Prospects for the retirement process in South Africa- How are we doing here?

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How does the outside world see the prospects for the elderly in our country?

In 2015, an index produced by Natixis ranked South Africa 130th out of 150 countries in retirement welfare, using four themes to cover key aspects of the retirement experience:

- the material means to live comfortably in retirement
- access to quality financial services to help preserve savings value and maximise income
- access to quality health services
- a clean and safe environment

Figure 9: Natixis Global Retirement Index: retirement experience themes

Source: Natixis Global Asset Management (2015).

Colour scale
91%–100%
81%–90%
71%–80%
61%–70%
51%–60%
41%–50%
31%–40%
21%–30%
11%–20%
0%–10%

Rank	Country	Health index	Finances in retirement index	Quality of life index	Material well-being index	Global retirement index
121	Botswana	29%	66%	45%	22%	37%
122	Senegal	22%	44%	47%	38%	36%
123	Afghanistan	21%	51%	35%	46%	36%
124	Madagascar	20%	51%	43%	38%	36%
125	Yemen, Rep.	29%	44%	37%	36%	35%
126	Burkina Faso	19%	44%	47%	42%	34%
127	Ethiopia	19%	34%	50%	39%	34%
128	Benin	20%	44%	37%	42%	34%
129	Myanmar	17%	33%	57%	44%	34%
130	South Africa	50%	62%	54%	8%	34%
131	Mozambique	17%	60%	49%	25%	33%
132	Djibouti	35%	57%	53%	11%	33%
133	Zimbabwe	18%	33%	60%	31%	33%
134	Sudan	28%	26%	41%	30%	32%
135	Haiti	35%	56%	25%	22%	32%
136	Guinea	18%	34%	43%	37%	32%
137	Tanzania	16%	55%	25%	45%	32%
138	Chad	12%	55%	36%	37%	31%
139	Malawi	18%	55%	63%	13%	31%
140	Mauritania	26%	55%	51%	11%	30%
141	Mali	9%	55%	33%	32%	30%
142	Burundi	17%	48%	40%	21%	29%
143	Liberia	18%	57%	33%	20%	28%
144	Niger	13%	42%	40%	29%	28%
145	Sierra Leone	8%	49%	36%	47%	28%
146	Lesotho	21%	56%	25%	16%	26%
147	Comoros	27%	58%	22%	10%	24%
148	Congo, Dem. Rep.	11%	45%	43%	14%	23%
149	Central African Republic	13%	52%	41%	10%	23%
150	Togo	20%	38%	7%	27%	19%

Source: Natixis Global Asset Management (2015).

Figure 11: Understanding South Africa's rankings in the Natixis Global Retirement Index

Source: Natixis Global Asset Management. (2015)

The reason South Africa ranked so poorly was a function of combined extremes.

On the positive side, South Africa has a Declaration of Rights for Old People. We have relatively high pension coverage (92.6%) thanks to our non-contributory state pension, the Older Person's Grant. That said, this pension is just R1 510 a month. But, importantly, we also have a high rating (relatively) on quality of life and one of the highest quality healthcare systems. If we consider only the private sector component of healthcare, this competes with world-class facilities elsewhere.

On the negative side, our image as a retirement destination is marred by perceptions of widespread poverty and an HIV/AIDS problem that has 'hollowed out' our caregiving resources. Our measure of material well-being (only 8%) was the lowest of all countries assessed. This measure assesses factors such as income per capita, unemployment levels and income equality. It's the fact that we remain so much a 'barbell economy' that's problematic. For higher income groups, retirement in South Africa can be highly desirable. For lower income groups, this is almost untenable without the support of family. The report points out that although older people are integrated into a development framework, there is no clear strategy for implementing this framework, or insight into who should be responsible for such a strategy.

If we scan the studies that assess the ageing experience in South Africa, the litany of issues is particularly concerning. These are highlighted as follows:

- **Ageing and South Africa's policy agenda**
  "Despite the potential impact of population ageing, the needs and interests of older people have largely been invisible on the South African policy agenda. This is largely because of other sizeable development and health challenges affecting the youth and working-age populations, such as: the HIV epidemic, poor education outcomes, unemployment, lack of access to basic services and general poverty[3]."
  - Primary healthcare in South Africa prioritises maternal and child health, HIV and AIDS.

- There is little clarity on who is responsible and accountable for different areas of government oversight, resulting in poorly coordinated delivery between the Department of Health and Department of Social Development[4].
- There is no comprehensive, holistic, integrated policy for older persons.
- Long-term care and rehabilitative services are underdeveloped.

- **Funding for long-term care**

  According to The Association for the Aged (TAFTA), "The current government funding model is woefully inadequate. When funds are forthcoming, they fall far short of the true costs of providing services to vulnerable elderly citizens." In 2015, TAFTA highlighted that the Department of Social Development had failed to honour its commitment to maintain its contributions in line with inflationary increases in service delivery costs in the following areas:
  - Frail care: Only 51.9% of costs were covered, a shortfall of about R3 800 per person per month.
  - Assisted living: There is no subsidy for this, leaving an approximate shortfall of R2 950 per person per month.
  - Social services at lifestyle centres: The department allocates R16 per person, per day, for a maximum of 100 people at each lifestyle centre, leaving a shortfall of R64 per person per day[5].

- **Administering the solution**

  South Africa is not short of innovative ideas about how to deliver more effective, humanistic long-term care solutions. There have been any number of excellent programmes that have targeted community development and training around longterm care. But inadequate administrative skills, fiscal imprudence, the absence of sustainable funding models and the absence of true sponsorship has meant that many public sector initiatives have simply shut down programmes prematurely.

- **Healthcare for the elderly**

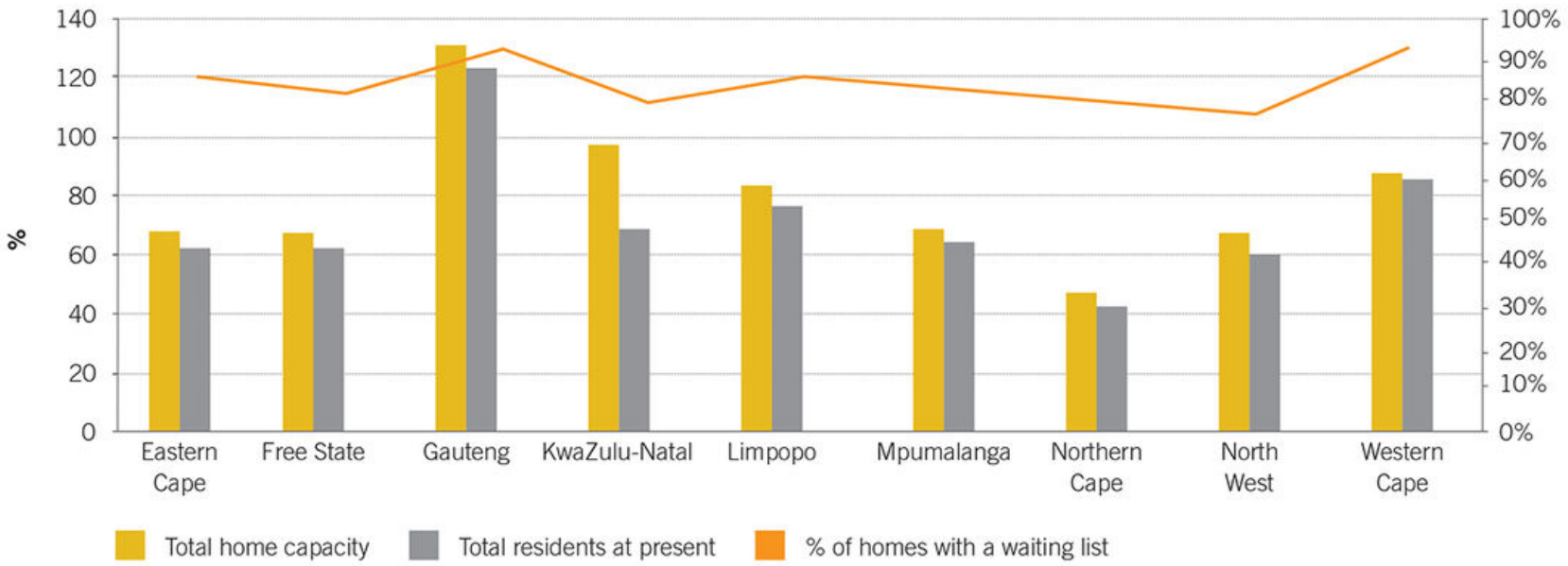
  "The quality and accessibility of healthcare for older persons in South Africa, who may have multiple health conditions and impairments and face both individual and systemic barriers to access, is particularly concerning. In an overburdened and underperforming health system, the needs of the elderly are often neglected. One of the most obvious indications of the low priority given to the elderly in the health system is the removal of gerontology and geriatrics from the South African Nursing Council curriculum[6]."
  - Health coverage of the elderly is around 48%, which suggests most of them are not using or are underusing health services, or end up impoverished by having to pay for health services which may or may not provide the care they need[7].
  - Although elderly people are entitled to free public healthcare, they struggle to access quality care because of capacity constraints and age-related barriers to access. Health services tend to be clinic-based and focus on acute conditions. The health system has no capacity to deal with the complex needs of older people who have multiple chronic conditions[8].
  - Staff shortages, time and resource constraints, and weak management systems lead to poor service delivery and the negligible treatment of patients[9].
  - Given the limitations of the health system, people who are not healthcare professionals are sometimes used to help identify problems in communities, but little has been done to ensure they are trained and accredited, and use the correct resources.

- **Housing for the elderly**

  An audit of housing facilities available for long-term care, conducted by the Department of Social Development[10], presented the following findings:
  - The distribution of residential facilities for the elderly is disproportionately high in the provinces of Gauteng and the Western Cape, with distinctly fewer facilities in provinces such as Limpopo, Eastern Cape and Free State. Most facilities (79%) are concentrated in formal metropolitan or small, formal urban areas. Only 5% are in informal or squatter areas while 16% are in rural areas.
  - The service providers that run significant sections of these facilities are mostly large non-governmental organisations and, in some outlying areas, smaller faith-based or community-based organisations.

South Africa is not short of innovative ideas about how to deliver more effective, humanistic long-term care solutions.

Figure 12: Housing for the aged: total capacity, total residents, % homes with waiting list[12]



- Most homes were not able to comply with current norms and standards, and were of the view they would require a huge financial investment in order to comply.
- As Figure 12 suggests, all homes were below their allowed capacity, yet had waiting lists of people who needed to be admitted. In most cases (89%), the waiting period for admission to a home was less than a year. In 2% of cases, it was between three to five years, and in 9% of cases people had to wait more than five years[11].

- **Ageism**
  "Societal ageism feeds perceptions that older people have little to contribute to society or the economy. Although the *Older Person's Act of 2006* exists to maintain and promote the rights, status, wellbeing, safety and security of older persons, the act and its regulations are poorly implemented and these issues are overlooked as older people retreat (often without wanting to) from economic and social life[12]." Although the South African Constitution expressly protects its people from ageism, employers generally employ mandatory retirement policies.

- **Retirement savings and long-term care**
  Most people are unable to save enough money for their long-term care. Families are too small to pay and provide long-term care for the older generation. "We need to change the current ideology of expecting individuals and families to finance long-term care[13]."

What now?

What can we conclude then from this lengthy discussion of ageing in South Africa? The data is starting to tell an important story. While the attention of policymakers is focused on the issues of our youth and unemployment, demographic changes – specifically increasing longevity and urban migration – are placing an increasing strain on our assumptions that a culture of reciprocity will mean that families will take care of their elders. The title of one study on this phenomenon says it all: *Who will take care of the caregivers?* What will happen in the absence of a policy focus? The biggest issues lie not with 'who' and 'how' but rather with 'what funding' and 'if funding exists, who ensures that it is properly administered?'

Potentially the answer may lie with the private sector, or with a hybrid for-profit/notfor- profit model. Probably one of the most successful models for funding long-term care solutions for both those who can pay and those who can't is the **Rand Aid Association**, a non-profit organisation that addresses the needs of both older people who can pay for long-term care facilities and those who can't. Two elements of the Rand Aid model make it stand out:

- It uses a portion of its profits from the sale of life rights retirement accommodation to fund the development and management of long-term care solutions for the aged in need, and men suffering from substance abuse. It in turn provides all the administrative and management support for both sets of solutions.
- It was the first long-term care facility in South Africa to adopt **The Eden Alternative**. This is a transformative model of care that advocates person-directed solutions of care as opposed to the conventional practice where the institution dictates the daily routines for an individual (see The Eden Alternative below).

Getting creative

If we really want to start thinking creatively here, then perhaps it's time that South Africans consider a model that has already been put to good use in both Japan and Germany. Both countries experience a double whammy when it comes to providing longterm care to their ageing population. Not only are medical care and caregiving expensive, but there is a serious shortage in locally sourced caregivers. The answer for many lies in a transnational care model. For the Japanese, the Philippines plays a key role. Any number of nursing homes have been set up by Japanese and Filipino businesses to take advantage of low medical care costs, the availability of English-speaking health professionals, and an attractive setting with a desirable climate. This is simply another variation of 'medical tourism', a phenomenon that has already proven to be an important foreign revenue generator for South Africa.

While this certainly challenges the notion that older people would prefer to stay near their loved ones, or are unwilling to make such drastic changes late in life, in European and North American contexts, finding lower-cost alternatives for retirement is making this a 'must-consider' option.

Could retirement tourism work in South Africa?

Consider what the implications could be for South Africa if such a model became more fully developed:

- Policymakers could make the licensing and visa facilitation conditional on the model supporting the funding and coadministration of a residential model for local indigent elders.
- This would in turn provide a further source of funding and development for much-needed frail care centres for low-income South Africans.
- Training of caregivers for both facilities would be paid for and facilitated by the long-term care facility operator.
- Caregiving training and employment could be extended to currently unemployed people.
- A life rights model of residential ownership would ensure that all property ownership would remain in South African hands.
- The model would provide an attractive source of foreign revenue for South Africa.
- A franchisable model would provide another ideal opportunity to develop a niched SMME business.

What makes this model particularly attractive is that it builds on aspects of strength for South Africa:

- Our private medical care and caregiving capabilities are recognised as world-class.
- We have a large population of unemployed people who need training in skills that can't easily be automated – ensuring sustainable job prospects. Caregiving as envisaged by such models as Eden Alternative requires high levels of compassion and emotional intelligence (EQ), something that is difficult to automate.
- The costs of such a service would be approximately a tenth of what would be available in Europe or North America.

It could work!

The Eden Alternative – a radically different approach to long-term care

The Eden Alternative is an international not-for-profit organisation dedicated to transforming care environments into habitats for human beings that promote quality of life for all involved. The brochure on The Eden Alternative uses the term 'culture change' to describe how the initiative is transforming our notions of long-term care globally.

Their care model advocates a shift from institutional models of care to person-directed values and practices that put the person first. This means it focuses on the unique needs, preferences and desires of each individual. Decisions and actions for care reflect the choices of the people receiving care, as opposed to standard routines designed to suit the care-giving institution. For The Eden Alternative, self-determination and purposeful living are at the heart of quality ageing. That means preserving choice, dignity and respect throughout an individual's life is paramount. As a living environment, The Eden Alternative recognises how life-enhancing a steady flow of exposure to youth, animals, plants, the outdoors and a rich and diverse daily life can be for the elderly.

But where The Eden Alternative has had its greatest impact is in the training of the carer. The Eden Alternative model for caregiving training infuses a much-needed sense of purpose into the caregiver's function. Here, caregivers are provided with the skills and tools to add real value to their patients' lives. This training can be applied to caregivers servicing people in a retirement residence, the community or their homes. This makes it a model that is ideally suited to caregiver training in South Africa.

WHY WE NEED TO START PAYING ATTENTION – NOW!

Perhaps the most chilling cautionary around the issue of ageing in a world that is making extraordinary medical studies is the one Gratton and Scott pose to governments, echoed in Yuval Noah Harari's book, *Homo Deus*. All of these authors see health inequality as being the biggest challenge of longevity.

For Gratton and Scott, the problem is as follows:

"Life expectancy gains are not spread equally across the population and an ever-widening gap between rich and poor is developing within countries. It is also clear that many of the options we explore to make the most of a 100-year life are most easily available to those with professional or technical backgrounds with high income. A long life requires resources, skills, flexibility, self-knowledge, planning and respectful employers. The danger is that the gift of a long life will only be open to those with the income and education to construct the changes and transitions required[14]."

For Harari, inequality of health could be an even greater disruptor to social order than financial equality. Here we return to our discussion of the Fourth Industrial Revolution and remember that, in addition to robotics and artificial intelligence, this revolution incorporates biotechnological advances. Harari paints a fairly realistic picture of a future where we have so mastered the art of body-part replacement and genetic re-engineering that amortality (not quite immortality) is within reach. He argues, though, that if only the wealthiest had access to these developments, we could well see the emergence of what he terms 'biological castes'. There would be a segment of the population that could afford upgraded bodies and access to unprecedented creativity and skill enhancements and then there would be the rest of humanity. It's a concept that might seem extreme to contemplate – but is it entirely outside the realm of possibility?

What it does suggest is that we start paying close attention to how health, ageing and caregiving play out in South Africa, lest this climate of inequality increase further.

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EDEN ALTERNATIVE | GLOBAL RETIREMENT INDEX | POLICY ON AGEING | FUNDING | LONG-TERM CARE | HEALTHCARE | HOUSING | RETIREMENT TOURISM