



Social protection and older persons with disabilities

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Charles Knox-Vydmanov, Alexandre Côte, Florian Juergens and Diana Hiscock

While this paper has been drafted for ILO, UNICEF, HelpAge International and ADB within the frame of the UNPRPD project on Inclusive Social Protection, its content does not necessarily reflect their official positions.

Please share any feedback you may have with Veronika Wodsak (wodsak@ilo.org), Alexandre Cote (acote@unicef.org), Florian Juergens (florian.juergens@helpage.org) and Meredith Wyse (mwyse@adb.org)

Introduction

Old age and disability are both core concerns of effective life cycle social protection systems, and the two issues are strongly intertwined. Prevalence of disability rises significantly at more advanced ages and is indeed a core part of the rationale for old age pension systems. However, not all older persons live with a disability, and there is significant diversity in the extent of functional limitations experienced by older persons with disability. Old age pensions alone are not equipped to address this diverse picture.

This brief seeks to bring greater clarity to the discussion by setting out the key issues at stake for building social protection systems that address disability in old age. The brief starts by surveying the landscape of disability and old age, and sets out the key building blocks of a comprehensive social protection response. The brief then describes the status quo in low- and middle-income countries, before outlining a trajectory for how countries can progressively realise a social protection system that addresses the challenges of disability in old age. While the brief primarily focuses on individuals who acquire disabilities at more advanced ages, the key framework, trends, and recommendations outlined are also relevant for persons who live with disability before reaching old age.

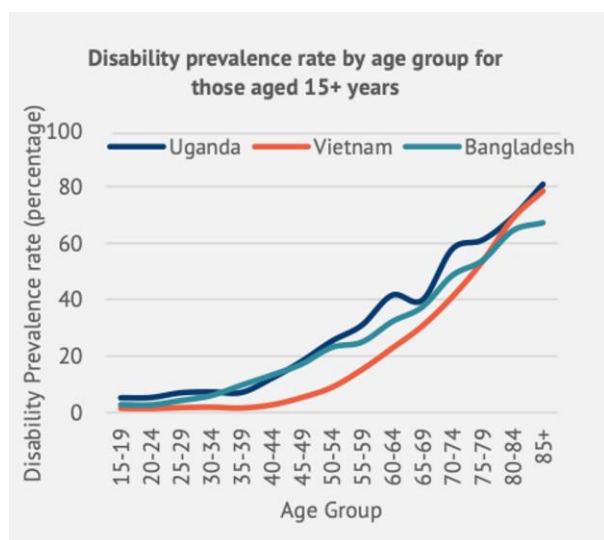
Overview of disability and old age

It is well established that prevalence of disability increases significantly with age. Estimates of levels of disability described in the 2011 World Report on Disability suggest between 38 and 46 per cent of older persons globally (aged 60 and over) live with moderate to severe disability, compared to between 15 and 16 per cent of the population on average. Levels of disability are found to be higher in low-income countries and for women. Elevated levels of disability in old age “reflect an accumulation of health risks across a lifespan of disease, injury, and chronic illness” (WHO, 2011). As a result, in many countries older persons make up the majority of the population with a disability, as in Georgia where, according to the 2014 census, 59 per cent of persons with disability are aged 60 and over. Even in South Africa, a country with a much younger population, the average age of a person with disability is 47 years. Levels of disability in old age may also be underreported given that many older persons may not self-identify as having a disability, considering significant functional limitations to be appropriate for their age (WHO, 2011).

Despite this strong tendency, there is significant diversity in the levels of disability amongst older persons. Notably, levels of disability increase significantly at more advanced ages. Figure 1 shows disability prevalence by age in three countries and illustrates the significant difference in levels of disability between people in their 60s (between 20 and 40 per cent) and those in their 80s (between 60 and 80 per cent). The nature and severity of disability also varies substantially between older people. One dimension of this is the severity of disability, as illustrated for the case of Thailand in Figure 2. While prevalence of functional limitations (in this case related to physical movement¹) are relatively common at all ages, a significantly smaller portion of older people have difficulties with the Activities of Daily Living (more strongly related to self-care²). The latter rise sharply beyond the age of 80, pointing to an elevated need for care. Other important dimensions of disability in old age include:

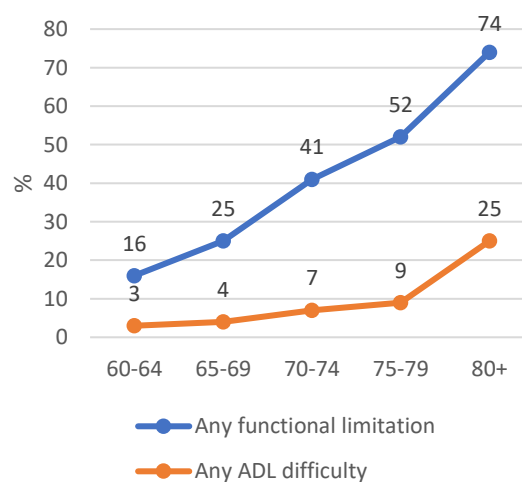
- **When functional limitations are acquired:** While many older persons only acquire functional limitations in later life, others will have been living with disabilities from earlier ages.
- **Varying functional limitations:** Data from the Global Burden of Disease project indicate that the greatest burden of disability is estimated to come from sensory impairments and chronic obstructive pulmonary disease (particularly in low- middle-income countries), dementia (particularly in high-income countries), back and neck pain, depressive disorders, falls, diabetes and osteoarthritis (WHO, 2015). However, the specific functional limitations vary substantially at an individual and country level.
- **Comorbidities:** A common feature of disability in old age is the presence of multiple health conditions and/or functional limitations. This can create greater complexity for health care and other service providers.
- **Gradual decline in functioning:** While individual pathways vary, disability in old age is often characterised by gradual declines in functioning, rather than sudden life-changing events (WHO, 2015)

Figure 1: Disability prevalence rates of people aged 15 and over (Bangladesh, Uganda and Vietnam)



Source: Kidd et al. (2019)

Figure 2: Proportion of older people with functional limitations and difficulties with activities of daily living, by five-year age group, Thailand, 2017



Source: Teerawichitchainan et al. (2019)

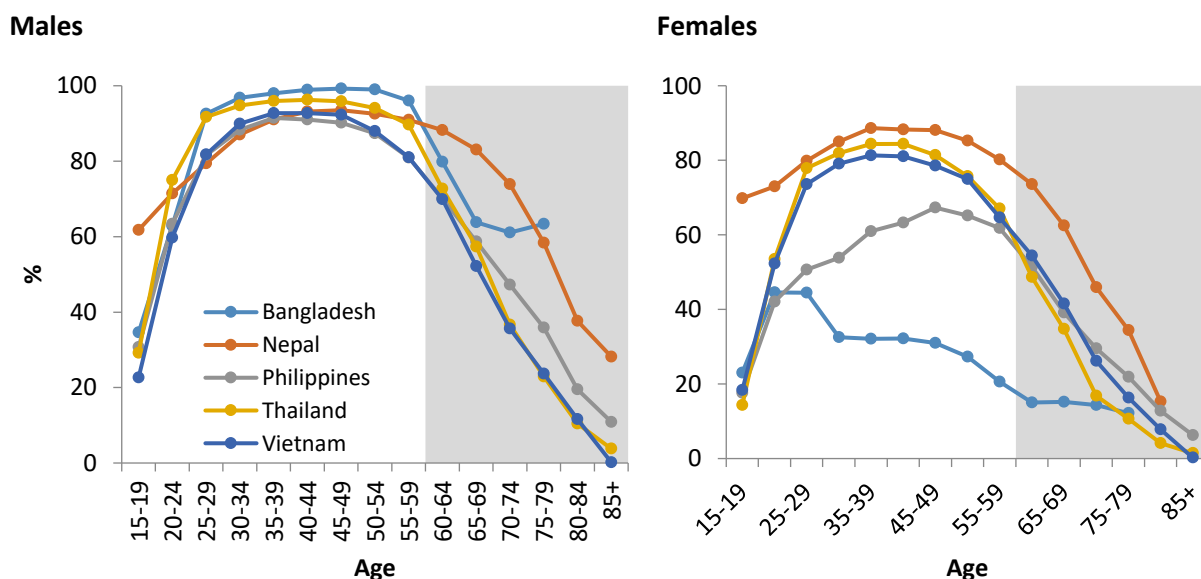
¹ The functional difficulties included in the survey are: Lifting 5 kilograms; Squatting; Walking 200-300 meters; Climbing 2 or 3 stairs.

² The Activities of Daily Living difficulties included in the survey were: Getting up from lying down; Using toilet; Bathing; Dressing; Wash face/brush teeth; Putting on shoes; Grooming self; Eating.

Disability in old age undoubtedly has a major influence on the ability of older people to work. Global labour force data shows that older persons are significantly less likely to be in employment than their younger peers in all regions of the world. Levels of employment in old age tend to be higher in countries with weak pension systems, but even in these countries there is a marked decline in employment at more advanced ages (HelpAge International, 2020; ILOSTAT, 2018). Figure 3 illustrates levels of employment by age in five Asian countries, highlighting the significant decline in later life, particularly for those of more advanced ages. Disability and ill health are clearly major drivers of lower employment levels, and for the majority of older people not in work in Bangladesh, the Philippines and Vietnam, health issues are reported as the main reason for being outside the labour force (HelpAge International, 2017).

However, drivers of older people's withdrawal from the labour force are not clear cut and are often intertwined with cultural norms and labour market dynamics. An important portion of older persons in the same three countries report family responsibilities as the main reason for not working (primarily women), which can include care responsibilities for children and persons with disabilities. It is not uncommon for older persons to be providing care to spouses or parents of more advanced ages while managing functional limitations themselves. Older persons may also face discrimination in the labour market despite absence of any functional limitation. For example, recent analysis of globally available data shows that in many countries persons aged 55 and over make up a substantial share of "discouraged jobseekers" (those with an interest in employment for whom existing conditions limit their active job search and/or their availability) (ILOSTAT, 2018).

Figure 3: Levels of employment by age (15+), males and females (Bangladesh, Nepal, Philippines, Thailand and Vietnam)



Sources: HelpAge International (2017)

These factors inevitably affect the income security of older persons and their families, contributing to higher levels of poverty. Lower labour income in old age implies a reduced capacity to financially contribute to household and family expenses, and an increased need for families to provide financial support. Disentangling older persons' income security from wider households is methodologically complex, however, in many countries older persons are more likely to be living in poverty than average. This is particularly the case when analysis takes account of economies of scale within a household, and the individual needs of older persons (Gelders, 2021).

Disability in also has important consequences for older persons' autonomy, dignity and social participation. In absence of an enabling environment, disability can limit the capacity for older persons to participate in

family life, socialise with friends and take part in community activities. A greater dependence on others for financial and care support also affect self-esteem, dignity and autonomy. These issues are strongly intertwined with income security, as a decreased capacity to financially contribute to households, families and communities can significantly influence older person's dignity and feelings of self-worth, and how they are perceived by others.

Demographic change is likely to bring the challenges of disability in old age increasingly to the fore. The proportion and absolute number of older persons is rising rapidly across the globe, and the pace of change is particularly fast in low- and middle-income countries. While demographic ageing may also be accompanied by more years in good health, the data on this issue remains inconclusive. Current evidence from high-income countries suggests that, while there may small reductions in disability at a given age, this trend is unlikely to keep up with the additional years people are living (WHO, 2015). It is therefore predicted that demographic ageing will be accompanied by a growing share of the population experiencing functional limitations. Demographic change will also influence the nature of financial support and care that older persons can rely on. Adult children have often been looked to as the main source of financial and care support for older persons but falling fertility rates mean that this support will be 'concentrated' among fewer children. This dynamic will particularly affect women who are more likely to be widowed – so less able to count on support of spouses - and also childless adults. Urbanisation and migration also have an influence on the nature of the family or kinship networks that older persons can look to for support. These factors highlight the central role of effective formal social protection systems both now and in the future.

The role of social protection in responding to disability in older age

Social protection is key to ensuring the income security, dignity, autonomy and participation of older persons in the face of often increasing levels of disability. Social protection systems are a key component of the wider environment that ensures that older people experiencing functional limitations can maintain their autonomy, and a standard of living that ensures a life in dignity. Social protection for older persons can be understood within the same framework set out in the introduction to this series. This includes measures which allow access to goods and services which are "common" to all persons, as well as services and transfers which cover the additional costs related with disability (such as health care, personal care and assistive devices) (UNPRPD, 2021a).

However, some specific dynamics can be identified, which are summarised in Table 1 and discussed below.

Table 1: Key components of social protection for older persons with disabilities

	INCOME SECURITY that enables access to common necessary goods and services	<ul style="list-style-type: none"> • Universal old age pension systems providing both minimum income support and income-replacement
	COVERAGE OF DISABILITY-RELATED COSTS, INCLUDING SUPPORT SERVICES including access to the required support	<ul style="list-style-type: none"> • Disability/inclusion support allowance • Community support services (long-term care, home visits, rehabilitation) • Concessions (e.g., tax exemption, discounts, free transportation cards) • Provision of assistive devices
	EFFECTIVE ACCESS TO HEALTH CARE including disability-related medical care and rehabilitation	<ul style="list-style-type: none"> • Including access to health care that addresses the particular needs of older persons with disabilities

Income security of older persons with disability is primarily addressed by old age pension systems. Pension systems are focused on providing an income in the context of the reduced capacity of older persons to engage in paid work described above. In some senses, pensions can be considered as a “blunt instrument” to address the increased functional limitations experienced by a significant share – if not the majority – of older persons, that create barriers to participation in the labour force. As with all social protection contingencies, old age pensions can be seen to have two dimensions:

- A *horizontal dimension* achieved via a social protection floor that provides a basic income security that should allow a life in dignity for all.
- A *vertical dimension* that provides higher-levels of guaranteed earnings-related benefits to those with greater contributory capacity (ILO, 2012).

Achieving both these dimensions usually requires a mix of contributory and non-contributory pension benefits.

However, old age pensions do not address the full range of costs experienced by older women and men with disabilities. While pension systems address some of the indirect costs of disability in old age, they cannot be expected to cover the direct costs such as assistive products, the need for care and support, higher needs in health care and different transportation needs. Importantly, they also do not address the indirect costs of disability for the families or wider social networks of older persons with disabilities. Some key aspects of these disability-related costs deserve highlighting:

- **Care and support:** For older people with more severe functional limitations, a life with autonomy, dignity and participation is only possible with care, support and assistance of others (WHO, 2015). This need for support generates significant disability-related costs which can only be addressed with development of support systems combining in kind or in cash support with effective case management. In kind support entails free or low-cost care and support services, such as home-based care and personal assistance which would often combine state and community contributions. Cash could allow older people to purchase or partially cover costs of paid care or opportunity costs of support provided by family members. Cash benefits can be provided to compensate for time allocated to caregiving, either paid directly to the carer or via the older person. This area, perhaps more than any other discussed in this paper, is raising the question of how to ensure choice and autonomy to older persons in a way that combines cash and in-kind support while providing decent work conditions for carers and support persons. It also has important implications for gender equality given the fact that the family caregivers are very often women and girls.
- **Health care:** Effective access to health care is key to both the well-being and financial security of older persons. Effective health care services enable older persons to better manage health conditions and limit the extent to which they result in functional limitation. Higher levels of ill health and disability at more advanced ages mean that older persons are particularly reliant on access to affordable health care. High user fees can stretch income from pensions or family support networks and may lead to older persons to forego health care, potentially contributing further to functional limitations.
- **Other costs:** As for persons with disabilities of all ages, older persons with disabilities may require assistive devices which come at an additional cost. Such costs can be covered by the free provision of such items (e.g. via the health system or social services) or via cash benefits which allow older persons to purchase them. Older persons with disabilities are also more likely to need to use public transport, which is why many countries have in place free or discounted transport for older persons. However, when public transport is unavailable or not accessible alternative point to point transport mechanisms have to be provided.

The status quo in low- and middle-income countries

This section provides a summary overview of the extent to which low- and middle-income countries have put in place social protection mechanisms that adequately respond to the situation of older persons with disabilities.

Income security (old age pensions)

While important gaps remain, there has been important progress in extending coverage of old age pension systems in recent years. According to the most recent ILO estimates, 78 per cent of older persons above statutory retirement age receive some form of pension income, which is higher than any other social protection contingency. Coverage tends to be significantly lower in low and middle-income countries, however, many of these countries have also seen significant initiatives to extend pension coverage in recent years (ILO, 2021). An important part of this trend has been the introduction and expansion of tax-financed social pensions in a wide variety of countries. Universal or near-universal schemes introduced in countries including Kenya, Nepal, Thailand and Timor-Leste have been particularly effective at rapidly expanding pension coverage (HelpAge International, 2020; Palacios and Knox-Vydmannov, 2014).

Adequacy of pension benefits remains a significant issue even in countries with relatively high levels of coverage. Benefit levels of social pensions vary significantly from those above relevant international poverty lines (Georgia and South Africa) to those falling well below (Thailand and Viet Nam).³ Contributory schemes, which usually cover only a minority of workers in most low- and middle-income countries, also confront issues of adequacy. Social insurance schemes often provide minimal protection for those with short or fragmented contribution histories, an issue which disproportionately affects women and individuals who have acquired disabilities earlier in their lives. Moves towards privatisation of national pension systems have often undermined pension adequacy (Ortiz et al., 2018). Meanwhile, provident funds – common in many Asian and African countries – provide limited protection in the form of lump sum benefits. Put simply, pensions often fall far short of providing a minimum income security, which will create specific challenges for older persons with additional disability-related costs.

Nevertheless, even relatively modest benefits can make a major contribution to improving the lives of older persons with disabilities. Even where benefits are not sufficient, they can make a transformative difference to older persons compared to receiving none. An extensive and growing body of research has shown how the introduction of social pensions – often with modest benefits – has resulted in significant impacts on areas including reduction of poverty and inequality, improved nutrition and increased access to health care. Social pensions have also been shown to improve autonomy and social relations which, in turn, have the potential to support older persons to receive care from family members (HelpAge International, 2020; Tran et al., 2019). Research in China, Mexico and Peru also shows how boosting the autonomy and dignity of older persons contributes to improved mental health, with significant decreases in levels of depression (Bando et al., 2016; Chen and Wang, 2016; Salinas-Rodríguez et al., 2014).

Health care

Health care services in low- and middle-income countries have major shortfalls in terms of both affordability and the appropriateness of care provided to older persons. Despite the increasing needs for health care at more advanced ages, this is not reflected in greater health care utilisation amongst older persons in low- and middle-income countries. A major driver of this mismatch are the gaps in affordable health coverage for the population as a whole, but which particularly older persons with disability. Health systems with a primary focus on short-term illness and communicable diseases are also often not suited to the health needs of older persons - often characterised by multiple longer-term chronic conditions (WHO, 2015).

³ See Figure 4 below for comparison of social pension benefits to international poverty lines relevant for country income groupings.

Affordability not only relates to the cost of services themselves, but to non-medical and indirect costs (UNPRPD, 2021b). The costs of accessing health care services include:

- **Direct medical costs**, including general healthcare services, rehabilitation and specialist health services, and also assistive products and community/home-based long-term care where these fall under the health care system;
- **Direct non-medical costs**, such as transportation, accommodation and personal assistance or interpreter required when accessing healthcare, which increase with often long waiting times and repetitive visits;
- **Indirect costs**, such as loss of income or time people with disabilities face while seeking care, or for other family members who provide personal assistance or caregiving support.

A lack of affordable health services in low- and middle-income countries is a major driver of high direct medical costs for older persons. However, direct non-medical costs – particularly transport – are also a major issue, being far more likely to be reported as a reason for not accessing medical services in the poorest countries (WHO, 2015). Effective pension systems can make an important contribution to covering these costs, as can supplementary disability benefits, related benefits and concessions (such as free or low-cost transport). Direct non-medical costs can also be reduced by improving the geographical reach of health services.

Evidence shows that a lack of affordable health care is strongly tied to issues of dignity and autonomy in old age. While older people may find it easier to justify (to themselves, and their families) access to pooled household resources, such as accommodation and food, health expenses are more challenging. Qualitative research highlights how older people often express shame in seeking resources from their families to cover these personal expenditures (Box 1). This evidence has often been gathered in contexts where the introduction of social protection schemes has provided older people with resources for these expenditures. However, while cash benefits can make an important contribution to covering indirect costs of health care (most notably transport), they should not be considered an alternative for affordable health services at the point of access.

Box 1: Health expenditure and dignity

“I used to be ashamed because I didn't have enough money to buy the things I needed. Whenever I got sick, I would have to beg for money. But now, at least we have some money. If I get sick, at least I can buy medicine now.” Mexican social pensioner (Salinas-Rodríguez et al., 2014)

“Sometimes I also need medicine for my cough. That is why the one who supports me, if she has the money, she will provide me the money to buy some. Sometimes I get humiliated when I talk to my daughter. ‘What can you do if you are sick and you don't have enough money to purchase your medicine?’ She said. ‘No one really supports you except me and your grandchildren when they have the money.’” Older woman (78), Philippines (Knox-Vydmanov et al., 2017)

Disability-related costs

A concern about “double-dipping” often stands in the way of an adequate consideration of the disability-related costs of older persons. In low- and middle-income countries it is common that individuals can either receive a disability benefit (before retirement age) or an old age pension (after retirement age). This approach does not take account of the additional direct disability-related costs of older persons with disabilities (such as personal care and assistive devices) that go beyond the indirect costs covered by old age pensions. The background paper on disability-related Extra Costs within this series highlight that they can often be substantial, particularly where personal assistance is required (UNPRPD, 2020).

A small number of middle-income countries have bucked the trend with cash benefits that complement general old-age pension income. Box 2 provides examples of five countries with such schemes, which vary to the extent to which they specifically address the costs of care (such as in South Africa) or seek to contribute

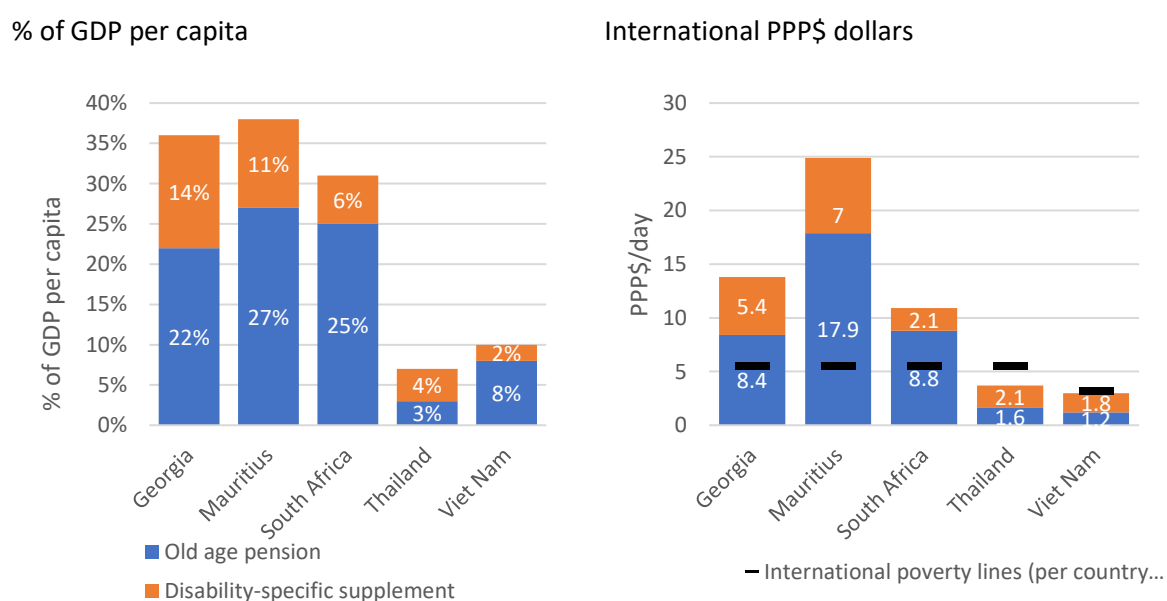
to a more general array of disability-related costs. These schemes also vary significantly in terms of their coverage and their adequacy. One other relevant feature of pension systems worth noting is where benefit levels are increased for persons of more advanced ages, which exists in the case of Thailand and Mauritius. While not always articulated as such, this can be considered to implicitly take account of the additional levels of disability (and associated costs) of older persons at more advanced ages.

Box 2: Supplementary disability benefits for older persons

The following middle-income countries have in place cash benefits that are paid in addition to general old age pension schemes to older persons with more severe disabilities.

- **Mauritius:** The Enhanced Basic Retirement Pension is payable in addition to its universal tax-financed Basic Retirement Pension, for recipients who are “totally blind or who suffer from a total paralysis or who need the constant care and attention of another person”.
- **South Africa:** The Grant-in-Aid benefit that is paid to beneficiaries of the disability, old age and war veterans’ grants that exist in the country. Recipients must have been certified by a Medical Officer as requiring regular attendance by another person. The scheme has a relatively low number of recipients (137,000) compared to the 4.3 million people receiving the disability, old age and war veterans’ grants (Kidd et al., 2018).
- **Thailand:** A disability allowance is paid to all persons with a disability card, including older persons who are also receiving the old age allowance. The benefit level is 800 THB/month for those aged 18 or over. More than half of those with a disability card in Thailand (and receiving the allowance) are aged 60 and over.
- **Viet Nam** has a complex array of social allowances for different population groups (including older persons) which are topped up according to disability status. For example, while older people aged 80 and over (without other pension income) are entitled to a minimum allowance, those with “an assessed reduced working capacity of at least 81%” are eligible for a higher benefit. The country also has a caregiver support benefit. (James and McClanahan, 2019)
- **Georgia:** In addition to the universal State Pension in Georgia (eligibility based only on age and citizenship/residency), older persons with “significantly pronounced disability status” can receive an additional benefit.

Figure 4: Adequacy of combined old-age pension and disability supplements, 2019



Notes: Benefits included are as follows: **Thailand:** Old Age Allowance for population 60-69 (600 THB/month) and Disability Allowance (800 THB/month), **Viet Nam:** Pensions-tested scheme for over 80s (270,000 VND/month) compared to total 675,000

VND/month for person aged 60 and over with an assessed reduced working capacity of at least 81%. **South Africa:** Old Age Grant (1,780 ZAR/month) plus Grant-in-Aid (430 ZAR/month). **Georgia:** State pension (240 GEL/month) plus supplement for “Persons with significantly pronounced disability status” (140 GEL/month). **Mauritius:** Basic Retirement Pension (9,000 MUR/month) plus Enhanced Basic Retirement Pension (3,500 MUR/month). International poverty lines used are: Lower-middle income country – 3.2 PPP\$/day; Upper-middle income country – 5.5 PPP\$/day. Sources: GDP per capita and PPP\$ conversion rates from IMF (2020)

Figure 4 gives an indication of the combined adequacy of each scheme, relative to average income (GDP per capita) of each country and in international dollars (PPP\$). The relevant international poverty lines per country income grouping are also indicated. Georgia, Mauritius and South Africa display strikingly similar configurations with total benefits reaching between 31 and 38 per cent of GDP. Benefits are also well in excess of international poverty lines. These benefits are at the higher end of adequacy of tax-financed disability and old age schemes, although this does not tell us whether such schemes cover actual disability-related costs. Thailand and Viet Nam are at the other end of the scale, at the low end of adequacy for tax-financed disability and old age benefits (10 per cent of average income or lower), and below international poverty lines for their country groups.

Provision of formal care and support to older persons is relatively limited in most low- and middle-income countries. Usually care and support to older persons is provided by family members, predominantly women and girls. This places a significant indirect cost on families and is an important driver of lower female labour force participation (ILO, 2018). In some countries, such as Mexico and Peru, there has been a growth in care provided by paid care givers amongst older people in urban areas. However, this care is almost always financed by out-of-pocket payments and usually provided by low-paid and untrained migrant workers (WHO, 2015). Cash benefits provided to cover disability-related costs including the cost of care (as discussed in Box 2) may make some contribution to renumerating the cost of care provided by families, or allowing older persons to purchase private care.




Nevertheless, an increasing number of countries are taking steps to strengthen care and support services. The issue has gained the greatest attention in high-income countries, but also in many middle-income countries already undergoing processes of rapid demographic ageing – most notable in Asia and the Pacific. For example, China and Thailand have established formal long-term care systems, including channelling additional funding to the area (World Bank, 2016). As with other areas of social protection financing, this is broadly achieved via a mix of tax-financing and contributions, and many high-income countries have introduced new approaches including long-term care insurance (WHO, 2015). Addressing effectively the extent and diversity of need for support requires the development of community support systems combining in-kind and cash support with effective case management, which will often mobilise public and community stakeholders and resources.

Greater investment in community systems of care and support can provide opportunities for the economy and the labour market, but also to build systems focused on strengthening dignity, autonomy, inclusion, and participation. It is estimated that the care economy could generate close to half a billion jobs around the world by 2030, significantly influencing the shape of future labour markets and economies. However, the opportunity provided by the care economy depends on factors including adequate investment, revaluing paid care work, and support for unpaid care workers (ILO, 2019). Investment in care and support services also provides the opportunity to build systems in a way that is most supportive of the dignity, autonomy, and participation of older persons. Residential care became common in many high-income countries during the second half of the 20th century, but low- and middle-income countries can put a greater focus on community-based care early in the development of their systems. Such an approach is more conducive to supporting independent living and “ageing in place”, which allows older people to maintain their social networks. This should also come part of a more “positive and proactive agenda” to enable the continued participation of older persons with disabilities, who require personal assistance (WHO, 2015).

A pathway to stronger social protection for older persons with disabilities

While low- and middle-income countries have a long road to building social protection systems that provide adequate support for older persons with disabilities, there are concrete steps that can be taken to substantially improve their well-being.

- **As a priority, ensure universal access to adequate health care and old age pensions.** Efforts to expand these systems can build on the significant progress on strengthening health and pension systems in low- and middle-income countries. In terms of pensions, high-coverage or universal tax-financed pensions can effectively contribute to extend coverage to some of the most vulnerable older persons with disabilities in countries with low contributory coverage. They are particularly relevant for women who usually have weaker entitlements under contributory systems. However, it is also critical to continue strengthening contributory systems. Expansion of both health and pension systems will often entail a process of progressive realisation – in terms of benefit levels, service coverage and cost-sharing – but a key starting point is to extend a universal entitlement to all. Universal disability allowance can also be a step toward universal coverage in countries without old age tax-financed pension.
- **Build these systems in a way that integrates tailored support for older persons with disabilities.** Within these broad-based and universal approaches, it is possible to incorporate elements which prioritise or provide additional support to older persons with disabilities. This includes ensuring that health care services are responsive to the kinds of health conditions faced by older persons with disabilities and are accessible to them. There are also ways in which different levels of disability amongst older persons can be recognised in the progressive expansion of such systems. For example, even where a country introduces a social pension with initially modest benefits, it could provide some form of top up to older persons with higher support needs, to take some account of additional costs. The extension of universal health coverage schemes (including rehabilitation and assistive devices) prioritising older persons and persons with disabilities also aligns with this approach.
- **Progressively build a more comprehensive set of mechanisms to cover disability-related costs, including care and support.** This includes:
 - **Community support and care system for older persons with disabilities:** The dearth of formal care and support services in most low- and middle-income countries means that there are few viable models. It is therefore critical to develop gender responsive models that build on existing patterns of community care and support and strengthen appropriate financing arrangements.
 - **Introduction of additional cash benefits for older persons with disabilities:** This should move away from the idea of “double-dipping” to incorporate mechanisms that provide additional cash benefits to older persons that cover disability-related costs, including access to assistive devices.
 - **Other measures to reduce the costs of older persons with disabilities:** These include approaches such as free/low-cost public transport for older persons.

	INCOME SECURITY	As a priority, expand universal pension systems that provide at least a minimum floor, and income replacement. This should be part of a life cycle social protection system.
	EFFECTIVE ACCESS TO HEALTH CARE	Expand universal health coverage for all, paying attention to specific needs of older persons with disabilities.
	COVERAGE OF DISABILITY-RELATED COSTS	<p>Include higher/additional benefits for OP with disabilities in process of expanding pension coverage that reflect the diversity of disability-related costs</p> <p>Take steps to gradually build formal care and support services, with a focus on community-based systems.</p>

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