REPORT OF THE ASIA-PACIFIC EXPERT MEETING
ON LONG-TERM CARE AND CHINA/ESCAP
"STRENGTHENING NATIONAL CAPACITY FOR PROMOTING
AND PROTECTING THE RIGHTS OF OLDER PERSONS"
PROJECT LAUNCHING CEREMONY

18-19 DECEMBER 2013
SHANGHAI
CHINA
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I. BACKGROUND

1. The Asia-Pacific Expert Meeting on long-term care was organized by ESCAP in cooperation with National Health and Family Planning Commission of the China, in the context of the project “Strengthening national capacity for promoting and protecting the rights of older persons”.

2. The Meeting was attended by experts from the Asian and Pacific region, including experts from China, representing Government departments and academia, as well as representatives of civil society and organizations of older persons and the UN system. The list of participants is annexed to this document as Annex-I.

II. OVERVIEW OF THE MEETING AND LONG-TERM CARE IN THE ASIA-PACIFIC REGION

3. On behalf of the organizers, Mr. He Zhaohua, Deputy Director-General of Department of Family Planning Family Development of the National Health and Family Planning Commission, China, welcomed participants and partners to the Meeting.

4. Opening remarks were delivered by Srinivas Tata, Chief, Social Policy and Population Section, Social Development Division, ESCAP; Ms. Zhang Yang, Deputy Director-General of Department of International Cooperation of the National Health and Family Planning Commission, China; Mr. Zhang Meixing, Vice Counsel, Shanghai Municipal Commission of Health and Family Planning Commission; and Mr. Wang Haidong, Director-General of Department of Family Planning Family Development of the National Health and Family Planning Commission, China.

5. Ms. Therese Bjork, Social Affairs Officer, ESCAP, briefly outlined the background, main objectives and the programme of the Meeting.

6. Mr. Tata reminded the Meeting of the commitments made by ESCAP member States in the Bangkok Statement regarding long-term care for older persons. He provided an overview of the status of population ageing in the in the Asia-Pacific region, emphasizing the rapid pace of ageing in countries of the region, the significant proportion of older persons living alone and the vulnerability of older women, who tend to outlive their male partners by several years. In his presentation, Mr. Tata outlined different financing modalities for long-term care, including insurance, general income tax, household cash or in-kind contributions, and voluntary contributions. In addition, he highlighted the various policy delivery options, ranging from self-care, to home care, community care and institutional care, both of a formal and informal nature, which he hoped would be taken up in detail during the Meeting.

7. Ms. He Jinglin, Senior Programme Officer, WHO China, focused on the four areas of action in which WHO is involved regarding population ageing: (i) age friendly environment through intersectoral action (Global Network of Age-Friendly Communities and Cities); (ii) healthy ageing across the life course; (iii) the need to reorient the health system to meet the needs of older persons (including by integrating ageing into national health plans, providing integrated service delivery to ensure continuity of care, providing health workers with appropriate skills, ensuring essential medicines and health techniques, and equitable health financing); and (iv) strengthening the evidence base on ageing and health.
III. COUNTRY AND SUBREGIONAL EXPERIENCES REGARDING HEALTH-CARE AND LONG-TERM CARE SERVICES FOR OLDER PERSONS

8. In his overview of the HelpAge/UNFPA study on models for community care, Mr. Eduardo Klein, Regional Director, HelpAge International, Thailand, emphasized that population ageing required not only ensuring the well-being of older persons, but redesigning societies in a deeper manner. He noted that this structural change included issues such as rethinking retirement age, pension systems and moving towards flexible work arrangements. He further called on countries to consider self-care, when possible, to reduce the burden of non-communicable diseases. He also emphasized the contribution of organisations of older persons, and to the need preserve the sense of generosity between generations. Mr. Klein noted that, when looking at labour income and consumption through the life-course, children and older persons sometimes have higher consumption than labour-income. The ways in which the gap between consumption and labour income is filled differs from country to country, with varying degrees of reliance on assets, private transfers, and public transfers.

9. One of the key lessons learnt through the study coordinated by HelpAge International was that one size does not fit all. Instead, Mr. Klein emphasized that the context of each country in the region should determine the specific balance between family and self-care, between institutional or community care, between civil society and government involvement, between the provision of cash and the provision of services, and between health-care and social care. He stressed community-based care as a priority for the future to ensure sustainability of long term care programmes, as well as the need to provide coverage for the most urgent cases, and to design an integrated social and health care system (Key elements of the presentation are provided as part of Annex-II).

10. Mr. Himanshu Rath, Founder of Agewell Foundation, India, provided an overview of health-care and long-term care in India. While noting a number of policies set up by the Indian Government, such as the National Policy on Older Persons adopted in 1999. He also provided details on the National Programme for the Healthcare of the Elderly (NPHCE) including its specific focus on mental health, day care homes, multiservice centres, mobile medicare units, help-lines and counselling centres, training of caregivers and an awareness generation programme on the needs and rights of older persons. Mr. Rath also acknowledged important challenges in their implementation, such as the limited coverage of health insurance and the lack of standardized quality of care (Key elements of the presentation are provided as part of Annex-II).

11. Ms. Quynh Nguyen Ngoc, United Nations Population Fund Country Office for Viet Nam, provided an overview of population ageing in Viet Nam. Viet Nam has entered the ageing phase 16 years earlier than expected, in 2011. Thirty per cent of older persons in Viet Nam live alone, the average years of sickness are 7.3, 14 per cent of older persons have difficulties in activities of daily living, and over 5 million (more than half) older persons do not receive income support. Ms. Nguyen further explained the strengths and challenges of different types of community care services in Viet Nam and the care models for older persons implemented by the Ministry of Health, which prioritize medical examination and treatment. The National Plan of Action on Older Persons 2012-2020, had been designed by the Ministry of Labour, Invalids and Social Affairs (MOLISA), but yet to be implemented, prioritizes a nursing and community-based service provision system with linkages and integration with nursing homes in the public and private sector; volunteer-based home care model; and self-help club models (Key elements of the presentation are provided as part of Annex-II).
12. In the discussions that followed, the need to share good practices regarding financing and revenue-generation, an issue of particular relevance for low-and middle income countries in the region dealing with ageing societies was highlighted. Human resources requirements for old-age economies were also discussed, with stress being placed on the need for health staff, social workers and volunteers to be invested with increased knowledge on service provision to older persons and enhanced care-giving skills; and for family members to be better equipped for home-based care and assistance in activities of daily living.

13. An overall picture of community care services for older persons in Thailand was presented jointly by Siriphan Sasat, Associate Professor, Chulalongkorn University, Thailand and Ms. Viennarat Chuangwiwat, Programme Officer, ILO Country Office for Thailand, Lao PDR and Cambodia. The presentation covered the implementation of existing policies on care of older persons in Thailand, with a particular focus on the Lamsonthi district model. In this model, long-term care was provided by a joint team formed by medical providers from the district hospital and paid care givers from the community. The value of paying volunteers was emphasized, thereby shifting from informal to formal care and increasing the quality of services provided by, and recognition of volunteers. This model was highlighted as a good practice as it overcome the shortage of skilled family carers, establishing good collaboration between the health and social sectors, and enabled “ageing in place” in a practical way (Key elements of the presentation are provided as part of Annex-II).

14. Ms. Sasat and Ms. Chuangwiway emphasized the need for institutional care as a complement when required, in spite of its higher costs as regards home- and community-based care, as in their experience it proves unrealistic to rely on family carers and volunteers only. They also noted the need to regulate private institutions to ensure quality standards and prevent abuses against older persons.

15. Mr. Cho Hyunse, member of the Advisory Committee on Ageing, Seoul City and member of the Policy Forum for the Elderly and the Policy Department for the Elderly in Ministry of Health and Social Welfare, Republic of Korea, shared the experience in implementing a programme on volunteer-based home care in the ASEAN subregion. He explained that the programme was delivered either by an NGO or by an Older Person’s Association, depending on the country. He outlined the positive outcomes of the programme as follows: (i) Reduced isolation of older persons; (ii) allowing younger family members to engage in productive activities while volunteers assisted older persons during the day, thus reducing the caring burden; and (iii) volunteers’ self-development. In terms of challenges faced in implementation of the model, he indicated that (i) services provided by volunteers were insufficient to meet the needs of older persons with non-communicable diseases, (ii) lack of manpower/ volunteers to attend to the older persons; and (iii) the need for more collaboration and coordination between implementing entities. In the discussion that followed, participants tackled the issue of introducing quality control in the implementation of ageing policies and programmes. The Meeting also discussed the improvements planned on the HelpAge Korea follow-up project in the ASEAN subregion to deal with non-communicable diseases (A copy of a brief drawn from key elements of the presentation is provided as part of Annex-II).
IV. CRITICAL ISSUES RELATED TO THE PROVISION OF LONG-TERM CARE SERVICES

16. Mr. Fang Ningyuan, Professor of Renji Hospital, Shanghai Jiao Tong University School of Medicine, highlighted some key issues affecting clinical diagnosis in older persons. He noted that environment factors such as education, preventive measures and financial conditions become more important in old age health and the genetic factors less so. Some of the difficulties faced in old age diagnosis and treatment were related to the fast pace of disease development among older persons and the prevalence of multi-organ involvement, which hinders the identification of the cause of illness or death. On a more personal level, he noted the difficulty experienced by many older persons and their family members in accepting death in spite of if being considered logical due to old age.

17. An overall picture on old-age nursing was presented by Ms. Hou Huiru, Deputy Director, Nursing Department, The General Hospital of People’s Liberation Army. She indicated the need for more personalized and cost-effective nursing due to the existence of multiple diseases. The difficulties experienced by many older persons in eating and swallowing, as well as the incidence of pulmonary diseases, required specific skills among nursing staff. She noted that the shortage of trained caregivers and nursing staff, which needs to be addressed through proper skills training, a proper evaluation system, and the extension of hospital services beyond the hospital walls and into communities and families.

18. As one of the key recommendations facing population ageing, Ms. Huiru noted that clinical nursing of older persons should address health in a cross-cutting manner spanning the various departments, so that caregivers address the impact of all diseases in an integrated manner. She also mentioned the need for nurses not only to reduce pain and reduce hospitalization period but also to facilitate self-care skills of older persons to enjoy a better quality of life. Being able to predict disease and making the patient aware of safety issues (such as preventing falls of older persons) were also noted as key requirements for old-age nursing.

19. The important role played by rehabilitation medicine for improving the functions of old persons and their health was explained by Mr. Shan Chunlei, Vice Director of Center of Rehabilitation Medicine, Zhongshan Elderly Rehabilitation Hospital. He described different evaluation techniques to assess the physical, cognitive, relational and emotional status of older persons. He also stressed the importance of physical therapy, occupational therapy (recreation, hand-eye coordination, improving at ADL, etc.), speech, cognitive and swallowing therapy as being central to improving the quality of life and improving the mobility of older persons. The role of traditional systems of medicine (including Chinese medicine) and advanced and innovative techniques for rehabilitation were also discussed.

20. Ms. Zhang Tuohong, Professor of School of Public Health, Peking University, delivered a presentation on old-age healthcare needs and utilization in China. She noted that, while the coverage of medical insurance system in China has increased significantly over the last decades to over 90 per cent currently, inequities exist in coverage between urban and rural areas, men and women and between age groups. For instance, in all security schemes, women have lower coverage than men, and the oldest old also have lower coverage than other age groups. Other challenges faced by the health care system in China include the low number of specialized geriatric hospitals and lack of awareness among medical professionals of the ways to address the needs of older persons.
V. LONG-TERM CARE IN CHINA

21. An overview of the policy and situation of long-term care services in China was provided by Prof. Du Peng, Institute of Gerontology, Renmin University of China. He outlined the process leading up to the revision of the law to protect the rights of older persons. Whereas the first version of the law, dating from 1996, stated that support to older persons was mainly the responsibility of the family, the Elderly Rights Protection Law revised in 2012 emphasized the role of the Government in providing social security and long-term care for the elderly. Prof. Du Peng described the current distribution of the three types of care in China: 90 per cent home care, 7 per cent community care, 3 per cent institutional care; and noted that incentives should be put in place to encourage the involvement of the private sector to provide services for older persons. Two types of support models were highlighted, i.e. direct services (direct allowance in which the service providers and service consumers can receive the subsidy directly); and indirect support (government purchasing of healthcare services). Further, he explained how each type was provided in different parts of China and noted the gaps in the social pension system in particular in rural areas in terms of targeting and benefits.

22. In his concluding remarks, Prof. Du Peng noted areas for further improvement including meeting the rising need for services, the need for a clear plan for home care, and better coordination of services. He recommended developing client-centred services, attracting diverse engagement in terms of financial investments and service provision, enforcing standards for service quality, and establishing long-term care insurance.

23. Mr. Wang Xiaodong, Deputy Director, Changzhou Population and Family Planning Commission, Jiangsu Province provided a presentation on the pilot study on elderly care services in selected urban and rural settings in China with a focus on Changzou, which was projected to have older persons contributing to one fourth of the population by 2015. He described the types of community care services provided to older persons in 12 out of the 60 selected communities in the city. These services included dining at a low cost, health insurance and housing schemes with preferential treatment to families that adhere to family policies, free health consultations, home visits by health community workers, rehabilitation, therapy, hot-lines, and trainings for professionals who deliver services. In the discussion that followed, participants raised the issue of increasing pension coverage within the informal sector and suggested that in order to increase effectiveness, countries should strive towards mandatory systems that do not depend on voluntary contributions. The challenges faced in providing long term care for older persons including the retention of care workers in rural areas and the ensuring adequate standards for service provision were also discussed.

VI. GROUP WORK AND RECOMMENDATIONS

24. Participants were divided into two groups to each answer questions related to the following topics: (I) Modalities for long-term care for older persons including home-care, community-based care and institutional care, where each may be suitable; (II) Financing and human resource requirements for sustaining a care economy. Upon return to plenary, representatives from each group presented the results of the discussion.

25. Recommendations related to modalities for long-term care for older persons including home-care, community-based care and institutional care, where each may be suitable:
i) The understanding of the different forms of care including self-care, home care, community care and institutional care vary across countries.

ii) There is a need to distinguish between volunteer and paid home-care, between different types of community centres, and between nursing homes, hospitals and long-term care hospitals in the context of institutional care.¹

iii) Different types of care are not mutually exclusive and should be considered as part of a continuum and complimentary to each other. They should be considered in a comprehensive and integrated manner, ensuring a smooth referral system between them as needed.

iv) The social and emotional dimensions of care are relevant and important to all types of care.

v) A balance between the different types of care should be maintained in such a way that the needs of older persons are effectively addressed keeping in mind financial sustainability. As a general rule, when a high level of autonomy of older persons is possible, home-based care may be more appropriate; and the lower older persons score in the activities of daily living assessment, the higher the need for more specialized types of care. Higher levels of economic development, training and infrastructure would increase the role of good quality institutional care, whereas community and home-based care can work well in developing countries/areas.

vi) **Home-based care:** The advantages of home-based care included keeping older persons at home in a familiar environment while attending to their care needs. This kind of care also enjoyed cultural and emotional acceptance and was cost-effective. The challenges of home-based care included the lack of professional skills in care givers; higher probability of caregiver stress, which may also lead a higher probability of abuse; and the possible social isolation of older persons.

vii) **Community-based care:** The main advantages of community care which were noted as follows: social interaction with other older persons and staff; the availability of a wide variety of services and skills; reduced burden of care by families of older persons; and its complementarity with home-based care. The disadvantages of community care underlined were as follows: the difficulty in accessing care (in terms of transportation and distance from home); the potential lack of supervision/standards and resulting low quality.

viii) **Institutional care:** The advantages identified for institutional care were: the alleviation of acute medical and psychological problems by specialized professionals; higher standards resulting in higher quality of services. As regards the disadvantages, the following were underlined: high cost of providing trained staff and adequate facilities, which results in a low coverage of older persons; and the separation from family and communities and therefore an often-resulting sense of isolation.

26. Recommendations related to financing and human resource requirements for sustaining a care economy:

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¹ In this context, reference is invited to Helpage publication entitled “Care in Old Age: Literature Review on Terminology” published in May 2013 which provides useful information.
Financing:

i) All strategies for implementing long term care should be accompanied by a viable financing strategy for their effective implementation, and should be backed by firm political commitment.

ii) A mix of different types of financing of long-term care is required to meet the demands of long term care in different country contexts.

iii) Many countries depend on tax-based revenues from either central, provincial or local governments, for the financing of long-term care services for older persons. It was suggested that people could pay different percentage in tax depending on their age to encourage public support for tax-based long-term care.

iv) Long-term care insurance is suitable in wealthier countries with many older persons with long life expectancies and few children living nearby (e.g. Japan, the Republic of Korea, China). The introduction of long-term care insurances should be upon a foundation of universal social protection insurance, covering universal health-care and social pensions. The group noted that some countries who have a universal health-care insurance often struggle with the different levels of quality of coverage and many diseases being excluded from coverage. A consensus from younger generations on the necessity of inter-generational solidarity is also required for the introduction of long-term care insurance on a universal basis.

v) Public long-term care insurances can also be supplemented by private insurances, keeping in mind that these are still not very commonly used in the region and would only be financially accessible to the wealthier segments of the population.

vi) Older persons themselves and their families currently finance a large share of the long-term care for older persons, through older persons’ and family members out-of-pocket and in-kind contributions from family members and volunteers. As the region is likely to continue to rely heavily on family care to meet future needs, older persons and caring family members can also be supported through subsidies and allowances.

vii) Community involvement can be through in-kind contributions, such as for adapting of the living environment of older persons, cooking and delivery of meals by volunteers. To support family and community care, tax exemptions for family members taking care of older persons and payment of family members and community volunteers can also be considered. Community funds are being utilized in some countries in the region for long term care.

viii) Associations of older persons, in addition to providing support and care services through volunteers, also mobilize funds for long-term care needs particularly in developing countries.

ix) In some countries in the region, charitable organizations, funded through private donations, also provide facilities for care of older persons. They often cover the needy and the poor, and target those who are not covered by, or do not qualify for, available public services.

x) The private sector is an underutilized actor in the area of long-term care and should be encouraged to become more involved by offering incentives to provide care
services to older persons, including through public-private partnerships and as part of corporate social responsibility.

xi) While official development assistance (ODA) may not be a long-term financing solution to the provision of long-term care services, development assistance and grants can be used for piloting of innovative long-term care initiatives.

xii) Promotion of a healthy lifestyle and the prevention of chronic diseases are critical to reduce the future costs of health-care and long-term care for older persons. Without prevention, the prevalence of non-communicable diseases would increase leading to an increase in medical and care-related costs. Some countries use a earmarked tax to collect revenues specifically for health promotion.

Human resources:

i) In relation to human resources, the recommendations covered the skills-sets needed to the address the needs of older persons. It was agreed that in general, professionals in the medical and care sectors need to be retrained.

ii) In the health sector, advanced medical skills on issues affecting the health of older persons, including on multiple diseases and mental health, are required. All general practitioners and specialists in all disciplines need general geriatrics training. General practitioners could also play a greater role in early health promotion to ensure healthy ageing.

iii) Most countries face a shortage of geriatric specialists/gerontologists and more medical colleges in the region should offer this speciality. South-South cooperation could play a role with countries having established institutions offering such courses to other countries.

iv) Other occupational groups in the health sector who require upgrading of skills on addressing the needs of older persons include nutritionists, physical therapists and occupational therapists, rehabilitation specialists, psychologists and mental health specialists.

v) Various care-givers also need basic medical skills and skills in relation to mental health of older persons. In the care sector, trained certified volunteers are needed (both formal and informal). A suggestion was made that volunteers should be given a minimum of 8 hours of training every three years.

vi) Skills training is also needed for social workers, care assistants/family helpers, domestic workers, family members and older persons themselves to provide self-care.

vii) Technology can greatly facilitate and assist in the provision of long term care of older persons, including for older persons living at home. Among the affordable priority technologies the following were cited as examples: websites to enable self-evaluation, hotline services by telephone, GPS location services, monitoring devices (alarms) and prosthetic devices to alleviate disabilities.

VII. FIELD VISIT

27. Participants undertook a filed visit to a pilot community for long-term care consisting of a community health centre, a cultural centre and a day care centre for older persons
located in Tianshan Street, in Changning district, of Shanghai. They gained an overview of the type of services provided at the centres.

VIII. MEETING EVALUATION AND CLOSING

28. In his closing remarks, Mr. Tata expressed his gratitude to the Government of China for hosting the well-organized and effective Workshop, and thanked all participants for their high degree of commitment and the quality of their contributions. As regards the way ahead, Mr. Tata indicated that a regional forum on older persons would be held tentatively mid-2014 to consolidate and elaborate on the lessons learnt from the expert meeting. Mr. He closed the meeting with expressions of gratitude towards ESCAP and all participants and indicated NHFPC’s interest in working closely together with other countries and UNESCAP on the important issue of population ageing with a focus on long-term care.

29. A meeting evaluation form was distributed to all participants. The responses to the evaluation indicated that an overwhelming majority of the participants found the workshop to be highly useful. The detailed results of the evaluation are at Annex IV.
ANNEX I

LIST OF PARTICIPANTS

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Mr. Chen Xueping, Associate Professor, Nursing College, Hangzhou Normal University, Zhejiang Province, China

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ANNEX II

BRIEFS

Experiences in providing home-based care: the ASEAN subregion
by Mr. Hyunse Cho, President, HelpAge Korea

I. Country/area

The project “Home Care for Older Persons in ASEAN” was implemented from 2003 to 2012 and covered the 10 ASEAN countries: Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Viet Nam.

II. Institution/s or organization/s responsible

The project “Home Care for Older Persons in ASEAN” was led by HelpAge Korea, in collaboration with HelpAge International, and local partners in each country. The implementing partner was either a non-governmental organization (NGO); an older persons’ association (OPA) in collaboration with NGO; or a government agencies, depending on the country. The local implementing agencies worked with HelpAge Korea to adapt the Korean home care model to their own national context. The implementing agency also recruited and managed unpaid volunteers who provided the home care services. The project was funded by the ROK-ASEAN Cooperation Fund (Ministry of Foreign Affairs and Trade, Korea).

III. Background

The project “Home Care for Older Persons in ASEAN” aimed to develop localized Home Care models in ASEAN countries, based on the volunteer-based home care programme used in the Republic of Korea. The intention was to eventually expand volunteer-based home-care to a nation-wide scale and ultimately support the development and approval of national home care guidelines in each country.

The population of older persons in ASEAN has been increasing consistently due to rising life expectancy. By 2050, one out of every four older persons will be over the age of 80, and the number of older people over 100 years old centenarians will at least triple in the South-East Asian region.

In spite of the increasing demands of welfare and health services for older people due to the ageing phenomenon, proper community-based services are not provided to older persons, because of a lack of related national policy, social service and family support system in the ASEAN countries.

In addition, in most ASEAN countries, the function of caring for older people has been weakened because the issues older people face are easily pushed back on the priority list of public policy and as the government budget for welfare and health of older people is limited.

The volunteer-based home care model provides an alternative to the lack of social/welfare service for older persons and is a suitable model for addressing ageing related issues which engage the attention of governments in ASEAN countries.
IV. Description of model and/or policy

Volunteer-based Home Care

Home Care is a volunteer-based program to provide care for frail older persons in their homes and to reduce the caring burden of family caregivers by regular visits of volunteers to provide basic social service such as housework, companionship, outdoor activity, etc. From 2003-2012, 3,397 volunteers provided basic home care to 5,080 older persons through the ROK-ASEAN Home Care Project.

a. Aim and Target Group

The main purpose of the ROK-ASEAN home care approach is to enable older people who have lost the ability to fully care for themselves to continue living as long as possible in their own home and community, whether independently or with their families.

b. Care Providers and Services

Local volunteers are recruited by implementing agencies and matched to older persons according to set criteria. They receive training tailored to the client, after which, the unpaid trained volunteer visits the older person at least once a week in their own home.

The underlying service in every project context is befriending to meet psychosocial needs. This companionship often means spending time chatting with older persons who feel lonely and need emotional support. Beyond this, the type of service rendered is flexible, depending on the needs of individual older persons, the preferences of volunteers and the local culture. In a supportive environment, the next three most common types of services are home help, personal care and escorting the older person to a place of worship, health centre, shopping, or other place outside the home.

c. Implementation method

The two principal tasks of the implementing agency are case management and volunteer management. Describing those tasks is essential to understanding how home care service is practically delivered. The tasks of case management include intake, need assessment, care plan, intervention and evaluation. The tasks of volunteer management include recruitment, training, monthly meeting, encouragement, monitoring and evaluation.

d. Delivery system of home care

(1) Delivered by non-governmental organizations (NGO): the NGO does case management and volunteer management (Indonesia, Laos, Malaysia, Myanmar, Thailand and Vietnam).

(2) Delivered by Older People’s Association (OPA) in collaboration with NGO: In collaboration with OPAs in the communities, volunteers provide home care services. In this model, the programme is led by the OPAs with some technical support from the NGOs (Cambodia, Myanmar, Vietnam and the Philippines).

(3) Delivered by governmental organizations (GO): Government agencies directly deliver home care services in the community (Brunei Darussalam and Indonesia).
e. Benefits of the ROK-ASEAN Home Care project

Among the benefits achieved through the project, implementing partners highlighted that the project had reduced isolation and improved quality of life indicators of participating older people. Older people also reported increased self-esteem, maintenance of existing abilities, and ability to age in place. The project decreased the caring burden of family members and family members could spend more hours in income-generating activities. Volunteers provided cost-effective services and for the volunteers, the project enhanced self-development and encouraged friendship among volunteers. Community relationships were strengthened and communities were encouraged to pay more attention to older persons. Government organizations appreciated the cost-effective nature of the home care project.

V. Challenges

The Home Care Project has been implemented successfully in most of the countries, but limitations and challenges still exist. Representatives from the 10 ASEAN countries met at the 'ROK-ASEAN Home Care Conference for Older Persons', held in Malaysia on 22-25 May 2012 to conclude the Home Care Project. The following challenges were identified:

First, home care services provided by unpaid volunteers are not sufficient for older persons who are suffering from non-communicable diseases (NCDs), limited mobility, or without access to an appropriate health care system.

Second, to expand the Home Care Project nationwide, collaboration between government organizations and NGOs is required. Some barriers to this collaboration are a lack of capacity within implementing organizations, a lack of professional manpower on ageing and limited funding supported by government.

Third, approving a national guideline for home care by governments and creating action plans which include it is required. However this is often delayed due to a lack of understanding of ageing issues and a limited capacity for developing policy frameworks by the governments.

Fourth, in some countries, while national home care guidelines have been adopted by the central government, the expansion of home care is still slow. Local authorities may not understand home care and there is often a lack of budget allocation by local authorities.

Fifth, collaboration and cooperation are needed between government organizations which are implementing home care projects under different ministries.

VI. Recommendations

While volunteer-based home care is recognized as a cost-effective and community-based approach, its services have limitations in providing comprehensive health and social care services for older persons with NCDs who have serious Activities of Daily Living (ADL) difficulties living in the community. It is recommended to find the best practice to provide comprehensive health and social care services for older persons with NCDs.

Countries are recommended to develop policy frameworks on community-based service. Many countries in ASEAN have formulated policies to provide community-based service such as volunteer-based home care for older persons. However, there are some countries which are still in process of developing a policy due to a lack of human resources, a slow process of formulating the policy etc.
In this regard, it is necessary to develop complementary solutions to provide various services for older persons at the community level to make up for the limitations identified in the Home Care project. HelpAge Korea has developed a new project of community-based services, which provides comprehensive social and health services for older people with NCDs, to be implemented from July 2013 for ASEAN countries.

An overview of HelpAge International’s work on care for older people
by HelpAge International, East Asia and Pacific Regional Office (EAPRC)

I. Country/area

East Asia and Pacific region

II. Institution/s or organization/s responsible

HelpAge International, East Asia and Pacific Regional Office (EAPRC)

III. Background

Three trends in East and South-East Asian countries are generating increasing interest in how to provide care in later life, a huge challenge that every country in the region already is, or will be experiencing during the next couple of decades. First, demographic changes in the region mean that most countries in East Asia are already experiencing rapid ageing, a trend which will only accelerate in the coming decades. Because people are living longer, they are exposed to longer periods of vulnerability, ill health in old age and even incapacity. There is a rapid increase in the older-old population (aged 75 or above) who are experiencing higher incidence of non-communicable diseases (NCDs) such as hypertension, cancer, diabetes, and Alzheimer’s disease, among others.

A second significant trend is that the traditional family support system is under pressure, a trend intensified by the shrinking of family size and the migration of children to cities in search of work. Lack of family support for older parents and relatives is particularly hard for the poor living in rural areas. Adult women in extended households are often the traditional source of support for ageing family members. Nowadays, they are participating in the workforce in greater numbers and are often less available than before to provide time and care for older people.

Finally, even as age-related care needs are escalating, many East and South-East Asian countries have limited resources to expand public services. Where such services exist, they are often poorly resourced, limited in its coverage or culturally inappropriate. Expensive institutional care for older people as found in affluent countries is an option for only a small minority. Cost-effective solutions for community-based care that allow people to stay at home for as long as possible are urgently needed.

IV. Description of model and/or policy

HelpAge International has a vision of a world in which all older people fulfil their potential to lead dignified, healthy and secure lives. Among HelpAge’s Global Actions for 2015 are to “enable older men and women and those they support to receive quality health, HIV and
care services.” HelpAge’s work in the East Asia and the Pacific Region has had a number of achievements and innovations in recent years, including:

- Implementation of the ROK-ASEAN project “Home Care for Older Persons in ASEAN”, a volunteer-based model of home care and home help in all 10 ASEAN countries, led by the affiliate, HelpAge Korea. This approach has been recognised and supported by some governments and other development organisations. As a result of this work, the ASEAN members of the HelpAge Network are now equipped with skills and the know-how on volunteer-based social care in addition to being linked to the relevant government ministries to promote collaborative work.
- As a result of the HelpAge Regional Conference held in May 2012 in Yangon, there is now a broader understanding of old age care and its complexities among the HelpAge Network and its dialogue partners. The conference also identified several priorities for HelpAge and its partners moving ahead on a care agenda, including gaining a better understanding of the care needs and situations of older people in developing country contexts;
- To address the identified priorities, a work plan on care for the year 2013-2014 was developed, comprising three key components: research, consultation with key stakeholders and dissemination, and advocacy. A regional situational analysis on care for older people in ASEAN countries and China, was completed in June 2013.

In collaboration with UNFPA, HelpAge is in the process of conducting a study on effective and replicable approaches of community-based care for older people as practiced in nine countries of East and South-East Asia (Indonesia, Philippines, Thailand, Vietnam, Cambodia, Myanmar, Singapore, South Korea and China). The study will comprise several country-level evidence gathering activities, which will be compiled and analyzed. The report is meant to provide a thorough analysis of community care options through an examination of models already in use in various countries of the region, and to present a range of effective options for UNFPA, HelpAge as well as other relevant agencies to consider for future promotion. The study is expected to be completed in early 2014 and its results will be shared and discussed with experts and HelpAge’s networks in the region in late March 2014. The findings will also be presented at the HelpAge Regional Conference to be held in May 2014, in China. The last planned key activity is a regional symposium for governments, UN agencies and civil society in late 2014.

V. Challenges

HelpAge International, East Asia and Pacific Regional Office, has identified various challenges and lessons learnt from our work in home and community care for older people in the region:

- Balance between -based care and care provided by non-family members:
  - Family -based care is the bedrock of care in all societies in the region. Other care schemes need to be presented clearly as complementary to family-based care.
  - Volunteerism by older people themselves could increase their own well-being and contribute to the expansion of services.
- Balance between care delivered by state, civil society and the private sector (for non-family care):
  - ROK-ASEAN and other models have demonstrated how government can encourage and support care delivered through civil society groups.
The strong and network of older people’s groups could help expand care.
The private sector can be supported to address the needs especially in urban or more affluent areas.

- **Balance between institutional care or community & home-based care:**
  - Community-based care models also reinforce the social networks that older people and their carers need.
  - Community-based care models should make good use of existing structures and institutions, including older people’s groups and community centres.

- **Balance provision of cash vs provision of services:**
  - Cash transfers can be useful, but are difficult to target and may be counterproductive if not well designed.
  - European and other countries have lessons of experience.

- **Balance between health care and social care:**
  - Mental health and emotional challenges of older people are stigmatised and poorly understood.
  - A neglected care-related need of older people in the region is social support and companionship, particularly for the 75+.
  - Countries such as the UK have found it challenging to reintegrate social and health care after splitting them.

### VI. Recommendations

- Place priority on community-based care;
- Consider older people as resource, not only care recipients and promote older people’s group to facilitate their contributions;
- Ensure coverage for the most urgent cases;
- Develop a comprehensive integrated social care and health care system;
- Foster and regulate the growing private market;
- Maximize the use of technologies to support community care and those living independently;
- Support family caregivers, which could be escalated through a rage of measures;
- Strategies for care services need to anticipate growing mental health challenges;
- A cost-benefit analysis of community-based care models could help to make the case for further public investment.

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**Status of healthcare and long-term care services for older persons in India**
by Agewell Foundation, India

I. **Country/area**

India, 693 districts across 35 States and Union Territories.

II. **Institution/s or organization/s responsible**

In almost all Indian communities there is a tradition of family members caring for the health and long-term care needs of their senior citizens. However, in a changing socio-economic scenario, the government has acknowledged long-term care of older people as its responsibility towards society. Still, there are no institutions or organizations directly responsible for long-term care of older persons in India.
III. Background

The Indian population has approximately tripled during the last 50 years while the number of elderly Indians has increased more than fourfold. The 2011 census showed that the elderly population (60+) of India accounted for 98.47 million and the elderly population crossed the 100 million mark in the same year. During the past decade, the Indian elderly population increased at the alarming rate of 39.3%. In coming decades the elderly population is expected to rise at the rate of 45-50%. By 2026, elderly population (60+) in India is projected to increase to 173.18 million (12.40% of the total population).

It took more than 100 years for the aged population to double in most countries, while in India it doubled in just 20 years. The life expectancy has increased to over 70 years; at the age of 60 life expectancy is 16 years for men and 18 years for women. Better medical facilities, healthcare and liberal family planning policies made the elderly the fastest growing section of the society in India. However, the current old age health-care scenario in the country is dismal. Irrespective of socio-economic status, non-communicable diseases (NCDs) requiring large quantum of health and social care are highly prevalent at old age. Disabilities resulting from these NCDs are also frequent, affecting the activities of daily life of many older persons.

According to several surveys, the prevalence and incidence of diseases as well as hospitalization rates are significantly higher in older people than in the population in general. It is also reported that about 8% of older Indians are confined to their home or bed. The proportion of such immobile or home-bound people rises with age and stands at 27% for persons above 80 years of age.

Presently, the elderly are provided healthcare by the general healthcare system. In India the family remains the primary caregiver to the elderly and training of family members would provide important support to the care of older persons. Little effort has been made to develop a model for health and social care in India in tune with the changing needs of the population. As India has no elderly care model equivalent to what exists in developing countries, with nursing homes, health insurance etc, it may be an opportunity for innovation of the healthcare system.

IV. Description of model and/or policy

Realizing the gravity of issues related to ageing, the government of India has formulated several policies and schemes. The “National Program for the Health-Care for the Elderly” (NPHCE) is an articulation of international and national commitments as envisaged under the UN Convention on the Rights of Persons with Disabilities; the “National Policy on Older Persons” adopted by the government in 1999, and Section 20 of “The Maintenance and Welfare of Parents and Senior Citizens Act” from 2007, contain provisions for medical care of senior citizen.

The vision of the NPHCE is to:

- Provide accessible, affordable and high quality long-term, comprehensive and dedicated care services to an ageing population;
- Create a new “architecture” for Ageing;
- Build a framework to create an enabling environment for a “Society for all Ages”;
- Promote the concept of Active and Healthy Ageing.
The NPHCE is a good new initiative to take care of a rapidly ageing population. More attention is however required to the implementation and coordination of the program to ensure it translates into action.

The “Maintenance of Parents and Senior Citizens Bill” of 2007, stipulates responsibilities towards aged parents, the establishment of homes for older persons, the provision of medical care, as well as the protection of life and property of senior citizens. It provides for an inexpensive and speedy procedure to claim monthly maintenance for parents and senior citizens. The Act casts obligations on children to maintain their parents/grandparents and also creates maintenance responsibilities for the relatives of senior citizen. Another key attraction of the Act is the provisions to protect the life and property of the elderly. The Act also provides for the establishment of old age homes for providing maintenance to the indigent senior citizens and parents.

There are several additional major healthcare projects/programs run by the government:

- Maintenance of Respite Care Homes and Continuous Care Homes;
- Running of Multi Service Centers for Older Persons;
- Maintenance of Mobile Medicare Units;
- Mental healthcare and Specialized care for the Older Persons;
- Help-lines and Counselling Centers for older persons;
- Training of Caregivers to the older persons;
- Awareness Generation Programs for Older Persons and Care Givers

V. Challenges

At present most elderly patients are treated in general medical wards as most hospitals lack a special geriatric facility. There are also very few institutes which offers post-graduate (M.D.) education in geriatric medicine. Similarly the nursing and other para-medical staff is not formally trained in providing care for elderly patients.

The National Mental Health Program focuses on the needs of elderly individuals who are affected with Alzheimer’s disease, dementia, Parkinson’s disease, depression, psychosomatic disorder and psycho-geriatric ailments, but awareness about the program is minimal in the country.

Though there are several schemes and programs for dealing with healthcare requirements of elderly, they are mostly for people belonging to the formal sector. The majority of older people who have worked in informal sector remain at the receiving end in their old age.

The government of India has introduced health insurance policy for older persons but it covers a limited number of older persons.

Existing medical issues of older persons, combined with the lack of infrastructure and sensitization of hospital staff and clinics towards the elderly is one of the main reasons why healthcare needs often remain unaddressed. The standard of care in of hospitals and clinics across the country remains uneven: while in urban India good healthcare facilities are available while for those with financial resources, the same is not available for a majority of elderly living in rural areas lacking medical infrastructure and sensitivity towards older persons.
VI. Recommendations

Older persons face many health-related problems, while at the same time it remains challenging to undergo treatment and checkups at various hospitals and clinics. Healthcare and long-term care in old age is an urgent area calling for the attention of the government and other stakeholders. Therefore, it is recommended that:

- Easy access of elderly to various healthcare facilities and services is ensured;
- Health problems of the elderly are identified and appropriate health interventions provided;
- Capacity-building measures on healthcare for senior citizens are undertaken, such as training of medical and paramedical professionals as well as caregivers within the family;
- Research and advocacy in the field of ageing is encouraged;
- A National Institute for Aged, on the lines of All India Institute of Medical Science (AIIMS), is established for treatment and research on age-related ailments;
- The corporate sector is encouraged to include healthcare in old age under their corporate social responsibility.

Family Based Long Term Care for Older People in Indonesia
by Tri Budi W. Rahardjo, Centre For Aging Studies University of Indonesia

I. Country

Indonesia

II. Institutions

The National Board of Population and Family Planning, in collaboration with the Ministry of Health and Ministry of Social Affairs

III. Background

Long Term Care (LTC) is aimed at older people who need help with basic activities involving mobility and self-care (such as moving around, bathing, dressing, eating and housework). Ideally healthy ageing should be accompanied by a longer period of good health, sustained sense of well-being, and extended periods of social engagement and productivity. If an enabling environment is not provided, ageing will only be associated with greater illness, disability, and dependency. In developing countries, such as Indonesia, providing home and community long-term care can be an effective option in enabling older persons with care needs to stay in their homes. Additionally the cost of supporting an older person in their own home is generally less than keeping them in a nursing home or another residential care option.

Health is a major concern for older persons. The demographic transition to an ageing population, accompanied by an epidemiological transition from the predominance of infectious diseases to non-communicable diseases and mental health, has led to an increasing demand for health care and long-term care. Many developing countries, including Indonesia, are challenged by a double cost burden: the costs related to infectious diseases are still high whilst population ageing and the increasing number of non-communicable diseases place
additional pressure on already resource-strained health-care systems. Notably, poor health conditions earlier in life make older people even more vulnerable to serious health problems in their later life.

In general, the majority of older persons still report a reasonably good health status. The overall morbidity rate in Indonesia in 2009 was around 31% among older persons (based on the Basic Health Survey or Riskesdas, 2007). However, the health status of older persons in the rural areas is usually much lower than those in urban areas (see Arifin and Hogervorst, 2013).

The length of illness reported by older persons is less than a week whilst the place of medication prescribed is mostly at primary health centres (Puskesmas) and private practices (data based on the Basic Health Survey or Riskesdas 2007). The most prevalent chronic morbidities (diseases) and disorders among older persons in Indonesia (based on the Basic Health Survey or Riskesdas 2007) are general disabilities (as assessed by activities of daily living or ADL), reported by around half of elderly and with prevalence increasing with age (from around half (51%) among the 55–64 year old to 62% among those who were 65+), vision problems (cataracts in 29-52%), osteo-arthritis (29-35%), oral disease (22-31%), non-communicable diseases (NCDs), such as hypertension, central obesity and diabetes (14-23%) and mental health problems which included a wide variety of disorders (16-34%). Dementia was not reported upon separately although its incidence is growing due to population ageing.

IV. Description of Model

Family-based long-term care in Indonesia is mostly provided by a family member or volunteer, and given to older people at risk who are frail and/or living alone, elderly with moderate to severe functional disabilities, those recovering from illness (post-hospitalization), terminally ill, and persons living with debilitating diseases or conditions e.g. mental illness, in their own homes. The ministries responsible for delivering LTC programs are the Ministry of Health (under Primary Health Care Centers), the Ministry of Social Affairs (under Directorate of Aging Welfare), and the National Board of Population and Family Planning (under Family Support System for Older People). At the grass roots level, LTC has been implemented by the Family Support System, supported by the local office (sub district level) of the National Board of Population and Family Planning. Recently, all provinces have implemented family-based LTC.

Family-based LTC provides support with ADL (e.g. self-care tasks related walking and moving around, bathing, dressing, using the toilet, brushing teeth, and eating) as well as instrumental activities of daily living (IADL). The latter are tasks that are not fundamental but which enhance an independent lifestyle, including cleaning the house, cooking, and shopping, as well as taking public and private transport, using various means of communication, keeping track of finances and managing medication. The example of family-based LTC in East Java showed that the group of caregivers (consisting of family members and/or volunteers) provides services for 20 older people who live with their family. For older people who do not have family and stay alone in their own homes, the caregivers are volunteers. The volunteers are are only paid a small stipend for transport from NGOs and/or from local government.

Beside being supported by the Family Support System for Older People, LTC is also supported by the local office of the Ministry of Social Affairs and Primary Health Centres, Additionally, the medical check-ups are conducted at Public Health Centres
along with mini laboratory tests, whilst a more basic check-up is provided at Posyandu Lansia (Community Integrated Post for Older people). Home visits and home nursing services are provided by medical doctors and nurses for fully disabled older people. If needed, a referral service to hospital is available. In the case where the care givers and family are not able to care due the limited facility and skills, older people can be cared in institutional home. However, the number of institutional homes in the country is very limited.

The above mentioned services are funded by community cooperation funding, family support funding from local office of National Board of Population and Family Planning, health support funding from Primary Health Centres and social support funding from local office of Ministry of Social Affairs. Basic health insurance for all has been implemented through the Public Health Maintenance Insurance scheme (Jaminan Pembiayaan Kesehatan Masyarakat /JPKM), but there is still no insurance system for LTC. The evaluation results of Family Based LTC show that this model it is cost-efficient, as services are provided at home, replicable, accepted by family and community since it in line with Indonesian culture and sustainable, as services provided meets the needs of users and is provided by and for the community.

V. Challenges

A major limitation at the national level is coordination. In remote areas funding is a significant challenge and there is some opposition from caregivers who lack training. In addition, limited capabilities and skills is a challenge for the LTC facilities at Primary Health Centres.

VI. Recommendations

1. Collaboration among stakeholders is necessary at both the national and local level.
2. Training and references materials are highly needed.
3. Resources need to be mobilized to strengthen care facilities.

Approaches to Home and Community Care for Older People: the Thailand Experience
by Siriphan Sasat, Ph.D., RN., Viennarat Chuangwiwat, PhD candidate
Chulalongkorn University, Bangkok, Thailand

I. Country/area

Thailand

II. Institution/s or organization/s responsible

In 2009, the National Commission on Older Persons established the Committee on Long-term Care (LTC) which is chaired by the Permanent-Secretary of the Ministry of Public Health. An Action Plan on LTC (2011-2013) was launched in 2011. The plan covers health, social and economic issues which should be implemented by the line ministries or designated organisations.
On 11 March 2013, the National Health Security Board established a Sub-Committee on Long-term Care to develop a long-term care system for dependent older persons. However, the National Health Security Office is not mandated for the direct provision of LTC.

### III. Background

Population ageing in Thailand has rapidly increased and will continue in future decades. Since 1960 the number of older people in the Thai population has increased five-fold to over 8 million by 2013 or 13% of the total population. Future population ageing will occur more rapidly with the number of older persons projected to increase to over 20 million by 2043, which will constitute over 30% of the population. Persons 60 and older will outnumber children under age 15 within the next decade.

In 2010, life expectancy was 67.8 years for males and 72.8 years for females. Life expectancy at 80 years is also projected to increase. The potential support ratio (persons 15-64/persons 65+) has been reduced by almost half (from 9.3 in 1994 to 6.3 in 2007) and the dependency ratio in older persons increased from 8.9 in 1960 to 19.2 in 2010.

Despite continuing widespread normative support for living with children, co-residence with children fell steadily from 77% to only 57% between 1986 and 2011 among persons 60 and older.

### IV. Description of model and/or policy

While health care is provided free-of-charge under the Universal Health Coverage (UC) for those who are not covered by other government health benefits or social security schemes, long-term social care is not covered by any scheme. Despite the shrinking family size and outmigration of the children, the government policy on LTC focuses on informal community-based care which mainly relies on family carers and volunteers, leaving the private sector to provide institutional care and home-based care assistants.

Since 2007, a number of policy advocacy and similar projects on LTC for older persons have been developed by many parties, including, the Ministry of Social Development and Human Security (MSDHS), the Ministry of Public Health (MoPH), the Senior Citizen Council of Thailand (SCCT), the Local Administrative Organizations (LAOs - the local government), hospitals, academic institutes, international organizations (e.g. UNFPA, ILO), donor agencies, NGOs, the civil society network including faith-based organizations such as Buddhist temples in the communities. Although, these efforts are fragmented, there are some good practices and lessons learned which could be applied and further developed. Some of these initiatives included i.e. (i) Village Health Volunteers and Home Health Care Programmes by the Ministry of Public Health; (ii) Community Volunteers for Older Persons by Ministry of Social Development and Human Security; (iii) Model development on community-based care in different settings and a comprehensive integrated long-term care system supported by UNFPA; (iv) Community-based care supported by the Japanese International Cooperation Agency (JICA); (v) Older persons volunteers for dependent older persons in the communities by the Senior Citizen Council of Thailand (SCCT); (vi) Community-based care and rehabilitation centres by the Local Administrative Organisations (LAOs); (vii) Community-based care initiated by some hospitals such as Lamsonthi Model;

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3 idem
Among the above initiatives, Lamsonthi Model is an example of a practical formal community-based care system which is summarized as follows:

**Lamsonthi Model - an area-based development on community-based long-term care**

A community-based LTC system has been developed in Lamsonthi District, Lopburi Province, with the aims to avoid the revisits to hospital and to overcome a shortfall of family carers for dependent older persons as well as younger people who require long-term care, such as those with disabilities.

A coordinated health and social care system has been established by Lamsonthi District Hospital in collaboration with the Local Administrative Organisations (LAO). Care management and technical support are provided by Lamsonthi District Hospital and the community health centres/community health promotion hospitals. The care team is composed of the care assistants and many of them are village health volunteers. They have been trained on basic care for older persons and received on-the-job training. Their modest monthly salaries of THB5,000. - (approx. USD155) are provided by the LAOs. Their duties include i.e. (i) helping patients to take medicine; (ii) arranging appropriate positions in bed; (iii) vital sign taking; (iv) supporting Activities of Daily Living (ADL) i.e. bathing, dressing, eliminating, transferring; (v) mental health support e.g. reading newspapers to the patients, making conversation; (vi) assisting in rehabilitation; (vii) household chores e.g. cleaning the house, making bed; (viii) giving general advice; (ix) coordination with relevant parties.

LTC services may be arranged according to the discharge plan or the notification of the cases in the community by the care assistants or the volunteers upon which an assessment on LTC needs will be conducted by the community health centres or the hospitals. Following the assessment results, further diagnosis may be conducted as required and a care plan will be developed by the multi-disciplinary team of the district hospitals i.e. doctor, family nurse, palliative care nurse, psychologist, physiotherapist, occupational therapist, nutritionist, and the data and plan officer. The multi-disciplinary team also provides technical support and supervision on community-based care for the care assistants. Services include health and social care of which the health care costs will be charged against the National Health Security Fund while social care costs will be borne by the LAOs, charity funds or in kind contribution from the volunteers, such as the carpenters who make the assistive devices or modify the homes.

V. Good Practices and Challenges

Thailand’s LTC policy is focused on the community-based system, in which the family carers and volunteers are expected to tend to the needs of dependent older persons. To date, only Lamsonthi District provides community-based care through paid care assistants, which could overcome a shortage of the family carers. This model is a good example of the collaboration between the health sector (hospitals) and social sector (LAOs, communities). It reduces the service gaps and enables ageing to take place in a practical way.

Despite a comprehensive service system in Lamsonthi, there is no linkage with other hospitals or networks outside this district. Thus, it is difficult to keep track of patients who
may receive treatment elsewhere. The provision of health care and social assistance has been running considerably well. However, the quality of care is questionable, since the operational aspects and the training curriculum of the care assistants are not based on agreed standards.

Following the decentralisation policy, the LAOs are expected to be responsible for the well-being of the population in their communities. However, there are limitations in the legal framework which do not allow the LAOs to fully provide financial support or implement the programmes, including in relation to staffing issues. Although the LAOs in Lamsonthi District use the alternative budget line to employ the care assistants, this category of staff is not included in the regulated list. Related laws and regulations should be amended to enable the LAOs to provide critical welfare and social services for the older persons in need.

VI. Recommendations

1. A comprehensive policy on long-term care system should be developed, which should include formal, informal, community-based and institutional care.
2. The legal framework has to be reviewed and amended to allow the appropriate operations and system financing.
3. The potential of social capital such as volunteers, family members, neighbours and the community-based network including the faith-based organizations should be maximized - their capacity should be strengthened and the support systems to facilitate their work should be established.

Care for Older Persons in Vietnam
by Ms. Quynh Ngoc Nguyen, United Nations Population Fund Viet Nam Country Office

I. Country/area

Viet Nam

II. Institution/s or organization/s responsible

Various institutions and actors

III. Background

One of the most important population trends in Viet Nam in recent years is population ageing, which has arisen as a result of declining fertility and mortality rates, consequently leading to longer life expectancy. Specifically, the total fertility rate (TFR) in Vietnam decreased from 5.25 in 1975 to 3.8 in 1989 and 2.01 in 2011. The mortality rate of children under 1 year of age reduced from 36 per cent in 1999 to 16 per cent in 2009. Notably, the average life expectancy in Viet Nam was recorded as 72.8 years in 2009, having increased by 8 years and 4.6 years of age in 1989 and 1999, respectively.

Population projections from the Viet Nam Population Census 2009 (GSO, 2011) had indicated that Viet Nam would enter the ageing phase in 2017. However, in 2011, the proportion of people aged 65 and above had reached 7 per cent, which means that Viet Nam entered the population ageing phase earlier than projected. The transition period from an ‘ageing’ to an ‘aged’ population structure in Viet Nam is likely to be much shorter (less than
than many countries with higher development levels, and even shorter in comparison to Japan and Thailand (respectively 26 and 22 years) which are considered to have the most rapid population ageing in the region.

In the context of Viet Nam’s status as a low-middle income economy, the rapidly ageing population has critical implications for policies and programmes on care for older persons, in order to ensure a healthy physical and mental older population that continuously contributes skills and experience for the development of the country.

The older population in Viet Nam has distinct characteristics which must be carefully considered when identifying the type of care needed for elderly. Firstly, the ‘feminization of ageing’ is very clear. The Vietnam Ageing Survey (VNAS) 2011 shows that for every 100 older men aged 60-69, 70-79, and 80 years or above, there are respectively 127, 161 and 195 older women. Therefore, special attention must be paid to older women, especially those in higher age group because they are more vulnerable to disease, poverty and loneliness.

Secondly, the living arrangements of older persons in Viet Nam have changed significantly, from multi-generational to nuclear units. With the strong flow of rural-urban migration, there are increasingly older persons living alone or living with a spouse or grandchild only (skipped generation family). Currently, around 30 per cent of older persons are living under these arrangements, which is a challenge in terms of providing adequate care and support.

Thirdly, the majority of Vietnamese older persons risk illness and injury, and only 35 per cent of older persons are in normal and good health (VNAS 2011). Nearly 70 per cent of older persons are suffering from non-communicable and chronic diseases, such as osteoarthritis, heart diseases and hypertension. Assessing the activities of daily living (ADL) indicates that around 14 per cent of older persons have difficulties and need support in their daily life. Furthermore, the prevalence of older persons who have difficulties in daily living increases with age.

Fourthly, the ratio of older persons living in the poor and near-poor households is high (Evans et al, 2007; 2012), while the level of access to the social security regime, including pensions and allowances, is low. Currently, only 13.11 per cent of older persons receive contributory pensions (VNAS 2011), whilst 100,000 people aged 60-79 and around 1.3 million people aged 80 and over receive monthly allowances (or social pensions). Thus, more than 5 million people aged 60-79 do not receive any income support in Viet Nam. In addition, the level of benefits available under social allowances amounts to only 36 per cent of the current urban poverty line defined by the government.

IV. Description of model and/or policy

The newly approved National Programme of Action on Older Persons 2012-2020 emphasizes various policy responses to care for older persons. Various programmes and models on care for older persons have been implemented but there has been little documentation of them. Care for older persons has generally been provided by public or private institutions and local organizations.

The Ministry of Health as introduced a policy on healthcare for older persons with a target to provide geriatric care in all district hospitals by 2020, and to ensure periodic health check-ups for older persons, at least once a year. However, the development of the geriatric care system for the elderly is too slow compared to the rapid increase of the elderly population and changes in disease patterns of the elderly. Most older persons have chronic, non-communicable diseases and are in need of vital medical treatment. However, of the 63
provinces in the country, there are only 22 central and provincial hospitals which have established a Department of Gerontology. The large disparity between supply and demand has led to overcrowding and a diminished quality of health care in hospitals and other medical facilities. The over-crowding rate at the central level is 130 percent and 110 percent at provincial level. Home visits by doctors and nurses are provided at the community level but they are very limited.

The Ministry of Labour, Invalids and Social Affairs (MOLISA) has been assigned to provide care for older persons through Centres for Social Protection and nursing houses. These models provide support for most vulnerable people including not only older persons who are poor, living alone, without any other support or disabled, but also orphans, homeless children, etc. Private care and rehabilitation centres have also provided services for older persons with better activities and services as compared to the public ones. However, the high costs and the lack of a referral system to local health facilities are weaknesses of the private models.

Community-based care models that provide long-term care for older persons have been piloted by local organizations and elderly associations through volunteer networks in the community. Examples of such models include the Inter-generational Self-Help Club model, a volunteer-based care model for disadvantaged older persons and a volunteer-based counselling healthcare model for older persons through physicians in the community. The unpaid volunteers provide support on instrumental daily activities such as cleaning the house, cooking, shopping, or just being a person to talk to. These volunteers also provide information for older persons on self-care and facilitate their participation in community activities. Community-based care for older people is included in the Law on Older Persons and the newly approved Programme of Actions on Older Persons 2012-2020. However, there has not been a state budget allocation to local levels to implement the legal provisions and the programme itself. These models tend to operate on funding from NGOs, donors and communities. Thus, despite its flexibility and inclusiveness of older persons, the funding limitations and the lack of commitment from local authorities pose a great threat to the sustainability of these models.

IV. Challenges

The following are existing challenges and obstacles to the provision of long-term care in Viet Nam:

- Knowledge and awareness on long-term care is limited, and there is yet to be a comprehensive system developed by the government;
- Difficulties and shortcomings in the implementation of policies and programmes. In addition, the coordination between sectors in the provision of services for older persons is poor;
- Limitations in funding, infrastructure and human resources;
- Community-based care models are still voluntary-based activities, and have not been well-integrated into programmes at the community level.

VI. Recommendations

- Improve data collection and information on older persons disaggregated by age groups, sex and socio-economic variables to identify their specific care needs
- Develop a national long-term strategy to ensure coordination and collaboration of various sectors and actors in providing long-term care for older persons.
• Mobilize resources to support addressing the needs of older persons.
• The government should invest in community-based care for older people supported by families, communities, older persons’ organisations and local authorities to reduce the cost and burden on the health system.
• Increase awareness raising efforts on the care needs of older people and knowledge/skills building to meet these challenges.
• Promote the use of social workers under the government’s programmes to address the needs of older persons.
• Encourage greater research and knowledge exchange on long-term care to develop a suitable cost-effective model, which is culturally sensitive to local conditions.
ANNEX III

THE AGEING SITUATION OF CHANGNING AND TIANNING
CHINA
By Kong Zheng, China Population and Development Research Center

1. Geographical distribution of older persons

1.1 Changning
Shanghai, situated in the middle of east coastal line of China, is known as the country's international metropolis. It covers an area of over 6,340 km² and has a population of over 23 million. Shanghai is ranked as the earliest ageing city in China. Already in 1979, the proportion of the elderly population to the city’s total population stood at 7.2 percent. By 2010, this number had increased to 10.1 percent. The absolute number of Shanghai’s elderly rose to 2.33 million the same year.

Changning district, located in the west of Shanghai, is one of the city’s five central districts. It has a total population of 690,000 in an area of 38.3 km². In the 2010 census, 97,554 persons in Changning were 65 years or older, amounting to 14.1 percent of the district’s total population, 4 percentages higher than the average level of Shanghai.

During the past decade, the number of elderly persons whose Hukou registered in the district has increased in average 1.38 percent each year. Population ageing in Changning has continued in recent years. The number of old people over the age of 60 increased with 18.4 percent, from 133,000 in 2008 to 157,000 in 2012.

1.2 Tianning
Situated in south of the Yangtze River and at the shores of Tai Lake, Changzhou is an ancient historical and cultural city in the Jiangsu province. It became “aged” in 1985 and has continued to have an average annual increase of 4.52 percent in the ageing rate during the first quarter of the twenty-first century. By the end of 2012, it had over 772,000 persons over the age of 60, amounting to 21.2 percent of the city’s total population.

As one of the oldest districts of Changzhou, Tianning is located in the centre of the city. It has a total population of 373,000 in an area of 67 km². The district is now administering six sub-districts and one province-level economic development zone, including 34 villages and 61 urban communities.

At the end of 2012, there were in Tianning 76,898 persons aged 60 and over. This amounted to 20 percent of the district’s total population and 10 percent of Changzhou’s elderly population. During the period of “Eleventh Five-Year Plan for National Economic and Social Development” (between the years 2006 and 2010), the elderly population increased by 3.2 percent in Tianning.

2. Ageing trends

2.1 Changning
It is forecasted that the number of persons over the age of 60 in Changning will reach 171,800 in 2015. Projections for the years 2020 and 2025 indicate that it will further increase to 209,100 and 227,100 respectively. This means its ageing rate will increase to 30 percent by the end of the first quarter of the twenty-first century.
With rapid ageing, Changning’s “young old”, namely those aged 60 to 69, are expected to increase to 121,500 by the year 2020. A similar trend is projected for the “middle old” (aged 70-79), expected to increase from 24 percent of all older persons in 2015 to 37 percent in 2025. In contrast, the proportion of “old old” (80-year-old and above) is expected to decline by 6 percent during the same period.

### Table 1: Ageing trends in Changning by age group (2015-2025)

<table>
<thead>
<tr>
<th>Year</th>
<th>60-69  (in thousands)</th>
<th>70-79  (in thousands)</th>
<th>80+    (in thousands)</th>
<th>Total  (in thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>96.3</td>
<td>41.6</td>
<td>33.8</td>
<td>171.8</td>
</tr>
<tr>
<td>2016</td>
<td>103.5</td>
<td>42.3</td>
<td>34.4</td>
<td>180.2</td>
</tr>
<tr>
<td>2017</td>
<td>111.4</td>
<td>44.8</td>
<td>34.2</td>
<td>190.4</td>
</tr>
<tr>
<td>2018</td>
<td>117.7</td>
<td>47.4</td>
<td>33.7</td>
<td>198.9</td>
</tr>
<tr>
<td>2019</td>
<td>119.6</td>
<td>51.0</td>
<td>33.0</td>
<td>203.7</td>
</tr>
<tr>
<td>2020</td>
<td>121.5</td>
<td>55.2</td>
<td>32.3</td>
<td>209.1</td>
</tr>
<tr>
<td>2021</td>
<td>121.0</td>
<td>59.4</td>
<td>31.9</td>
<td>212.3</td>
</tr>
<tr>
<td>2022</td>
<td>121.0</td>
<td>64.6</td>
<td>31.3</td>
<td>216.8</td>
</tr>
<tr>
<td>2023</td>
<td>122.2</td>
<td>69.9</td>
<td>30.7</td>
<td>222.8</td>
</tr>
<tr>
<td>2024</td>
<td>117.3</td>
<td>77.1</td>
<td>31.0</td>
<td>225.5</td>
</tr>
<tr>
<td>2025</td>
<td>111.7</td>
<td>84.3</td>
<td>31.0</td>
<td>227.1</td>
</tr>
</tbody>
</table>

2.2 Tianning
In Tianning the absolute number of elderly persons is expected to reach 86,200 by the year 2015, representing 25 percent of the total population. This is an increase of 34.7 percent from 2010 to 2015 whereas the total population is projected to increase only by 7.5 percent over the same period.
3. The “old-old”

In 2010, Changning’s old age dependency ratios for 60 year-olds and for 65 year-olds are 27 percent and 17.9 percent, respectively. At the end of 2012, there were 33,773 octogenarians and 92 centenarians in the district, constituting 5.24 percent of Changning’s total population. During the period 2000-2010, the proportion of “old old” increased significantly from 11.1 percent to 18.7 percent, an average increase of almost 7.2 percent each year. There were 13,027 younger old stepping into the “old old” population cohort over the same time and Changning is therefore ranked as the third oldest district of Shanghai. This trend is projected to continue in the coming years with the number of the “old old” expected to be 33,800 by 2015, as one in every five elderly persons will be very old.

There were about 11,000 people over the age of 75 in 2010 in Tianning, representing 3.1 percent of the district’s total population. At the end of 2012, the number of the “old old” stood at 11,312, amounting to 14.7 percent of the elderly population. Although Tianning’s elderly dependency ratio registered a lower level at 12.9 percent according to the 2005 National 1% Population Sampling Survey, projections reveal that the number of elderly persons in need of other’s help is expected to rise to 10 percent of Tianning’s total population in the next five to ten years.

4. Comparison in demographic characteristic

4.1 Age-sex structure

Nearly half of the elderly persons in Changning are aged 60 to 69 years old according to the 2010 census, one third are 70 to 79 years old and one fifth are over the age of 80. The census data also shows sex ratio of the elderly population. Except for the 60 to 64 years age group, which has nearly equal numbers of men and women, the female elderly are much more numerous than male in all other age groups. Moreover, the gap between men and women widens further the older the age group. The sex ratio for the group aged 60-64 stood at 99.9 whereas for the group over the age of 95 it was only 70.3.
As shown in chart four, the “young old” constituted 56 percent of Tianning’s elderly population in 2012. The relative weight of the “middle old” and the “old old” stood at about 30 percent and 15 percent respectively. Similar to Changning, a majority of the elderly population in Tianning consists of women and the female majority increases further among the “old old”.

4.2 Life expectancy and health condition
Over the past few decades, the decline in mortality rate in China is reflected in a remarkable increase in life expectancy. The average life expectancy of in China according to the 2010 census stood at 74.83 years (72.38 for men and 77.37 years for women). Shanghai is now ranked as the city with the highest average life expectancy in the whole country, with 82.13 years (79.8 years for men and 84.4 years for women). Data shows that Changning has a higher level of average life expectancy than that of Shanghai, at 83.5 years old (81.5 for men and 85.6 year for women).

In the 2010 census, 87.3 percent of the elderly persons in Shanghai self-rated their physical conditions as “healthy”, 9 percent reported “not good” but could “self-care”, while 3.7 percent rated themselves “in poor health” or “disabled”. 56.8 percent of 1,156 centenarians reported that they can take care of themselves in daily lives.

The 2005 National 1% Population Sampling Survey showed that 80 percent of the elderly persons in Changzhou rated their health status as “quite well” or “fine” while 20 percent of them felt “in poor or very poor health”. For people older than 75, however, only 65 percent
considered themselves as healthy. A comparison between urban and rural (suburban) elderly persons in chart five revealed that city dwellers over the age of 75 are in better physical conditions than their counterparts living in the rural areas.

<table>
<thead>
<tr>
<th>Table 2: Self-rated health status in Changzhou (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health status</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>In good health</td>
</tr>
<tr>
<td>In poor health</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Chart 5. A comparison of health status of Changzhou’s elderly of 75+ (%)

4.3 Education level
The 2010 census showed that half of the elderly persons in Changning had completed secondary education and one quarter had finished college education. By age group, the “young old” had much higher education levels than the “old old”. 28.2 percent of the elderly persons aged 60 to 69 had a college education, while only 14.1 percent of the 80 year-olds had the same education level.

<table>
<thead>
<tr>
<th>Table 3: Education level of Changning’s elderly population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education level</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>Primary and below</td>
</tr>
<tr>
<td>Secondary</td>
</tr>
<tr>
<td>College and above</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Data is lacking about elderly persons’ education level in Tianning District. But the 2005 National 1% Population Sampling Survey showed that elderly illiterates constituted 76 percent of the total number of adult illiterates in Jiangsu province. Rural elderly women are generally disadvantaged in terms of education. A majority of elderly women in rural areas of Changzhou City had not completed seven years of formal education and a large percentage of them cannot read or write.
4.4 Pension coverage and economic status

The China Social Security Development Index Report 2012, released in November 2013 by the China Social Security Research Center of Central University of Finance and Economics, showed that by the end of 2011 Shanghai’s pension system covered more than 90 percent of the city’s old persons, but the replacement rate for pensioners stood only at 36.9 percent, a lower level compared to the nation’s average of 51.9 percent. In Changning, as demonstrated in table 4, more than 95 percent of elderly persons were pensioners.

<table>
<thead>
<tr>
<th>Income mainly from</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pension</td>
<td>95.34</td>
</tr>
<tr>
<td>Job</td>
<td>2.15</td>
</tr>
<tr>
<td>Family</td>
<td>1.57</td>
</tr>
<tr>
<td>Social assistance</td>
<td>0.79</td>
</tr>
<tr>
<td>Property</td>
<td>0.01</td>
</tr>
<tr>
<td>Others</td>
<td>0.14</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4: Economic status of Changning’s elderly population

In the Investigation of Demand of Elderly Population for Care and Services in Changzhou in 2009, slightly more than 70 percent of the respondents reported that their income was less than 1,500 RMB per month and 2 percent of the respondents said they had no income. Quite a few of respondents received financial help from their children or grandchildren and some respondents benefited from government minimum living allowances. By the end of September 2012, pension coverage rates had reached 99.5 percent in Changzhou. For those who live in urban areas and retired from the formal sector, the average monthly pension payment was 1,894 RMB. Elderly persons in rural areas can get a monthly basic pension payment of 110 RMB from the government.

5. Ageing families

5.1 Families are ageing

Nearly 40 percent of Changning’s families have at least one member over the age of 60. Almost 20 percent of these families are composed completely of old members, out of which about 9 percent live alone.

<table>
<thead>
<tr>
<th>Number of elderly persons</th>
<th>Number of households</th>
<th>% of total households</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>147,387</td>
<td>60.7</td>
</tr>
<tr>
<td>1</td>
<td>47,946</td>
<td>19.7</td>
</tr>
<tr>
<td>2</td>
<td>45,155</td>
<td>18.6</td>
</tr>
<tr>
<td>3 and more</td>
<td>24,84</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>242,972</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5: Families with elderly persons in Changning (2010)

In 2005, the average family size of Changzhou was 2.8 persons, with nuclear families representing 32.6 percent of the city’s total families. In the 2010 census, 21 percent of the families in Changzhou had at least one member over the age of 65. This means one out of every five families has an old member.
5.2 Elderly families
During China’s process of urbanization and modernization, families are increasingly often geographically separated as their younger members have opportunities to work in other cities or go abroad for education. Furthermore, adult children often move into the newer housing schemes when they marry and live separated from their elderly parents. Consequently, more and more families are composed only of elderly members. These families are called “elderly families”.
At the end of 2010, elderly families constituted more than 8 percent of Changning’s total number of households. The number of elderly persons in these elderly families accounted for 24 percent of the total elderly population in the district.

Table 6: The structure of elderly families in Changning (2010)

<table>
<thead>
<tr>
<th>Family members</th>
<th>Number of households</th>
<th>% of total households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>7076</td>
<td>2.91</td>
</tr>
<tr>
<td>Couple</td>
<td>12234</td>
<td>5.04</td>
</tr>
<tr>
<td>Three old members</td>
<td>442</td>
<td>0.18</td>
</tr>
<tr>
<td>Total</td>
<td>19752</td>
<td>8.13</td>
</tr>
</tbody>
</table>

In Tianing district, the proportion of single elderly person households and old couple households to the total number of elderly families amounted to 34.2 percent in 2005. In terms of living arrangement, 40.3 percent of the old people living in urban areas of Tianning are geographically separated from their children and 37.8 percent of the elderly persons in suburban areas live alone.

5.3 Empty nest families
The dramatic fall in the average Chinese family size which has occurred in the last three decades, has resulted in the prevalence of nuclear families and a large number of elderly persons living alone. By the end of 2012, elderly parents constituted more than 80 percent of the “new” elderly population in Shanghai. It is expected that a substantial majority of the older persons will consist of elderly parents in nuclear families in the next few years. Parents in nuclear families are more likely to face an “empty nest” when they get older. An investigation on empty nest elderly persons made by Shanghai Family Planning Association (n=1164) in 2011, showed that empty nest elderly persons in nuclear families in Changning are characterized as younger, healthier, wealthier and better educated than the average of the district’s total elderly population. However, half of the respondents indicated that they worry about inadequate care from their children when they get aged. It is alarming to note that 12.9 percent of the empty nest elderly parents in this group have lost their children, some of whom were living in poverty.
Table 7: Empty nest elderly persons of families that complied with family-planning policies in Changning

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>60-69</td>
<td>72.1</td>
</tr>
<tr>
<td>70-74</td>
<td>14.1</td>
</tr>
<tr>
<td>75+</td>
<td>13.8</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
</tr>
<tr>
<td>Primary or below</td>
<td>2.3</td>
</tr>
<tr>
<td>Secondary</td>
<td>52.7</td>
</tr>
<tr>
<td>College or above</td>
<td>45</td>
</tr>
<tr>
<td><strong>Career before retirement</strong></td>
<td></td>
</tr>
<tr>
<td>Officer/manager/business owner</td>
<td>61</td>
</tr>
<tr>
<td>Worker</td>
<td>30</td>
</tr>
<tr>
<td>Others</td>
<td>9</td>
</tr>
<tr>
<td><strong>Income per month (RMB)</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 2000</td>
<td>11.7</td>
</tr>
<tr>
<td>2000-3000</td>
<td>28.2</td>
</tr>
<tr>
<td>3000-5000</td>
<td>42</td>
</tr>
<tr>
<td>More than 5000</td>
<td>18.1</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
</tr>
<tr>
<td>Born before 1980</td>
<td>73.8</td>
</tr>
<tr>
<td>Born between 1981-1985</td>
<td>22.7</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td></td>
</tr>
<tr>
<td>Live in other cities or countries</td>
<td>86.4</td>
</tr>
<tr>
<td>Dead</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>Level of self-care</strong></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>94.2</td>
</tr>
<tr>
<td>middle</td>
<td>4.6</td>
</tr>
<tr>
<td>low</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Perceiving ageing as a problem because of</strong></td>
<td></td>
</tr>
<tr>
<td>Lack of care</td>
<td>48</td>
</tr>
<tr>
<td>Sickness</td>
<td>17.9</td>
</tr>
<tr>
<td>Economic difficulty</td>
<td>5.8</td>
</tr>
<tr>
<td>Poor house condition</td>
<td>9.4</td>
</tr>
</tbody>
</table>

6. Care and support

6.1 In Changning
An elderly persons’ demand survey carried out by Changning District Government in 2010 revealed that 90 percent of the 13,000 surveyed elderly persons want to stay at home at old age, 70 percent expressed the same intention when their health situation deteriorates. More than 85 percent reported that they will need help from the community when they face difficulties in dealing with housework. Guided by the awareness that the family is the best environment suited to the lifestyle of the elderly, while at the same time recognizing the fact that the family’s traditional role as caregiver to its elderly members is weakening, the district government has since 2009 initiated several programs to develop an “elderly-friendly” society. The goal was to respond to the needs of elderly persons by introducing a “happy old age” care and service system. In
2010, a satisfaction survey made by the district government showed that 85.2 percent of Changning’s elderly persons were satisfied with the “happy old age” system.

6.1.1 Financial support
A non-contributory, state-supported financial program has been introduced during the period of “Eleventh Five-Year Plan for National Economic and Social Development”, based on which governments at both municipal and district levels have made many efforts to:

- provide a bottle of fresh milk every day for low-income persons over the age of 70, for war and labour veterans over the age of 80 and for people over 90 years old who have Hukou in Changning;
- offer old age allowances to persons over the age of 80 who are poor, disabled or live alone. In 2012, the amount of old age allowance was 153,300 RMB;
- give out nutrition allowances to persons who are over 100 years old. The amount of nutrition allowance in 2012 fiscal year was 237,600 RMB;
- grant one-child-lost elderly parents with a special allowance of 150 RMB per month and 120 RMB per month to one-child-disabled elderly parents. A lump sum of 10,000 RMB is available for one-child parents in their fifties since 2011;
- provide concessions in public transportation and on entertainment fees to all senior citizens.

6.1.2 Health care
The community, as a bridge to shorten the gap between the family and the state, could play a crucial role in providing health care for older persons. By the end of 2010, Changning had established 10 community health service centres (at sub-district level) and 42 community health service stations (at housing estate level). Based on these community facilities, health care focuses on the following:

- free physical examination once a year for low-income elderly persons over the age of 60, who have local Hukou;
- concessions to persons over the age of 65 who are not covered by the social security system when they need an emergency treatment at community clinics;
- door-to-door periodic health screening for poor elderly over the age of 80;
- professional doctors providing door-to-door health services for persons over the age of 100.

6.1.3 Home-based services
For elderly living alone who are walk-retarded or disabled, governments at both municipal and district level have launched 25 programs providing activities of daily living (ADL) services. The provisions are mainly focusing on meals-on-wheels and home help in cleaning, bathing, hairdressing, hospitalizing, transportation and emergency-on-call. At the end of 2010, there were 13,600 elderly persons benefiting from the programs, 60 percent of them subsidized by local authorities.

Considering that low-income elderly families, especially the “old old” who live alone, have difficulties in making their houses well-equipped for life at old age, the government provided adaptive housing renovations for 1,000 elderly families in 2012. The action was based on contracts with given construction companies.

To prevent unexpected accidents from water, electricity and gas leakage, the government launched the “Mutual Aid” campaign to carry out periodic safety inspections for elderly
families. In 2012, 960 “young old” were organized to provide mutual aids for 4,800 “old-old”.

6.1.4 Community facilities
In recent years, local authorities have made various efforts to build and support community-based elderly facilities. Altogether 12 day centres, 178 old age homes and 43 elderly cafeterias are currently operating across the district. These community facilities are available for almost all the elderly persons in the area. Day centres supply daily care for those in need. Old age homes provide a congenial atmosphere where elderly persons can meet for recreation and share experiences. Elderly cafeterias serve meals at a lower price for some categories of elderly persons.

The government also attaches special importance to the elderly population’s social participation, education and legal protection. The Community Senior University has opened its branch campus in all of 10 sub-districts and delivers online education with 80 classes, covering tens of thousands of elderly students. The Community Senior Association currently has more than 2,519 members offering volunteer services. With respect to legal protection, public lectures on the rights of old persons are frequently held and pamphlets to safeguard the legal rights of the elderly are regularly handed out.

6.1.5 Financing of long term care
In China, long-term care for the elderly persons is governed, managed and financially supported by the Ministry of Civil Affairs and its branches at local level. Before the year 2000, long-term care and services for old persons were in severe shortage at the community level. To solve this problem, the Ministry of Civil Affairs in 2001 launched the “XingGuang Plan”. The “XingGuang Plan” used 20 percent of the yearly income from selling social welfare lottery tickets to finance the development of community service centres for older persons in need of long-term care and services. Communities provide offices, infrastructures and main staff members for the centres financed by the “XingGuang” campaign. For Shanghai’s older persons who have difficulties in self-caring, community service centres are committed to help searching and paying for their caregivers or elderly institutions if they are very poor without children, or single or widowed and never have been employed in the formal sector. In Changning, some highly qualified elderly institutions can get financial support from the government. Older persons who receive long-term care from private elderly institutions have to pay all costs including nursing and daily-life fees by themselves.

6.2 In Tianning

6.2.1 Financial support and wellbeing

- In 2012, Tianning launched the “One Yuan for One Meal” program for family-planning elderly families. Under the program one-child elderly parents receive meals at a nominal cost of one Yuan at elderly cafeterias;
- Elderly persons without income, with no children and no home are provided with residential care in an old age institution and a living allowance of 560 RMB per month;
- One-child elderly parents living in rural areas receive a family planning allowance of 60 RMB per month(each) or 120 RMB per month(combined) from the government;
- War or labour veteran elderly persons without children receive a monthly home service worth 200-300 RMB;
The government provides allowances of 50 RMB per month for persons over the age of 80, and 100 RMB per month for those over 90 and 300 RMB per month for people over 100;

All elderly can enjoy concessions in public transportation costs and entertainment fees.

6.2.2 Medical care and home services
The government has established personal health records for the majority of the elderly population in the district. On a monthly basis, community doctors provide door-to-door health screening and treatment for those in need. The government also extended the coverage of home-based services for older people by contracting civil society, non-governmental organizations and private businesses. Some categories of elderly persons can receive basic daily services such as cooking, cleaning and bathing. When older persons are ill or stay alone at day time, they can ask for a home visit or nurse visit from volunteers. The services also include accompanied shopping services, chatting and going to hospital although these services are provided against a fee.

6.2.3 Community facilities
By the end of 2010, Tianning had two old age activity centres, 10 old age fitness plazas, 30 community clinics and 51 home-based elderly service stations. In recent years, Tianning has made the use of internet and hot-lines to serve the elderly population. “12349” is an information platform to provide help for elderly persons. It facilitates the communication between the elderly users and the service suppliers. The content of “12349” includes housework assistance, home safety maintenance, legal consultation and psychological consolation. Since it began operating in 2010, there has been 41,000 elderly persons users.

6.2.4 Financing of long term care
Along with the “XingGuang Plan”, Changzhou in 2010 opened the charitable care and service zone for old persons in poverty. In the zone, elderly persons’ bed fees are free, nursing and daily-life charges can be halved. In recent years, the Tianning government spent around 20 million Yuan on the programme. To promote the development of community service centres in the district, Tianning also attaches importance to the role of non-government organizations in the provision of long-term care for elderly persons. At present, there are a few of old age institutions involved in long-term care for older persons, operated by private owners.

7. Key challenges
The two pilot areas are both confronting challenges and issues generated by a rapidly growing population aging, which is expected to pose not only a huge financial pressure but also an increasing medical burden on society, as the “old old” are more likely to need medical attention than others. Families, as the traditional care takers of their elderly members, are undergoing great change. With the process of socio-economic development and the change in family structure and value, the family’s supportive role will continue to deteriorate.

Faced with this trend, governments in the pilot areas have made many efforts to build home-based and community-centred care and service systems for elderly persons. The systems have become a basic framework of providing social services for the elderly population. However, it is difficult at the present time for the government to offer a comprehensive range of social services covering all elderly persons in need. The system targets the frail, the poor, the homeless and war and labour veterans who are beneficiaries of social welfare. The network therefore seems to be a welfare-like system which only some categories of elderly
persons can benefit from. The evident care gap in the pilot areas will become more pronounced in the future with advanced population ageing.

Currently, most of the home-based services and the community facilities are built, organized and heavily subsidized by the government. Non-governmental and voluntary organizations are at the initial stage as caregivers, organizers and operators. In the era of population ageing, we need a transformation from the Welfare State Model of social policy to the Caring Society Model, in which all social institutions can be involved.

There is a crippling shortage of expertise, professionals, qualified workers and volunteers in this field. Very few of younger working-age people are willing to be employed to care for the elderly. Most of the caregivers currently working in elderly institutions and community facilities are those marginalized at the job market. They lack skills, qualification and adequate supervision, leading to elderly persons largely receiving non-professional care and nursing service. There is also a lack of adequate knowledge, education and training in the conceptual recognition of the elderly. Older persons cannot be viewed only as a needy and dependent group as their productive and active functions serve as an important contributions to society and to the family, which needs to be recognized.

Women often have a longer life expectancy and a worse economic situation than men. The predominance of females in the older population will have a tremendous impact on the needs and provisions of elderly care and support. Elderly women have not yet fully been taken into account or given special consideration in policies and measures taken in the pilot areas.

With increasing living standards, the volume and pattern of consumption of old people in the pilot areas are shifting towards expenditures on non-essential goods and services. Their demand for specifically-designed elderly products with high quality calls for the development of ageing industry, which requires the market sector to supply what the elderly population actually needs.
ANNEX IV

EVALUATION

The Meeting was relevant and useful
The Meeting introduced new concepts and ideas
Addressing gender dimensions
Time used efficiently
Conference services, including logistics, efficient
The Meeting was relevant and useful