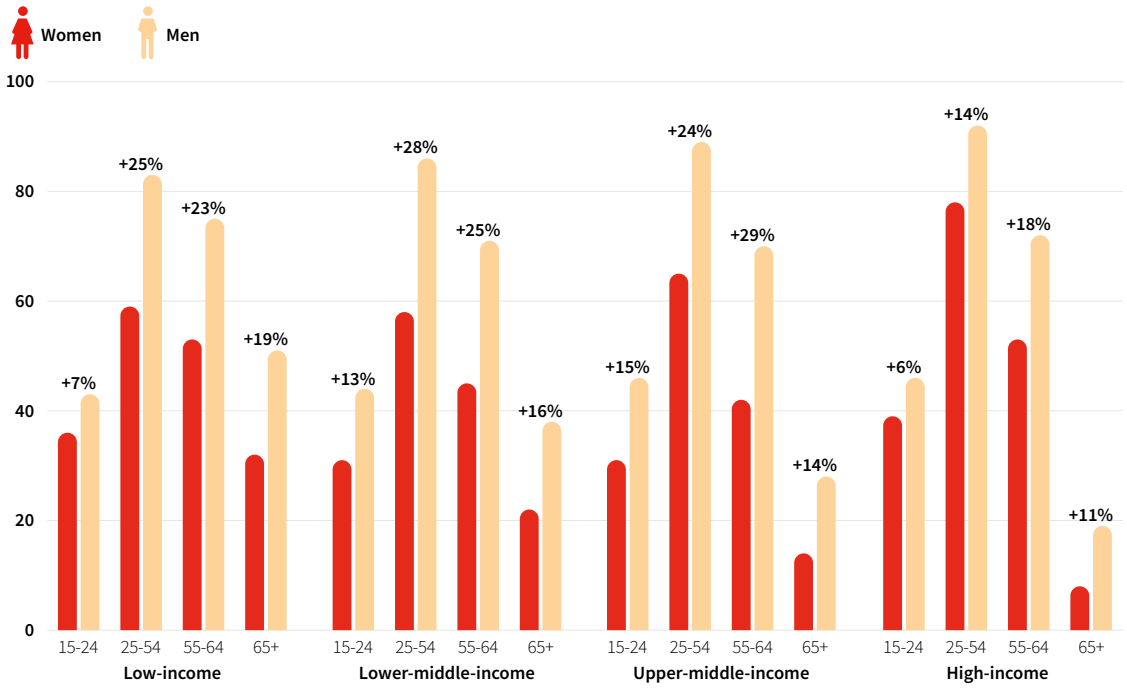
The inequity experienced by women can be tracked through their socio-economic position across their lives–particularly when it relates to their education and employment. This in turn affects their financial security in older age. This inequity is further compounded by gender-based discrimination.

- **Educational opportunities:** While women have made significant strides around the world in education, as of 2020 they still lag behind men in indicators such as overall literacy rates–54% versus 69% in low-income countries (LICs), and 70% versus 83% in lower-middle-income countries. Only in upper-middle-income countries do they achieve near parity.[34] Restricted access to education early in life prevents equal access to the public sphere and its opportunities, along with society's resources–such as obtaining employment or using financial or legal resources that require a certain level of knowledge to navigate.[35]

As of 2020, women still lag behind men in indicators such as overall literacy rates—54% versus 69% in low-income countries, and 70% versus 83% in lower-middle-income countries. Only in upper-middle-income countries do they achieve near parity.

Figure 3. Gender disparities in labor force participation exist across age groups and across countries of different income levels.

Labor force participation rate (% of population), by gender, age group and country income level



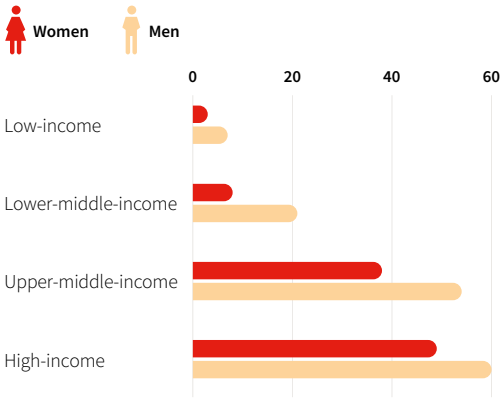
Sources: International Labour Organization, Economist Impact calculation based on latest available data.

- **Employment:** Gender disparities in labor force participation are larger in LMICs than in HICs (Figure 3), and women there tend to face a greater barrier to earnings than those in HICs. Women's lower level of labor force participation is due in part to their role as primary caretakers for children and sick or older family members. They also are more frequently responsible for unpaid domestic work, which has limited avenues for transition to the paid workforce. For example, a 2019 study based on national household surveys from 61 LMICs shows that women are responsible for water collection in 74% of households.[36] In LMICs where the informal economy accounts for 70% of employment (see Section III-A), women—particularly in low- and lower-middle-income countries—often operate at the margins of informal jobs and struggle to be compensated financially for their labor. The proportion of women in informal employment who are contributing family workers[37] (generally unpaid) is more than threefold that of men.[38]
- **Income/financial security:** Lower education and employment levels inhibit women's ability to generate income and accumulate wealth over their lives, as well as to access social protection, hence threatening their financial security in older age.[39] Women are also less likely than men to contribute to a pension plan and are, therefore, less likely to receive one. While this gender gap in pension coverage exists across countries regardless of economic development status, it tends to be more pronounced in those with lower income levels (Figure 4). Additionally, contributory pension plans designed to ensure financial security in older age can exacerbate inequities experienced by older women if they do not credit pension accounts during maternity leave or if they have lower statutory retirement ages than men.[40]
- **Cultural sexism:** Sexism is defined as prejudice, stereotypes, or discrimination based on gender, most commonly toward women.[41] This gender-based discrimination accumulates exponentially and systemically throughout individuals' lives. In many LMICs, women are forced to depend on men for resources and property, raising the risk of dependency, isolation, poverty, and neglect.[42] This particularly affects unmarried older women and widows, who may lack other forms of support if their male partner is deceased.[43] When women are able to enter the workforce, they face barriers around physical safety as well as culturally mandated restrictions that limit their access to public spaces.[44]

Despite the impact of gender on inequity among older adults, efforts to measure and address the simultaneous impacts of old age and gender fall short so far.[45] Little attention has been given to quantifying the differences between women's and men's experiences with aging, and gender remains a traditional binary construct of male/female when this analysis is attempted, offering yet another avenue for future research to include other narratives, such as those from nonbinary and transgender older persons.[46] [47]

Figure 4. Substantial gender gaps exist in the coverage of pension schemes, and middle-income countries (MICs) overall see the most pronounced disparity.

Proportion of working-age population (15+ years) covered by pension schemes, by gender and country income level, 2020



Sources: International Labour Organization, Economist Impact.

Solutions spotlight: supporting women in older age and over life courses

Governments in some LMICs have focused on alleviating the impact of gender inequity by providing direct support to marginalized older women. In other cases, innovative programs are working to empower women not only in older age, but also among younger generations to reduce gender inequalities.

In **Bangladesh,** the government, with financial and technical support from the World Bank, launched two complementary programs focusing on low-income and vulnerable women through unconditional cash transfers: the **Old-Age Allowance Program (OAA)** and the **Widow, Deserted, and Destitute Women Allowance Program (WA)** (Appendix-A1). OAA focuses on older adults (including both men and women) with an annual income below TK10,000 (US$120), and WA targets women with an annual income below TK12,000 (US$145) while prioritizing older persons. Both programs improve women's wellbeing and social standing, especially for those engaged in the informal economy or without the means of production (e.g., land) in rural regions. From the program's inception in 1998 to 2019, the number of OAA beneficiaries increased by almost ninefold, reaching 4 million people. Over the same period, the number of women benefiting from WA tripled to 1.4 million, many of whom were more than 40 years old and illiterate.[48]

In **Mexico, Someone Somewhere,** a social enterprise established in 2012, partners with indigenous artisans—mostly older women in rural areas—to sell products produced using traditional methods, which are marketed to younger consumers domestically and in the U.S. (Appendix-B1).[49] By integrating traditional work into innovative and profitable products, Someone Somewhere helps indigenous artisans to engage in constant income-generating activities that reduce poverty while preserving traditional knowledge. In 2021, Someone Somewhere worked with 273 artisans, 48% more than in the previous year. Three-quarters of the artisans are women, and many are from poor states as well as indigenous ethnic groups.[50]

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>
> **Fátima Álvarez**
>
> Co-founder and CIO, Someone Somewhere

Fátima Álvarez, Co-founder and CIO of Someone Somewhere, asserts that it is important for the private sector to leverage their business resources to support marginalized communities: "Whether or not an organization is a social enterprise, it should look to involve vulnerable and marginalized communities in its value chain."[51]

The **Mission Shakti in Odisha, India** (Appendix-B2) is focused on improving women's access to economic opportunity over their life course. In India, the informal economy accounts for 88% of total employment; the percentage is even higher among women, at 90%.[52] Mission Shakti, a State Government of Odisha program, works with about 600,000 community self-help groups, including 7 million women, to develop income-generating activities (such as farming and helping women sell products outside of their local markets). They also provide financial services and help build professional skills.

Currently, almost all the women who are members of Mission Shakti have access to a bank account at their nearest bank branch. Over the next few years, Mission Shakti aims to improve the financial health outcomes of women with low incomes in rural areas and to build women-led micro-enterprises in Odisha.[53]

B. The rural-urban divide bifurcates the aging experience

While urbanization is occurring rapidly around the world, most people will remain in rural areas in the coming decades. By 2050, over 3 billion people will reside in rural areas, of which 95% will live in LMICs. In LICs, half of the population will still live in rural areas, and the percentage for lower-middle-income countries will be 41. By contrast, the percentages for upper-middle-income countries and HICs will be 17 and 12 respectively.[54]

People living in rural areas in both HICs and LMICs are more likely to struggle to obtain access to essential resources than urban dwellers. Globally, 83% of the population living in rural areas has access to electricity, 44% can use safely managed sanitation services, and 49% have access to clean fuels and technologies for cooking. By contrast, the percentages for urban areas are much higher, at 97, 62, and 87 respectively.[55] This lack of access has a negative impact on rural dwellers' health outcomes and is a major contributor to inequity. "Very often the people who don't have access to services are the ones who will have chronic conditions," says Dr. Jeremy Veillard, Senior Health Specialist in the Latin America and Caribbean Region of the Health, Nutrition, and Population Global Practice, World Bank.[56]

The geographic inequity among older adults is compounded by rural dwellers' disadvantages in accessing social protection and healthcare, formal employment, and educational opportunities, all of which tend to be more severe in LMICs than in HICs. An interview with Chandra Devi Kafle, a 79-year-old from Kathmandu, Nepal, sheds some light on the lived experiences of rural older adults (see Profile 1).

Profile 1: Chandra Devi Kafle, 79, Kathmandu, Nepal

Chandra Devi Kafle faced hard times earlier in life, especially as a girl in her rural community. "Inequality started when I was child. Due to the social taboo on girls' education, my parents did not allow me to enroll in school. Then, my father arranged my marriage when I was just 13 years old." After her husband died, she moved to the community where she lives now, and Chandra struggled to raise four small children while digging roads for a living.

Reflecting on her past, she says, "I have seen both good and bad times here. So, I am emotionally attached to this place. I love the environment: the field with seasonal crops and the green forest behind my house." Now, her children are grown and able to provide for her. Her children "never miss a chance" to make her happy, she says, and she enjoys living with them and in her community.

Despite her satisfaction with life, Chandra points out the inequity experienced by rural older adults throughout their life course, and their resiliency in facing these difficulties: "They have many fewer opportunities for earning, getting an education, and learning other skills at a young age. So, they are compelled to suffer from poverty and health problems in their old age." Older adults from lower castes, or those who are not from the community, face additional difficulties when it comes to equal treatment.

Facing these challenges, Chandra believes there are solutions. The government's old-age allowance is a "great support for poor older people," she says. Non-governmental organizations have helped her, too, providing a basic literacy class as well as a range of other services. The literacy class, provided by Ageing Nepal, in particular has given her the confidence to write her name, rather than signing with her thumb print, and has provided her with the skills to use a mobile phone so that she can stay connected with her relatives. In addition, Chandra feels that awareness of aging inequity and actions to tackle it will help to improve older adults' health and livelihoods.

Unequal access to social protection and healthcare

Access to social protection systems—ranging from child and family benefits to unemployment support to pensions to healthcare—is essential to older adults' wellness and quality of life. However, a large geographic divide exists in these domains that prevents equity among older adults.

By 2050, over 3 billion of the world's population will reside in rural areas, of which 95% will live in LMICs. Globally, 56% of rural populations lack access to healthcare services, more than double the proportion of urban populations.

Like the gender divide, the rural-urban gap is a common challenge for most HICs and LMICs, but its impact on older adults in LMICs is compounded by the under-development of social protection systems—manifested in, for example, much lower population coverage compared with HICs (see Section III-B).

In its 2021 World Social Report, the UN Department of Economic and Social Affairs (UNDESA) called for heightened awareness of the geographic inequity in access to social protection, calling for policies explicitly targeting older adults in rural areas. UNDESA noted that in many countries social protection systems such as old-age pensions and social security simply did not penetrate rural areas. This left older adults dependent on informal networks of care such as those provided by their children.[57]

Lack of local resources, along with poor transportation infrastructure, prevents rural dwellers, and particularly older adults, from accessing essential healthcare services. Globally, 56% of rural populations lack access to healthcare services, more than double the proportion of urban populations.[58]

> [In the Caribbean,] access to healthcare clinics for many older adults, especially those in rural areas, is limited due to transportation and mobility barriers."
>
> **Dr. David Walcott**
>
> Founder and Managing Partner, Novamed

Where limited country-level data are available, the divide is still present. For example, in Ghana, rural areas make up 45% of the population, but only 26% of the health workforce is present. In Thailand, while half of the population resides in rural areas, only 38% of the health workforce is present there.[59]

Because of resource inadequacy, people in rural areas need to travel to access health services that do not exist locally, but a general lack of transport infrastructure, in tandem with long distances, creates additional barriers.[60] For example, in the Caribbean, "access to healthcare clinics for many older adults, especially those in rural areas, is limited due to transportation and mobility barriers," says Dr. David Walcott, Founder and Managing Partner of Novamed, a healthcare innovation business.[61]

Divide in informal employment

People working in informal employment (see **Key definitions**) do not have secure employment contracts, workers' benefits, and social protection (see Section II-B).[62] Globally, rural dwellers are nearly twice as likely to engage in informal employment as urban dwellers, a result of the dominance of agriculture in rural economies. This contributes to disparities in access to social protection between rural and urban older dwellers.

The gap between rural and urban informal employment is larger in LMICs than in HICs: 84% of rural workers and 53% of urban workers in LMICs are in informal employment, while the proportions in HICs are 22% and 17 % respectively.

The gap between rural and urban informal employment is larger in LMICs than in HICs: 84% of rural workers and 53% of urban workers in LMICs are in informal employment, while the proportions in HICs are 22% and 17 % respectively.

The dominance of informal employment in rural areas can also contribute to less income security for older rural dwellers. As Thuy Bich Tran, the Vietnam Country Director of HelpAge International, points out, older adults living in rural areas are mostly confined to informal agricultural work, in contrast to the more diverse opportunities in urban areas.[65] In addition, incomes associated with work on the land are more vulnerable to weather and environmental conditions. For example, farming communities in Ghana depend on rain for their livelihoods and are particularly at risk owing to the effects of climate change.[66]

However, income security for rural and urban older adults is not always a clear-cut picture. For example, Ms. Tran says that older adults with lower incomes may still be better off in rural areas, because they often own land and can subsist in better living conditions than poor older adults in urban areas, who cannot obtain resources such as food from their own land and have to buy basic necessities on very limited incomes.[67]

Unequal access to educational opportunity

In many LMICs, educational opportunity is less accessible in rural areas than in urban areas due in part to under-resourced and underdeveloped education systems (see Section III-B). The unequal access to early life education, as well as life-learning opportunities, has a substantial impact on individuals' socio-economic status over their life course, shaping their experience in older age.

The geographic divide is demonstrated in the wide gap in upper secondary education completion. The UN's 2030 SDGs set the target of achieving universal completion of upper secondary education. However, in LICs, children living in urban areas are nearly five times as likely as those in rural areas to complete upper secondary education. This contrasts with 2.2 times in lower-middle-income countries, just 1.4 times in upper-middle-income countries, and near parity in HICs.[68] Among the 10 deep-dive countries, Ethiopia and Malawi see the largest rural-urban divide: children living in urban areas in these countries are 7.7 times and 3.6 times as likely, respectively, as those in rural areas to complete upper secondary education.[69]

Solutions spotlight: expanding healthcare access in rural areas

Considering the barriers rural populations face when accessing healthcare, governments in some LMICs—at national and local levels—have taken action to increase the provision of high-quality healthcare services in rural areas, yielding early success in improving health outcomes of local populations including older adults.

The National Health Extension Program (HEP) in Ethiopia, part of the country's National Comprehensive Primary Health Plan, aims to mitigate health inequities by dispatching trained government staff, known as Health Extension Workers (HEWs), to community posts to deliver essential health services and education to rural villages throughout the country (Appendix-C1). By conducting home visits and outreach and promoting hygiene and sanitation, the HEP, as a life-course intervention, has improved maternal and child health, health knowledge, and community hygiene in rural villages. In addition, it creates civil service training and employment opportunities, as the program deploys more than 42,000 salaried female HEWs around the country.[70]

The Comprehensive Care Model for Rural Health in Sumapaz, Colombia, is another program that has improved access to high-quality healthcare for people in traditional agricultural communities (Appendix-C2). The population of the Sumapaz region, located in the rural and largely agricultural area of Bogotá, has long grappled with high rates of disease and poor nutrition, compounded by the lack of access to high-quality healthcare. Since 2001, primarily funded by the district government of Bogotá and managed by Subred-Sur, a local health institution, the model has established 10 community networks to target the health needs of different demographics in the region, including older adults, women, and people with disabilities. It uses bi-directional education to learn about local communities' cultures, traditional medical preferences, and healthcare needs before providing residents with basic health services through home visits. In operation for more than 20 years, it has achieved universal health coverage in the Sumapaz locality, and maternal, perinatal, and infant mortality rates have stabilized to zero.[71]

C. Race and ethnicity driving inequity

Unlike in HICs such as the U.S., disaggregated data by age, race, and ethnicity are lacking in most LMICs, and a persistent research gap exists in understanding the impacts of race, ethnicity, and caste on health and the aging experience.[72] [73] [74] However, available evidence indicates clear disparities, and is critical to understanding the inequities experienced by older adults.

For example, a 2021 report by the UN Development Programme and the Oxford Poverty and Human Development Initiative shows stark inequalities among ethnic groups in 41 countries.[75] According to that report, indigenous communities in Bolivia account for about 44% of the population but represent 75% of those who are the most susceptible to certain disadvantages, including poor health, insufficient education, and a low standard of living. A similar situation is found in other deep-dive countries. In Vietnam, ethnic minorities account for only one-sixth of the population but nearly half of those experiencing the disadvantages covered in that report. In India, five out of six people who experience disadvantages are from lower tribes or castes, the more common social dividers in that country.[76]

In Bolivia, indigenous communities account for about 44% of the population but represent 75% of those who are the most susceptible to certain disadvantages, including poor health, insufficient education, and a low standard of living. In India, five out of six people who experience disadvantages are from lower tribes or castes.

The limited existing literature that examines racial and ethnic disparities among older adults reveals how these aspects can affect lived experience. For example, one study in Colombia found that people over age 60 who were dark-skinned and perceived themselves as Black or Afro were the most socially and economically vulnerable.[77] Another study found that health literacy and health-seeking behavior in Bangladesh is poor among indigenous older adults generally, and health and social services are dramatically less available to them.[78]

Expert interviews conducted for this report shed further light on how the racial and ethnic disparities experienced over life courses can lead to inequity in older age. For example, in India, the caste system prevents some people from accessing public-sector jobs or other employment with an associated pension scheme.[79] Race and ethnic origin is also an important factor in the kind of employment opportunities available to people in some countries in the Andean region of South America.[80]

Solutions spotlight: empowering indigenous communities

Indigenous people are among the most marginalized populations globally. Innovative programs led by both public and private sector actors have empowered these communities to reduce inequities. For example, **Someone Somewhere in Mexico** creates income-generating opportunities for indigenous artisans, helping to improve local livelihoods.

While Someone Somewhere focuses on economic empowerment, some governments are working to empower local health workers through professional training to improve healthcare access and quality in indigenous communities. In **Brazil**, since 2009 the government's public health institution Firocruz and the non-governmental Federation of Rio Negro Indigenous Community Organizations have jointly implemented **the Indigenous Community Health Agent Professionalization Programme** (Appendix-C3). The program provides training to community health workers using a comprehensive approach that incorporates cultural values and indigenous people's voices.

The program was the first to blend a biomedical approach to health and disease with traditional indigenous medical practices. To help community health workers access biomedical training, it also provides high-school education. Six years after the program's launch, secondary school education attainment quadrupled to more than 80% among community health workers, and program participants reported increased confidence in their work. Because indigenous communities are often severely marginalized, equipping local health workers with formalized and contextualized skills helps to ensure that the healthcare services they deliver to these remote communities are culturally appropriate and high quality.[81]

D. Insufficient data hamper solutions

The evidence cited in this report notwithstanding, aging-related data are lacking across countries around the world. In particular, while demographics and socio-economic status have significant impacts on aging inequity, data disaggregated by these factors are scarce. According to the World Health Organization (WHO) *Decade of Healthy Aging Baseline Report 2020*, only 32% of countries have nationally representative, cross-sectional data (i.e., covering health, economic status, and family and social relations) on older populations available in the public domain. In addition, while longitudinal data enable the changes associated with aging and the impact of aging-related policy reform to both be examined, only 24% of countries have nationally representative, longitudinal data on the health status and needs of older populations.[82] The lack of data is a challenge shared by HICs and LMICs, but it can be greater in LMICs as a result of governments' failure to recognize the importance of preparing for an aging society and, in turn, the need to invest in data.

Globally, only 32% of countries have nationally representative, cross-sectional data on older populations available in the public domain; only 24% have nationally representative, longitudinal data on the health status and needs of older populations.

Insufficient data make it difficult to understand the heterogeneous and complex experiences of older adults, and they further hide marginalized populations within the aging cohort. In turn, this restricts the ability of policymakers and decision-makers to evaluate and respond to older adults' needs and ensure more equitable healthy aging. As Biju Mathew, Director and State Head (Kerala) of HelpAge India, says of that country, "The data gap makes specific policies targeting older adults difficult to formulate and implement effectively. Policies and systems are slowly getting placed; but the government mechanism doesn't yet have the technical knowledge it needs to effectively serve older adults."[83] Another example is Thailand, where the many different agencies looking after older adults collect data separately and manually, and there is no centralized system to compile databases to provide local government agencies with the information needed to help older adults.[84]

The effort to expand aging studies is hindered by both the prohibitively expensive costs of large-scale surveys and the underdeveloped national statistical systems in many LMICs. According to the World Bank's *World Development Report 2021*, half of LICs have not undertaken a population and housing census in the last 10 years. Civil registration and vital statistical systems (e.g., on births and deaths) don't cover the entire population in any LICs, and the coverage percentage is 22% in lower-middle-income countries and 51% in upper-middle-income countries, contrasting with 95% in HICs.[85] Furthermore, the specific cultural arrangements of LMICs can also complicate data measurement, as people tend to live in intergenerational households, and it can be hard to disaggregate the financial situation of individual older adults because they share finances with their households.[86]

Solutions spotlight: collecting aging-related data

HICs have been in the lead when it comes to building robust longitudinal databases on aging. Pioneering initiatives include the University of Michigan Health and Retirement Study (HRS) in the U.S. (since 1992), the English Longitudinal Study of Ageing (ELSA) in the U.K. (since 2001), and the Survey of Health, Ageing and Retirement in Europe (SHARE) (since 2004).[87, 88, 89] These studies target the population aged 50 and over and collect data on a wide range of health and socio-economic factors to enable a better understanding of the dynamics among these factors and the associated effects over people's life courses.

Recognizing that the lack of data hinders effective policymaking to achieve equitable healthy aging, some LMICs have stepped up efforts to collect data on older populations, while often referring to existing studies in HICs and learning from their experiences.

Sponsored by the national government, **the China Health and Retirement Longitudinal Study (CHARLS)** fielded its baseline national wave in 2011, covering about 10,000 households and 17,500 residents aged 45 and over across the country. The study aims to build a nationally representative database on factors ranging from demographics and health status to work, income and wealth assets, to enable scientific research on the older population. CHARLS designed the surveys based on those used in the HRS, the ELSA, and the SHARE. Since 2011, follow-up surveys have been conducted every two to three years, and all the data are made publicly accessible.[90]

Another pioneering example is **the Health and Aging Study in Africa: A Longitudinal Study of an INDEPTH Community in South Africa (HAALSI)**, which collects data from individuals aged 40 and over in the region of Agincourt. Launched in 2014, the study aims to explore the interrelationships between physical and cognitive functioning, HIV infection, lifestyle risk factors, and household income and expenditure, among other health and socio-economic factors. HAALSI is led by an interdisciplinary team consisting of experts from local and regional academic institutions as well as Harvard University in the U.S. While referring to the HRS and sister studies in the U.K., Europe, China, and other countries, the study has been adapted to capture characteristics specific to the aging process in rural South Africa.[91]

More recently, India has also increased its investment in mapping the situation of older adults. The national government sponsored the first **Longitudinal Ageing Study in India in 2017-19**, a full-scale national survey of the health, economic and social determinants, and consequences of population aging; it plans to repeat the study every three years.[92, 93] A major contribution of the study is disaggregated data by gender, age (e.g., 60 years and older versus below 60) and other variables (e.g., place of residence, marital status, living arrangement, religion, and caste). The survey was conducted in every state and union territory in India, generating subnational data that will facilitate monitoring and evaluation of the government's aging-related policies and programs.

Given the challenges in large-scale data collection, qualitative research may provide an alternative option to generate useful knowledge about older adults in LMICs, though it is a complement and not a substitute for quantitative data. It has the added advantage of telling accurate stories of marginalized populations and identifying their specific needs.[94] One study from 2021 on the invisibility of older women's work in Malawi and Ethiopia demonstrates how to conduct meaningful qualitative research: in order to understand women's experiences, the research team held multiple in-depth discussions with individuals, along with focus-group discussions.[95]

III. Challenges in tackling aging inequity in LMICs

LMICs face a variety of economic, policy, and social challenges in tackling aging inequity, including large informal economies, underdeveloped and often under-resourced public institutions, and strains on informal, familial networks of care. These challenges are not unique to LMICs but tend to be more pronounced. For example, 89% of working older adults in LMICs are in informal employment, more than double the proportion in HICs.[96] Meanwhile, 87% of the working-age population in LICs and 75% in lower-middle-income countries are not covered by any social protection benefit—over five times the percentage in HICs, at 15%.[97] Solutions and innovative practices for solving these challenges include strengthening social protection systems and providing direct support to the most marginalized, along with empowering disadvantaged groups when they are younger to prevent entrenchment of inequities.

A. Large informal economies inhibit equitable aging

LMICs are generally characterized by large informal economies, where people are employed in jobs without access to adequate income and employment benefits. The high levels of informal employment, coupled with deficits in public institutions, contribute to income and wealth disparities as well as unequal access to social protection throughout a person's lifespan, culminating in inequity in older age.[98]

"The most important [variable driving inequity] is type of employment rather than employment itself," says Armando Barrientos, Emeritus Professor of Poverty and Social Justice at the Global Development Institute, University of Manchester. He emphasizes the precarity of informal employment "because [formal jobs can provide] an entry point into a pension plan."[99]

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>
> **Armando Barrientos**
>
> Emeritus Professor of Poverty and Social Justice, Global Development Institute at the University of Manchester

Globally, two billion workers—representing 61% of the world's employed population—are in informal employment; 93% of these are in LMICs.[100] Seventy percent of the working population in LMICs is employed informally, 3.8 times higher than in HICs (Figure 5-a).[101]

Informal work is often characterized by long working hours, absence of sick pay or health insurance, precarious wages, and a lack of social benefits.[102] In addition to having no access to the contributory pension plans associated with employment contracts, informal workers are often not considered "poor enough" to be eligible for some narrowly defined safety net benefits, leading to income insecurity.[103] Studies reveal that informal workers often live in poor communities, and poor people often face higher rates of informal employment.[104 105]

"A big issue [in many developing countries] is the informal sector, where people work long hours [for] many years, but they don't have social security benefits," says Dr. Susan Parker, Professor at the School of Public Policy, University of Maryland. "At the time of retirement, they're not covered by either a pension or health benefits. A big factor explaining why older adults tend to be poor in Mexico and across Latin America is that they don't have a stable pension income."[106]

When informal workers enter older age, they often must continue to work due to inadequate savings and lack of access to guaranteed income such as pensions. People aged 65 and over have the highest percentage of informal employment among all age groups: Worldwide, 78% of workers aged 65 and over are informally employed, and in LMICs this figure stands at 89%, more than double the percentage in HICs (Figure 5-b).

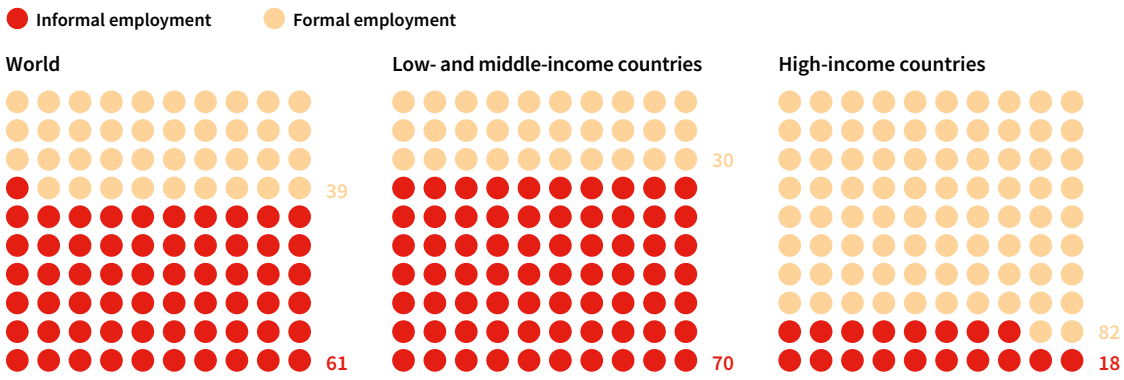
Worldwide, 78% of workers aged 65 and over are informally employed, and in LMICs this figure stands at 89%, more than double the percentage in HICs.

Among the nine deep-dive countries for which data are available, the share of workers aged 65 and over in informal employment ranges from 83% in Thailand to as high as 97% in India and Vietnam.[107] Inequities driven by informal employment accumulate throughout a person's lifespan and culminate in later life.

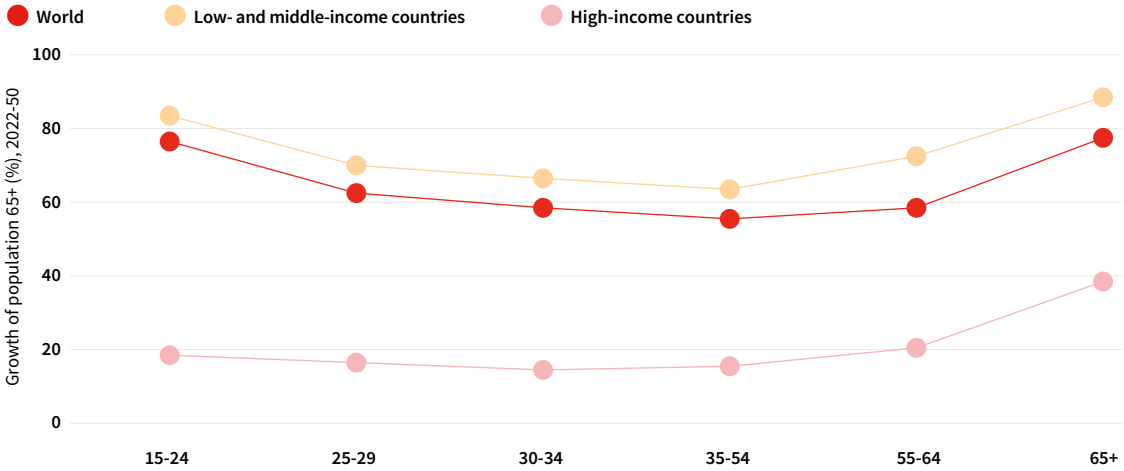
Many of the programs discussed in other sections address the inequities driven by the large informal economy in LMICs as well. **Someone Somewhere in Mexico** (see Section II-A) works to alleviate the poverty of older informal workers in indigenous communities, and **Mission Shakti** (see Section II-A) focuses on economically empowering younger generations, particularly women.

Figure 5. LMICs are generally characterized by large informal economies.

a) Informal versus formal employment (% of employed population aged 15 and over)



b) Informal employment by age group (% of employed population in each age group)



Sources: International Labour Organization, Economist Impact.

B. Underdeveloped public institutions fail to prevent inequity

The challenges

Public institutions can play a central role in preventing and eliminating social inequalities through social protection, public health, and education systems. However, in LMICs, these are often underdeveloped and under-resourced due to fiscal and capacity constraints of national governments and short-term austerity or fiscal consolidation reforms.[108] Henry Mbene, 64, from Abuja, Nigeria, Yola Sowan, 67, from Beirut, Lebanon, and Luisa Pelamo, 80, from Buenos Aires, Argentina, shared their experiences for this report (see Profiles 2-4).

Profile 2: Henry Mbene, 64, Abuja, Nigeria

Henry Mbene finds life for older people in his community difficult because of the lack of social protection and because of the challenges that older adults face in accessing healthcare and economic opportunities. He does not feel that the government offers much assistance: "The only support is my monthly pension," he says. As a result, Henry and his family have taken a more active role in ensuring his financial security; he does odd jobs to make money from time to time in addition to receiving family support.

Non-governmental organizations (NGOs) and faith-based organizations provide Henry with food, routine health checks, and health-related lectures. The assistance from these organizations has improved Henry's quality of life as well as providing "knowledge about the effects of aging, diet, and leading a healthy lifestyle," he says. NGOs and family members are the two go-to sources of support for older adults in his community. But Henry hopes this will change.

He is passionate about improving conditions for older people in Nigeria. He believes the best way to promote equity for and among older adults would be "the provision of a robust legal framework that addresses their welfare, dignity, rights, and inclusion." This has been an ongoing effort for him. As a younger person, he was involved in developing a framework to work toward understanding the plight of older people. Henry also sees an opportunity for the private sector to take a more active role in the lives of older adults by providing needed legal and other resources and amenities.

Social protection systems: Social protection systems are designed to protect vulnerable people and prevent poverty, inequality and social exclusion across lifespans.[109] They play a key role in improving people's living standards and ensuring economic security, especially for vulnerable groups in LMICs, who experience higher levels of income inequality than those in HICs.[110] Despite considerable progress (see Box 3), substantial gaps remain in the coverage and adequacy of social protection, particularly in low- and lower-middle-income countries, and informal workers are especially susceptible to social protection deficits.

- **Coverage:** As of 2020, only 13% of the population in LICs and 25% in lower-middle-income countries are covered by at least one social protection benefit (excluding healthcare and sickness benefits). This compares with 64% in upper-middle-income countries, and 85% in HICs. In addition, only 23% of people above retirement age in LICs and 39% in lower-middle-income countries receive a pension, while the percentage is over 90% in upper-middle-income countries and HICs (Figure 6).[111]
- **Adequacy:** The scope and level of available social benefits are often limited. As shown in Figure 6, only 8% and 15% of vulnerable persons in LICs and lower-middle-income countries, respectively, have access to social assistance cash benefits, and unemployment benefits are nearly non-existent.[112] Moreover, benefit levels are often inadequate. For example, the level of non-contributory pensions in old age—a means-tested payment to older adults who don't qualify for retirement pensions—in many LMICs is set below 50% of the value of the national poverty line.[113]

Profile 3: Yola Sowan, 67, Beirut, Lebanon

For 34 years, Yola Sowan taught Math and Science to fifth, sixth, and seventh graders. After retiring in 2013, she joined the University for Seniors, an educational, cultural, and advocacy program at the American University in Beirut (AUB), to keep active.

Yola has fond memories of how Beirut used to be when she was younger, especially before more recent economic and political crises, and she feels that the interaction between community members isn't as strong as it once was. This has made it more difficult for older adults, and people in general. Yola still has her community of family and friends, for which she is grateful.

The economic crisis in Lebanon, which escalated in 2019, has seen the country's GDP plummet by more than half and the Lebanese pound's value drop by about 95%. This has driven many Lebanese into poverty, and Yola's finances and living environment were negatively affected. As she puts it, "The situation in the country has deteriorated." Case in point: There is no electricity much of the time. She feels that the current situation has been particularly difficult for people with fewer means. Wealthier people were able to move their money outside of the country before the currency deteriorated, or they have migrated to places like the U.S., Canada, and Australia. Many older people's grown children have moved elsewhere, leaving them on their own, and the majority cannot afford to visit their loved ones.

While Yola is aware of a national strategy for older adults, meant to promote their rights and welfare, she wishes for additional financial support from the government to help older people gain their independence. Most of all, she would like the government to promote healthy aging, by offering health insurance and prescription medication. Instead, she has to obtain her mother's high-blood pressure medication from friends who live abroad.

Yola believes advocacy can help raise awareness of the challenges that older people face in her country. Through her engagement in AUB's University for Seniors, she has led peers to reach out to the authorities regarding the rights of older adults for social protection and a social pension. This program also provides a good opportunity for her to build community and engage with younger people.

Profile 4: Luisa Pelamo, 80, Buenos Aires, Argentina

Luisa Pelamo used to own a clothing business with her husband, but she made the decision to close the shop after he passed away. Luisa is excited that older adults today can stay active, take courses, participate in workshops, and contribute to society. Luisa and her late husband would frequently volunteer at a nursing home for older adults, as well as for other organizations. "I view my life as that of a young person with the wisdom of an adult and the dreams of a child," she says.

Today, Luisa spends her free time volunteering with AMIA, a Jewish community center. She feels grateful for her involvement, which helps keep her active and provided her with a community at the height of the COVID-19 pandemic. A group of older people met every Sunday to talk about literature, their heritage and personal stories. They continue to meet even now that life has opened back up following pandemic restrictions.

Still, Luisa sees other older people struggle. Some are not as active as she is and lack friends and companions. She also feels that many older people are not treated fairly, particularly women. In addition, many older people are poor, due to the small pensions and lack of employment opportunities, which also keeps many "cloistered in their houses." This is even more of an issue for older people with pre-existing health conditions or for those who find it difficult to afford prescription drugs.

Luisa recognizes that the state has tried to provide aid for older people, including by opening gyms and organizing entertainment events. However, she believes that the government should do more, such as improving the quality of healthcare.

Public health systems: Access to affordable, quality healthcare is an integral component of social protection systems. Yet many LMICs face challenges related to population coverage, accessibility and availability of services (including for older adults), and financial protection, which collectively constrain the ability of residents to achieve equitable healthy aging. Social health schemes include national health insurance, subsidized health coverage for the poor, and national healthcare services guaranteed without user fees.

- **Coverage:** Some LMICs have made remarkable progress on extending social health protection by establishing entitlements to healthcare for the entire population within national legal frameworks (Box 4). However, coverage remains limited overall in low-income and lower-middle-income countries. As shown in Figure 7-a, only 17% of the population in low-income and 34% in lower-middle-income countries are covered by a social health scheme.[114] A major driver of this gap is high levels of informal employment, alongside lack of awareness of rights and entitlements, and exclusion of self-employed and domestic workers in mandatory schemes.[115]

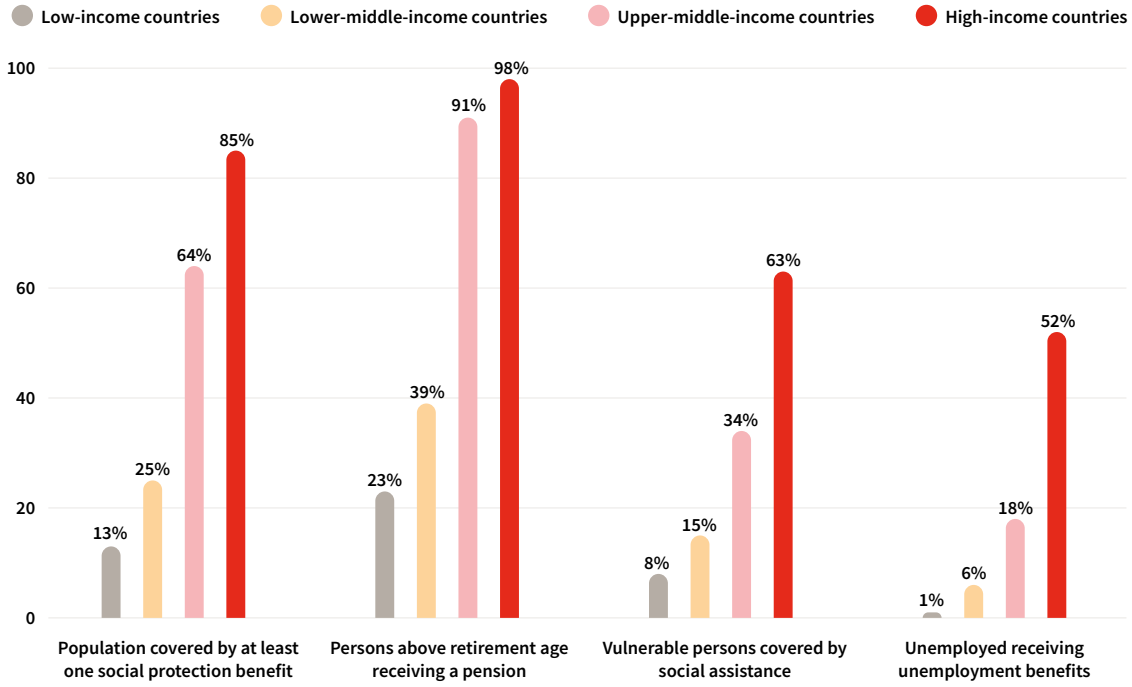
Box 3: Expansions in pension coverage

Many countries, including some low- and middle-income countries (LMICs), have made significant progress toward universal pension coverage. One LMIC example is Bolivia. Despite having the lowest GDP per capita in South America, it has one of the highest coverage rates for pensions in old age. Renta Dignidad, the country's non-contributory old-age pension, which provides recipients between US$40 and US$55 per month, covers nearly 100% of the population aged 60 and over. Since Renta Dignidad's inception in 2007, the household poverty rate has decreased by 14%.[120]

Several LMICs successfully expanded effective pension coverage between 2000 and 2019, including India (from 7% to 43%), Vietnam (from 16% to 41%), Colombia (from 14% to 51%), and Thailand (from 5% to 89%). These countries mainly achieved these expansions by establishing or extending non-contributory pension plans, or by extending contributory plans to uncovered populations in conjunction with measures such as further financing to emergency programs.[121]

Figure 6. Substantial gaps remain in the coverage and adequacy of social protection systems, particularly in LICs and lower-middle-income countries.

Proportion of population covered by social protection systems, by country income level, 2020



Sources: International Labour Organization, World Bank, World Health Organization, Economist Impact.

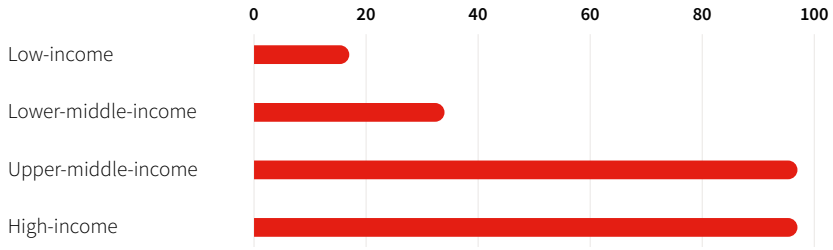
- **Accessibility:** A lack of physical and human resources limits equitable access to healthcare within LMICs. This challenge is particularly acute in Africa, where for every 10,000 people, there are only 8.8 hospital beds and 15.7 skilled health staff.[116] The resource deficit has contributed to the divide between urban and rural populations in terms of healthcare access (as discussed in Section II-B). In addition, complex administrative procedures and geographic distance can create barriers to registration, disproportionately affecting those in informal employment and those living in rural areas.[117]
- **Service availability for older adults:** Health systems are poorly equipped to meet the needs of older adults. Investment in the prevention and treatment of non-communicable diseases is lacking, and geriatric care has not been prioritized. As Ritu Sadana, Unit Head of Aging and Health at the WHO, and the lead author of the *WHO Decade of Healthy Aging Baseline Report 2020*, puts it, "Because of disease burden and lower life expectancy, the idea from the last century—that we only have to focus on maternal and child health—still drives the resource allocation in many countries, even where the proportion of older persons is [now] much greater. Instead, we need to invest in health and other systems to take a life-course approach covering all age groups."[118] In addition, the need for long-term care is projected to increase as the population ages, yet long-term care systems that provide and finance services for older adults and their families are generally nonexistent or only nascent in LMICs (see Appendix-C4 for the example of the Buurtzorg home care model in China).
- **Costs:** People in LMICs tend to bear a larger share of health expenditure than their counterparts in HICs. Out-of-pocket spending represents 43% of health expenditure in low-income and 48% in lower-middle-income countries, more than triple the percentage in HICs (Figure 7-b). The high share of health costs borne by households can be attributed to the low levels of cost coverage in social health schemes and the failure of these schemes to match benefit packages due to the rapid increase in services that are both provided and demanded.[119]

Box 4: Expansions in healthcare coverage

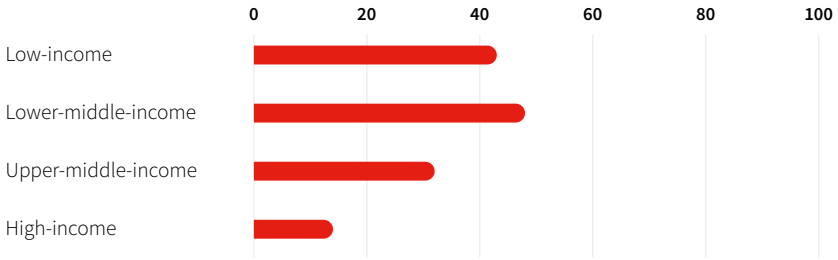
Extending healthcare coverage to all is achievable. Some low- and middle-income countries, including Colombia, Thailand and Vietnam, have demonstrated this, despite high levels of informal employment and limited incomes and institutional capacity. In Vietnam, 90% of the population is covered by a social health scheme, and the percentage is even higher in Colombia, at 95%, and in Thailand, at 98%.[122] These high levels of coverage have been achieved through sustained political and financial commitment, combined with a rights-based approach. In these countries, all citizens, including older adults, are entitled to healthcare by national law.[123]

Figure 7. LMICs overall see a significant gap in their health systems, including limited population coverage and financial protection.

a) Population covered by a social health scheme (%), by country income level, 2020



b) Out-of-pocket expenditure as percentage of current health expenditure, by country income level, 2020



Sources: ILO, World Bank, WHO, Economist Impact.

Education systems: Ensuring inclusive and quality education for all is essential to improving social mobility and mitigating inequities throughout people's lifespans. Globally, there has been notable expansion of educational opportunities in recent years, primarily driven by improvements in LMICs.[124] However, barriers remain high for access to high-quality education, particularly in LICs, and this disproportionately affects disadvantaged populations including women, rural residents, and those living in poverty.

- **Accessibility:** The lack of human resources and poor infrastructure are major obstacles to inclusive education in LMICs. Teachers are the cornerstone of high-quality education, yet 36% of teachers in LICs had not received adequate training as of 2018.[125] Inadequate sanitation facilities and a lack of electricity further prevent the creation of a safe and quality learning environment for children, and electricity is more readily available in some areas than internet availability. In MICs overall, 40% of primary schools and 35% of upper secondary schools have electricity but no internet.[126] Poor infrastructure not only inhibits students in these countries from developing digital skills but can also widen the digital divide (Box 5).
- **Education financing:** LMICs also grapple with underinvestment in education. LICs account for only 0.5% of total spending on education worldwide, while HICs stand at 65%, even though the number of school-aged children is roughly equal in these two groups.[127] In addition, households pay for a larger share of education spending in LICs than in HICs, suggesting a greater risk of educational gaps driven by wealth inequality.[128]

Box 5: The digital divide inhibits aging equity

Digital literacy can help mitigate inequity in aging, and it remains an area of relatively untapped potential in high-income and low- and middle-income countries (LMICs).[129] In the U.S., nearly 40% of adults aged 70 and over lack basic digital skills—a higher rate than in any of the younger age cohorts and five times the rate of those aged 16 to 34.[130] Digital literacy among older adults is likely even lower in many LMICs given the lack of internet infrastructure and technological penetration, particularly in rural areas. Globally, the share of internet users in urban areas is two times that of rural areas, with the divide even higher in LMICs overall.[131]

The lack of digital literacy among older adults results in them being unable to access resources such as telemedicine as well as educational and employment opportunities. Because employment in the digital age is shifting toward jobs that require high-level cognitive skills, there is an urgent need for governments, employers, and society at large to focus on lifelong learning to allow older adults to keep up with technological changes and develop adaptable skills.[132]

Digital training programs are emerging in LMICs to enable older adults to leverage the power of technology to improve their lives. For example, **The SilverTech Program in Argentina** recognizes that older adults, who are generally excluded from employment searches, can bring valuable experience and socio-emotional skills (Appendix-B3).[133] IDB Lab and Eidos Global, a nonprofit education institution, partnered to start the program in 2022, providing training to adults over 50 to improve their digital skills, employability, and job placement. While the project is still in its early stages, it has demonstrated the potential to lessen gaps in education, income, and wealth among older adults.

Solutions spotlight: alleviating poverty through cash-transfer programs

Governments in LMICs have increasingly adopted cash-transfer programs, usually focused on vulnerable older adults and younger generations, as part of their social protection and poverty reduction strategies.[134] Cash transfers have been effective tools for alleviating poverty around the world: More than 80 countries run such programs today, compared with just three (Brazil, Mexico, and Bangladesh) in 1997.[135]

Cash transfers have been effective tools for alleviating poverty around the world: More than 80 countries run such programs today, compared with just three in 1997. Recipients of cash transfers have experienced a wide range of positive outcomes, including increases in school attendance and financial savings, increased use of health services, and women's empowerment, among others.

According to a systematic review of empirical evidence on such interventions, recipients of cash transfers have experienced a wide range of positive outcomes, including decreases in poverty measures, increases in school attendance and financial savings, increased use of health services, improvements in diversity of diet, and women's empowerment.[136]

Social protection cash-transfer programs can be classified as either "conditional," meaning they require beneficiaries to follow certain conditions like children's school attendance or healthcare visits, or "unconditional," meaning beneficiaries do not have to take any specific actions to receive transfers (Box 6).[137]

Conditional cash-transfer programs (CCTs) originated in Latin America and the Caribbean during the 1990s. Such government efforts to support the consumption of poor households are designed to help break intergenerational cycles of poverty and promote the accumulation of human capital among children.[138] Conditions initially focused on requiring recipients to comply with protocols for health, nutrition, and school attendance. Later, they evolved in some countries to include health promotion and preventative services, as well as enrollment in post-secondary education.[139]

Box 6: Conditional vs. unconditional cash-transfer programs

Research on the effectiveness of unconditional cash-transfer programs (UCTs) relative to conditional cash-transfer programs (CCTs) has been inconclusive. CCTs have been effective in both increasing household consumption and reducing the intensity and incidence of poverty and inequality for beneficiaries.[140] A 2022 review found evidence suggesting that UTCs may improve some health outcomes, healthcare expenditure, and school attendance, but that they have little impact on health service use for children or adults in low- and middle-income countries (LMICs).[141] Even so, governments in LMICs have used UCTs to make meaningful improvements to the lives of low-income families.

While both conditional and unconditional cash transfers are growing in popularity, there is much debate in academic literature around conditionality.[142] [143] In countries where infrastructure is limited, or where improvements would be costly to fund, conditions on healthcare visits or school enrollment can exclude vulnerable populations who need the benefits the most.[144] In addition, conditionality requires significant human and financial resources to successfully implement, monitor, and evaluate, making the programs vulnerable to fiscal budget constraints.

One of the earliest CCTs was **Mexico's Progresa-Oportunidades-Prospera (Prospera)**, a government-administered sequence of pioneering CCT schemes for vulnerable and poor families (Appendix-A2). The program gave cash payments to families on the condition that family members got checkups at health clinics and children regularly attended school.[145] Prospera led to significant improvements in health outcomes for the aging population, improved intra-household gender equality, and increased school enrollment. Consistent monitoring and rigorous evaluations by independent researchers contributed to its continued success. After surviving numerous election cycles, Prospera was eliminated in 2019 by Mexico's incumbent president, Andrés Manuel López Obrador, who replaced its funding with an education grant program.[146] Nevertheless, the positive results of the Prospera program, and the continued success of CCTs around the world, demonstrate their potential to reduce poverty across generations.[147] [148]

Another successful regional program is the **Human Development Bond (BDH) in Ecuador**. This program aims to mitigate income disparities for older adults by targeting poor households that include older adults (over 65 years of age) without social security or contributory pension schemes (Appendix-A3). BDH initially targeted families with cash transfers of US$150 per month, conditional on school enrollment and maternal and child health checkups. Due to a lack of administrative capacity, these conditionalities have not been enforced, though the program encourages households to spend transfers on their children. Cash transfers for older adults (US$50 or US$100 per month based on need) have no conditions.[149] While the schooling component of BDH helps to reduce disparities in education over the life course—helping to minimize the intergenerational transfer of poverty—the separate transfer scheme for older adults could help to reduce economic inequality among older adults.

In other parts of the world, unconditional cash transfer programs are becoming a popular policy instrument to make meaningful improvements to the lives of low-income families. Two prominent examples of unconditional cash transfer programs are the **Old-Age Allowance Program (OAA) and the Widow, Deserted, and Destitute Women Allowance Program in Bangladesh** (see Section II-A). The Bangladeshi government has steadily increased its social protection spending for vulnerable older adults and women, driving the success of these two programs.[150]

Solutions spotlight: financing healthcare

Some government programs focus on bolstering healthcare financing schemes to extend access to marginalized communities, in recognition of the cost burden faced by these communities when accessing healthcare.

The Kaundu Community-based Health Insurance (CBHI) in Malawi aims to reduce out-of-pocket expenditure and increase access to health services in the Dedza-East region through a collaborative, community-operated and-owned insurance scheme (Appendix-D1).[151] In this region, which contains about 40 rural villages, government health facilities are largely inaccessible, so residents rely on nearer, fee-for-service health facilities that are often unaffordable. To increase access and reduce costs, community volunteers, traditional village leaders, and local health center staff collaborate to manage the insurance scheme's financing. By sustaining consistent access to healthcare and offering financial stability, CBHI has helped to reduce the health inequities experienced by these rural communities since its establishment in 2015.

In **India** the Ministry of Labor and Employment helped lower the cost of hospital visits and improve access to healthcare among people living in poverty throughout the country through the **Rashtriya Swasthya Bima Yojana (RSBY) Health Insurance Scheme**. Launched in 2008, this program provided fully subsidized health insurance to informal workers and households living below the poverty line (Appendix-D2). Because it contained no age limit or pre-existing condition exclusions, RSBY had the potential to alleviate inequity in healthcare for many marginalized populations.

Even so, RSBY had overall been insufficient in reducing the financial burden for poor families, due to regional discrepancies in enrollment and a lack of financial support for outpatient expenses.[152] Dr. Kavita Sivaramakrishnan, an expert on the program, also suggests that RSBY's awareness campaigns did not sufficiently reach marginalized populations of older adults, many of whom are illiterate and in lower caste groups.[153] Dr. Sivaramakrishnan emphasizes that "stronger monitoring and accountability mechanisms, as well as acknowledgement of old age and poverty as multifaceted issues, are needed for improving program implementation."[154] RSBY was replaced in 2018 with the Pradhan Mantri Jan Arogya Yojana program, which has significantly greater coverage and aims to reach over 500 million individuals. However, the scheme faces similar limitations regarding outpatient care coverage.

C. Legislation and policies lack the imperative to support aging populations

The challenges

Overall, there is a lack of a policy imperative to support older adults in LMICs, resulting in limited to no attention or effort to tackle aging inequity.

Although people are living substantially longer than in the past, older adults' needs are not yet at the forefront of policymaking in many countries. Many Sub-Saharan, Middle Eastern, and Asian countries lag in their awareness of older adults' potential to contribute to national development.[155] Expert interviewees for this report underscored this issue. According to Professor Harper, "While many Asian governments have 'woken up' to the growth of their older populations, along with many Latin and South American governments, in Sub-Saharan Africa, there is still a dismissal by many of the urgency of the oncoming demographic shift."[156]

The lack of awareness and imperative among policymakers has been mirrored by an absence of comprehensive aging policy frameworks.[157] Dr. Sadana remarks that "there is sparse legislation in many LICs and even some MICs enshrining the rights of older adults and the responsibilities of different sectors towards them."[158]

Only 54% of countries globally have national policies, strategies, and plans aligned with healthy aging, and only 31% have national policies in place to support comprehensive assessment of the health and social care needs of older adults.

This lack of aging policy framework is not unique to LMICs. According to the *WHO Decade of Healthy Aging Baseline Report 2020*,[159] only 54% of countries globally have national policies, strategies, and plans aligned with healthy aging, and only 31% have national policies in place to support

Box 7: Ageism and elder abuse hamper age-friendly societies

In many countries, ageism and the abuse and mistreatment of older adults are both prevalent and under-examined. This discrimination compounds existing older-age inequity, particularly for older women.

The World Health Organization (WHO) defines ageism as "when age is used to categorize and divide people in ways that lead to harm, disadvantage and injustice and erode solidarity across generations."[160] It is the expectation or belief that older adults do not have the right to be contributing members of society, which then plays out in people's sense of self, self-worth, and willingness to get what they deserve.[161]

These ageist attitudes, and the lack of existing legal protections, have material consequences for older adults in LMICs, and can affect older people's ability to receive high-quality care. Health workers are often discriminatory, prejudiced, or otherwise resistant to older adults.[162]

Ageism may increase the risk of elder abuse.[163] The WHO estimates that one in six older adults experiences some form of abuse annually, most commonly reported as physical abuse, psychological abuse, sexual assault, material exploitation, and neglect.[164] Estimates of elder abuse's prevalence rates exist mostly for high-income countries; the impact in LMICs has not been as well documented.[165,166]

Even so, existing reports reveal its regular occurrence. A 2018 HelpAge survey in India found that nearly a quarter of surveyed older adults self-reported experience of elder abuse.[167] The Multiple Indicator Survey on Ageing in Malawi, conducted in 2017, found that in many communities, the rights of older adults are often violated because they are accused of being responsible for almost every misfortune occurring in the community, including death, floods, and drought.[168] One study of older women in India found a significant relationship among the experience of abuse, gender, and social class, with poorer women reporting significantly higher levels of abuse.[169]

Finally, ageism and elderly abuse can be compounded by accusations of witchcraft in some LMICs. For example, witchcraft persecution has long been a major issue Sub-Saharan Africa.[170] Often, those accused of witchcraft are middle-aged or elderly—particularly those exhibiting signs of poor health and women.[171] This, combined with biases and a lack of understanding around aspects of aging, puts older adults at a high risk for abuse.[172]

comprehensive assessments of the health and social care needs of older adults. Despite the prevalence of ageism worldwide (Box 7), about 40% of countries globally do not have national legislation and enforcement strategies against age-based discrimination.

Even countries that do have aging policy frameworks struggle to find the political will for implementation or funding, and existing programs are often either poorly funded or implemented.[173] In Ghana, the government adopted a national policy on aging in 2010, which has not yet been funded or implemented.[174] In India, the government enacted the National Policy for Older Persons in 1999 to promote the health and welfare of older adults in anticipation of India's aging population. However, implementation, particularly in rural areas, has been negligible, indicating difficulty implementing policy across a vast geographic scope.[175]

Finally, there is a lack of social awareness of legal protection for older adults and aging programs, and older adults frequently lack a platform to have their voices heard. Geography also impacts this awareness. For example, in Vietnam, there are explicit laws and action programs targeting older adults, yet less than 30% of older adults are aware of them.[176] Older adults in the country's urban areas know of and use the benefits available to them more often than those in rural areas.[177]

An interview with Letitia Figueroa, 58, from Mexico City, sheds some light on the lived experiences of older adults in LMICs where governments are slow or just starting to take action to support aging populations (see Profile 5).

Profile 5: Letitia Figueroa, 58, Mexico City, Mexico

Letitia Figueroa, who feels close to her community, says that "older people are respected and supported." She refers to her relationships with other older people in the community as "empathetic and cordial."

Despite the sense of community, Letitia faces challenges when it comes to accessing basic services and navigating in her community. "The streets are not suited to older persons who are handicapped, and there are no nearby social and medical care centers for older persons," she says. Letitia also has observed that older people in the community are not treated equally, especially women.

The challenges among older adults that she witnessed earlier in life instilled in her the need to prepare for the future. "Having seen older adults' poor life conditions helped me to plan and get ready for this stage of my life," she says, "I hope my financial and health planning help me avoid becoming a burden to my family and allow me to lead an easier life as an older person." Letitia hopes the government will allocate more resources to support older adults in all communities, both rural and urban. She notes that governmental support is somewhat stronger than it was in the past, but there's still room for improvement.

Letitia believes there is great potential to be unleashed among older people. For example, the knowledge and skills of older women can be passed on through established programs, courses, and conferences: "For women who have always been housewives, assistance should be provided to help them share their knowledge that, in some cases, has been passed down from generation to generation. This knowledge includes cooking, textile manufacturing, and painting, among other things." Letitia hopes the knowledge that specialized, technical workers have amassed can also be shared, with older adults training the new generation. She also wishes for universities to promote and support programs for older adults.

Solutions spotlight: lifting voices of older adults

A fundamental problem underscoring the legislative and policy landscape in LMICs is the lack of a voice that older adults have in the policies that impact them, or ownership over existing programs that directly affect them. Multiple expert interviewees emphasized that this must change.

> "A key ingredient of success, particularly as it relates to interventions aimed at alleviating inequity, is that older adults feel they have direct ownership of targeted interventions."
>
> **Katie Smith Sloan**
>
> Executive Director, Global Ageing Network, and President/CEO, LeadingAge

As Katie Smith Sloan, Executive Director of the Global Ageing Network and President/CEO of LeadingAge, puts it: "A key ingredient of success, particularly as it relates to interventions aimed at alleviating inequity, is that older adults feel they have direct ownership of targeted interventions."[178]

Civil society organizations have been playing an important role in lifting older adults' voices to ensure that policies, laws, and strategies reflect their concerns. This has been seen in several HICs, including Canada, France, and Ireland, where national governments have deliberately consulted with civil societies to enable the direct participation of older people.[179] In LMICs, some NGO-led efforts have empowered older adults to gain political representation and prompt action and improvement.

In **Serbia, Older People's Self-help Groups (SHGs),** community-based groups established in 2010 with support from the Red Cross of Serbia, provide older adults with support networks through regular meetings and mutual aid in their communities (Appendix-E1). They operate in a variety of settings, from rural villages to urban cities and suburban towns. Members discuss matters of importance to them, identify common challenges and peers experiencing hardships, and work toward solutions. When needed, they make requests to local governments and sometimes even government ministries.[180]

SHGs have proved to be an effective way for older adults to increase their political representation and drive positive change. One group successfully lobbied to replace its village's water pipes, which previously contained asbestos. Others have successfully requested to add bus stops, benches, and trash cans to their communities. Milutin Vracevic, a Program Manager who has helped to implement SHGs in Serbia, ascribes their success to the fact that they help people see older adults not as passive recipients of help, but as active and enthusiastic organizers and advocates of their own rights.[181]

D. Traditional informal networks of care are weakened

The challenges

Most older adults in LMICs rely on their families for support. This is also known as "informal networks of care."[182] However, a range of demographic and social shifts, including declines in birth rates, urbanization, and growing migration, are threatening traditional, informal networks.[183 184] As LMICs undergo rapid urbanization, there is rising tension between individuals pursuing economic opportunities in urban areas and the older, predominantly rural populations left behind.[185]

As a result, older adults in LMICs face a growing challenge in accessing care and support when needed, either from formal social programs and professional institutions or from informal familial networks. Those not living in larger family units are particularly vulnerable and tend to experience worse health outcomes, higher rates of poverty, and a worse quality of life.[186]

Solutions spotlight: improving access to home care

In LMICs, and particularly LICs, few institutions support older adults. Facilities run by the private sector tend to be unregulated or require high out-of-pocket payments, and there is a lack of holistic infrastructure to support home caregiving, much of which is provided by women and undervalued globally.[187]

One innovative practice that helps to increase equitable access to home care for older adults is **The Buurtzorg community-based home care model replication in China** (Appendix-C4).

Since 2014, Buurtzorg, a nonprofit based in the Netherlands, has established 10 local branches in Chinese cities (including Shanghai, Chengdu, Ningbo, and Fuzhou) to offer nurse-led, patient-centered home care and health services for over 1,000 older adults. Daniel Chiati Huang, General Manager of Buurtzorg China, notes the similarity of elderly care needs across high-income and middle-income countries, which allows for wide replicability and adaptation of Buurtzorg in China.[188]

Buurtzorg uses the internationally standardized Omaha System[189]—a research-based, comprehensive practice and taxonomy designed to describe and measure the impact of healthcare services—to evaluate patients' care needs and prepare care plans and interventions. Buurtzorg employees also engage family members and neighborhood resources to sustain a community network of care that empowers older adults to become autonomous. The Buurtzorg model allows small and professional teams of locally trained caregivers to exercise autonomy over their work and schedule.[190]

A KPMG study of Buurtzorg Netherlands indicates below-average home care costs compared with other Dutch home care providers, despite higher hourly costs, impacts that implementers hope will translate to the Chinese context.[191] In China, in conjunction with the government's pilot experiments of long-term care insurance, Buurtzorg has the potential to increase equity in older-age care by cutting costs. Mr. Huang reported Buurtzorg home nursing services to be about half the cost of common alternatives such as senior living facilities and 24-hour in-home living assistants.

Solutions spotlight: empowering and mobilizing older adults

As traditional informal networks of care weaken and access to public resources remains limited in LMICs, older people's associations (OPAs) are gaining traction. These represent an effective solution for mobilizing support for older adults, helping them to stay healthy and actively engaged in their communities.[192] Ms. Tran asserts that OPAs are a relatively inexpensive, simple way to empower older adults, and they have high levels of buy-in at the community, local, and national levels.[193]

While there are a variety of models, OPAs often focus on older adults' livelihoods, health, and rights and empowerment. They offer community-based activities such as social events for retirees, or national networks that represent older adults' interests to policymakers.[194] The **Older People's SHGs in Serbia** is one example.

Intergenerational Self-Help Clubs (ISHCs) are a form of OPA developed in Vietnam in partnership with HelpAge International, an international NGO focused on enhancing the lives of older adults.[195]

The ARC 3.0 report, which focused on innovation in healthcare and wellness, highlighted ISHCs. Recognizing their success in Vietnam, HelpAge has helped several countries in the region, including Bangladesh, Indonesia, and Cambodia, to establish contextually appropriate OPAs and provide support to make them sustainable, effective, and engaging.[196] One example is **the OPA model in Bangladesh**, a low-cost, community-based solution that strengthens older adults' social networks, addresses their needs, and improves their health access through home visits and neighborly care (Appendix-E2). Like Serbia's SHGs, the OPAs in Bangladesh amplify older adults' political voices.[197]

IV. A call to action: translating insights into impact

Rising inequality is a global challenge that causes tremendous social and economic losses.[198] Combating aging inequity is essential to helping people fulfill their potential. Addressing these inequities will shape the ability of all countries, both low and high income, to prepare for and prosper in a rapidly aging world

- **LMICs** are aging fast, and many lack the established social and institutional infrastructure to support older adults. They are, therefore, at risk of continuing to neglect marginalized groups, such as older women and adults in rural and indigenous communities. Although LMICs face greater challenges in addressing aging inequity, including large informal economies, underdeveloped institutions, and lagging policy frameworks, they can act early in the demographic transition, avoiding some of the policy pitfalls that have hampered HICs.
- **HICs** overall have older populations than LMICs. Many have also been in the lead of building and/or adapting institutional systems to support older adults and cultivating age-friendly societies.[199] However, inequity persists in HICs, threatening the wellbeing of current and future generations of older people. For example, although HICs overall have a higher percentage of their populations using safely managed sanitation services than LMICs, the rural-urban divide in HICs is as large as that in upper-middle-income countries.[200] Similarly, despite the overall better pension coverage in HICs compared with LMICs, the coverage for men (60%) remains noticeably larger than for women (49%) (Figure 6). Furthermore, in countries such as the U.S., health disparities by race and ethnicity are widening.[201]

Both LMICs and HICs can take advantage of some key takeaways from the solutions spotlighted in this report, including the 14 programs profiled in the Appendix:

- **Equitable healthy aging is achievable—even in a society with a large informal economy and limited institutional capacity—but it requires sustained commitment from governments.** Governments play a central role in enhancing national legislation on protecting equal rights, building physical and institutional infrastructure, and implementing aging-related policies.[202] As a result, their commitment is essential for combating aging inequity at both the national and local levels. This is demonstrated in the remarkable progress that has been achieved in Colombia, India, Thailand, and Vietnam on expanding pension and/or healthcare coverage over the past several decades, and the success of the Comprehensive Care Model for Rural Health in Sumapaz, Colombia.
- **Action that targets intersecting segments of gender, race and ethnicity, ability, geography, and socio-economic status among older adults can more effectively improve their livelihoods and wellbeing, reducing inequities.** The heterogeneity of disparities experienced by older adults across different intersecting segments requires targeted efforts to meet their specific needs. Recognizing this, some innovative programs provide support and empowerment focused on specific groups of disadvantaged older adults. Successful examples include the national government's cash-transfer programs in Bangladesh that support older women living in poverty, and Someone Somewhere in Mexico, which creates income-generating opportunities for older artisans in indigenous communities.

- **Community-centered approaches can effectively reach underserved groups among older adults, and cross-sector collaboration is key to their design and implementation.** The success of community-centered programs lies in the ability to tailor them to local contexts and needs while tapping into existing networks of support. Innovative practices have yielded early success in places where stakeholders across sectors collaborate. This is demonstrated in the success of the OPAs in Vietnam and Bangladesh, and the Kaundu CBHI program in Malawi.
- **Adopting a life-course approach is imperative to reduce aging inequity in the long term.** Inequalities accumulate throughout people's life course. Therefore, mitigating inequities among older adults requires effective intervention to reduce disparities in earlier stages of life. Some innovative programs have focused on economically empowering younger generations, particularly women, such as Mission Shakti in India. Other programs adopt life-course interventions to improve health outcomes of current and future older populations, as seen in the HEP in Ethiopia.
- **A lack of aging-related data is hampering solutions to aging inequity; immediate action is needed to conduct more robust data collection.** While demographics and socio-economic status have significant impacts on aging inequity, disaggregated data at the intersection of these factors are scarce globally. This lack of data leaves stakeholders with limited knowledge on how to best create avenues for equitable healthy aging. Nationally collected data need to be inclusive of the older population and consistently disaggregated by demographic and socio-economic factors as a foundation for other collection efforts. The CHARLS in China, the HAALSI in South Africa, and India's first Longitudinal Ageing Study in 2017-19 provide some encouraging examples of such an effort at national and regional levels. In addition, region- and community-specific qualitative research—such as through focus groups and interviews—can enhance understanding of older adults' needs that are innately tied to physical locality and unique lived experiences.

Achieving equitable healthy aging requires all parts of society to work together to help individuals overcome disadvantages that could accumulate over their lifespan. Sources of support include, but are not limited to, the following:

Public sector:

- Governments can **enhance national legislation** on protecting equal rights by age, gender, race and ethnicity, and ability and design and implement **stronger comprehensive national aging policies**. They can **expand and refine existing infrastructure**—such as pensions, healthcare, and education systems, along with transport—to deliver aid where it is most needed and reach marginalized populations such as indigenous communities or informal workers.
- International organizations and governments, in collaboration with civil society and academia, can invest in and lead the effort to **collect data on older populations and healthy aging**, including disaggregated data by age, gender, race and ethnicity, ability, geography, and socio-economic status.

Private sector:

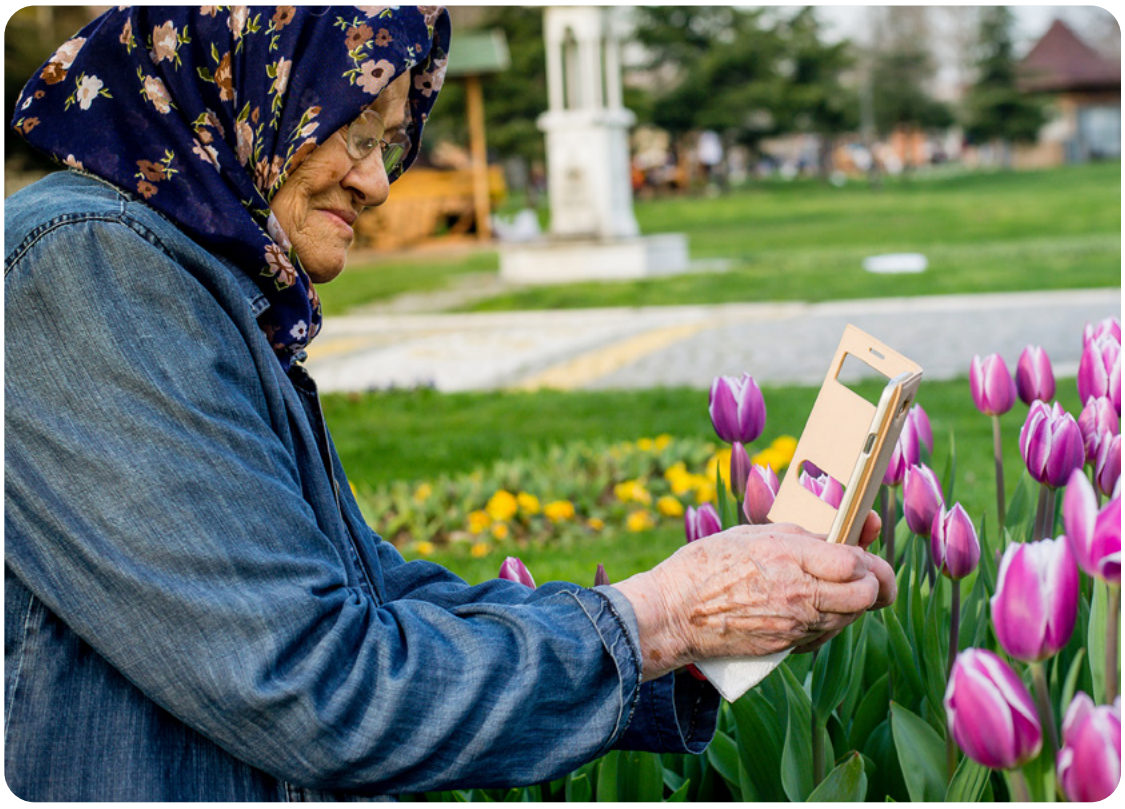
- Companies can be **inclusive of the needs and preferences of older adults** when designing, developing and providing products and services, particularly for new technologies and technologically mediated services. They should **deliberately extend market outreach to rural and remote communities** to meet the demands of underserved people, including older adults. In addition, they can leverage their business resources to **create income-generating opportunities** for marginalized groups, such as older women living in remote areas or in poverty.
- Employers should **incorporate age into Diversity, Equity, and Inclusion policies** to support a multigenerational workforce and **create an inclusive work environment**, offering equal pay and equal access to jobs, upskilling/training and career advancement opportunities. They can **contribute to employees' health and wellbeing** by allocating funding for health coverage costs, improving work-life balance, and increasing paid time-off allocations and employer pension contributions.

Civil society:

- NGOs and community organizations can **drive grassroots efforts** to promote health equity and cultivate robust community-based networks of support for older adults and other marginalized groups.
- International organizations and local NGOs, along with stakeholders in other sectors, should **collaborate to create, replicate, or scale-up effective models**, benefiting older people and society at large.

Individuals:

- Individuals also have a personal responsibility to **raise their own and others' awareness of discrimination** based on age, gender, race and ethnicity, ability, and socio-economic status. People can **contribute to building an age-friendly society** by combating ageism, reporting elder abuse, and listening and responding to older people's needs, through acts like volunteering or engaging with other older adults.



Appendix: select programs and leading practices

A. Cash transfers:

1) Cash transfers in Bangladesh: the old-Age Allowance (OAA) and Widow, Deserted and Destitute Women Allowance (WA) programs
2) Mexico's pioneering conditional cash transfer scheme: Progresa-Oportunidades-Prospera (Prospera)
3) Reducing poverty through targeted cash transfers: the Human Development Bond (Bono de Desarrollo Humano, BDH) in Ecuador

B. Economic empowerment:

1) Creating income-generation opportunities for rural artisans: Someone Somewhere in Mexico
2) Accelerating women's economic empowerment: Mission Shakti in Odisha, India
3) Improving employability and digital literacy for adults who are 50+: SilverTech in Argentina

C. Access to healthcare and home care:

1) Expanding access to healthcare for rural communities: the National Health Extension Program (HEP) in Ethiopia
2) Improving rural healthcare: the Comprehensive Care Model (CCM) for Rural Health in Sumapaz, Colombia
3) Enhancing healthcare services in indigenous communities: Brazil's Indigenous Community Health Agent Professionalization Programme (ICHAPP)
4) Improving access to home care for older adults: Buurtzorg Neighborhood Care in China

D. Healthcare financing:

1) Community-driven expansion of healthcare access: Kaundu Community-Based Health Insurance (CBHI) in Malawi
2) Subsidizing health insurance for households experiencing poverty: India's Rashtriya Swasthya Bima Yojana (RSBY) Health Insurance Scheme

E. Self-support and self-advocacy:

1) Building community: Older People's Self-help Groups (SHGs) in Serbia
2) Empowering older adults: Older People's Associations (OPAs) in Bangladesh

A. Cash transfers:

1) Cash transfers in Bangladesh: the Old-Age Allowance (OAA) and Widow, Deserted and Destitute Women Allowance (WA) programs

These two complementary programs provide vulnerable groups, including poor older women and older widows, with unconditional cash transfers to improve their wellbeing and economic standing.

The focus

Due to deeply ingrained patriarchal norms in Bangladesh, women have fewer means of supporting themselves than men. Widowed and divorced women especially face significant financial, legal, and social constraints and are at high risk of becoming destitute.

How it works

The OAA and WA were introduced in 1998 by the Government of Bangladesh. These two complementary unconditional cash-transfer programs are managed by the central government, and the OAA was the country's largest anti-poverty safety net program as of 2019. For the OAA, committees consisting of local government representatives select and approve recipients, who must be older than 62 for women and 65 for men. Beneficiaries should have an annual income below Tk10,000 (US$120). WA has an expanded age limit, selecting women above the age of 18 with income below Tk12,000 (US$145). Priorities are given to older women, those who do not own land, and those unable to work. Both programs provide Tk500 (US$6) monthly allowances to those enrolled, but beneficiaries can only participate in one.

Drivers of success

The government's efforts in developing and implementing these two programs have been primarily responsible for their success. Bangladesh's only old-age pension until the late 1990s was a civil service pension, which covered just 1% of the elderly population. Since then, however, Bangladesh has steadily increased its social protection spending to meet the needs of vulnerable older adults and women. Because OAA eligibility overlaps with WA, with assignment determined by availability, marginalized older women are more likely to access the support provided by one of the programs than if only one or the other were in place.

Impact

From 1998 to 2019 the number of OAA beneficiaries multiplied almost ninefold, reaching 4 million people, and the benefit amount increased fivefold. In the same period, the number of women benefiting from the WA increased from 400,000 to 1.4 million and the monthly allowance increased from Tk100 to Tk500. The allowance contributes on average 30% of the monthly income of the lowest quintile of earners, providing meaningful support. A significant number of women enrolled in the WA are aged 40 or over and many are illiterate. The monthly OAA payments also improve marginalized older adults' access to finance, thanks to the assurance of regular funds.

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A. Cash transfers:

2) Mexico's pioneering conditional cash transfer scheme: Progresa-Oportunidades-Prospera (Prospera)

From 1997 to 2019, the central government of Mexico administered Prospera, a sequence of conditional cash transfer (CCT) schemes for vulnerable and poor families that has since been replicated in over 50 countries and has benefitted over 6 million families.

The focus

Prospera was part of a government effort to implement targeted anti-poverty programs following a macroeconomic crisis in 1995 that left Mexico grappling with heightened inequality and poverty.

How it works

For families below the poverty line, Prospera provided cash for food, nutritional supplements, and school supplies; free access to basic healthcare services; educational grants; and support for adults over 70 years of age. The program conditioned cash payments to families (US$115.20 per month for families with primary and secondary students and US$185.80 per month for families with college-level students) on family members getting checkups at health clinics and children regularly attending school.

Drivers of success

Consistent monitoring and rigorous evaluations by independent researchers contributed to the program's continued success. Prospera also had a well-defined target population, with clear mechanisms for selecting beneficiaries. Lastly, it benefitted from close coordination with other government agencies' programs, such as the Programme for Direct Assistance in Agriculture for rural farmers and government-funded health insurance for the informal sectors (Seguro Popular). Prospera also had a strong presence on the ground, facilitating direct communication with beneficiaries and helping its staff identify issues and improve social cohesion.

Impact

Prospera led to significant improvements in health outcomes for the aging population, improved intra-household gender equality, reduced poverty in rural areas, and increased school enrollment and educational attainment. One analysis suggests that educational attainment increased by roughly 1.3 years on average, with girls exposed to Prospera seeing a 65% increase in their labor earnings as adults. Although Prospera was eliminated in 2019, due to Mexican politics and a sticky perception of the program as ineffective in reducing poverty, the program's positive results and the continued success of CCTs globally demonstrate the potential of such schemes to reduce poverty across generations.

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A. Cash transfers:

3) Reducing poverty through targeted cash transfers: the Human Development Bond (Bono de Desarrollo Humano, BDH) in Ecuador

The Ministry of Economic and Social Inclusion (MIES) in Ecuador provides cash transfers to families living in extreme poverty, particularly with children who are under 18 years old, people with disabilities, and adults aged over 65. This has helped to reduce inequities in schooling and incomes for older adults living in poverty.

The focus

Ecuador experienced significant reductions in poverty from 2007 to 2017. However, the percentage of the population living in poverty increased from the 2017 low of 21.5% to 33% in 2020 when measured against the country's national poverty line. Inequalities in wealth, education, and access to healthcare have increased in turn.

How it works

BDH cash transfers, established by MIES in 2003, are delivered monthly to recipients through bank counters, ATMs, and non-banking correspondents. The program was initially designed to transfer cash to families (US$150 per month) on the condition of school enrollment and maternal and child health checkups, but due to a lack of administrative capacity these conditions have not been enforced. The cash transfers for older adults (two programs, one at US$50 per month and one at US$100 per month based on need) and people with disabilities (US$50 per month) are targeted, but have no conditions.

Drivers of success

While the national government is currently administering and funding the BDH, the program benefitted from initial bilateral and multilateral funding from the Inter-American Development Bank and the International Bank for Reconstruction and Development. The BDH has a large budget—approximately US$251 million as of 2016, or about 0.25% of Ecuador's GDP. The BDH also benefits from accurate targeting via an assessment based on an unmet-needs index.

Impact

By 2008—five years after its launch—the BDH covered 40% of the population, which was one of the highest relative coverage rates in Latin America. The BDH has been criticized for disincentivizing work, but there is no evidence of such an effect, and the transfers provided by the BDH are well below the country's minimum wage (US$375, as of 2017). Conditional cash transfers (CCTs), including the BDH, have great potential to improve the health of the poorest populations. Receipt of the BDH has been associated with improved children's cognitive outcomes and school enrollment, increased household food expenditure, reductions in child labor, and lower mortality rates for children under five. However, its long-term effects on schooling and employment are modest, and more research is needed on the impacts of CCTs in general for long-term poverty reduction.

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B. Economic empowerment:

1) Creating income-generation opportunities for rural artisans: Someone Somewhere in Mexico

Someone Somewhere, a social enterprise in Mexico, works with rural artisans—most of whom are older women—to produce and promote traditional textiles, helping reduce older women's poverty through consistent income generation.

The focus

People living in rural and indigenous communities in Mexico—accounting for roughly one-tenth of Mexico's population—and, in particular, older women have limited access to markets and resources. Younger people migrating out of these communities into urban areas further reduces economic opportunities for older people.

How it works

Someone Somewhere, established in 2012, partners with local artisans—mostly older women in rural areas—who use traditional methods to create products. Through this partnership, it aims to establish regular income-generating activities, reduce poverty, and preserve traditional knowledge. The company provides the raw materials for artisans, and then the final products are marketed and sold at retail stores and online, targeting younger consumers domestically and in the U.S. Someone Somewhere also promotes the welfare of older adults by subsidizing specialty eyecare.

Drivers of success

The co-founders of Someone Somewhere spent years learning and researching the communities' values and concerns, and how they self-organize before launching the enterprise. The model accommodates the lifestyle of local, rural communities by allowing artisans to work from home. To allow this innovative business model to flourish, the company and artisans have leveraged the growing awareness of and consumer preference for socially and environmentally conscious products. The company maintains an active presence on social media and analyzes digital marketing and fashion trends to maximize its market reach.

Impact

In 2021 Someone Somewhere reported working with 273 artisans, up 48% from the previous year. Three-quarters of them are women, and many are from poor states as well as minority and indigenous ethnic groups. The artisans receive 30% of the product's cost, which is roughly 50% more than the national minimum standard wage in Mexico.

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B. Economic empowerment:

2) Accelerating women's economic empowerment: Mission Shakti in Odisha, India

This social and economic inclusion initiative in the state of Odisha, India aims to strengthen women's economic wellbeing through income-generating activities, financial inclusion and skill building.

The focus

Women in India face persistent inequities, including unequal access to education and employment. This leaves them more at-risk of poverty and social exclusion in older age.

How it works

In partnership with local governments, Mission Shakti aims to improve women's livelihoods and opportunities across the state of Odisha. The Living Lab, for example—one of the past approaches used by Mission Shakti—pursued this by addressing the barriers that women face in achieving financial freedom, such as limited access to and knowledge of digital technologies, access to affordable financial solutions, and social norms limiting their societal roles. Mission Shakti works directly with about 600,000 community self-help groups (SHGs), which include over 7 million women in Odisha, to develop income-generating activities (such as farming and selling products outside of local markets), provide financial services, and build professional skills. The goal is to empower women and improve their access to economic opportunities over their life course.

Drivers of success

The SHGs that Mission Shakti works with have been cultivated by the state government over many decades to promote financial and social inclusion. The program has successfully connected with many of these groups—and, in turn, many women—and has worked to strengthen existing networks of support. Increases in mobile and smartphone access have also reduced some of the barriers in connecting women with financial services and engaging in digital literacy activities.

Impact

Currently, almost all the women who are members of Mission Shakti have access to a bank account at their nearest bank branch. Over the next few years, Mission Shakti aims to improve the financial health outcomes of women with low incomes in rural areas and to build women-led micro-enterprises in Odisha, which would help promote gender equity over the life course of these women.

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B. Economic empowerment:

3) Improving employability and digital literacy for adults 50+: SilverTech in Argentina

SilverTech, a digital training program for adults over 50 years old, aims to improve digital skills, employability, and job placement for older adults, especially those with low incomes.

The focus

Argentina—and Latin America more broadly—is grappling with a lack of digital literacy and technological access among older adults. This is on top of a shortfall of talent to meet the growing demand for skilled workers in the information and communication technology industry. Among countries with available data, there is an enormous gap in internet use between younger and older people. For instance, the reported internet use gap between those aged 15-19 and older adults is sevenfold in El Salvador and Honduras, eightfold in Mexico, and almost ninefold in Ecuador and Paraguay. Older adults with lower incomes face acute inequities in access to technology and education.

How it works

In 2022, IDB Lab, in partnership with Eidos Global, a nonprofit education institution, piloted SilverTech, a digital training program for adults over 50 years old. It provides three main services: digital training, labor intermediation, and awareness and evaluation. The program gives priority to older adults who have lower incomes and are in the process of re-skilling, either because they are job hunting or need to build their skills to remain employable. To address any discomfort among older adults around technology, SilverTech uses peer-to-peer learning strategies and includes socio-emotional tutoring. SilverTech partnered with adult learning experts and technology companies, including Microsoft, Accenture, Red Hat, and Salesforce.

Drivers of success

SilverTech is an ambitious, large-scale initiative that requires a multi-stakeholder approach. To achieve this, the program has hired civil society experts with territorial reach and experience, worked alongside human resource departments, and conducted government outreach. SilverTech has also consulted with other similar initiatives in the region, comparing the lessons learned elsewhere to understand how to best apply their model to Argentina.

Impact

While the project is still in its early stages, it has demonstrated that it is prioritizing older adults from lower social classes, a group who otherwise lack access to educational resources and job-related information. Success will be determined by factors such as the ability of the program to successfully engage with vulnerable older adults, the employment outcomes of participants, and companies' behavior regarding agism and other forms of discrimination.

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C. Access to healthcare and home care:

1) Expanding access to healthcare for rural communities: the National Health Extension Program (HEP) in Ethiopia

The HEP—part of Ethiopia's National Comprehensive Primary Health Plan—promotes equitable access to preventative health interventions and education across the course of people's lives, especially in rural villages.

The focus

Rural Ethiopians, particularly those engaged in sustenance farming, struggle with accessing healthcare, with over half of those living in rural areas lacking access to services due to both distance and insufficient infrastructure.

How it works

Established in 2003, HEP trains and dispatches salaried government Health Extension Workers (HEWs) to set up community health stations, from which they deliver essential services and education. Five health stations and a health center form the basis of a Primary Health Care Unit that serves approximately 25,000 people. Typically, two HEWs are assigned to one health station. The HEWs divide their time between conducting home visits, outreach, providing family health services (e.g., family planning, immunization, nutrition, and reproductive health), and disease prevention and control (e.g., HIV, tuberculosis, and malaria). They also promote hygiene, sanitation, and health education.

Drivers of success

Despite its status as a low-income economy, Ethiopia has experienced relatively high economic growth and reduced poverty levels over the past two decades. In addition, the program's holistic focus across not just health provision, but also health education, hygiene and sanitation, and disease prevention and control. HEP benefits from government support and a favorable policy environment.

Impact

As a life-course intervention, HEP provides early-stage improvements in healthcare, health knowledge, nutrition, and hygiene. As child-rearing village women are the primary utilizers of community health posts and services, the program helps reduce gender inequities in healthcare access. One study examining the effectiveness of HEP over time found that village-based health posts achieved statistically significant improvements in maternal and child health, health knowledge, and community hygiene. The same study also found that HEP generally improved health services coverage and moderately narrowed the health inequity among populations related to literacy and wealth. Additionally, more than 42,000 salaried female HEWs are deployed around the country, which represents a significant source of civil service training and employment opportunities for women. Lastly, primary healthcare coverage rose from 76.9% in 2005 to 90% in 2010, largely due to HEP.

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C. Access to healthcare and home care:

2) Improving rural healthcare: the Comprehensive Care Model (CCM) for Rural Health in Sumapaz, Colombia

The CCM improves access to high-quality healthcare for people in the informal economy and traditional agricultural communities, helping to reduce inequities in the region.

The focus

The population of Sumapaz, a rural district of Bogotá that is largely agricultural, has long grappled with challenges in access to and the quality of healthcare, poor health outcomes, a lack of drinking water, poor nutrition, and issues stemming from economic exclusion.

How it works

The CCM, which receives annual funding of approximately US$1 million (primarily from the district government of Bogotá), is currently managed by Subred-Sur, a local health institution. Since 2001, it has established 10 community networks to target the health needs of different demographics, including older adults, women, and people with disabilities. It uses bi-directional education to learn about local communities' cultures, traditional medical preferences, and healthcare needs before providing them with health services. The model consists of three main components: 1) community participation throughout all phases of the model's implementation; 2) health promotion and access, which provides comprehensive solutions to healthcare access through education, social integration, and home medical visits; and 3) food security and environmental protection, including the use of natural ancestral medicine.

Drivers of success

As the memory of armed rural conflicts during Colombia's prolonged civil war is still fresh for many inhabitants, this non-prescriptive, co-learning approach played a role in easing some of the social tension inherent in engaging Sumapaz's inhabitants. The model's intersectoral approach, which established networks across actors and organizations, facilitated comprehensive health interventions. Lastly, the model has benefited from strong government support and public recognition, ensuring its continued implementation.

Impact

The CCM has made a significant difference to inhabitants' health, covering 100% of the rural population. The region now has among the best health indicators in Colombia, particularly compared with regions that have similar characteristics. Goals related to improving maternal and perinatal health and nutrition have been met: according to program assessments, maternal, perinatal, and infant mortality rates have been reduced to zero. The model has also improved the region's quality of life, as it has reached inhabitants who are suffering from acute pain or disabilities due to agricultural work and reduced the use of agrochemicals. Lastly, this intersectoral and interdisciplinary model has improved the knowledge of environmental care throughout the region.

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C. Access to healthcare and home care:

3) Enhancing healthcare services in indigenous communities: Brazil's Indigenous Community Health Agent Professionalization Programme (ICHAPP)

ICHAPP, a community health worker education program, aims to improve the quality of healthcare services in indigenous communities and therefore reduce the inequities in accessing healthcare for local older adults.

The focus

Remote indigenous communities in Brazil, which have higher rates of poverty, also face inequities in healthcare services stemming from their distance to health facilities and a lack of cultural sensitivity in the national healthcare system.

How it works

ICHAPP was established in 2009 and is jointly implemented by a government public health institution, Fiocruz, and the non-governmental Federation of Rio Negro Indigenous Community Organizations. It incorporates cultural values and indigenous people's voices into a contextualized training program for community health agents in indigenous communities. The program was developed holistically using participatory community design, and uses a place-based, bi-directional learning approach that allows for training to be designed and delivered according to cultural and geographical differences in each community. ICHAPP is the first program to blend biomedical approaches to health and disease with traditional indigenous medical practices. To help community health agents access biomedical training, the program also delivers high school education services.

Drivers of success

Collaboration, communication, and inclusion helped ICHAPP develop community trust and commitment for the program and secure support from government and non-government stakeholders. Community health agents received support from field coordinators and researchers, who traveled to indigenous communities served by the program for prolonged periods. The program also demonstrates the importance of understanding traditional community knowledge, cultures, and values when striving to improve health systems for marginalized communities.

Impact

Health outcomes in the community have not been evaluated due to the unavailability of relevant data, but the program trained 139 community health agents in its first cycle (2009-15). Secondary school completion increased from 21% to 84% among community health agents, and program participants reported feeling valued as a result of the training process and had increased confidence in their work.

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C. Access to healthcare and home care:

4) Improving access to home care for older adults: Buurtzorg Neighborhood Care in China

Buurtzorg Neighborhood Care in China—the Chinese branch of a Dutch nonprofit—provides older adults with better access to high-quality home care through a community-based integrated care approach.

The focus

China contains one of the most rapidly aging populations in the world—the number of adults aged 65 and over is projected to reach 18% of the total population by 2030—and demand for efficient, equitable long-term care is rising rapidly.

How it works

Since 2014, Buurtzorg, a nonprofit based in the Netherlands, has established 10 local branches in Chinese cities (including Shanghai, Chengdu, Ningbo, and Fuzhou) to offer nurse-led, patient-centered home care and health services for over 1,000 older adults. The Buurtzorg model allows small, professional teams of locally trained caregivers to exercise autonomy over their work and schedules. Buurtzorg uses the internationally standardized Omaha System—a research-based comprehensive practice and taxonomy designed to describe and measure the impact of healthcare services—to evaluate patients' care needs and prepare care plans and interventions. Buurtzorg employees also engage family members and neighborhood resources to foster a community network of care that empowers older adults to maintain or regain their autonomy.

Drivers of success

Buurtzorg's original popularity in the Dutch home care industry was based on its core practice of comprehensive care. Nurse autonomy, patient-centricity, community-based solutions, back-office efficiency, IT integration, and lean management also drive its success.

Daniel Chiati Huang, General Manager of Buurtzorg China, noted the similarity of basic care needs among high- and middle-income countries, which supports Buurtzorg's replicability in China. Furthermore, long-term care services in China have benefited from favorable insurance environments. Since 2014, some Chinese cities have started experimenting with long-term care insurance (LTCI) and exploring the marketization of certain care services. Under the scheme, general living assistance provided by non-profits qualifies for LTCI coverage. Patients and their families can also elect to pay out-of-pocket for comprehensive care, akin to the original service in the Netherlands.

Impact

A KPMG study of Buurtzorg Netherlands indicates below-average home care costs compared with other Dutch home care providers, despite higher hourly costs, impacts that implementers hope will translate to the Chinese context. In China, in conjunction with LTCI, pilots show that Buurtzorg has the potential to increase equity in elderly care by reducing cost barriers. Mr. Huang reported that Buurtzorg home nursing services are about half as expensive as common alternatives such as senior living facilities and 24-hour in-home care. In addition, reported client and employee satisfaction rates are higher than alternative models.

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D. Healthcare financing:

1) Community-driven expansion of healthcare access: Kaundu Community-Based Health Insurance (CBHI) in Malawi

This community-run insurance innovation improves healthcare access and offers financial stability for rural populations, which can help to reduce health inequities among rural and urban populations later in life.

The focus

In the Dedza-East region of Malawi, which consists of about 40 rural villages, government health facilities are largely inaccessible due to their distance from local communities. Accordingly, residents must rely on closer, fee-for-service health centers that are often unaffordable.

How it works

Established in 2015, CBHI is a bottom-up, collaborative, and community-operated and-owned insurance scheme that aims to reduce out-of-pocket expenditure and increase healthcare access. The Kaundu CBHI is facilitated by Kaundu Health Center—an affiliate of the Christian Health Association of Malawi (CHAM) and the country's largest private not-for-profit health provider, which serves hard-to-reach rural communities. Community members each contribute a monthly amount (MK300 [US$0.42] for pregnant women; MK150 [US$0.21] for children under five; and MK200 [US$0.28] for those above 6 years of age). This money goes toward reducing the future costs associated with accessing healthcare services. Community volunteers and village leaders provide knowledge to the community and establish committees to oversee the insurance scheme's operations. In the initial stage of CBHI, CHAM provided technical assistance, such as defining benefit packages and the roles of different stakeholders.

Drivers of success

As a collaborative project, the involvement of communities and health center staff are crucial. The existing functional governance structure in these rural localities and the support of the traditional village leaders have given the community-run scheme more credibility and made it viable. In addition, CHAM's technical assistance supported program delivery.

Impact

CBHI has helped reduce the health inequities experienced by these rural communities by increasing access to healthcare and offering financial stability. From 2014 to 2017, facility-based delivery at Kaundu increased tenfold, and out-of-pocket payments were reduced by 80% for enrolled members. As of 2018, CBHI included 4,476 members, about 18% of the targeted population served by Kaundu Health Center. As a result of increased health center visits, the Kaundu Health Center has been able to hire additional healthcare staff and purchase essential medicines. However, CBHI schemes in general have low participation levels and the poorest people often remain excluded due to the required monthly payments. Social protection schemes implemented by the government have shown more potential to reach universal healthcare coverage goals than voluntary, community-based schemes.

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D. Healthcare financing:

2) Subsidizing health insurance for households experiencing poverty: India's Rashtriya Swasthya Bima Yojana (RSBY) Health Insurance Scheme

RSBY, administered by India's Ministry of Labor and Employment, was a fully subsidized national health insurance scheme for households below the poverty line and informal workers.

The focus

Every year an estimated 55 million people in India fall into poverty due to the burden of out-of-pocket spending on health services and over 17% of households face unmanageable levels of health expenditure. These dynamics force impoverished households to forego healthcare services because they cannot afford them.

How it works

Launched in 2008, RSBY aimed to lower the cost of hospital visits and improve access to healthcare among people living in poverty. As a part of the program's co-financing scheme, the central government contributed 75% and local governments contributed 25% of the premium to the selected insurer. The scheme had an annual registration and renewal fee of Rs30 (US$0.40) paid by the beneficiary, and a household can enroll up to five family members. RSBY provided hospitalization coverage up to Rs30,000 (US$377) and transportation coverage up to Rs1,000 (US$13) each year. Beneficiaries were provided with biometric smartcards that entitled them to cashless treatment in participating hospitals. Notably, outpatient care, which majorly contributes to the country's increasing expenditure on health, was not covered.

Drivers of success

RSBY built on previous national, state, and non-profit health insurance schemes in India. Noticeably, it aimed to use a cashless, paperless, and nationally portable model to alleviate the inequalities associated with cost and literacy barriers while increasing access for migrant workers. However, corruption and misuse of the loose enrollment process and smartcards often meant that RSBY did not always benefit households below the poverty line.

Impact

RSBY reached millions of families and reduced out-of-pocket costs in some states. As of 2016, approximately 41 million families were enrolled in RSBY, representing 63% of the targeted households living below poverty. A UNDP report found that RSBY reduced out-of-pocket costs in the state of Kerala and improved health access. However, RSBY was overall insufficient in reducing the financial burden for poor families, due to regional discrepancies in enrollment and a lack of financial support for outpatient expenses. Experts also suggest that RSBY's awareness campaigns did not sufficiently reach marginalized older adults, many of whom are illiterate and from lower-caste groups. RSBY has been replaced by the Pradhan Mantri Jan Arogya Yojana program since 2018, which has significantly greater coverage and aims to reach over 500 million individuals. However, the scheme faces similar limitations regarding outpatient care coverage.

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E. Self-support and self-advocacy:

1) Building community: Older People's Self-help Groups (SHGs) in Serbia

SHGs in Serbia provide older adults—and especially those in marginalized groups—with a regular space to discuss pressing issues and offer mutual assistance.

The focus

Serbia is already one of the oldest countries in the world: 21% of its population is aged 65 and over as of 2021. Ageism is prominent too, putting older adults at risk of exclusion and abuse.

How it works

SHGs, established in 2010, are community-based groups that provide older adults with support networks through regular meetings and mutual aid. SHGs are supported by the Red Cross of Serbia, with assistance from HelpAge International. The EU Delegation to Serbia provided the initial financing. In addition to socialization, SHGs' activities include day-to-day peer support and living assistance. Typically, one member takes charge of organizing meet-ups using space provided by the Red Cross. Members discuss matters important to them, identify common challenges or peers experiencing hardships, and then work toward solutions. SHGs transitioned into telephone-based support groups during the COVID-19 outbreak.

Drivers of success

One key to SHGs' efficacy is recognizing older adults not as passive recipients of help, but as active and enthusiastic organizers and advocates of their own rights. Additionally, the low costs of SHGs and the flexibility of their activities make them a sustainable solution that can cater to local contexts. SHGs benefit from a favorable political and policy environment—Balkan countries have seen consistent policy and humanitarian efforts to improve older people's wellbeing. SHGs, for example, were established under the "Instrument for Pre-accession Assistance Project: 'Dialog of Civil Society Organizations in Western Balkans'," which was implemented in Serbia, Albania, and Bosnia and Herzegovina. The longstanding credibility, experience, and institutional networks of the Red Cross of Serbia also drives their success.

Impact

SHGs have proven to be a successful innovation in Serbia. There are at least 50 serving over 550 older adults in a variety of settings, from rural villages to urban and suburban towns. Mental health and psychological support for older adults, especially those facing social isolation, has also been key to empowering older adults in their communities and reducing loneliness. Older adults participating in SHGs report a significant improvement to their wellbeing and benefit from a more robust support network. SHGs have also proved to be an effective means through which older adults can increase their political representation. One group, for instance, successfully lobbied to replace their village's water pipes, which had contained asbestos. Others have successfully requested to add bus stops, benches, and trash cans to their communities.

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E. Self-support and self-advocacy:

2) Empowering older adults: Older People's Associations (OPAs) in Bangladesh

OPAs in Bangladesh promote active engagement with older adults in their communities through advocacy, income-generating activities, and home care visits, driving more equitable access to resources and community support—particularly for marginalized older adults.

The focus

The share of adults aged 65 or over in Bangladesh is expected to increase from 5.6% of the total population in 2020 to 15.4% in 2050. Older women are particularly at risk of living in poverty and struggling to access resources like healthcare, support for disabilities, nutritious food, and adequate housing.

How it works

OPAs in Bangladesh were established in 2013 by HelpAge International and its local implementing partner, the SHARE Foundation. They promote the active engagement of older adults within their communities. Networks of OPAs exist at different geographic scales, corresponding to governmental administration levels, which focus primarily on monitoring and advocacy, as well as at the village level, which engage in activities for older adults such as home visits and neighborly care. According to a 2020 report, there are 298 documented OPAs. Some are multi-functional, covering different domains such as healthcare, social activities, and livelihoods. Others are intergenerational, bringing older and younger generations together to improve each other's lives and contribute to their communities. The average number of members in each OPA is 20-35.

Drivers of success

OPAs have been successfully implemented in Bangladesh because of strong partnerships with the SHARE Foundation and local governments, as well as sufficient staff capacity and strategic flexibility in tailoring interventions to different cultural contexts. Adaptations have included delegating responsibilities to local coordinators to effectively lobby different levels of the government. When designing income-generating activities, OPAs are attuned to local needs and older adults' physical capacity, which fosters suitable innovations. OPAs are also supported by the 2013 National Policy for Older Persons, which calls for establishing community associations for the benefit of older people, although it does not specifically refer to OPAs.

Impact

OPAs in Bangladesh improve advocacy and help increase access to important resources for marginalized groups such as women and rural populations, including social engagement, healthcare, home care, health education, and income-generating opportunities. After concerted efforts by HelpAge to increase women's participation in OPAs, over 40% of members in the intergenerational self-help clubs established since 2018 are women, a significant jump from 25% when the OPAs were first established.

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