The Elderly in Barbados: Problems and Policies[1]

FARLEY S. BRATHWAITE[2]

♦♦♦

Empirical data on conditions affecting elderly people in the Caribbean are very limited. To help deal with this lack of information in the specific case of Barbados, in 1982 a survey was conducted of 525 randomly selected people 65 years of age or older. This article summarizes data derived from that survey in order to provide an overview of the social and economic circumstances affecting Barbados' elderly population. While it is true that these circumstances do not necessarily mirror those found elsewhere, they clearly have elements in common; and it seems likely that the survey approach applied in this instance could prove useful elsewhere in obtaining worthwhile information.

Barbados is one of the more developed countries in the English-speaking Caribbean. It is small, with an area of only 166 square miles; but its population numbers around a quarter-million people (248,983 in 1980), giving it an extraordinary population density of about 1,500 inhabitants per square mile.

Historically, the country had a one-crop (sugarcane) economy, but in recent times a new pattern has emerged. As of 1984 (2) the main contributors to the gross domestic product were retail trade (19.8%), government services (14.2%), finance and insurance services (13.0%), manufacturing (12.7%), and tourism (9.9%).

This article dealing with the nation's elderly (defined as those over 64 years old) has the following aims: (1) to present a demographic profile of the elderly in Barbados, paying particular attention to demographic growth patterns; (2) to describe the elderly population's social, psychological, and economic characteristics; and (3) to give an overview of social policy approaches being used to deal with problems of the elderly, together with a tentative assessment of those approaches.

DEMOGRAPHIC PROFILE

The last hundred-odd years have seen a dramatic increase in both the number and proportion of elderly people in the Barbadian population. In 1871 the number of those 65 and over stood at 6,942, in 1921 it stood at 13,299, and in 1980 at 25,601—with a prospective projected increase to around 40,000 by the year 2000. Similarly, the elderly accounted for 4% of the total population in 1871, 8.5% in 1921, and 10.5% in 1980—with a prospective projected increase to around 15% by the year 2000 (3).

Comparison of these data with world and regional estimates (4) suggests that the elderly population's pattern of growth in Barbados more closely resembles the pattern seen in the industrialized countries (where the elderly were estimated at about 11.4% of the total population in 1980) than the pattern seen else-

[1] This article, which will also be published in Spanish in the *Boletín de la Oficina Sanitaria Panamericana*, Vol. 109, 1990, summarizes findings previously published in F. Brathwaite (ed.), *The Elderly in Barbados* (1).

[2] Department of Sociology, University of the West Indies, Barbados.

where in the Caribbean (where they accounted for about 6.2% of the total population in 1980) or in other developing nations (where they accounted for about 3.9% in 1980).

Like such changes anywhere, the changes seen over the past century in Barbados can be assessed in terms of changes in the birth rate, death rate, and migration. Between 1940 and 1980 mortality in Barbados declined from 26.7 deaths per thousand inhabitants to 8.6 per thousand (5), while in 1921–1965 life expectancy rose from 28.5 to 65.5 years for males and from 32.9 to 70.9 years for females (6). Also, birth rates declined from 29.2 live births per thousand inhabitants in 1940 to 16.4 live births per thousand in 1980 (5). Finally, available migration statistics indicate a net loss of 32,600 people, most of them young, between 1951 and 1970 (7)—a substantial loss for a national population totalling only 193,680 in 1946 and 236,891 in 1970.

Review of the 1980 census statistics presented in Table 1 shows that the elderly in that year were more likely to be female (60.1%) than male, more likely to be legally married (44.0%) than single (27.3%) or widowed (26.3%), and more likely than not to have ended their formal education at the primary level (88.4%). In addition, data from the 1970 census indicate that in that year most elderly people (59%) were living in one or two person households.

Comparisons with the general population, data for which also appear in Table 1, indicate the following:

- The elderly were more likely than members of the general population (88.4% versus 59.4%) to have ended their formal education at the primary level. (For this purpose the "general population" was considered to include all people age 15 and over not attending school.)

Table 1. Demographic characteristics of the elderly population in Barbados as compared to those of the general population. All the data cited are for 1980 except where indicated.

Characteristic	Elderly (%)	Total population (%)
Age:		
65–74	63.1	
≥75	36.9	
Sex:		
Male	39.9	47.4
Female	60.1	52.6
Marital status:		
Legally married	44.0	30.9
Single	27.3	60.9
Widowed	26.3	5.2
Other	2.4	3.0
Education:		
Primary	88.4	59.4
Post-primary	11.6	40.6
Housing companions:		
Living alone	31.8	19.6
Not living alone	68.2	80.4
Household size:[a]		
1–2	59.0	37.4
3–4	22.4	31.0
>4	18.6	31.6
Religion:		
Anglican	46.1	39.7
Protestant (denominational)	9.5	9.0
Sectarian	20.1	18.0
None	9.1	17.5
Other	15.1	15.8
No. of rooms in house:[a]		
1	3.0	2.4
2	17.8	14.8
3	20.2	19.0
4	35.2	37.7
5	14.7	18.8
>5	9.1	12.3

[a] 1970 data.

- The elderly were more likely than members of the general population to be legally married (44% versus 30.9%) and five times more likely to be widowed (26.3% versus 5.2%).
- The predominance of females among the elderly was far greater than among members of the general population (20.2% versus 5.2%).
- The elderly were more likely to be

living in small (one or two person) households than were members of the general population.

SOCIAL PROBLEMS

While conventional wisdom in the Caribbean holds that old age is a period of great difficulty, development of empirical data on social conditions prevailing among elderly people in the Caribbean has been slow. To help deal with this lack of information, a national survey of people over 64 years old was conducted in Barbados in 1982 (*1*). The survey, which dealt with a randomly selected group of 525 subjects, sought to define the social and economic circumstances affecting the elderly population. The findings presented in this article, including those shown in Table 2, represent a summary of the previously published findings of that survey (*1*).

With respect to economics, nearly a third (31.9%) of the survey subjects expressed dissatisfaction with their economic condition. Over three-quarters (75.1%) said their weekly income was BDS$50 or less; in contrast, only 25.3% of the general population was in this low-income category (BDS$2=$US1). Although far more of the elderly survey subjects appeared to receive income from pensions than from any other single source, 24% reported no pension income. Large percentages said they had no earned income (65.6%), received no financial support from relatives (65.8%) or friends (91.6%), or received no income from other sources (87.0%).

To a degree, this calls into question the widely held view that economic deprivation consequent upon old age in the Third World may be mitigated by network support. Further analysis of sources of income shows that those who got income from such social networks did so infrequently and tended to get small amounts. This matter is complicated by the fact that the elderly survey subjects, especially those with relatively higher incomes, tended to report weekly expenditures in excess of weekly income, with the expenditures being devoted mainly to food, housing, and fuel.

Regarding food and nutrition, 10.1% said they were dissatisfied with their food situation, and 18.5% reported getting less than two meals a day. In this same vein, 11%, 15%, and 23% of the survey subjects said they had no breakfast, lunch, or dinner, respectively, during the 24 hours preceding the interview. Also, nutritional analysis of the meals consumed in this 24-hour period indicates that they tended to be energy-rich but were often low in "protein-rich" foods and "protective" foods (fruits and vegetables).[3]

With respect to housing, the picture was generally more favorable. Only 18.5% of the elderly subjects (versus

[3] Meals consumed in the 24 hours preceding the interview were classified in terms of the Caribbean Food and Nutrition Institute's 12 food groups, which are as follows:

Group 1: Cereals
Group 2: Starchy foods, roots, and tubers
Group 3: Sugars and syrups
Group 4: Pulses, nuts, and oilseeds
Group 5: Vegetables
Group 6: Fruits
Group 7: Meats and poultry
Group 8: Eggs
Group 9: Fish and shellfish
Group 10: Milk and milk products
Group 11: Fats and oils
Group 12: Miscellaneous foods

The category "protein-rich" foods employed in the Barbados survey consisted of groups 7 through 10; the category "energy-rich" foods consisted of groups 1 through 4 and group 11; and the category "protective foods" consisted of groups 5 and 6. This classification has its shortcomings, because the foods in the different groups are not exclusively in one category or another (e.g., some of the "energy-rich" foods can also be sources of proteins, vitamins, and minerals). Nevertheless, it does provide a useful if rough working system.

Table 2. Elderly survey subjects in Barbados (*1*) classified in terms of 72 economic, psychological, social, and health indicators.

Indicator	% of elderly survey subjects
A. Economic indicators:	
1. Dissatisfaction with economic circumstances	31.9
2. Weekly income less than BDS$50.00	75.1
3. No pension income	24.0
4. No earned income	65.6
5. No income from relatives	65.8
6. No income from friends	91.6
7. No income from other sources	87.0
8. Weekly expenditures BDS$50.00 or less	41.8
9. Dissatisfaction with food situation	10.1
10. Get less than two meals daily	18.5
11. Had no breakfast	11.0
12. Had no lunch	15.0
13. Had no dinner	23.0
14. Low-protein breakfast	40.2
15. Low-protein lunch	15.5
16. Low-protein dinner	38.8
17. Low "protective food" (fruits and vegetables) breakfast	82.5
18. Low protective food lunch	56.5
19. Low protective food dinner	81.3
20. Dissatisfaction with housing conditions	18.5
21. Nonownership of house	18.0
22. No piped water supply	8.3
23. No flush toilet	52.8
24. No gas or electric stove	37.0
25. No electric light	19.0
26. No access to motor car	75.2
27. No access to refrigerator	28.7
28. No access to telephone	56.0
29. No access to radio	23.8
B. Psychosocial indicators:	
30. Concerned about crime	27.4
31. Concerned about lack of social care	2.0
32. Labelled "old"	55.0
33. Labelled "old girl"	52.9
34. Negative concept of self	5.5
35. Happy with country's religious nature	12.1
36. Happy with country's improvement of living standards	14.4
37. Happy with freedom in the country	11.0
Psychosocial indicators (cont).	
38. Perceives public negativism toward elderly	67.2
39. Dissatisfaction with social treatment	49.9
40. Young people treated better than elderly	84.1
41. Things have gotten worse	31.0
42. Did not realize life ambitions	52.6
43. Past-oriented	10.9
C. Social relations indicators:	
44. Single person household	27.1
45. No children alive	24.7
46. No contact with children	20.7
47. No help from children	24.8
48. No contact with grandchildren	18.3
49. Bad relations with spouse	33.3
50. Experienced feelings of loneliness	38.0
51. No contact with siblings	23.3
52. Friends far away	10.8
53. No visiting to or from friends	12.5
54. Cannot rely on neighbors	58.4
55. No spare/leisure time activities	5.0
56. No organizational membership	79.0
D. Employment/retirement indicators:	
57. Not retired	15.2
58. Not happily retired	34.5
E. Health indicators:	
59. Subjective health not good	62.2
60. Had arthritis	47.4
61. Had hypertension	41.1
62. Had diabetes	15.7
63. Had eyesight problems	17.4
64. Had memory problems	4.7
65. Had not visited doctor in years	22.7
66. On medication	45.0
67. On self-prescribed medicine	12.8
68. Noncompliant behavior	46.0
F. Attitudes toward death and dying:	
69. Talked about death	44.2
70. Fears death	6.4
71. Thinks about death	60.8
72. No plans for death	81.1

29.1% of the general population—*8*) expressed dissatisfaction with their housing conditions, 82.0% (versus 82.4% of the general population) owned their own homes, only 8.3% lacked piped water, and all but 19% (versus 17% of the general population) had electric light. Larger proportions of the elderly subjects said they had no flush toilet (52.8%, as compared to 56.4% of the general population), and no gas or electric cook stove (37%). Many of the elderly subjects said repair and maintenance were major problems.

High percentages of the elderly subjects also said they had no access to an automobile (75%), telephone (56%), refrigerator (29%), or radio (24%). However, here again the percentages involved were comparable to those found in the general population (*9*), where the respective reported percentages without access to an automobile, telephone, refrigerator, or radio were 75.5%, 45.3%, 20.8%, and 18.4%.

Turning to social psychology of the elderly, substantial percentages of those interviewed said they were concerned about the cost of living (48.4%), crime (27.4%), and health (16.5%). It has been reported that the major concerns of the general population were unemployment and the cost of living, in that order (*9*).

Regarding social labeling, large percentages of the survey subjects said they were labelled as "old" (55.0%), "old girl" (52.9%), or "granddad" (45.9%). However, most were unconcerned about labels other than "old" and "shaky." In this same vein, few appeared to have a negative concept of themselves as elders, only 5.5% indicating they felt embarrassed by their age.

Regarding contentment with the social fabric, however, only small percentages of the interview subjects expressed satisfaction with improvement in their standard of living (14.4%), with the religious nature of the country—the extent to which the country and its people are devout—(12.1%), and with the existence of freedom in the country (11%). Many also perceived their own social situation in unfavorable terms. About two-thirds (67.2%) said they felt the general public was unfavorably disposed toward them, 49.9% expressed dissatisfaction with the treatment society accorded them, 84.1% felt young people were treated better than themselves, and 52.6% said they had not realized their goals in life. However, 51.4% said they felt that things were better for them now than in the past, while less than a third (31%) felt their situation had gotten worse.

In terms of temporal orientation, the survey found that most of the elderly subjects were oriented to the present (62.4%) or future (26.7%) rather than to the past (10.9%), and that most cited either God (32.9%) or the cost of living (21.5%) as the subjects they thought about most.

Answers dealing with social relationships indicate that 27.1% of the elderly subjects were living in one person households; 24.7% had no living children; of those with children, 20.7% had no contact with their children and 24.8% got no help from their children; of those with grandchildren, 18.3% had no contact with their grandchildren. Regarding spouses, siblings, and friends, the interviews indicated that 33.3% of the elderly subjects with spouses had bad relations with their spouses; 19.7% had no living siblings; of those with siblings, 23.3% had no contact with their siblings and 14.1% had bad sibling relations; 8.6% had no friends; and of those with friends, 10.8% had friends who lived far away, 12.5% did not visit their friends, and 18.9% did not have good relations with their friends. The pattern was somewhat different regarding neighbors, with only 5.6% saying they had bad relations with

their neighbors but 58.4% saying they could not rely on their neighbors for help. Nearly all of those interviewed (all but 5%) said they had "spare or leisure time" activities. However, most of these activities were essentially sedentary (such as watching television or listening to the radio), and levels of membership in organizations were low, with 79% indicating they did not belong to any organization.

Regarding employment and retirement (the fourth area dealt with by the survey), the data show that 84.8% of the subjects were retired. Most of these (75.3%) said their retirement was compulsory, nearly half (48.6%) said financial difficulty was the main disadvantage of being retired, and about a third (34.5%) said they were not happily retired. Of the 15.2% who remained actively employed, 40% said that they did so because they had to; over half (57.4%) of those employed were working for BDS$50 or less per week.

With respect to health conditions, 62.2% subjectively perceived themselves as not being in good health. Just under half (47.4%) reported suffering from arthritis, 41.1% from hypertension, and 15.7% from diabetes. In addition, 17.4% said that they had bad eyesight, 7.9% said they had poor appetite, and 4.7% said they had bad memory. Data relating to medical care indicated that over a fifth (22.7%) of the survey subjects had not seen a doctor in over 12 months; over half (52.1%) had used private as opposed to public medicine on their last visit; just under half (45.0%) were on medication; 12.8% were taking self-prescribed (as opposed to doctor-prescribed) medicine; and 46.0% indicated that noncompliance with medication was a problem.

Regarding death and dying, the survey found that 60.8% of the subjects said they thought about death, 44.2% said they talked about it, and 81.8% had made no plans for it; only a small minority (6.4%) said they were afraid to die.

While investigating selected social policy programs in the course of this survey, we wished to learn whether the elderly knew about the existence of certain services for them—including an old age pension program, a free bus pass program, district hospitals, certain features of the national assistance program, a national insurance program, and the home help services—and what their experience in receiving benefits had been.

Overall, the survey results showed that 43.6% of the respondents were unaware of the home help service, but that well over three-quarters were aware of the other services. With respect to benefits, 68.8% said they had benefited from the old age pension program and 41.5% reported benefiting from the free bus pass program. However, less than 15% reported benefiting from any of the other programs—the percentages reporting benefits from the home help program and district hospitals being only 1.0% and 1.2%, respectively. Over half (54.8%) of those surveyed said they had no complaints about the public services provided, although 83.9% clearly indicated a need for better financial assistance, 11.2% said they wanted help in the home, and 44.5% said that they did not think enough was being done for the elderly.

Up to now this discussion has tended to emphasize the problems, and hence the weaknesses, of the elderly. This, of course, does not present a complete picture and should not be interpreted to mean that deprivation, ill health, broken social relationships, and psychosocial stress are the lot of all elderly people—especially since the data show that many of the problems investigated were affecting only small (sometimes very small) percentages of the elderly survey population.

The survey data were also used to ana-

lyze ways in which certain conditions (living standards, income, age, sex, retirement, class of occupation, education, and social isolation) related to the lives of elderly people. This was done by systematically cross-tabulating data on these conditions with various indicators.

Overall, examination of the epsilon values in these cross-tabulations showed two things. First, it showed that income, class of occupation, social isolation, education, age, and living standards were the factors most likely to differentiate elderly subjects in terms of the various indicators tested, while sex and retirement status were the factors least likely to do so. Second, the elderly subjects most likely to experience the kinds of problems described above were those with relatively low incomes, those who were relatively older, those living alone, those socially isolated, those subjectively reporting bad health, those who were males, and those who were retirees.[4]

SOCIAL POLICY

To help cope with the increasing numbers and concomitant difficulties of the elderly, a number of social policy programs have been developed. These programs provide retirement pensions, institutional care, in-kind benefits, community care, and health services.

Retirement Pensions

There are two basic classes of retirement pensions. One class is provided by the state as social security, while the other class consists of private pensions. Pensions of the first kind, administered by the National Insurance Board (NIB), include noncontributory old age pensions (until recently these were means-tested), contributory old age pensions, and pensions paid under the Sugar Workers' Provident Fund.

The noncontributory old age pension dates back to the days of poor relief, and even though we do not know much about its dispensation in that early period, there is clear evidence that the elderly benefited (*10*). In 1937 an old age pension act was passed that provided for testing people's means and benefited those 68 years of age or more who met certain residential requirements. This program, as since modified, is now administered by the NIB; it provides benefits to all people 65 and over who meet certain residential requirements and who are not receiving disability, government, or social security pensions. In 1984 this program made payments totaling BDS$37,562,726 through 18,059 pensions (*11*).

Contributory old age pensions also have a long history, in that friendly societies (informal self-help savings and loan societies) sometimes provided old age benefits in the early post-emancipation period. However, the number of these organizations and the size of their membership declined after 1946, with the advent of commercial banks (*12*). A more formal system of social insurance, also administered by the NIB, emerged in 1966 after decades of debates and reports.[5] This was designed to provide both

[4] While some variables used in the cross-tabulations were self-explanatory, others required definition. Specifically, the "older" elderly were defined as those 75 and over; those with "low income" were defined as having a weekly income not exceeding BDS$50.00 per week (the common NIB old age pension level at the time of the interview); and those deemed moderately or highly isolated socially were defined as those scoring 2 or 3–5 points, respectively, on a five-point scale in which one point was assigned for no contact with each of the following: (a) the respondent's children, (b) the respondent's grandchildren, (c) the respondent's siblings, (d) the respondent's neighbors. In addition, one point was assigned if the respondent did not belong to any organization.

[5] Between 1936 and 1966 there were at least four official reports looking at the feasibility of various

contributory old age pension benefits and survivors' benefits. In 1984 this program made payments to contributors totaling BDS$26,136,000 through 9,145 contributory pensions (*11*).

Survivors' benefits under this program are payable to the spouse or children of a qualified deceased person at half the rate that would have been payable to the deceased were he/she alive. (Children are eligible to receive these benefits up to age 22 if they are in school full-time and up to age 16 if they are not.) In 1984, survivors' benefits were paid through 360 pensions and totaled BDS$583,671 (*11*).

Pensions paid through the Sugar Workers' Provident Fund (SWPF) were introduced in 1968. These cover sugar workers 65 and over who worked on sugar plantations of at least 25 acres for at least 10 years. Administration of this program, financed by the Sugar Workers' Labor Welfare Fund, was transferred to the NIB in 1975. In 1984 it made payments totaling BDS$1,172,730 through 3,000 pensions (*11*).

Private pensions arranged between employers and their employees are basically of two types: public servants' pensions and private pensions for other employees. Private pensions for other employees consist of employers' superannuation plans (which are usually based on contributions by both employers and employees) and annuity pensions (which are normally purchased by self-employed persons). As of 1985 there were 887 private pensions for other employees registered with the Department of Inland Revenue, 250 of the superannuation type and 637 of the annuity type (*13*).

Pensions for public servants have long existed in Barbados on a very selective basis—as indicated by the 1907, 1937, and 1947 pension acts for colonial civil servants. Extension of such pensions to other kinds of public workers began in 1925 with the passing of the Teachers' Pension Act, and by 1961 they had been extended to casual employees (persons employed on a temporary basis) and unestablished civil servants (public servants employed on a regular basis without established posts).

At present a variety of acts and regulations provide pension benefits for civil servants (*1*). The terms and conditions of these vary considerably. However, most are noncontributory, and most are paid to civil servants completing at least 10 years' service. In general, there are also provisions for early retirement, options for taking a full pension or a reduced pension plus a gratuity, and options for obtaining a cost of living allowance. One estimate (*14*) suggests that approximately 15,000 people were covered by public service pensions at the end of 1984 and 4,853 were receiving benefits. In fiscal year 1983/84, BDS$29,861,845 was spent on pensions for public employees (*15*).

Institutional Care

Institutional care of the elderly, like the noncontributory old age pension program, has a long history because it grew out of the poor relief provisions of the early post-emancipation period. (These provisions, while not directed exclusively at the elderly, made them disproportionate beneficiaries—*10*.) By the 1870s Barbados had 11 almshouses and was placing an emphasis on institutional care that has continued to the present.

Institutional care for the elderly is currently provided at district hospitals (which perform the functions of the former almshouses), private nursing homes for the aged, and homes for the elderly.

aspects of a national social security scheme. These were the report of the Committee on Old Age Pensions (1936), the Wells Report (1953), the Richardson Report, and the Stockman Report (1963).

As of 1985 there were five district hospitals administered by the Ministry of Health. These were serving 871 people and operating at an annual total cost of BDS$11,330,489 (*15*). The demand for places far exceeded the number of places available (*16*).

In addition to these district hospitals, in 1986 there were also two homes for the elderly administered by the National Assistance Board (NAB) serving 54 people and 14 private nursing homes caring for 230 people (*17*).

Nonmonetary Benefits and Community Care Services

Services of these sorts are varied, but all are intended primarily to promote community care. In essence, there are three classes: services providing "in-kind" benefits under the national assistance program, services provided through Welfare Department or NAB programs, and other services providing benefits outside the Welfare Department.

The first class, "in-kind" benefits provided under the national assistance program, include assistance with clothing, household furniture, wheelchairs, spectacles, food vouchers, water rates, electricity rates, and land rent for those deemed to be in need. These benefits are not provided only to the elderly, and it is not possible to say with any certainty how much the elderly have benefited. However, there is good reason to suspect that the elderly are disproportionate beneficiaries.

The second class of services, administered by the Welfare Department and/or the NAB, is used almost exclusively by the elderly. These services consist of free bus transportation, assistance with food, housing welfare, and home help.

The free bus pass program is open to all people 65 and over. To benefit from it, those in this age range need only show their national identification card on boarding public transportation. It is not known how many benefit from this service or how many free trips are provided. However, the Welfare Department reports that BDS$100,000 is paid to the Transport Board each month to cover the program's cost.

Food assistance is provided through a program jointly organized by the Welfare Department and the Salvation Army. This program provides daily meals through a food center that benefited 34 people in 1980, and also through a meal delivery service that benefited 46 people in 1980. The total cost of these services in that year was BDS$60,000 (*18*).

The purpose of the housing welfare program is to repair or replace the houses owned by old age pensioners and other needy people. Demand for the service, for which BDS$4,000,000 was allocated in 1988, has been quite high. The 1988 Report of the NAB (*19*) indicated that 3,500 applications (not all filed by elderly applicants) were outstanding, and that needs exceeded benefits. For example, in 1987/88 there were 457 welfare houses in existence, 670 applications for houses, and about 2,500 applications for home repairs (*18*).

The Home Help Service, which employs the most explicit approach to community care of the elderly, was established in 1980 to help elderly people who were bedridden, chronically ill, living alone, and getting no assistance from relatives or friends. The program, which also seeks to reduce the per capita cost of care for elderly people (*20*), offers assistance with such tasks as cooking, cleaning, washing, shopping, bathing, and visiting the doctor; in addition, it provides elderly people with companionship. In 1983/84 the Home Help Service had 114 home helpers and provided care to 800 persons at an annual cost of BDS$500,000 (*21*). By 1988 there were 150

home helpers, and they were providing care for over 800 persons.

The third class of services includes "in-kind" benefits offered outside the Welfare Department. These benefits include land tax relief (old people are not the exclusive beneficiaries of this relief, but they appear to benefit disproportionately), a degree of income tax relief, and rent-free accommodation in national housing units for people whose only source of income is old age pensions.

Land tax relief is offered under the 1937 Land Tax Act to those people who can demonstrate a need for such relief. In addition, limited income tax provisions favor the elderly. Among other things, the personal allowance is BDS$3,000 for a single person, BDS$5,000 for a married person whose spouse had no income, and BDS$5,500 for a person 65 or over. Also, the minimum assessable income for tax purposes is BDS$3,000 for people under 65 but BDS$5,000 for those 65 and over. Finally, a dependent relative allowance permits an individual to claim up to BDS$500 for a relative who is maintained by that individual if the dependent relative is incapacitated through old age.

Health Services

Health care for the elderly in Barbados must be seen within the context of the overall health care system—which has both a private sector and a public sector administered by the Public Health Service. This public sector—besides providing outpatient care through health centers, polyclinics, and district medical officers—also operates a hospital for adult patients, a psychiatric hospital, and a leprosarium. Together, these last three facilities provide a total of nearly 1,300 beds.

It is impossible to precisely specify the benefits provided for the elderly through these public health services, because no published data grouped by beneficiary age are available. However, two additional kinds of health service institutions deal almost exclusively with elderly clients. These are, first, the district hospitals, public and private nursing homes, and the Golden Rock Home (a home providing accommodation and nursing care for the indigent elderly administered by the NAB); and second, the recently established National Drug Service that provides medicaments free of cost to those elderly people using government pharmacies and at a nominal fee to those using private participating pharmacies. Primary health care is also made available free of charge to all elderly persons through the walk-in services provided at the several polyclinics scattered around the country.

DISCUSSION

Many of the findings described above tend to bear out other findings obtained through cross-cultural research. Noteworthy departures from the cross-cultural research findings, as well as other findings that appear especially deserving of attention, are as follows:

- Analysis of demographic trends shows that just over 10% of Barbados' population was elderly and that over a quarter of the elderly people lived alone. Both of these circumstances are more consistent with patterns found in developed countries than with those of the Third World.
- The psychosocial data do not support the view that the elderly are primarily oriented to the past. On the contrary, they appear to be essentially present and future oriented.
- While the cross-cultural evidence suggests that elderly people have a tendency to view themselves nega-

tively, this does not appear to be the case in Barbados, where the elderly appear to display a distinctly positive self-concept.

- Some evidence suggests a marked degree of social isolation among the elderly in Barbados. Many live alone; a fifth are classifiable as highly isolated socially; and aside from church membership, few belong to formal organizations. However, there is also evidence that a large share of the elderly have contact with networks of friends, relatives, and neighbors with whom they have good relations.
- The findings on retirement and employment reflect patterns similar to those found in urban industrial societies, while the extent of elderly people's continued participation in the work force is way below that expected in Third World countries.
- Health patterns among the elderly in Barbados also appear similar to ones found in urban industrial societies, with specific reference to the types of disease suffered and to the fact that a relatively high proportion of those involved seek help.
- While the evidence relating to economic deprivation closely approximates the findings of cross-cultural research, comparatively small proportions of the elderly in Barbados were receiving a wide range of social service benefits.
- The survey data obtained on death and dying give no indication of a widespread fear of death.

Theoretical Implications

Five major sociologic perspectives—those of role theory, activity theory, disengagement theory, exchange theory, and socioenvironmental theory—have been applied in mainstream gerontologic research (22). What implications do the reported findings on the elderly in Barbados have for these applications?

As previously noted, there is some evidence of disengagement by the elderly in Barbados—evidence such as high levels of active retirement and living alone; loss of contact in some cases with children, other relatives, and friends; and lack of organizational participation. Interestingly, systematic cross-tabulation of the dependent variables with three indicators of disengagement cited by Kermis (23) (retirement, social isolation, and a decline in health status as subjectively assessed by the elderly person) shows that those classified as disengaged according to these indicators were far more likely to experience major living problems than were their "engaged" counterparts. This implies that the disengaged are far more likely to display signs of social breakdown.

These findings also relate to the proposition in activity theory asserting that many characteristics of the middle years are retained in later life, and that their retention tends to prevent social and personal breakdown. Consider, for example, the large percentages of the elderly in Barbados that retain contacts with relatives, friends, and neighbors, and who live in multi-purpose households, as well as the minorities that belong to organizations and that are actively employed. Cross-tabulations show that those who continued these pre-old-age activities were far less likely than counterparts who did not to experience adjustment problems.

By the same token, these findings tend to bear out a proposition advanced in role theory—that those among the elderly who lose roles and status in their old age are more likely than their counterparts to experience adjustment problems.

Finally, with respect to social environ-

ment theory, cross-tabulation of the data obtained makes it possible to assess how certain factors relate to social breakdown in elderly people—breakdown evidenced by economic deprivation, psychological difficulties, social isolation, health problems, unsuccessful retirement, lack of policy program awareness and usage, and negative attitudes toward death and dying. In general, these signs of social breakdown were more prevalent among low income groups, the older elderly, the retired, the less educated, those from backgrounds with lower occupational status, those highly isolated from society, and those in poor health. These findings tend to corroborate the results of cross-cultural research.

More specifically, social psychological difficulties were found to be more prevalent among the retired, those in lower income groups, the most socially isolated, and those reporting that their health was poor. In a similar vein, the greatest economic deprivation among the elderly was experienced by low income groups, the older elderly, the retired, the less educated, those from backgrounds with lower occupational status, those highly isolated from society, and those reporting that their health was poor. Those most likely to show social isolation were those in the lower income groups, the retired, those with lower occupational status, and those reporting that their health was poor. And social breakdown signalled by health problems was most prevalent among the low income groups, the older elderly, those with lower occupational status, and the less educated.

It should be noted that retirement adjustment problems were most prevalent among those from backgrounds with higher occupational status—as well as among those with low incomes and those reporting that their health was poor. With respect to death and dying, those from poorer socioeconomic backgrounds and those with lower levels of education were the most likely to indicate adjustment problems.

Pension and Income Problems

While any assessment of the social policy programs discussed above must be tentative—because the data needed for this purpose are often unavailable, nonexistent, or incomplete—it is apparent that the vast majority of the elderly in Barbados receive some kind of pension. It is also evident that the terms and conditions of the programs involved vary considerably and that there is need for more coordination between them. Furthermore, pensions are basically fixed (with the possible exception of the public servants' pension program that recently incorporated cost of living allowances), and so inflation poses severe problems for elderly people's living standards.

To cite a few examples: A retired head teacher who was receiving a salary of BDS$1,800 per month at retirement in 1979 now receives a pension of BDS$1,392 per month. This includes a cost of living allowance on which she pays BDS$182.00 in taxes, although it should be noted that since 1986 pensions have been exempt from taxation.

Or consider the case of a retired unestablished public servant who retired in 1980 at a salary of BDS$800 and who currently receives a pension (including a cost of living allowance) of BDS$372 per month.

Or else, at the lower end of the economic spectrum, consider the case of an agricultural worker who upon retirement in 1972 was receiving a salary of BDS$80 per month. She now receives a pension of BDS$40 per month.

In all instances the reduction in income is immediately apparent; moreover, given the declining value of money, the apparent reductions are really underesti-

mated. Indeed, it would appear that except for people in the higher echelons of public service or with similar occupational backgrounds, the annual incomes of pensioners tend to fall way below per capita income. This was substantiated in 1982 by survey data showing that 93.6% of the pensioners (compared to 52.2% of the population) reported annual incomes below BDS$4,800 that year, at a time when per capita income was BDS$7,192 (*24*). Therefore, it is not surprising that the cost of living emerged as the main concern of the elderly in this survey, or that computation of Gini coefficients for the collected data (*25*) showed that there was a high degree of relative poverty among the elderly.

These pension and income problems are complicated by a series of exclusion clauses in the various pension plans, by attempts to regulate the number of pensions an individual can receive, and by the recognized (*17, 18*) tendency of pension plan regulations to discourage employment among the elderly.

Other Needs

Obviously, institutional care presents a number of difficulties for the elderly. The survey data presented show it is not favored by the elderly—perhaps partly because of its historic link to poor relief and the stigma attached to that. Indeed, one of the major fears expressed by the elderly in the survey was that of being placed in an almshouse. In addition, some institutionalized elderly people have expressed fears about loss of freedom, lack of individualism, lack of privacy, and the quality of care (*26*). It is nonetheless evident from departmental reports (*4*) that demand for places in such institutions exceeds the number of admissions granted.

Data regarding in-kind benefits are generally incomplete or inaccessible; and while existing reports do give an idea of the number of people benefiting, they seldom say anything about the actual needs of the elderly or about the existing demand for the services involved. The survey described in the first part of this article showed that sizeable elderly minorities were unaware of the various benefits available, and also that the elderly would use the services involved despite their historic tie with poor relief, and despite the fact that means testing is commonly used as a basis for allocating these benefits.

With respect to the housing welfare program, the survey evidence presented clearly indicates that demand for that program's help was exceeding the services provided, although it should also be noted that the demand commonly exceeded true need (*20, 21*).

The free bus pass program emerges as one of the most widely used and most accessible services. Indeed, it has imposed virtually no restrictions. Nevertheless, some survey subjects voiced concern about the quality of service offered, indicating that the conductors and traveling public made them feel that they were begging for something, or that they were getting services free that they should be paying for like everyone else.

The Home Help Service is a welcome development, and the level of services provided compares favorably with that provided in countries of the industrial world. For example, available evidence shows that the number of house helpers per 100,000 inhabitants in selected countries vary from 0.1 in Italy to 41.7 in Switzerland. Barbados records an impressive 45.9.[6] Departmental reports suggest that needs are being satisfied, but this must be judged against the following facts:

[6] See R. Morris and T. Leavitt, "Issues of Social Service Policy," in Binstock (*4*), p. 199.

56.4% of our elderly survey subjects were unaware that the service existed;[7] and 11.2% of those surveyed said they needed help in the home, but only 1.0% said they were getting any. In this vein, early reports showed that the home health service was not fully developed in rural areas (*21*) and that it needed improved supervision and transportation (*27*). However, official reports since then (*19*) have shown that various steps have been taken to rectify these problems by widening the supervisor base, training supervisors, allowing workers to report directly to their assignments, appointing home helpers who reside in the outlying rural areas to which they are assigned, and introducing time and job sheets.

With respect to health care, it is not easy to examine government-related provisions for the elderly (except work performed by the district hospitals, activities of the National Drug Service, and services provided at health centers on the recommendation of the Welfare Department) because of the format of the available data. However, we know that 8.0% of our elderly survey subjects received Welfare Department assistance because they said their last visit was to a parish doctor, and that an additional 39.9% received care at a government hospital or clinic.

We also know of financial constraints on elderly people seeking medical care. Among other things, the survey showed that 48.8% of those interviewed had their medical bills paid for them, and that the problem of noncompliance reported by 46% was due in part to the fact that the elderly people surveyed had avoided buying medications because "they were too expensive" and because they "wanted them to last as long as possible."

It is anticipated that this situation will be alleviated by the activities of the aforementioned National Drug Service. However, given the lack of available data and research, it is hard to provide any further relevant information about actual needs, the extent to which such needs are being satisfied, and the difficulties that the elderly experience, if any, in satisfying such needs.

CONCLUDING REMARKS

The foregoing account shows that a variety of programs have been implemented in an effort to meet the needs of the elderly in Barbados, and it can be argued with some justification that significant progress is being made. Nonetheless, much remains to be done.

The effectiveness of pension plans, to the extent that they involve virtually fixed payments, will be considerably limited by the ravages of inflation. Therefore, a clear need exists to provide a way of indexing pensions.

Beyond that, the survey data presented here point to various programs and services—including the housing welfare program, the home help service, institutional care services, and some of the "in-kind" benefit services—that are reported to be meeting existing needs inadequately. In such cases the genuinely existing needs must be identified (recognizing that demand sometimes exceeds need), and then efforts must be made to meet those needs.

In this same vein, the findings presented indicate that significant minority shares of the elderly population have not always been aware of the services available. Since needs often depend on an awareness of programs, steps need to be taken to better inform the elderly of all benefits available to them.

[7] It should be noted that in 1982, when the survey was performed, the Home Help Service (introduced in 1980) was still relatively new.

It is also apparent that the existing programs have generally tended to focus on the tangible needs of income, housing, and other material requirements. However, there is clear evidence of other needs in the less tangible spheres of companionship, the quality of care, independence, and self-respect that obviously must be addressed. At present a beginning is being made toward meeting such needs through embryonic day care and social recreation programs.

While institutional care may always be needed, the drive toward community care must continue—because there is evidence that the elderly want community care, that institutional care can have debilitating consequences, and that community care may be more cost-effective. This drive can be continued through expansion of the home help service and the community health service.

Also, certain strategies employed by other societies suggest additional courses to pursue. Among other things, efforts need to be made to promote the concepts of elderly self-care and care within a family context; the latter can probably be encouraged through more attractive tax incentives. Also, evidence suggests that some elderly people would like to remain actively employed but are discouraged by pension plan restrictions; therefore, modification of such restrictions needs to be considered. In addition, the low wages often paid to employed elderly people can only act as a disincentive, so this issue likewise needs to be addressed.

It is generally assumed (*4*) that Third World societies may find such strategies especially desirable because of the existence of extended kinship structures and greater opportunities for extended participation in the work force, as well as because they confront underdevelopment, recession, and tight budgets (*28*). Nevertheless, close scrutiny of the contemporary scene in Barbados suggests that implementation of these strategies will require major structural adjustments.

For example, the assumption that there are strong extended kinship networks readily available to provide support must be reconsidered in the light of rapid social change, heavy outward migration, and the impact of social mobility on family structures over roughly the past two decades. Moreover, it is now being argued that what such networks can or cannot offer may be a more important consideration than their mere existence (*29*).

Further difficulties will have to be overcome in attempting to extend elderly participation in the work force. For example, while Binstock (*4*) estimates that the participation rate among men 65 and over is usually in excess of 50%, the evidence from our survey and the 1980 Census suggest this rate is between 12% and 15% for all those 65 and over in Barbados. One likely explanation is that unemployment in Barbados is high (currently in the region of 17–18%), and this can be expected to militate against plans for extending elderly participation in the work force.

These points are made not to dispute the value of the proposed approaches, but rather to suggest that difficulties exist and that these approaches must be used to complement other services for the elderly rather than replace them.

REFERENCES

1. Brathwaite, F. (ed.). *The Elderly in Barbados*. Carib Research and Publications, Bridgetown, 1986.
2. Barbados, Ministry of Finance, Economic Affairs Division, Prime Minister's Office. *Barbados Economic Report 1984*. Bridgetown, 1984, p. 23.
3. Barbados Population Census.

4. Binstock, R., W. Chow, and J. Schultz (eds.). *International Perspective on Aging: Population Policy Challenges*. United Nations Fund for Population Activities, New York, 1982, pp. iii, vi, 19, and Chap. 5.
5. Registration Office, Law Courts. Reports of Vital Statistics and Registration for the Years 1940 and 1980. Bridgetown, Barbados.
6. Massiah, J. The Population of Barbados: Demographic Development and Population Policy in a Small State. Unpublished doctoral thesis. University of the West Indies, Jamaica, 1981, Table v:13, p. 76.
7. Ebanks, O. Barbados. In: A. Segal (ed.). *Population Policies in the Caribbean*. Lexington Books, New York, 1975, pp. 35–36.
8. Dann, G. *The Quality of Life in Barbados*. MacMillan, London, 1984, p. 84.
9. Brathwaite, F. It is unemployment that Barbadians are most concerned about. *Nation Newspaper*, Bridgetown, 12 December 1980, p. 7.
10. Barbados. *Report of the Commission on Poor Relief in Barbados 1875–1877*. Barclay and Fraser, Printers to the Legislature, Bridgetown, 1878.
11. National Insurance Board. *Report of the National Insurance Board, 1984*. Bridgetown.
12. Fletcher, L. The decline of friendly societies in Barbados. *Caribbean Studies* 15(4):73–84.
13. Personal communication, Inland Revenue Department, Barbados.
14. Personal communication, National Union of Public Workers in Barbados.
15. Barbados. *Barbados Estimates, 1985/86*. Government Printing Department, Bridgetown, p. 27.
16. Barbados, Welfare Department. *Report of the Welfare Department 1984*. Bridgetown, p. 15.
17. Pan American Health Organization. Health Service for the Elderly in Barbados. PAHO feasibility study report, IADB Project ATC-2521-BA. Bridgetown, 1986.
18. Barbados, Welfare Department. *Report of the Welfare Department 1980–1981*. Bridgetown, pp. 5, 6, Appendix 4.
19. National Assistance Board. *1986–1988 Report of the National Assistance Board*. Bridgetown, pp. 10, 14–16.
20. Barbados, Welfare Department. *Report of the Welfare Department 1978*. Bridgetown, p. 24.
21. National Assistance Board. *1983–1984 Report of the National Assistance Board*. Bridgetown, pp. 3–5.
22. Kart, G. *The Realities of Aging: An Introduction to Social Gerontology*. Allyn and Bacon, Boston, 1981, chapter 6.
23. Kermis, M. *The Psychology of Human Aging*. Allyn and Bacon, Boston, 1984, p. 71.
24. Barbados, Ministry of Finance, Economic Affairs Division, Prime Minister's Office. *Barbados Economic Report 1983*. Bridgetown, p. 21.
25. Downes, A. Income Distribution and the Elderly in Barbados. Mimeographed document. 1982.
26. Russell, B. Some Aspects of the Aged in Barbados. Mimeographed document. University of the West Indies, Bridgetown, 1985, pp. 32–33.
27. Benjamin, J. Community Care in Barbados: An Evaluation of the Home Help Service. Unpublished document. University of the West Indies, Bridgetown, 1983, pp. 28–30.
28. Barbados. *Barbados Estimates, 1985/86*. Government Printing Department, Bridgetown, pp. 8–9.
29. Brathwaite, F. *Unemployment and Social Life*. Antilles Publications, Bridgetown, 1983.