



Research Project on

Care for Older Persons in ASEAN+3

The Role of Families and Local and National Support Systems

Department of Older Persons, Ministry of Social Development and Human Security, Thailand
College of Population Studies, Chulalongkorn University, Thailand
Association of Southeast Asian Nations (ASEAN)



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Research Project on

Care for Older Persons in ASEAN+3

The Role of Families and Local and National Support Systems

Edited by Elke Loichinger and Wiraporn Pothisiri

List of Country Abbreviations

BRN	Brunei Darussalam
CHN	China
IDN	Indonesia
JPN	Japan
KHM	Cambodia
KOR	Republic of Korea
LAO	Lao PDR
MMR	Myanmar
MYS	Malaysia
PHL	Philippines
SGP	Singapore
THA	Thailand
VNM	Vietnam

Acknowledgements

This report was made possible through the collaboration of the Department of Older Persons, Ministry of Social Development and Human Security, Thailand, the ASEAN Secretariat, and the College of Population studies at Chulalongkorn University. We thank all three institutions for their crucial roles in the successful completion of the project.

The individual country reports about the care situation in each ASEAN+3 country represent the core of this project. We sincerely thank all authors who took time out of their busy schedules to prepare these chapters. We also thank all those who participated in the kick-off conference of the project in May 2017 and contributed to vital discussions during the event.

We are grateful to the government officers at the Department of Older Persons who initiated this two-year project and provided financial support as well as valuable comments in the course of this report. Our special gratitude goes to Professor John Knodel of the University of Michigan for his input in defining the report topic and his constructive comments on the conceptual framework of the study, and to Professor Vipana Prachuabmoh of the College of Population Studies for her contributions to the kick-off conference of the project.

Our appreciation goes to Paolo Miguel Vicerra for language editing of and feedback on each country chapter. Editing and formatting of the full report for publication would not have been possible without the professional and tireless assistance of Busarin Bangkaew, Bussaba Rooncharoen, and Salita Kamsook who we thank very much. Thereath Pinnarathip was responsible for graphic design and layout and we are grateful for his professional work and the smooth collaboration.

Elke Loichinger and Wiraporn Pothisiri (Editors)

Bangkok, August 2018

Foreword

Care provision and care providers for older people are part of one of the three priority directions, advancing health and well-being into old age, under the Madrid International Plan of Action on Aging (MIPAA) which is the main international guideline on aging issues adopted at the Second World Assembly on Aging in April 2002. This topic is also reflected in the Kuala Lumpur Declaration on Aging: Empowering Older Persons in ASEAN, 2015.

In ASEAN+3 region, implementation on elder care provision and role of families, private sectors and governments as elder care providers are different across countries. Thailand by the Department of Older Persons, Ministry of Social Development and Human Security, in collaboration with College of Population Studies, Chulalongkorn University, initiated the project on “Care for Older Persons in ASEAN+3: the Role of Families and Local and National Support Systems” as a concern on gaps and diverse implementations on care provision for elderly among the region.

This two-year project demonstrates a cross-country comparative synthesis of care systems and five main actors as care providers which are the family, the state, local communities, NGOs and the private sectors. It also provides an opportunity for ASEAN and the plus three countries to share and exchange knowledge and good practices, including develop the ideas or model on the elder care for the better quality of life for older persons in the region.

The study received very kind cooperation from the nominated national experts from each respective country to complete their own parts which are the most essential components in this report. On behalf of the Royal Thai Government, Ministry of Social Development and Human Security, it is my great honor to express gratitude to national experts and also the SOMSWD+3 focal points in ASEAN+3 region.

I hope that this study will be an information source regarding care for the elderly of ASEAN and plus three countries to governments, researchers, students, and related stakeholders. I sincerely hope that policy recommendations presented in the report will provide useful guidance in the development of a plan on elder care provision in ASEAN+3 region.

Bangkok, July 2018

Mrs. Thanaporn Promsuwan

Director - General, Department of Older Persons

Ministry of Social Development and Human Security, Thailand

Executive Summary

Project Background and Motivation

The older population in ASEAN countries has been increasing, and with it the number of older persons who require care. Adequate availability of and access to care is a crucial aspect of the well-being of older persons. In the Brunei Declaration (2010), family is jointly recognized as the mainstay of care and support for older persons, and that the role of family, along with that of communities, the government, the private sector and other non-governmental organizations should be strengthened to promote active and healthy lives of older persons. To drive forward the commitment, the Department of Older Persons (DOP), Ministry of Social Development and Human Security, Thailand, has taken the initiative of launching the first review report on the current situation of care provision to older persons in 10 ASEAN countries, plus the 3 East Asian countries Japan, China and the Republic of Korea. This report constitutes a background document which can serve as a basis for monitoring and evaluation of the progress made towards the achievement of optimal support of older persons and their families.

Participating Parties

In order to produce this background report, the DOP appointed the College of Population Studies (CPS), Chulalongkorn University, Thailand, in 2016 to undertake a two-year project, entitled Care for Older Persons in ASEAN+3: The Role of Families and Local and National Support Systems. This project aimed to (1) compile country-level reports drafted by national experts, (2) provide a cross-country comparative synthesis of care systems, particularly the role of the previously mentioned care actors, as well as current and emerging issues related to care provision and their implications, (3) disseminate the report to a wide audience, in particular to governmental organizations involved in the organization and provision of care for older persons in their respective countries, and (4) strengthen cooperation and collaboration among ASEAN+3 countries. CPS was responsible for leading the project, which entailed defining the cornerstones of the project and its conceptual framework; outlining the content of the country reports; providing feedback on drafts and revised reports to the country experts; providing the introductory and concluding chapters for the full report as it is presented here; and designing and producing a summary booklet of the full report for a wider circulation. The DOP was responsible for the selection of country experts, in collaboration with the ASEAN Secretariat, and for supporting CPS in its communication with the country experts. The DOP also coordinated with CPS in organizing a conference to kick-off the project in Bangkok in 2017, provided feedback as well as advice on matters arising during the course of the project, and organized an event at the end of the project in August 2018 to showcase the full

report and the summary booklet.

The initial goal was to recruit a country expert from each ASEAN+3 country. While 11 countries participated in the initial conference, reports were only delivered for 9 countries. For the remaining 4 countries – namely Cambodia, China, Japan and Myanmar – CPS appointed contributors to provide an overview of the care situation in these countries. Most contributors come from government ministries or agencies involving social welfare or community development, while a few are from a research institute or universities.

| Key Findings

- The different stages of economic development and population aging of ASEAN+3 countries entail that the setup of older person care and the distribution of responsibilities of the involved actors differ vastly across countries.
- As expected, the family is still the main provider of care in each of the ASEAN+3 countries. What differs is the degree to which families are supported in their care tasks, and who of the other actors is organizing and/or providing this support.
- This support can be financial, in kind or in terms of services that are provided.
- Care for older parents is explicitly addressed as legal responsibility of children or/and the family in seven countries: China, Indonesia, Cambodia, Myanmar, the Philippines, Singapore and Vietnam.
- In cases where older persons cannot rely on support from their immediate families, other support mechanisms are often in place through which basic support and care is provided.
- Care needs and provision tend to differ between urban and rural areas, creating differing challenges in each area.
- Expenses for health care are mentioned as a crucial issue for older adults in several countries, and the situation is more favorable in those countries where older persons have access to health insurance or even free health care and where co-payments are low.
- In countries with a shortage of local care-givers – for example in Singapore, Japan and Thailand – foreign domestic workers that work as care-givers are playing an increasingly important role.
- A basic observation is that while the ASEAN+3 governments share similar roles in policy making, regulating/directing, financing/funding, and providing care services to older persons, the degree of involvement in each role varies considerably across countries.
- In terms of policy making, ten countries have overarching national legislation (e.g. a law, an ordinance, or act) to provide a legal framework for national policies, action plans and programs related to older persons.

| Policy Recommendations

The recommendations are deliberately kept broad to do justice to countries' very diverse demographic and socio-economic settings.

- In order to estimate future demand for LTC and related expenses, it is more fruitful to categorize people as dependent based on individual characteristics (e.g. ADLs, chronic diseases, or a combination of several indicators) instead of using a certain chronological age above which persons are assumed to become independent. Research has shown that individual characteristics are important determinants of health status, and that older persons of the same age can be quite heterogeneous in their care requirements because of this.
- The regulation of the long-term care sector is important in order to ensure quality of care. Besides having regulations and standards, monitoring of compliance and in cases of non-compliance the enforcement of these regulations need to be guaranteed.
- The earlier systems like LTC insurance are put into place, i.e. the lower the number of beneficiaries, the lower are the initial costs. This means that also countries with still relatively young populations should consider implementing such systems rather sooner than later in order to not have to shoulder a large burden later on.
- The availability of data on the presented topic differs between countries, and particularly in those countries where no recent data on the living circumstances of older persons in general and care needs and care provision in particular are available, it would be recommended to include questions on such aspects in ongoing or new data collections.

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Introduction

Wiraporn Pothisiri
Elke Loichinger

| Project Background

The older population in ASEAN countries has been increasing, and with it the number of older persons who require care. Adequate availability of and access to care is a crucial aspect of the well-being of older persons. In the Brunei Declaration (2010), family is jointly recognized as the mainstay of care and support for older persons, and that the role of family, along with that of communities, the government, the private sector and other non-governmental organizations should be strengthened to promote active and healthy lives of older persons. To drive forward the commitment, the Department of Older Persons (DOP), Ministry of Social Development and Human Security, Thailand, has taken the initiative of launching the first review report on the current situation of care provision to older persons in 10 ASEAN countries, plus the 3 East Asian countries China, Japan and the Republic of Korea. This report constitutes a background document which can serve as a basis for monitoring and evaluation of the progress made towards the achievement of optimal support of older persons and their families.

In order to produce this background report, the DOP appointed the College of Population Studies (CPS), Chulalongkorn University, Thailand, in 2016 to undertake a two-year project, entitled *Care for Older Persons in ASEAN+3: The Role of Families and Local and National Support Systems*. This project aimed to (1) compile country-level reports drafted by national experts, (2) provide a cross-country comparative synthesis of care systems, particularly the role of the previously mentioned care actors, as well as current and emerging issues related to care provision and their implications, (3) disseminate the report to a wide audience, in particular to the governmental organizations involved in the organization and provision of care for older persons in their respective countries, and (4) strengthen cooperation and collaboration among ASEAN+3 countries.

CPS was responsible for leading the project, which entailed defining the cornerstones of the project and its conceptual framework; outlining the content of the country reports; providing feedback on drafts and revised reports to the

country experts; providing the introductory and concluding chapters for the full report as it is presented here; and designing and producing a summary booklet of the full report for a wider circulation.

The DOP was responsible for the selection of country experts, in collaboration with the ASEAN Secretariat, and for supporting CPS in its communication with the country experts. The DOP also coordinated with CPS in organizing the conference in Bangkok in 2017, provided feedback as well as advice on matters arising during the course of the project, and organized an event at the end of the project to showcase the full report and the summary booklet.

Conference in Bangkok in May 2017

In order to bring together all participating country experts, the DOP and CPS convened a conference from May 14 to 16, 2017, at Dusit Thani Hotel in Bangkok. At this event, country experts from ASEAN+3 countries presented an initial overview of the current situation of older person care in their respective country. Altogether, 11 countries agreed to participate in this project and one or more representative from each country attended. The objective of this conference was to kick off the project and to gather initial information for each participating country on care needs, care provision, the most important issues related to care of older persons, legal circumstances,

and challenges in conducting research on this topic. Each country expert's presentation and joint discussions were crucial in finalizing the content, format and methodology of the country reports that are presented here.

The 11 participating countries were Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Singapore, the Republic of Korea, Thailand and Vietnam. Their approximate 15-minute presentations were followed by Q&A sessions, where immediate questions could be asked by all participants. The main discussions relating to the topic as well as the specifics of the country reports took place on the last day of the conference.

Contributors

The initial goal was to recruit a country expert from each ASEAN+3 country. Table 1 lists the experts who participated in the conference. Most experts come from government ministries or agencies involving social welfare or community development, while a few are from a research institute or universities. While 11 countries participated in the conference, reports were only delivered for 9 countries. For the remaining 4 countries – namely Cambodia, China, Japan and Myanmar – CPS appointed contributors to provide an overview of the care situation in these countries. The list of contributors to each country report is presented in Table 2.

Table 1: Country Experts that Participated in the Conference, May 2017

Country	Name	Affiliation
Brunei Darussalam	Dk Hj Nur Satri PG HJ HASHIM	Department of Community Development, Ministry of Culture, Youth and Sports
Cambodia	Monorum SOM	Department of Elderly Welfare, Ministry of Social Affairs, Veterans and Youth Rehabilitation
Indonesia	Mujiyadi BENEDICTUS	Social Welfare Research and Development Centre, Ministry of Social Affairs
Lao PDR	Berthor TONGPAOTHOR	National Committee for Disabled People and The Elderly, Ministry of Labor and Social Welfare
Malaysia	Rahimah IBRAHIM	Department of Human Development and Family Studies, Universiti Putra Malaysia
Myanmar	Kyaw Myo THANT	Department of Social Welfare, Ministry of Social Welfare, Relief and Resettlement
Philippines	Bonn Michael CANOZA	Department of Social Welfare and Development
Republic of Korea	Yongho CHON	Department of Social Welfare, Incheon National University
Singapore	Chek Hooi WONG	Geriatric Education and Research Institute, Ministry of Health
Thailand	Siriphan SASAT	Faculty of Nursing, Chulalongkorn University
Vietnam	Do Thi Thanh HUYEN	Department of Social Protection Studies, Institute of Labor Science and Social Affairs

Table 2: Contributors to the Country Reports

Country	Name	Affiliation
Brunei Darussalam	Dk Hj Nur Satri PG HJ HASHIM	Department of Community Development, Ministry of Culture, Youth and Sports
Cambodia	Vatana CHEA	College of Population Studies, Chulalongkorn University
China	Dang Ngoc Hoang TRUC	College of Population Studies, Chulalongkorn University
Indonesia	Mujiyadi BENEDICTUS	Social Welfare Research and Development Centre, Ministry of Social Affairs

Table 2: (continued)

Country	Name	Affiliation
Japan	Hai Yen Thi NGUYEN	College of Population Studies, Chulalongkorn University
Lao PDR	Berthor TONGPAOTHOR	National Committee for Disabled People and The Elderly, Ministry of Labor and Social Welfare
Malaysia	Rahimah IBRAHIM	Faculty of Human Ecology, Universiti Putra Malaysia
	Tengku Aizan HAMID	Faculty of Human Ecology, Universiti Putra Malaysia; Malaysian Research Institute on Aging
	Chai Sen TYNG	Malaysian Research Institute on Aging
	Asmidawati ASHAARI	Malaysian Research Institute on Aging
Myanmar	Khin Myo WAI	Myanmar Knowledge Management Co., Ltd.
Philippines	Florita R. VILLAR	Department of Social Welfare and Development
	Rhodora G. ALDAY	Department of Social Welfare and Development
	Bonn Michael CANOZA	Department of Social Welfare and Development
Republic of Korea	Yongho CHON	Department of Social Welfare, Incheon National University
Singapore	Chek Hooi WONG	Geriatric Education and Research Institute
	Chin Yee CHEONG	Geriatric Education and Research Institute
	Mimaika Luluina GINTING	Geriatric Education and Research Institute
	Rachel PULLEN	Geriatric Education and Research Institute
	Peter Kay Chai TAY	Centre for Aging Research and Education
	Angelique CHAN	Centre for Aging Research and Education
Thailand	Siriphan SASAT	Faculty of Nursing, Chulalongkorn University
Vietnam	Do Thi Thanh HUYEN	Department of Social Protection Studies, Institute of Labor Science and Social Affairs

An Overview of Population Aging in ASEAN+3

Aging Trend: 2015-2050

The ASEAN+3 countries differ significantly in terms of their share of the population that is above age 60 (Table 3). In 2015, Lao PDR had the lowest share (6%), followed by Brunei Darussalam, Cambodia and the Philippines (7%). The oldest countries were Japan (33%), Singapore and the Republic of Korea (18%), and Thailand (16%). During the next 35 years, the share of the older

population is projected to double for the Philippines and more than double for every other country, with the exception of Japan where the current level is already almost double as high as in any other ASEAN+3 country. Brunei Darussalam is exceptional in so far as the share of the population 60+ will increase by over 300%, from 7% to 29%. When it comes to the share of the population 80+, the Republic of Korea and Singapore are expected to join the ranks of Japan by 2050, with Thailand being fourth with 10%, illustrating the rapid increase in the oldest old population.

Table 3: Shares of the Population Age 60+ and 80+, ASEAN+3 Countries, 2015, 2030 and 2050

Country	% 60+			% 80+		
	2015	2030	2050	2015	2030	2050
Brunei Darussalam	7	16	29	1	1	5
Cambodia	7	10	17	1	1	2
China	15	25	35	2	3	8
Indonesia	8	13	19	1	1	2
Japan	33	37	42	8	12	15
Lao PDR	6	9	16	1	1	2
Malaysia	9	14	23	1	2	4
Myanmar	9	13	19	1	1	2
Philippines	7	10	14	1	1	2
Republic of Korea	18	32	42	3	6	14
Singapore	18	31	40	2	5	13
Thailand	16	27	35	2	4	10
Vietnam	10	18	28	2	2	7

Source: United Nations (2017), author's calculations.

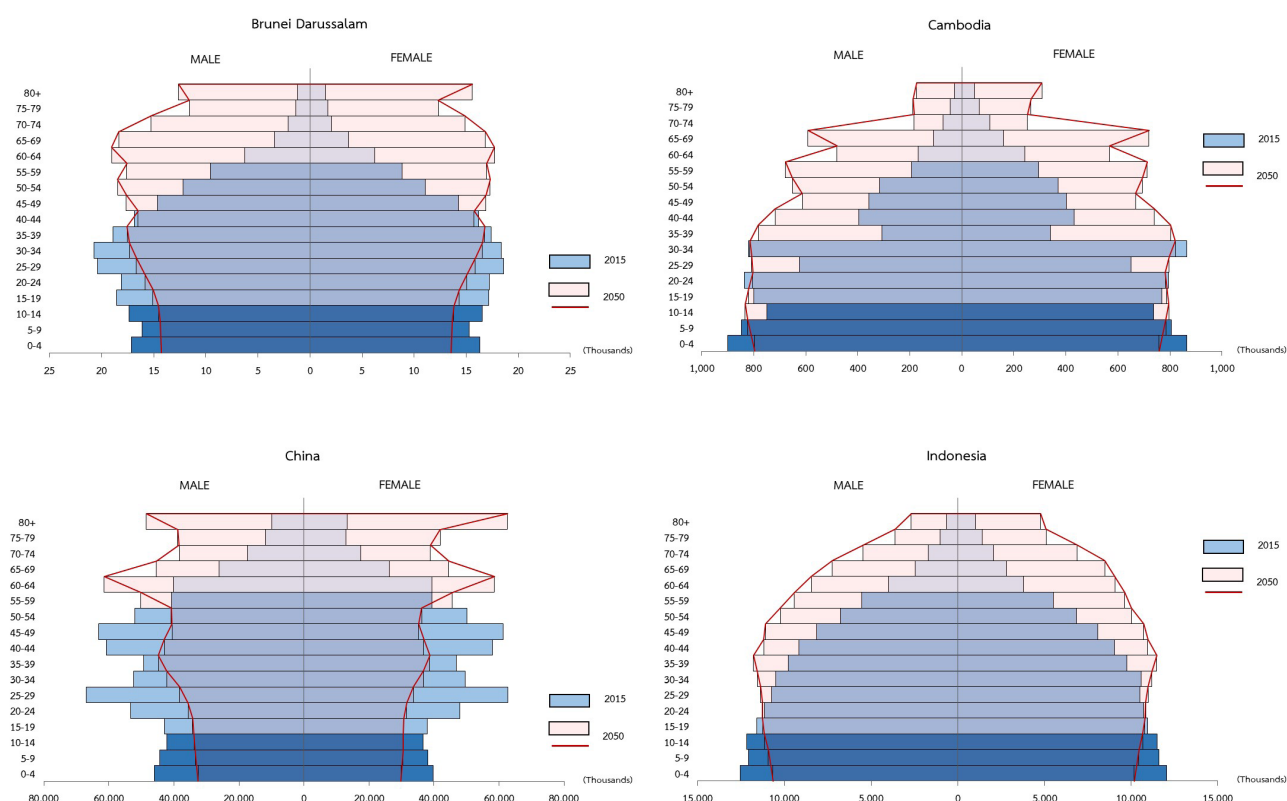
The Changing Population Age Structure

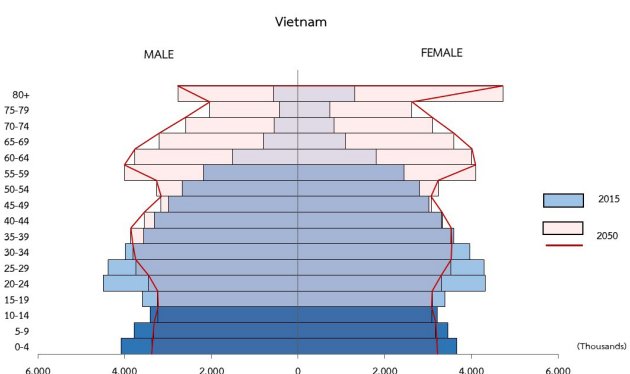
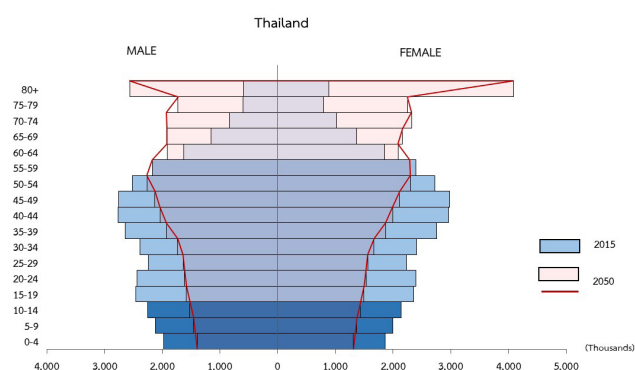
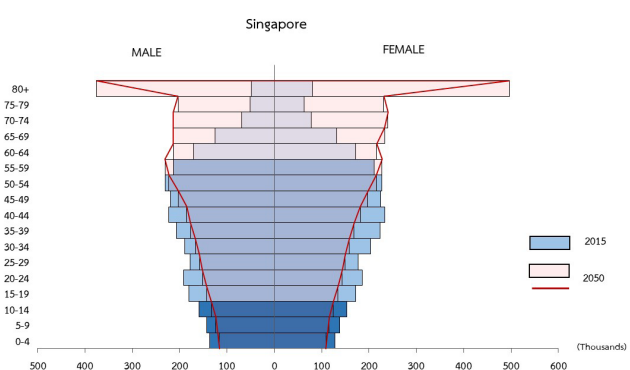
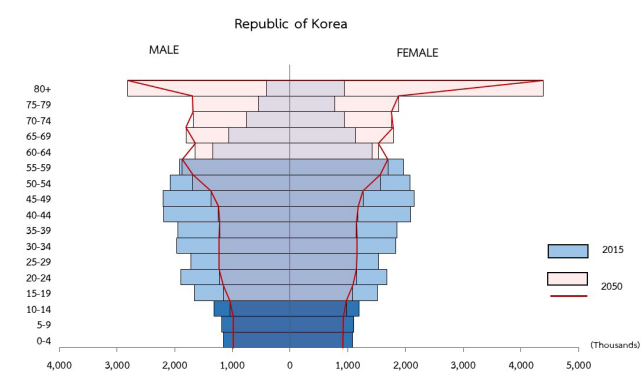
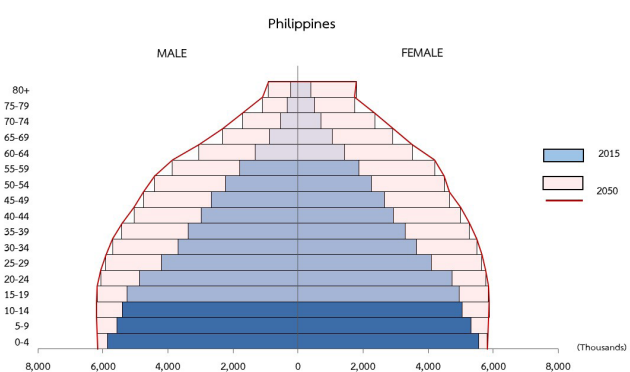
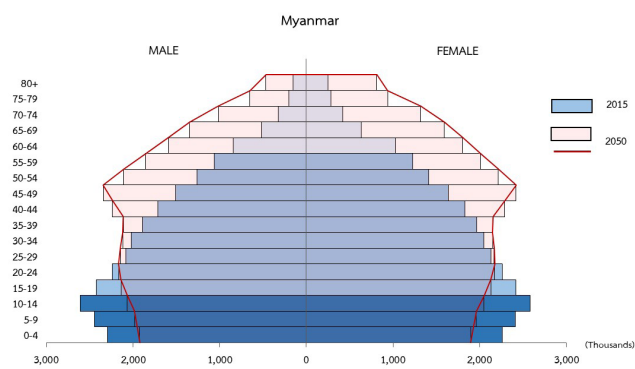
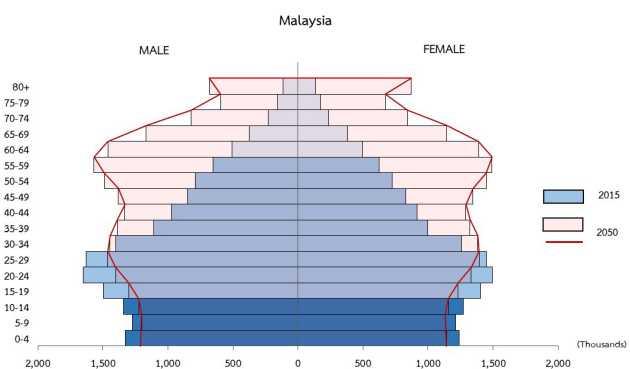
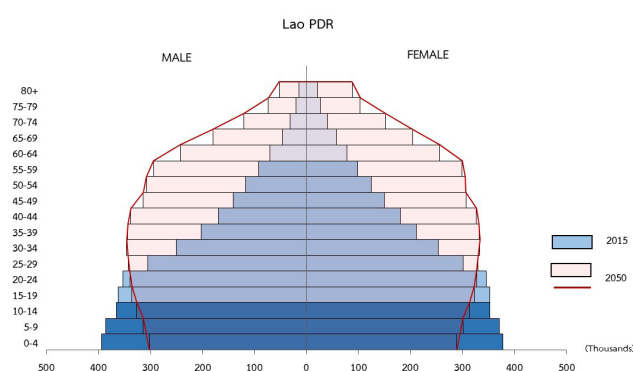
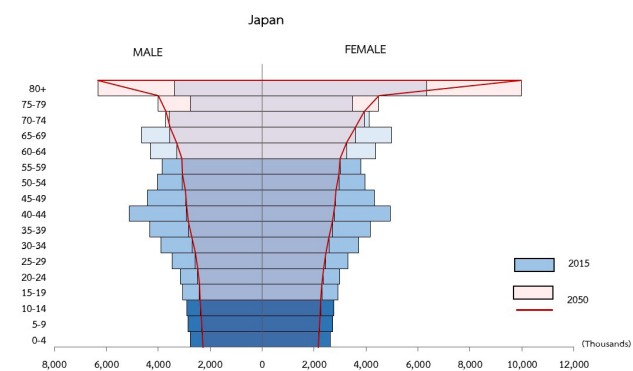
The demographic transition from a high mortality and high fertility regime to a low mortality and low fertility regime has entailed a shift in the age structure from younger to older age-groups, subsequently re-shaping age pyramids. As depicted in Figure 1, the shape of age pyramids varies considerably from country to country, reflecting that ASEAN+3 countries are experiencing different stages of the demographic transition. In 2015, Cambodia, Lao PDR and the Philippines have similarly shaped age pyramids with a broad base and narrow top, meaning the young population is still growing. By contrast, the age pyramids of Japan, the Republic of Korea and Singapore have a narrow base and tapered towards the top, showing a shrinking proportion of its young

population and an increasing proportion of its older population. For other countries like Brunei Darussalam, China and Thailand, their age pyramids are remarkably bloated in the middle with a narrow base and wider top, suggesting a larger proportion of the working-age population and an increasingly aging population.

By 2050, all ASEAN+3 countries are projected to experience further population aging, as described earlier. The age structure of Brunei Darussalam, China, Japan, the Republic of Korea, Singapore and Thailand will become more alike with a distinctively larger share of their older population. Older women, particularly in the oldest old age groups, will overwhelmingly outnumber older men.

Figure 1: Population Pyramids, ASEAN+3, 2015 and 2050





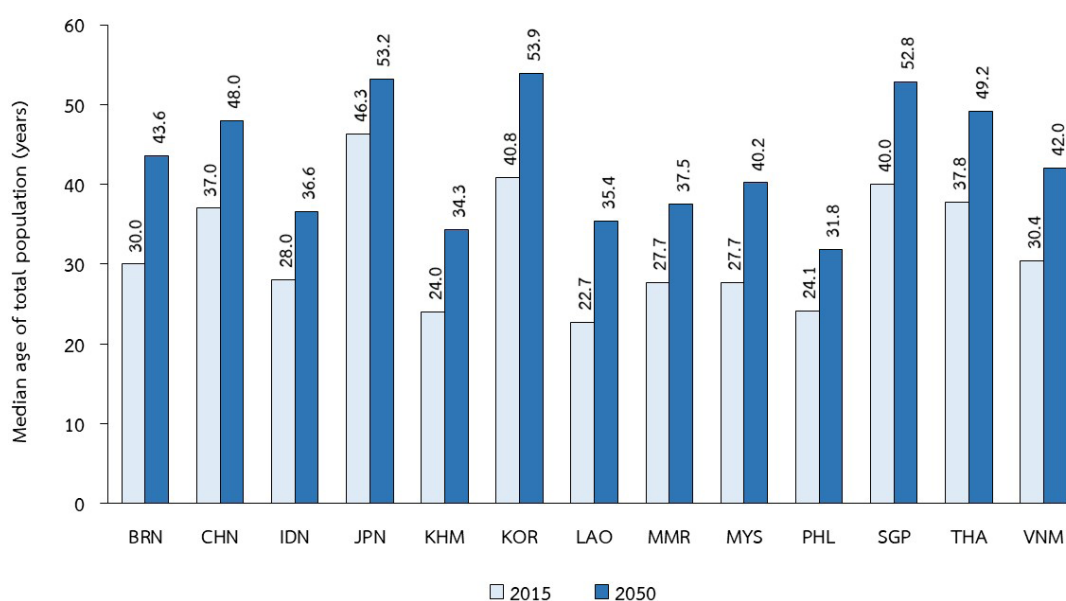
Source: United Nations (2017).

Median Age

Besides age pyramids, median age is another widely-used indicator to capture the implications of a changing population structure. Median age is the age that divides the population into two equal groups—half of the population is younger and half of the population is older than this age. As the median age generally increases with the proportion of a country's older population, it is not surprising to see that Japan has the highest median age at 46.3 years in 2015. The Republic of Korea's median age is the second highest at 40.8 years,

followed by Singapore at 40.0 years, Thailand at 37.8 years, and China at 37.0 years. Lao PDR has the lowest median age at 22.7 years, with Cambodia (24.0 years) and the Philippines (24.1 years) following next. By 2050, Japan and the Republic of Korea will have median ages greater than 50 years. At the same time, the Philippines will replace Lao PDR to become the youngest country in the region with a median age of 31.8 years. Hence, the median age of the Philippines in 2050 is projected to be about the same as that of Brunei Darussalam today (30.0 years).

Figure 2: Trends in the Median Age, ASEAN+3, 2015 and 2050



Note: The data for China do not include Hong Kong and Macao, Special Administrative Regions (SAR) of China, and Taiwan Province of China.

Source: United Nations (2017).

Potential Support Ratio

The potential support ratio is defined as the ratio of the population age 15-64 years to the population age 65 years and above. This ratio estimates the available support from the working-age population

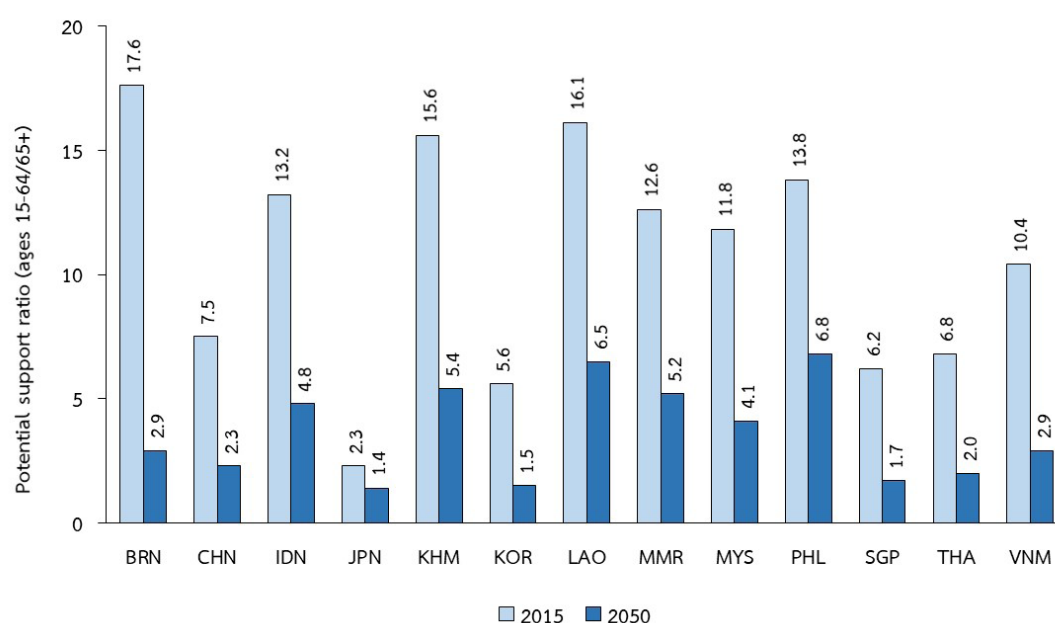
for the older population and is widely used to illustrate a country's fiscal implications of population aging, particularly in presence of a pension system under which the payroll tax of workers pays for pensions and welfare of older persons. The ratio

is based on the assumption that the population age 15-64 is working while those age 65 years and over are not. However, in fact, a number of persons age 65+ are still engaging in productive employment whereas the increases in high-school or college enrollment have increased the proportion of the population age 15-25 years who do not work. Thus, the ratio may not give a completely accurate picture of potential support available to the older population but can still provide a useful estimate.

In 2015, Brunei Darussalam has the highest potential support ratio among the ASEAN+3 countries with about 18 potential workers per older adult, while Japan has the lowest ratio of only about 2. As the population ages, the potential

support ratio tends to drop. This relationship is witnessed in all ASEAN+3 countries. In 2050, the Philippines, followed by Lao PDR and Cambodia, have the highest projected potential support ratios of 6.8, 6.5 and 5.4, respectively. The country with the lowest potential support ratio is still Japan (1.4), followed by the Republic of Korea (1.5), Singapore (1.7), Thailand (2.0), and China (2.3). Brunei Darussalam and Vietnam have the identical level of 2.9 potential workers per person age 65 years and over, however, given its higher starting level in 2015, the potential support ratio of Brunei Darussalam is seen to drop more rapidly than that of Vietnam as well as those of other ASEAN+3 countries.

Figure 3: Potential Support Ratio, ASEAN+3, 2015 and 2050



Note: The data for China do not include Hong Kong and Macao, Special Administrative Regions (SAR) of China, and Taiwan Province of China.

Source: United Nations (2017).

Economic and Social Developments

Table 4 shows that the ASEAN+3 countries are characterized by various similarities and differences. In terms of demography, about half of the ASEAN+3 countries have experienced major fertility declines with the recent levels of the Total Fertility Rate (TFR) ranging from 1.2 to 1.9 for 2010-2015. The Republic of Korea and Singapore have the lowest TFR at 1.2, which is far below the replacement level of 2.1. Although fertility in Indonesia, Malaysia, the Philippines and Thailand began to decline around the same time during the 1960s, Thailand is the only country whose TFR has fallen below the replacement level. During 2010-2015, the Philippines has the highest level of TFR at 3.1, followed by Lao PDR (2.9) and Indonesia (2.5).

The selected socio-economic indicators further show dramatic differences among the ASEAN+3 countries when it comes to adult literacy, urbanization, GDP per capita, employment structure, access to electricity and level of development in general. While nearly all adults in 11 out of the 13 ASEAN+3 countries are literate, about 20 percent of them in Lao PDR and Cambodia are not able to read or write. With respect to urban development, even though the majority of the ASEAN+3 populations

live in cities, the percentage living in urban areas in 2015 varies strikingly. In the Southeast Asian countries, except Singapore (100%), the variation of urbanization levels is remarkable with the highest level in Japan at 93.5% compared to the lowest level in Cambodia at 20.7%. Gross Domestic Product (GDP) per capita also shows sharp differences in the level of economic development across the ASEAN+3 countries. In 2017, Singapore had the highest GDP per capita in the region, followed by Brunei Darussalam, Japan and the Republic of Korea. Cambodia has the lowest GDP per capita which equals about 50% of that in Lao PDR, 25% of that in China and 4% of that in Singapore. The proportion of population engaged in agriculture is largest in Lao PDR (61%) and smallest in Brunei Darussalam (1%), with virtually none in Singapore. The access to electricity is universal in all countries with the exception of Cambodia and Myanmar where the access is relatively low at 48% and 61%, respectively. Lastly, the Human Development Index (HDI) which provides a summary picture of cross-country differences in socioeconomic development shows that Singapore, Japan and the Republic of Korea rank in the top ten percent whereas Cambodia and Myanmar rank in the lowest quartile.

Table 4: Selected Demographic and Socio-economic Indicators, ASEAN+3

	Total Fertility Rate, 2010-15 ^a	% Adult literacy, 2005-15 ^b	% in urban areas, 2015 ^d	GDP per capita (PPP), 2017 ^e	% Employment in agriculture, 2017 ^c	Access to electricity, 2015 ^d	Human Development Index (out of 186 countries), 2014 ^b
Brunei Darussalam	1.9	96.4	77.2	71,226	1	100.0	30
Cambodia	2.7	77.2	20.7	3,654	27	47.6	143
China	1.6	96.4	55.6	15,175	18	100.0	91
Indonesia	2.5	93.9	53.7	11,274	31	97.5	113
Japan	1.4	NA	93.5	39,013	3	100.0	17
Lao PDR	2.9	79.9	38.6	6,709	61	89.7	137
Malaysia	2.1	94.6	74.7	26,452	11	100.0	59
Myanmar	2.3	93.1	34.1	5,687	50	60.5	146
Philippines	3.1	96.3	44.4	7,574	26	89.1	114
Republic of Korea	1.2	NA	82.5	35,918	5	100.0	18
Singapore	1.2	96.8	100.0	85,535	0	100.0	4
Thailand	1.5	96.7	50.4	16,264	33	99.6	88
Vietnam	1.9	94.5	33.6	6,297	41	100.0	115

Note: ^a United Nations (2017).

^b United Nations Development Program (UNDP), (2016).

^c The World Bank, <https://data.worldbank.org/indicator/SL.AGR.EMPL.ZS> (accessed May 15, 2018).

^d The World Bank, World Development Indicators Data Bank (accessed May 9, 2018).

^e International Monetary Fund, World Economic Outlook Database, April 2018.

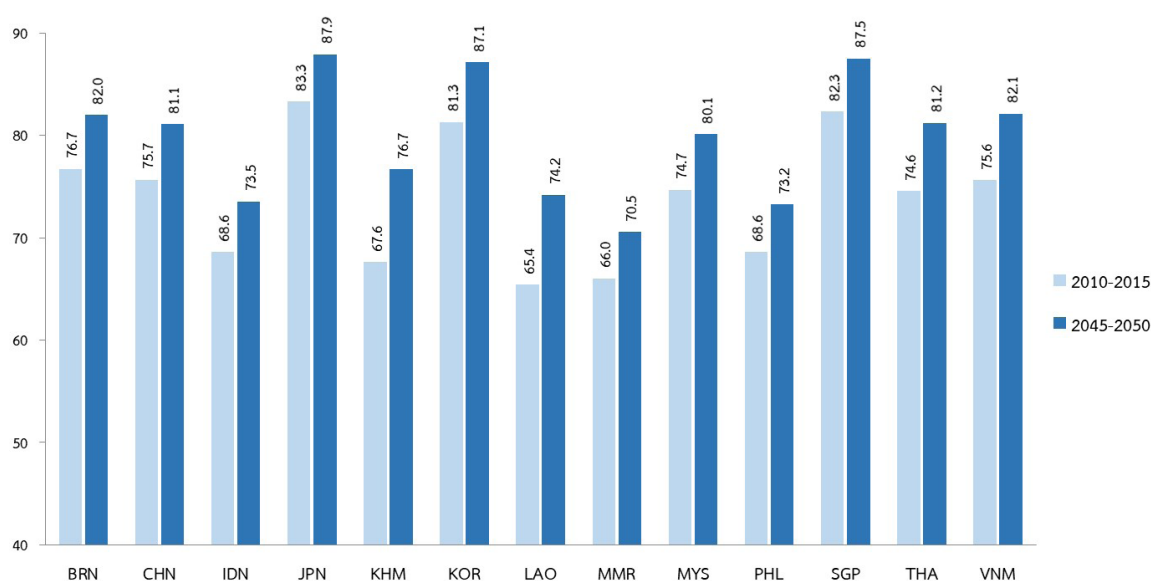
Health Profile of Older Persons

Increasing Longevity

The increasing share of older persons can be partly explained by past and ongoing mortality decline which is reflected in the improvements of life expectancy at birth as well as at age 60. Life expectancy at birth (e_0) is an indicator that summarizes the mortality experience of populations. It is defined as the number of years a newborn can expect to live if the age-specific mortality

pattern at the time he/she was born remains unchanged during his/her life. Figure 4 shows the expected improvements of life expectancy at birth between 2015 and 2050 in ASEAN+3 countries. Babies who were born in 2015 in three countries, namely Japan, the Republic of Korea and Singapore, are expected to live longer than 80 years. Brunei Darussalam, China, Malaysia, Thailand and Vietnam are expected to catch up with them during the next 35 years and also have life expectancies at birth beyond 80 years.

Figure 4: Life Expectancy at Birth (e_0), ASEAN+3, 2015 and 2050



Source: United Nations (2017).

Healthy Life Expectancy

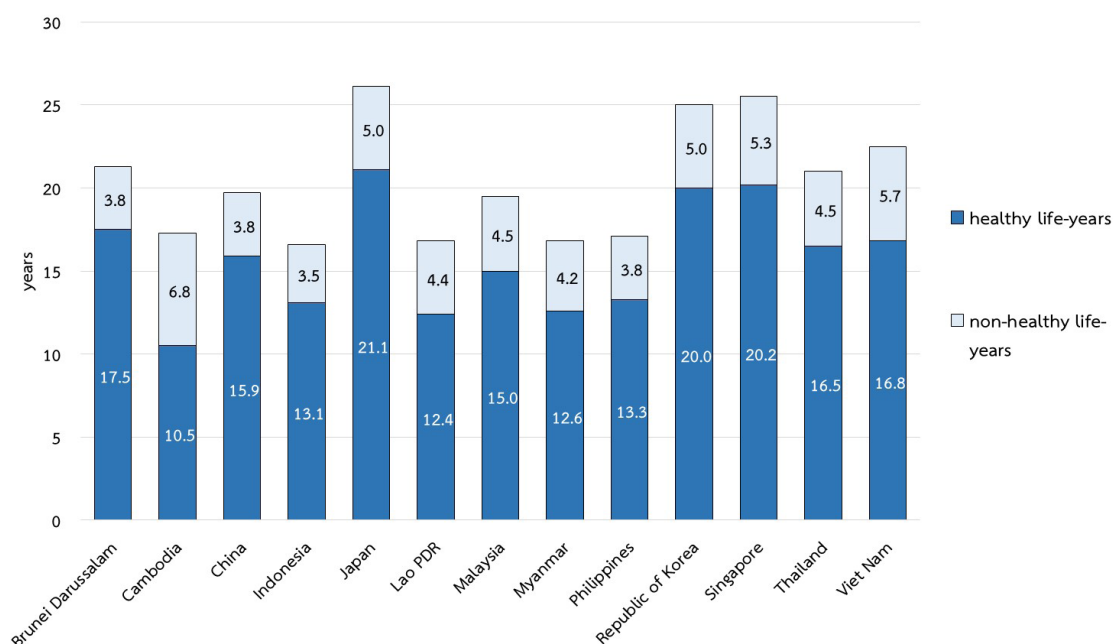
As people live longer, mortality trends may not provide sufficient information to describe the situation of older persons' health developments across countries. Increases in the length of life may be accompanied by increasing morbidities and complex need for care. Figure 5 shows the healthy and unhealthy life expectancy at age 60 for the ASEAN+3 countries in 2015. Life

expectancy at age 60 (e_{60}) refers to the average number of years a person can expect to live after reaching 60 years. These years can be divided into healthy- and unhealthy-life years. The life expectancy at age 60 ranges from 16.6 (Indonesia) to 26.1 (Japan) years, while the number of years lived without the presence of disease or injury vary from 10.5 (Cambodia) to 21.1 (Japan) years. The variation seems to be

large when we look at it in absolute terms. In relative terms, with the exception of Cambodia where the share of healthy life-years is only 60%

of total life expectancy at age 60, older persons in the other 12 countries can expect another $\frac{3}{4}$ of their remaining life expectancy in good health.

Figure 5: Life Expectancy and Healthy Life Expectancy at Age 60 in ASEAN+3 (2015)



Source: Global Health Observatory (GHO) data repository, WHO, <http://apps.who.int/gho/data/view.main.HALEXv?lang=en>

Disability-Adjusted Life Years (DALYs)

Another indicator that allows to combine information on mortality and health status are Disability-Adjusted Life Years (DALY). This measure is the sum of the number of years that are lost because of premature death due of a specific disease (also referred to as YLL, years of life lost) and the number of years that are lived in less than good health due to that disease (also referred to as YLD, years lost to disability) (WHO, 2017). For example, DALYs for diabetes mellitus represent the number of years that are lost because 1) people are dying of diabetes mellitus and 2) people are living with the disease but in less than good health. DALYs give the total number of years lost in a specific

year and a specific country. They can be broken down and quantified for specific age-groups.

Table 5 shows DALYs per 1000 population for each of the 13 countries, revealing substantial variations in DALYs lost to diabetes, Alzheimer and cardiovascular disease among the older population across countries and age groups. Taking into account the population size, in 2015 China had the highest DALYs lost due to diabetes with 85.2 per 1,000 population age 60-69 years, while Brunei Darussalam had the highest loss for the 70+ age group with 129.2 per 1,000 population. Singapore had the lowest loss of healthy life years associated with diabetes with 7.7 per 1,000 population age 60-69

years and 14.4 per 1,000 population age 70 years and over. Myanmar lost the largest number of DALYs due to Alzheimer disease and other dementias with 14.0 per 1,000 population age 60-69 years and 99.5 per 1,000 population age 70 years and over. Singapore had the lowest DALYS due to Alzheimer with 1.6 per 1,000 population age 60-69 years and 18.3 per 1,000 population age 70 years and over. In terms of cardiovascular diseases, the Republic of

Korea had the highest DALYs for its population age 60-69 years (342.0 per 1,000 population) while Lao PDR had the lowest (41.5 per 1,000 population). For the population age 70 years and over, China had the highest DALYs with 642.7 per 1,000 population while Singapore had the lowest DALYs with 177.7 per 1,000 population.

Table 5: Estimates of DALYs per 1,000 Population Lost to Diabetes Mellitus, Alzheimer Disease and Other Dementias, and Cardiovascular Diseases, ASEAN+3, 2015

	Diabetes mellitus		Alzheimer disease and other dementias		Cardiovascular diseases	
	60-69	70+	60-69	70+	60-69	70+
Brunei Darussalam	63.5	129.2	5.3	40.6	77.9	287.9
Cambodia	20.4	27.2	9.8	58.3	210.7	512.6
China	85.2	91.1	9.7	59.4	329.9	642.7
Indonesia	13.1	15.1	4.3	39.6	53.9	157.7
Japan	39.0	53.2	9.1	56.8	253.6	581.3
Lao PDR	25.7	47.3	3.8	48.9	41.5	155.1
Malaysia	58.3	77.1	9.2	61.0	264.3	591.8
Myanmar	65.6	86.2	14.0	99.5	238.9	560.4
Philippines	38.1	52.0	12.6	74.6	192.9	452.7
Republic of Korea	76.8	82.6	4.2	20.0	342.2	560.9
Singapore	7.7	14.4	1.6	18.3	81.0	177.7
Thailand	44.3	58.4	11.0	62.8	130.0	275.9
Vietnam	34.1	53.1	8.4	59.4	152.6	355.7

Source: WHO (2016).

Structure of the Report

This report comprises 15 chapters including this introductory chapter. The following 13 chapters, from chapter 2 to chapter 14, are the country reports. The country report chapters are arranged in alphabetical order, and broadly structured as follows: after an initial overview of population aging and the care situation, the next section discusses the main theme of this book—the roles of families, communities, government/state, NGOs, private sector in care provision for older persons. This includes descriptions of care actors existing in the current care system and how these existing actors, individually and collectively, provide care for older persons. It is followed by the discussion of how care provision is financed and whether it is likely to be sustainable. Subsequently, issues and concerns related to care provision, for example,

care access, equity and quality, are presented. Most reports also have a section on laws, regulations, plans, policies or measures that deal with care provision for older persons, as well as the performance results if they were assessed. Each report concludes with policy recommendations for improving the provision of care to older persons. While certain sections like for example the overview of population aging in each respective country, and the provision of policy recommendations, are part of every country report, it depends on the country-specific circumstances whether and in what detail the other mentioned sections are covered. The final chapter (chapter 15) provides a synthesis of the information provided throughout the country reports, summarizing each country's situation when it comes to care for older persons and pointing out similarities and differences across each country's experiences.

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Brunei Darussalam

Dk Hjh Nur Satri Pg Hj Hashim

Introduction

The increase in the aging population in ASEAN countries provides continued challenges as well as implications to care providers of older persons. In 2010, Brunei Darussalam affirmed and promoted the rights and welfare of older persons in ASEAN through the 'Brunei Darussalam Declaration on Strengthening Family Institutions: Caring for the Elderly'. The declaration states the commitment of ASEAN Member States to take concerted efforts to promote the quality of life and well-being of old persons and reduce social risks as well as strengthen the role of the family in promoting active self-care and healthy older persons. ASEAN Member States agree that the family should remain the main provider of care and support for older persons bearing in mind the demographic, socio-economic, and cultural changes that are affecting family relationship and filial responsibilities.

Objectives

The objectives of the research project are to:

1. Examine the accessibility of care provision for

the older persons, since this is one of the crucial aspects of their well-being; and

2. Compile data on the role of families and local and national support systems in care provisions for older persons. This entails a comprehensive account of care needs and care provision.

Methodology

This paper focuses on two main aspects: first, the provision of care for older persons; and second, how families attempt to maintain the traditional patterns of living arrangements faced with the demographic and socio-economic changes encountered in this modern world.

In examining the issue, the project took five months and reviewed basic data on social care and support systems at the local and national levels for older persons in Brunei Darussalam. Data has been gathered from the Department of Community Development, Ministry of Culture, Youth and Sports; informal discussion with stakeholders both the government and non-government organization (NGOs) including the Ministry of Health and the

Brunei Council on Social Welfare (Majlis Kesejahteraan Masyarakat), as well as readily available reports and statistics. The research sample data, to be handled with utmost confidentiality and anonymity, will consist of the vulnerable group.

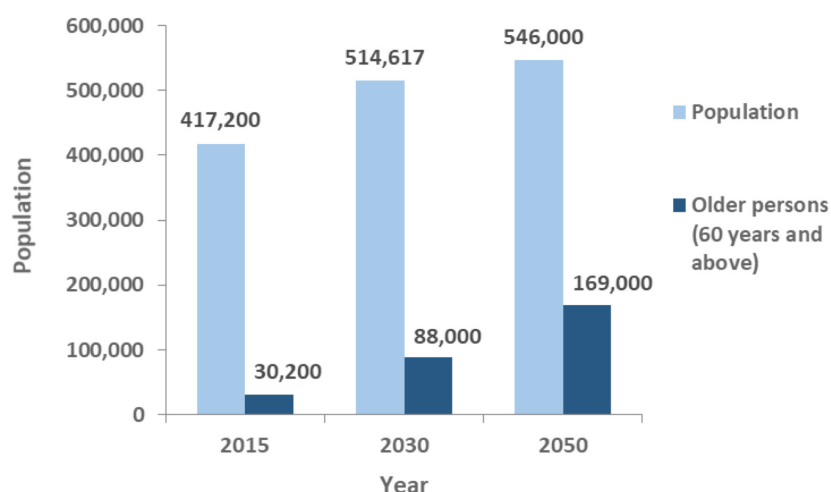
Overview of Population Aging and Care Needs in Brunei Darussalam

Demographics of Older Persons

For Brunei Darussalam, the definition of an older person is someone aged 60 years and above. Figure 1 shows that Brunei Darussalam is a small

county with a relatively young population. In 2015, the total population was 417,200 with a total older population of 30,200 representing 7.2% of the population. Over the years, the population will increase gradually whereby in 2030 the population will reach 514,617 and 546,000 by 2050. The total number of older persons will increase to 88,000 by 2030; representing 17.1% of the total population. The numbers of older persons will reach one-third of the total population in 2050 amounting to 169,000. The trend is clearly a steady increase in the numbers of older persons in Brunei Darussalam over the years.

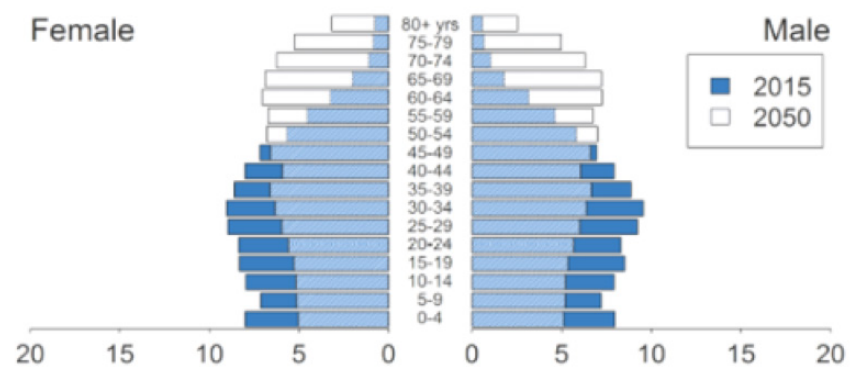
Figure 1: Actual and Projected Total Population and Population Aged 60 Years and Above, 2015, 2030 and 2050



Source: Data from HelpAge International, retrieved <http://www.helpage.org/resources/aging-data/>.

Despite the relatively low proportion of persons aged 60 years and above as mentioned earlier, the trend suggests an emergence of an aging population in Brunei Darussalam by 2050 as seen in Figure 2. It also illustrates a shrinking of the young working population over the years. Such trend will present challenges to the fiscal and

healthcare systems, living arrangement structures, and most crucially the main providers of care to older persons like women and young adults. Brunei Darussalam like any other ASEAN member state must be equipped to face the challenges especially with the continuously improving life expectancy and hence the possibility of an aging population.

Figure 2: Population Structure (in %), by Age and Sex, 2015 and 2050

Source: Department of Statistics (2016).

Life Expectancy

In 2015, the life expectancy in Brunei Darussalam was 76.3 years for males and 79.2 years for females (World Health Organization, 2016). With the declining mortality rates among women, females are tending to live longer than males. Statistics have shown that the proportion of older women has risen significantly with women aged

60 years to 79 years comprising 3.3% of the total population while men comprised 3.2%. Further, women aged 80 years and above comprised 0.4% as compared to men who only comprised 0.3% of the total population (Department of Statistics, 2016).

Table 1: Brunei Darussalam's Survival Rates (in %), by Sex, 2000-2005, 2025-2030, 2045-2050

	Age	2000-2005	2025-2030	2045-2050
Total	60	89.9	92.7	93.8
	65	84.4	88.4	90.2
	80	46.5	55.4	61.1
Female	60	92.9	94.7	95.5
	65	88.7	91.6	92.9
	80	54.7	64.5	69.3
Male	60	87.6	90.9	92.3
	65	81.0	85.6	87.8
	80	39.8	48.1	53.8

Source: United Nations (2001).

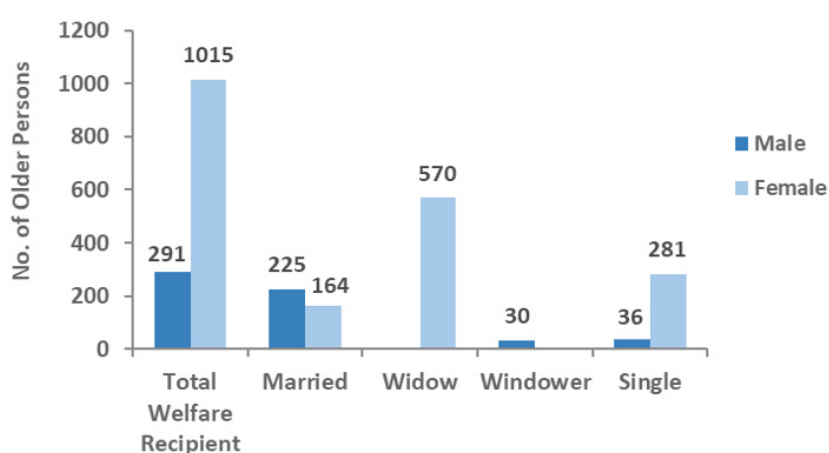
Table 1 shows the chances of surviving to old age improved greatly in Brunei Darussalam, and those who survive to age 60 years can also expect to live longer. In 2025-2030, the survival probability to age 60 years is about 95% among women, and 91.6% and 64.5% are anticipated to reach age 65 and 80 years, respectively. In the same period, older men show lower percentages of 90.9%, 85.6% and 48.1% for respective ages.

Marital Status

Many studies have documented a longevity advantage for married persons relative to their unmarried counterparts across all age groups

including among older persons. Marital status might affect the socio-economic status, living arrangement, overall health as well as physical and mental wellbeing of older persons. Married older persons, especially women, are less likely to show signs of depression as compared to their unmarried counterpart. Figure 3 suggests that only 164 married older women received welfare benefits compared to 570 widows receiving the same benefits. For unmarried older persons, 281 women received welfare benefits as compare to only 36 men. This suggests that older women are more susceptible at old age in this aspect compared to men.

Figure 3: Welfare Recipients at Age 60 and Above, by Sex, 2015



Source: Data from Department of Community Development, Ministry of Culture, Youth and Sport (n.d.)

Living Arrangement and Support

In Brunei Darussalam, a majority of older persons are still residing in extended family settings that may comprise up to four or five multigenerational families staying under one roof. More often than not, the older person is highly regarded by the family as the head of the household. The older person receives direct support from their children,

grandchildren, as well as great grandchildren or sometimes siblings. The continuous support given by the family members in old age constitute part of caregiving.

In the above setting, support can be of two folds; the older person receives much needed care as well as financial assistance from their adult children

and in many cases the older person in turn provides help with childcare. The extended family institution strongly believes in raising their own generation according to their own mold and at the same time feel satisfied and happy being surrounded by their own grandchildren while undertaking the daily household chores or activities with the local community. In addition, some older persons whose children are still attending school prefer to remain in the labor force to provide for their livelihood.

Since 2004, there were 49 older persons registered under the Homecare Project for Older Persons. Among those registered, 23 have since been delisted due to either being successfully reunited with their respective families; returning home to their country; or having passed away. Also, out of the 49 older persons, 30 were single and widowed while 8 lived alone in their own homes. In 2015, there were six¹ cases of older persons being neglected by their care providers. Knowing the stoicism of older persons, it is not surprising if physical, environment and financial abuses are not reported.

Employment

A majority of older persons continue to reside with their extended families and hence their daily necessity is taken care of by the household. There is no urgent need for them to engage in any economic activity to provide for themselves. These older persons will get the financial support and assistance from the people with whom they co-reside. Nevertheless, while a large majority gets support and assistance from their children, some

older persons do not rely entirely on their children for their daily necessities but instead prefer to earn a living by actively engaging themselves in economic activities either through self-employment or engagement in the labor force. In 2014, the number of persons recorded in the labor force aged 60 to 64 years is 3,955 and 2,843 for persons aged 65 and above (Department of Statistics, 2016).

Health Status

Advancing the quality of healthy lifestyle at old age is among the priority directions of the Madrid International Plan of Action on Aging and the Global Strategy and Action Plan on Aging and Health (2016-2020) for active aging. Through the Ministry of Health in its effort to provide quality health care for older persons, Brunei Darussalam has undertaken a number of initiatives including provision of primary health care through a network of government centers, clinics, and outpatient services in hospitals; provision of free medical treatment and care with a minimal charge of registration of BND 1.00 (USD 1.34); and the provision of special lanes and a queuing system for older persons in hospitals.

All the efforts mentioned above have the aim to ensure that Brunei will achieve its *Wawasan* 2035, a quality of life that is amongst the top 10 nations in the world including the older population. In addition, to ensure optimal quality of life of older persons to make them independent and productive members of the community, continuous monitoring of health issues relating to older persons is undertaken.

¹ Statistik Isu Sosial, the Department of Community Development

Non-communicable Diseases

Non-communicable diseases have been one of the leading causes of death amongst older persons. In 2015, about 60% (Ministry of Health, 2016), that is 920 out of 1,547 of total deaths (Department of Statistics, 2016) were for older

persons aged 60 years and above. Statistics revealed that four (4) of the top five (5) leading causes of deaths constituted non-communicable diseases (NCDs): cancer (malignant neoplasms), heart diseases including acute rheumatic fever, diabetes mellitus, and cerebrovascular diseases.

Table 2: Causes of Death Among Persons Aged 60 Years and Above, 2015

	2014	2015
Cancer (Malignant Neoplasms)	182 (20.5%)	178 (19.3%)
Heart Diseases (including Acute Rheumatic Fever)	133 (15.0%)	115 (12.5%)
Diabetes Mellitus	95 (10.7%)	94 (10.2%)
Cerebrovascular Diseases	76 (8.5%)	66 (7.1%)
Influenza and Pneumonia	50 (5.6%)	62 (6.7%)

Source: Data from Ministry of Health (n.d.)

Table 2 shows the decline in the percentage of total deaths for older persons aged 60 and above for the top leading NCDs from 60.3% in 2014 to 55.8% in 2015. This amongst others indicates an improvement in the health care provision especially for older persons.

Dementia

Another common health challenge faced by care providers is dementia. It occurs amongst older persons who are in the state of depression often due to loneliness and anxiety. The improvement in the healthcare system ensures that quality health care reaches the needy including older persons. In Brunei Darussalam, it was reported

that there is an estimated 1,000 people living with dementia and in 2016 the number had increased to 2,000 people, many of them undiagnosed (The Brunei Times, 2016). This may present a challenge to the family as well professionals caring for older persons with dementia. Hence, it is crucial that the social support interventions for caregivers of older persons with dementia be given the necessary attention as informal carers often rely on their social networks for support.

Access to Health Care

The formulation of the National Health Policies with the aim to provide the highest level of health

care that is accessible, cost-effective, sustainable and able to provide a high quality of life to the people have been made a national priority (The 11th ASEAN & Japan High Level Officials Meeting on Caring Societies, 2013). Further, the government of Brunei Darussalam has accorded the utmost political will and commitment to provide the highest quality health care in line with the strong recognition of health care as one of the major public investments in human development as well as supporting sustainable socioeconomic development, peace, and social security. The significant decrease in mortality rates and increase in life expectancy over time is a manifestation of the improvement in the standard of health care services provided by the government. Provision of health care services in Brunei Darussalam is accessible to all and is provided either free with a nominal registration fee or it is very heavily subsidized.

The government emphasizes people-centered healthcare with the focus directed at the provision of primary health care by integrating it with a spectrum of services including maternal child health, school health, community-based mental health, and dental and eye clinics delivered by trained healthcare professionals (The 11th ASEAN & Japan High Level Officials Meeting on Caring Societies, 2013). Furthermore, the Travelling Clinic and Flying Medical Services provide primary health care in certain remote areas (The 11th ASEAN & Japan High Level Officials Meeting on Caring Societies, 2013).

Overview of Actors Involved in Care Provision for Older Persons

The close-knit society of Brunei Darussalam dictates that the main care provider for older persons remains to be the immediate family. However, a number of challenges have been identified that could shift the main actors of care provision over the years. This amongst others includes the shrinking in the number of young adults and women outliving men at old age therefore increasing the number of widows.

Currently, there are five crucial care providers for older persons in Brunei Darussalam namely: the family, communities, the government, NGOs, and the private sector. These actors provide care provisions either individually or collaborate to form networks of support in an effort to enable active aging for older persons and bring about a high quality standard of living and well-being.

Family

In Brunei Darussalam, the older person is seen as the oldest person in the family and most the time receives the highest respect from members of the family. They act as the unifying factor in strengthening the family institution especially in the extended family setting. Respect for the older persons has become embedded in the Brunei society in line with the Malay Islamic Monarchy that forms the basis of living in Brunei Darussalam.

In Brunei Darussalam, the family institution is still seen as the main care provider whether financially, socially, or emotionally, to older persons to ensure

their well-being throughout their old age. The extended-family institution ensures that the provision of care for older persons is the responsibility of everyone and not limited only to adult children.

Women

In the Brunei society, women are traditionally acknowledged to be the main caregivers of older persons. Being the backbone of the family, the responsibilities to care for older persons usually fall in the hands of women. However, with the increase in women engaging in employment, a shift in the responsibility for the provision of care to older persons may also occur. Care provision for older people can no longer be placed in the hands of women alone but must be seen as a collective responsibility.

Sharing Responsibilities

The provision of care for older persons, in the majority of the time, is a shared responsibility amongst the children in the society of Brunei. The respect for older persons makes this possible. In addition, adherence to Islamic teachings increases the awareness for shared responsibility in care provision for older persons. The presence of an older person in the family acts as a natural family bonding mechanism. It is a norm in the Brunei culture whereby a house where an older person resides will become the center for family bonding activities.

Local Communities

The close-knit society of Brunei Darussalam allows local communities to participate actively in the

provision of care for older persons within the village context. Brunei Darussalam is comprised of 447 villages that are mostly self-sufficient communities with access to schools, clinics, library, mosques, police stations, fire stations, shops, market, outdoor spots, and community centers. The Head of Village, supported by Village Consultative Council (MPK), administratively runs the village. Collectively they ensure the security, peace, and well-being of the village folks by organizing community activities, thus indirectly engaging older persons in programs that can benefit them. One such program is the *'Healthy Mukim'* Program organized by the Ministry of Health in collaboration with local communities to promote healthy lifestyle in a sustainable way.

In addition to the village set-up, the design of new housing settlements too has been organized in a manner that encourages for a harmonious and caring neighborhood. Such living environment allows shared responsibility for care provision amongst the older persons within the settlement.

Amongst the responsibility placed on the village head on a monthly basis is the distribution of the old-age pension, allowances as well as welfare assistance to older persons within the village. Indirectly, this provides a great opportunity for the village head to monitor the progress of older persons residing in his village and at the same time suggests any intervention required by the older person, if necessary.

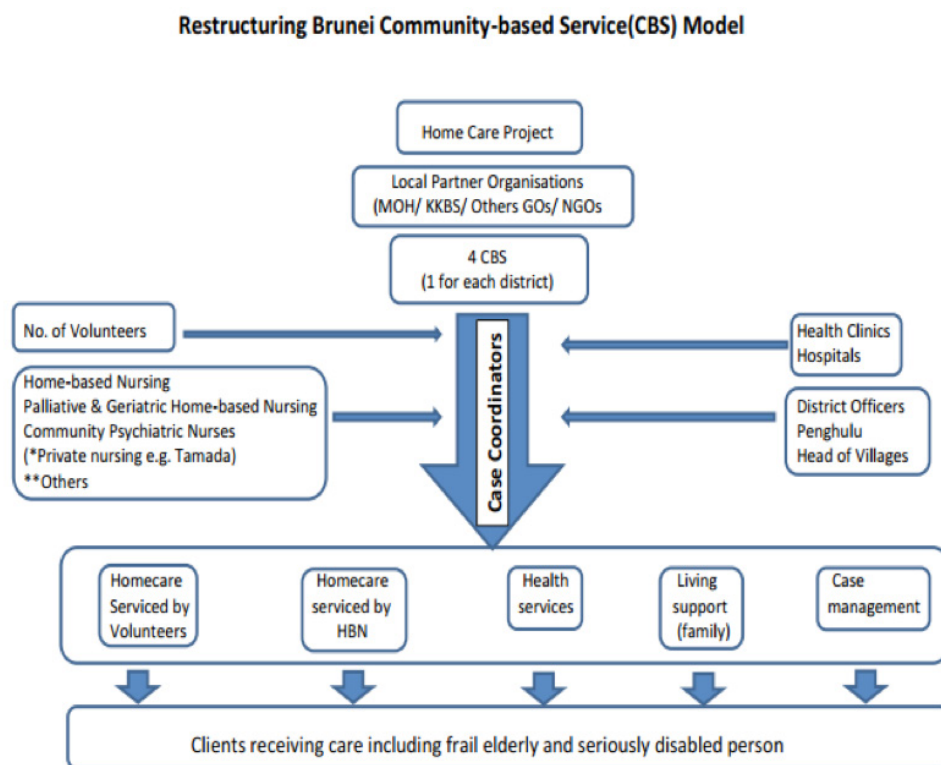
Government

In Brunei Darussalam, older persons are treasured as they are considered the most valuable assets

of the family as well as the country. Collectively, they provide years of experience and knowledge and can become knowledge treasures that should be cultivated and appreciated by the current generation. The number of these older persons is expected to increase steadily over the years and hence healthcare services provided by the government are anticipated to shift, especially care provisions required by older persons.

Currently, the government has established several initiatives relating to care provisions for older persons including expansion of the homecare project to become community-based. Such initiative has been undertaken to ensure long-term care (LTC) for older persons. Figure 4 illustrates the model for community-based services in caring for older persons.

Figure 4: Community-based Services (CBS) Model in Caring Older Persons



Note: The diagram was created by Dr. Muhd. Nurhasanuddin Abdullah Kelali.

Figure 4 illustrates the integrated health and social services provided collectively by the government, NGOs, and the local communities. The model above ensures support for both the older person as well as the care provider. The local community such as Village Consultative Members can support the care provider in caring for the older person by conducting homecare

service on random visits.

Homecare

Initially, the Homecare for Older People project was a project undertaken in collaboration with HelpAge Korea between 2004 and 2012. The volunteer-based project provides social care to older persons by giving assistance with

daily chores like cooking, bathing, cleaning and toilet-use. Apart from that, volunteers also provide emotional support through companionship. The project is still ongoing with the expansion of community-based involvement.

To be eligible for receiving assistance under the homecare project, the older person must be aged 60 years and above, living alone at home as well as sick and frail. At present, 27 older persons are receiving homecare assistance.

Table 3: The Process Flow for Receiving Homecare Assistance

Process	Source data or information	Action taken by
1 Case received from either Family, Women and Children's Section (FWC), or Medical Social Workers	<ul style="list-style-type: none"> • 141 Helpline report case forwarded by FWC section. • Memorandum from RIPAS hospital • Text alert (viral) 	<ul style="list-style-type: none"> • Pension Section
2 Field visit by the project team and provide report on older persons (OPs) including details about the house, family background, economic status, health status, and hobbies, as well as obtain consent from the OPs or the family members on the need for homecare assistance	<ul style="list-style-type: none"> • Case file and profiling 	<ul style="list-style-type: none"> • Pension Section • FWC Section • Head Village • OPs • Family
3 Health diagnose by Geriatric or Palliative Unit RIPAS	<ul style="list-style-type: none"> • Case profile 	<ul style="list-style-type: none"> • Diagnosis report on OPs to be shared by a medical doctor
4 Case management	<ul style="list-style-type: none"> • Case report 	<ul style="list-style-type: none"> • Project team
5 2nd field/home visit	<ul style="list-style-type: none"> • Activity report 	<ul style="list-style-type: none"> • Project team
6 Volunteers to be assigned. Homecare meeting reports and case profile to be shared with the assigned volunteers.	<ul style="list-style-type: none"> • OP profile 	<ul style="list-style-type: none"> • Project team • Volunteers
7 Volunteers first field/home visit to OPs. Ice-breaking session between OPs and volunteers.	<ul style="list-style-type: none"> • OP profile 	<ul style="list-style-type: none"> • Project team • Volunteers • OPs • Family
8 Volunteers put up report on the field/home visits. Report should include any assistance needed, if any.	<ul style="list-style-type: none"> • Activity sheets file • Attendance file at OP's house 	<ul style="list-style-type: none"> • Project team

Figure 5: Process of Gathering Information of Older Persons that Need Homecare

Table 3 and Figure 5 have referenced three crucial groups in the gathering of information relating to older persons needing homecare assistance, namely:

1. The project team as they are front liners in direct contact with the OPs. The information gathered during the field/home visit relating to the well-being of the OPs including their home condition, health status, socioeconomic status as well family background will be very useful in giving an overview of the condition of the OPs;
2. The medical doctors' or medical social workers' health diagnosis reports will determine whether

or not homecare is required and to what extent assistance is needed; and

3. The head of village and family provide information to have a better understanding on the condition of the OPs in terms of living conditions and challenges faced in the provision of care for the OPs concerned.

The data in Table 4 suggest that there is definitely a need for care provision for older persons. In 2015, eight older persons were known to be living alone while six had been reported to be neglected. This simple data provide evidence that there is a requirement for the government to put in place care provision for older people.

Table 4: Issues Relating to Care Need and Provision

Older persons (OPs) aged 60 and above	Total for 2015 (30,200 or 7.2%)
Number of OPs living alone	8
Number of OPs being neglected	6
Percentage of OPs diagnosed with Dementia	6.6%
Percentage of OPs being widowed	2.0%
Percentage of OPs being single	1.0%
Percentage of OPs receiving welfare assistance	4.3%

Source: Data from Department of Community Development (n.d.)

Laws and Regulations

In line with the directions of the Madrid International Plan of Action on Aging, and the Global Strategy and Action Plan on Aging and Health (2016-2020) for active aging, the government carried out a review of the National Plan of Action for Older Persons in 2017.

One of the priority directions in the Plan of Action states that one of the initiatives to promote the well-being of older persons with disabilities and the sick and frail should take into account the strengthening of LTC for older persons and the necessity for reassessment of the need for LTC to be institutionalized.

Capacity Building of Care Providers

The government remains the major provider of care for older persons in Brunei Darussalam. In addition, the government also provides financial support to groups that engage in providing care to older persons. The government continuously provides support and assistance to care providers of older persons including care professionals, the family, the local community, volunteers, as well as NGOs and the private sector.

Care Professional

The government through the collaboration between the Ministry of Health and the Ministry of Culture, Youth, and Sports continuously organizes trainings in order to enhance the capabilities and competencies of professional care providers of older persons. Amongst the programs organized were Dementia Skill Care and 'Training of Trainers'. Specialized

programs such as counselling on dementia, one-on-one case management, as well as coordinated health and welfare services specifically targeted for professional care providers such as doctors, medical officers, medical social workers, social workers, pension officers, and community development officers are organized to ensure a holistic approach in handling the needs of the older population.

The 'Training of Trainers' program on the other hand is carried out with the objective to share knowledge with other stakeholders and hence further expand the support base for care provisions to older persons. Participants of this program are expected to provide workshops to students, volunteers, communities, and older persons at the Senior Citizen Activity Centers especially on awareness and early indication of any issues that require professional help.

Family Care Givers

In an effort to provide high quality care to older persons, the government of Brunei Darussalam continuously supports family caregivers by providing awareness programs and activities such as the Workshop on Advanced Dementia and Counselling. In addition, government personnel actively participate in activities such as Zumba-Gold and health screening at the Pusat Amal CeraH Subok (PACS), an institution dedicated specifically for activities for older persons.

Local Community

The local community also plays a role in the provision of care to the old persons in the village.

In further enhancing the capacity of the local community in providing care especially in their villages, the government has taken the initiative to host workshops and courses relating to provision of care for old persons to members of the Village Consultative Council (MPK). The members of the MPK are encouraged to organize activities promoting active aging within the village such as promoting a healthy lifestyle, a 'healthy mukim' as well as workshops on dementia.

Volunteers

Another group of old-person care providers are the volunteers. Similarly, the government provides workshops such as 'train the trainers' to volunteers registered under the homecare project and PACS in order to improve their competencies in delivering temporary care to old persons specifically for homecare services at the designated old person's house. Provision of training to volunteers helps ensure that proper and high-quality care will be delivered.

NGOs and Private Sectors

The government through the Whole of Nation approach provides support and workshops to NGOs involved in volunteer work on social care and services to older persons in Brunei Darussalam. Among those volunteer organizations actively involved in providing such care is the Brunei Council on Social Welfare (Majlis Kesejahteraan Masyarakat). The government will continue to provide support and assistance to volunteer organizations that make up part of the social support system to provide care provision for the older persons.

Social Protection

Several initiatives have been implemented to support the family in caring for the younger as well as older persons. The family institution is still seen as a very crucial factor in the provision of care for older persons as well as a platform for creating a caring society. In addition, the family institution needed to be integrated with other stakeholders in order to provide for a support base in strengthening the provision of care for older persons. Some initiatives in place at present include:

1. Formulation of the Plans of Actions on:
 - a) Family Institution, Women, and Children
 - b) Older persons
 - c) National Health Policies
2. Declaration by His Majesty the Sultan and Yang Di-Pertuan of Brunei Darussalam that the Sunday of the first week of May to become National Family Day. This is to reinforce the family institution as a unit, caring for each other in difficult times.
3. The provision of free education to all citizens in Brunei Darussalam ensures that the values of the Malay Islamic Monarchy are instilled in each and every child. Respect, responsibility, and care for each other especially the older persons are embedded in the curriculum at all levels in the education system.
4. Free or heavily subsidized medical and health care services are provided to all citizens of Brunei Darussalam to ensure accessibility to high quality health services for all. The government continues to explore and invest in more cost-effective interventions such as health screening, strengthening health promotion and preventive

activities, and strengthening at the secondary and tertiary level of care encompassing cure, treatment, and rehabilitation so as to ensure that the citizens of Brunei Darussalam receive the best health care services available.

5. Old-age pension as a social insurance program which is to ensure all citizens and permanent residents have a minimum level of support in old age to protect against or to reduce the risk of poverty. It is a recognition and appreciation for older persons toward their socioeconomic development. It is inclusive and non-discriminatory.

It has non-contributory financial benefit whereby the government spent \$93 million for 29,186 older persons, covering 97% of the older population.

6. Under the Old-Age Pension and Disability Act of 1954, apart from receiving the old-age pension, specific older persons are also eligible to receive a Blind Pension including dependents. At present, there are 219 recipients recorded to receive the Blind Pension; and 47% of the total recipients are older persons who are receiving dual benefits of old-age pension and blind pension.

Issues and Analysis: Recommendation on Added-Value and the Rational in Considering Provision

Issues	Analysis
<ol style="list-style-type: none"> 1 Provision of care for older women against income and economy 	<p>Figure 3 shows that only 164 married older women received welfare benefits as compared to 570 widows, and for unmarried older persons, 281 older women received welfare benefits as compare to only 36 men.</p> <p>This is an indication that older women are more vulnerable than older men in socioeconomic aspects. It is greatly recommended that the plan of action on older persons be reviewed in considering the participation of older women who are receiving welfare benefits and are in good health to be given chances on empowerment programs such as entrepreneurship. Secondly, massive awareness on “family support” is necessary for formal and informal sectors especially those who have older persons to take care of at home.</p>
<ol style="list-style-type: none"> 2 Lack of process on data of old age groups receiving welfare benefits considering the older persons in acquiring the provision of care are met 	<p>Figure 3 shows that 1,015 older women received welfare benefits compared to only 291 older men. The data show that about 78% of welfare recipients are older women compared to 22% of older men.</p> <p>There should be a more detailed investigation on the groups of older persons in this data involving further consideration on whether such assistance meets the needs of older persons.</p>
<ol style="list-style-type: none"> 3 Provision of care for older persons against supporting the working age group in raising grandchildren 	<p>In an extended family context whereby the adult children are working, being surrounded by and raising their own grandchildren can make older persons happy.</p> <p>This can be seen as a strong family institution mechanism on active aging, however, the working age groups should not become overly dependent or place the responsibility on raising or caring of their children on the shoulders of the older persons at all time as they need time for self-care and spirituality. Awareness on sharing responsibilities in the family settings are needed in care provision for older persons.</p>

Issues	Analysis
4 Provision of care for older persons against small families	<p>There are six (6) cases recorded of older persons having been neglected. This could create unhealthy family institutions, develop feelings of insecurity among older persons and thus deteriorate their health. Further studies are needed to understand the characteristics of small family settings. An increase on the awareness program on “family support” or community-based services is needed as well.</p>
5 Lack of investigation on the process of older persons living alone and no longer requiring full- time health care	<p>Out of the 49 older persons registered under homecare project, 30 were single and widowed; eight (8) were living alone in their own homes.</p> <p>Older persons living alone could be in good health and active however, as their age approaches the older-old threshold, their health will be deteriorating due to loneliness, depression, and anxiety. Further investigation is needed on data of older persons living alone to consider the requirement of social care needs as to maintain being active in the society.</p>
6 Interest of the community towards caring for older persons	<p>Challenges of modern living may disrupt the present situation. The implication of technological, social, and environmental context may affect the provision of care for older persons in the communities.</p> <p>The massive awareness program on being a caring society should be carried out as to influence the interest of the community about sharing responsibilities and maintaining a support network to enable older persons and a friendly environment.</p>

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| Introduction

Population aging has emerged as a primary concern among developed countries in recent decades. It is now also a widely discussed topic in the developing states particularly among ASEAN member countries where the percentage of older population has considerably increased due to fertility decline and medical advancement. The distinct characteristic of aging between the northern and the southern states is the pace of change, which appears to be extremely rapid for the latter affording them relatively much less time to prepare their social infrastructure and security system. As a result, it poses serious problems to the developing countries in term of socio-economic development and welfare provision for older persons. While Cambodia continues to attain exceptional growth in terms of economic indicators, the government has also recognized this unprecedented, rapidly changing demographic setting resulting in a number of challenges in health services delivery, older adult care, and public support system. Remarkable improvements have been concentrated on health and social protection for the general population and also

among the vulnerable and poor older persons in particular since the major reform by the fifth cabinet in 2013.

This paper aims to explore the trend and characteristics of Cambodian aging population and care provision, and to examine and provide an overview of recent policies and legal frameworks existing in the country where older people are defined as those who are 60 years old and above. Lessons, further issues, and prospective further studies toward improving care management can be identified given the thorough review. This report utilizes existing data, literature, reports, and legislative developments. These sources are sparse due to the recentness of the emergence of the theme of aging for a nation where two-thirds of the population are younger than 30 years. The term “care” used in this paper refers mostly to health care, unless otherwise indicated, as we do not have substantial information regarding of physical support for functional tasks in older person’s daily lives. The words “Cambodian” and “Khmer” are also used interchangeably.

Socio-Economic and Political Background

It is better to understand contemporary Cambodia by gaining basic knowledge of the Khmer Rouge's legacy and the three-decades civil war after the coup d'état in March 1970 by general Lon Nol underwritten by the United States. Cambodian demographic and socio-economic development is highly influenced by long periods of turmoil and despair. Between 1970 and 1975, before the Khmer Rouge (KR) staged a successful insurgency and began their reign of terror, Cambodia was largely torn by conflict which was the spillover effect of both the second Indo-Chinese War and American massive bombardment that destroyed the entire eastern half of the country. In 1975, the KR's armies consolidated power over Phnom Penh. Cambodia's communication with the rest of the world was then disrupted and geographic borders were closed.

The KR had caused the demise of the entire socio-economic structure and financial system literally within a single night. Remaining infrastructure were razed or used as holocaust camps for intellectuals, urban population, former government officials, and the elites. Within four years under their rule, Cambodian territory became a massive killing field. It was also estimated that 70% of primary and secondary school teachers and pupils; and 90% of university lecturers and students, were either massacred or died of forced labor, diseases, and starvation (Clayton, 1998; Hang, 2016). In 1979, the KR regime collapsed, but the civil war continued for

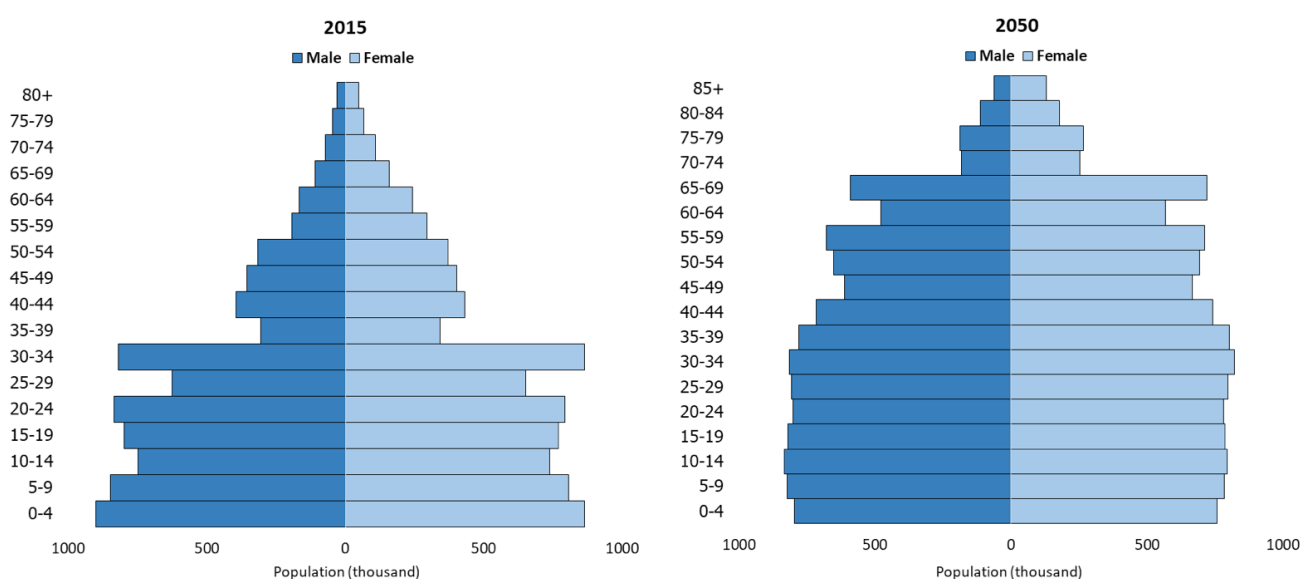
another two decades causing combatants and civilians to perish. Due to socialist approach of Phnom Penh government in the 1980s and economic embargo placed by the Western Bloc, the recovery was greatly hampered. Moreover, many intelligentsias who survived fled from the kingdom making national reconstruction increasingly onerous. Cambodia has only made a significant improvement in the quality of life of its own population subsequent to the end of internal strife in 2000. Since then, economic rebuilding missions have been largely undertaken with annual growth rate of 7% for the last 20 years. This has, however, started from a very deprived foundation and by 2014 placed Cambodia in lower-middle income country group.

Cambodia lies between Vietnam and Thailand with its north-eastern border shared with Lao PDR and a total area of 181,035km² divided administratively into 24 provinces excluding Phnom Penh, the capital and largest city. The population is roughly 16 million where a large proportion are the youth and 23% of the total population live in urban area (United Nations, 2017). During the KR regime, it was estimated that about two to three million or one-third of Cambodians perished of execution or succumbed to diseases (Gellman, 2010). Despite that, the baby boom that occurred during the late 1980s and 1990s has also greatly changed the age structure making Cambodia a young-labor country with approximately 250,000 workers entering the market annually. Under current condition, the population is expected to grow with the rate of 1.49%, and reach 22 million by 2050 (United

Nations, 2017). However, this growth rate has decreased dramatically from 2.63% in 2000. Figure 1 presents population structure of Cambodia in 2015 and 2050. The effect of political turmoil exhibits a small proportion of population at the upper half in 2015. A high gender imbalance

as seen on the top is also attributed to KR's targeted victimization of male adults who generally had better education and social status. The ratio of female older population to total older persons in Cambodia is among the highest in ASEAN region.

Figure 1: Population Structure of Cambodia in 2015 and 2050



Source: Adapted from United Nations (2017). Medium variant projection.

The fifth cabinet's commitment to major structural reform since late 2013 has substantially accelerated and supported Cambodia's development and progress toward industrialization and regional integration. The country, once recognized as primarily rural and largely destitute, has continued to attain macroeconomic development. However, demographic challenges particularly the increase in the percentage of older population is as dramatic as Cambodian economic changes. Although this Southeast Asian nation is yet an aging population with small figure of old-age individuals aged 60 years and over accounting for 6.8% in 2015, reaching that stage is inevitable. If observed tendency remains unchanged, it is

anticipated that Cambodia will become an aging and complete aged society by 2030 and 2060 respectively when the baby boomers enter retirement age. This value will be magnified by lower total fertility rate and higher life expectancy. As a rapidly aging country where the statistic of older persons doubled in merely 30 years, the government is given very short duration to be prepared in terms of policies and programs.

Characteristics of Aging Population

Concomitant effect of bloodshed including socio-economic disruption, eradication of social

protection and health care system, and widespread poverty means many people particularly rural households would suffer the worst form of deprivation and could hardly escape it. The reverberations tend to linger for a strikingly long period due to tremendous loss of educated adult population who would have been the drivers of economic growth and potential care and material providers for older persons. This even discounts a substantial number of people who became physically impaired after having fallen victim to landmines or other remnants of war scattering invisibly across the country where the bombing campaigns and battlegrounds took place.

Disassembly of families during Pol Pot's regime also triggers a severe breakdown in kinship relation which, together with the aforementioned, shapes societal aging context and undermines the prospect of healthy and active aging. It should be highlighted that Cambodian older adults today were young adults at the beginning of civil war and hence have experienced the history of violence. These people's lives could have been spent on employment and saving but was rather spent in combat. Many among the current generation of Cambodian older people are left without any familial support or pension and have to continue to work under economic compulsion. Presented in Table 1 is the number of older persons by sex, age group, and employment

status. A person is regarded as employed if he had worked for wage, salary, family gains, or profit in cash or in kind at least 6 months or more during the past 12 months prior to the survey reference date of March 3, 2013.

It is stressed that there has been no aging survey since 2004 when a representative study was conducted by Royal University of Phnom Penh in collaboration with University of Michigan. Borne of this data, selected studies have been published revealing socio-economic circumstances and older persons' living condition in Cambodia (Knodel, Zimmer, Kim, & Puch, 2007; Zimmer, Knodel, Kim, & Puch, 2006; Zimmer, Korinek, Knodel, & Chayovan, 2008). But information gathered then can hardly describe the rapidly changing context of old-age people at present. Information from the 2013 Cambodia Intercensal Population Survey and the 2014 Cambodia Socio-Economic Survey provide latest available data that can offer a clearer picture of the background situation of the older population. These surveys bear limitation, part of which is the knowledge regarding the condition of older persons' diseases and care provision because the purpose of the studies was not to realize the current predicament or prominent issues of aging population nor was it planned to have policymakers be cognizant of intergenerational solidarity in family.

Table 1: Percentage of Employed Aging Adults by Employment Status, Gender, and Age Group

Sex	Age Group	Total Population	Employed Population	Share of Employed Population	Employment Status			
					Employer	Paid Employee	Own Account Worker	Unpaid Family Worker
Male	60 - 64	156,355	138,843	0.9	0.4	15.8	78.8	5.0
	65 - 69	111,775	90,156	0.8	0.3	11.2	83.1	5.4
	70 - 74	80,798	45,610	0.6	0	8.7	81.9	9.3
	75+	98,606	35,798	0.4	0.4	4	76.5	17
Female	60 - 64	234,264	164,174	0.7	0	4.8	48.1	46.9
	65 - 69	160,882	90,044	0.6	0.3	3.6	54	42.1
	70 - 74	121,192	40,384	0.3	0.3	3.3	56.2	39.9
	75+	153,275	29,209	0.2	0	1.9	50.4	47.7
Both sexes	60 - 64	390,619	303,017	0.8	0.2	9.8	62.2	27.7
	65 - 69	272,657	180,199	0.7	0.3	7.4	68.5	23.7
	70 - 74	201,989	85,994	0.4	0.1	6.2	69.9	23.7
	75+	251,881	65,007	0.3	0.2	3.1	64.8	30.8

Source: Adopted from Cambodia Intercensal Population Survey (2013).

This table does not show the number of older people who are economically inactive and those who are willing to work but unable to find employment. The percentage of employment tends to diminish with age which possibly comes from the reason that they are either retired completely or restricted to work due to age-based discrimination. In addition, the percentage of employed male seniors within the same age group is, on average, higher than their female counterparts who are more likely to be engaged in unpaid family work. This also means that women are more financially vulnerable and riskily dependent if they do not have any saving or are

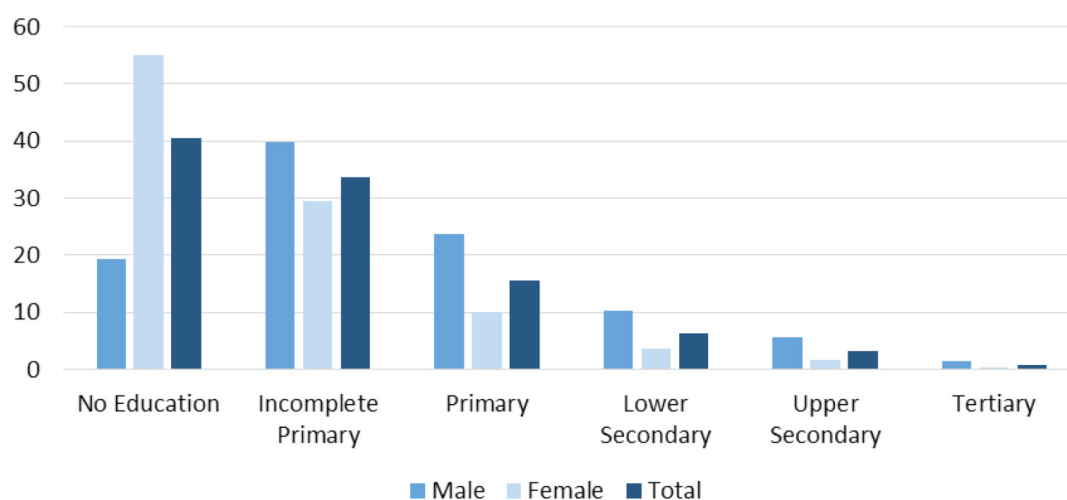
not covered by any type of social security scheme. Even though a large number of older people who are economically active is a promising signal for positive contribution to national economic growth and active aging, it can also be an indicator of underdeveloped pension and social security system for old-age, a topic that is to be discussed in the next section.

Figure 2 presents the percentage of older persons by education and gender. More than half of older females have no education or never attended school at all compared to about 20% of older males. In general, three out of four older adults

have lower than primary education. A notable difference between educational attainment of males and females in all age groups reflects the traditional gender roles of Khmer society where women were convinced not to go to school as their job was mainly staying at home and looking after children and other family members; and their success was measured by their respective husband's economic and social status instead (Dy, 2004; Velasco, 2004). In contrast, financial and psychological encouragements were typically placed upon males especially in times of dire condition. Social pressure on unmarried women is also a main reason that dissuades them from

attending higher education and hence higher status. As women gain higher level of education means delaying marriage and childbirth and having more difficulty in finding a monogamous partner which can potentially lead to involuntary infecundity due to older age, an impairment many Khmer women are wary (Velasco, 2001, 2004). This concept remains to be observable today in rural areas as well as by some families in the cities. It is perceivable as the age of first birth in Cambodia coincides with the time of marriage. The median age at first birth is 22.4 years old in 2014 which bears slight increase from 20 years in 2000 (National Institute of Statistics et al., 2001, 2015).

Figure 2: Level of Education (%) of Older Adults 60+ by Gender



Source: Cambodia Socioeconomic Survey (2014), author's tabulation.

In total, 85% of old-age adults have less than lower secondary education. This is largely attributed to severe fatalities of educated people because of the Khmer Rouge's genocidal practice. Partially, it is also a legacy of the French's ninety years colonial rule (1863 – 1953) during which they spent almost nothing on Cambodian educational system (Church, 2017). Regardless,

low education directly puts older persons in the country with little or no pension in a detrimental frontier. Economic and social changes such as technological advances in production means those who are willing to work but do not have skills that match labor demand cannot find employment. Consequently, they are forced to leave the labor market early and become

structurally unemployed. Higher education is, on the other hand, translated into higher and faster adoption capabilities of new technology, knowledge, and skills and thus in a more favorable opportunity of remaining in the labor forces. This figure may explain why only a small fraction of working older persons in Cambodia are in paid employment whereas vast majority are own-account workers.

Indirectly, low education leads to limited understanding regarding health care, nutritional promotion, and disease prevention while restricted financial resources mean limited access to better quality of health provision system, at least in the context of contemporary Cambodia. It is also recognized that highly educated individuals are more resilient to most infections as well as non-communicable diseases because of their healthier lifestyle and neighborhood. But detailed endogenous causality between health benefit of education and education benefit of health is very complex to cover given limitation of this report. It should be highlighted again that there is a lack of information in term of disease prevalent rate among the seniors in Cambodia, but figures are available regarding the percentage of disabled older persons and estimates of healthy life expectancy by the World Health Organization which captures a general picture of aging population's health condition and morbidity. A disabled person is defined by the Cambodian

government as those who experience one or more types of disability including movement, seeing, speech, hearing, mental retardation, and mental illness, and some other specific dysfunctions. By having disabilities, it can be assumed that the older persons are automatically limited to perform many ADLs and IADLs. However, the data is not indicative of whether a person's disability starts from birth or at a latter period in life.

Table 2 demonstrates percentage of older people with disabilities by age group, gender, and their locality. Overall, the incidence of disability and frailty seems to commensurately increase with age. In accordance with the Population Survey in 2013, the most prevailing type of disability among those who are 60 years old and above both gender is hearing, followed by seeing and movement respectively. Moreover, 46% of total disabled people are experiencing more than one type of disablement and it is more prevalent among women (National Institute of Statistics, 2013). But as people advance in age, their immunity and vulnerability worsen. Despite the fact that women usually live longer than men and will largely occupy the old age structure eventually, more of them in term of absolute number and relative to males, live in an unhealthy condition. Nevertheless, this does not refer that men enjoy healthier lives as they are more likely to die at younger ages and hence fewer of them reach old age and experience disability.

Table 2: Percentage of Old-Age People with Disabilities by Age Group, Gender, and Region of Residence

Age Group	Male			Female			Both sexes		
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
60 - 64	6.4	6.0	6.0	9.0	6.9	7.2	7.6	6.4	6.6
65 - 69	7.5	5.1	5.4	9.3	7.2	7.5	8.4	6.1	6.4
70 - 74	5.5	4.7	4.8	5.5	7.0	6.8	5.5	5.8	5.8
75+	9.1	6.5	6.9	7.3	12.4	11.7	8.2	9.4	9.2

Source: Adapted from Cambodia Intercensal Population Survey (2013),

The percentage of older persons with disability in urban cities is higher than in rural area even though urban population on average has higher socio-economic status and better access to quality health care. This seems counterintuitive but it can be the case that old-age parents with disability are more likely to be asked to migrate to live with their children or other family members in the cities so that they can easily go to the hospital and attend better health care treatment more regularly. Another possible scenario is that they think they will be cared for with better attention if they stay with their migrating children instead of being left behind at home in a remote region with no adult. If anything happens, no one will know or be able to reach them on time. Likewise, those who are 75 years old and above may have issues with mobility, thus, they have no choice but to remain in rural areas. This is why as age increases, the percentage of disabled older people in rural province starts to become higher. In addition, there is a common perception among the oldest

old persons that they prefer to spend their remaining few years at their home village where they will be ultimately laid to rest in a local pagoda.

To supplement toward a more complete picture of Cambodian older population's health condition, information regarding of healthy life expectancy, a combined measurement between morbidity and mortality data, are presented. Table 3 displays WHO data on healthy life expectancy. Healthy Life Expectancy (HLE) at age 60 years refers to the remaining active life expectancy a person is expected to spend in good life without chronic diseases, limitation, or difficulty in performing activities of daily living (ADL). Having difficulty to perform either activities of daily living namely bathing, dressing, walking, eating, or toileting is typically considered as an indication of a kind of disability or functional disorder that is necessary for being self-sustaining (Verbrugge & Jette, 1994). HLE is also an appropriate indicator to monitor public healthcare system, evaluate health

program, and measure quality of life of the population because not the entire duration of a person's lengthy life will be in perfect health

especially in Cambodian context whereby many older persons tend to suffer from rising non-communicable diseases for a prolonged period.

Table 3: ASEAN Countries' Healthy and Unhealthy Life Expectancy at Age 60 by Gender

Country Name	Life Expectancy			Healthy Life Expectancy			Unhealthy Life Expectancy		
	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female
Brunei Darussalam	21.3	20.4	22.3	17.5	16.8	18.3	3.8	3.6	4.0
Cambodia	17.3	16.5	17.9	10.5	9.3	11.4	6.8	7.2	6.5
Indonesia	16.6	15.4	17.9	13.1	12.2	14.1	3.5	3.2	3.8
Lao PDR	16.8	15.9	17.6	12.4	11.8	13	4.4	4.1	4.6
Malaysia	19.5	18.6	20.3	15	14.3	15.7	4.5	4.3	4.6
Myanmar	16.8	15.7	17.6	12.6	11.8	13.2	4.2	3.9	4.4
Philippines	17.1	15.5	18.6	13.3	12.0	14.5	3.8	3.5	4.1
Singapore	25.5	22.8	28.0	20.2	18.2	22	5.3	4.6	6.0
Thailand	21.0	19.2	22.9	16.5	15.2	17.8	4.5	4.0	5.1
Vietnam	22.5	19.5	24.9	16.8	14.7	18.4	5.7	4.8	6.5

Source: WHO Global Health Observatory Data Repository. Accessed February 13, 2018.

Note: Unhealthy Life Expectancy is the difference between life expectancy and healthy life expectancy. Emphasis is by the author.

Women in Cambodia tend to live not only longer but also with better health condition than men. However, the expected value of unhealthy years of Cambodian male is not substantially higher. But this is remarkably distinct from the rest of ASEAN countries, as their older female populations

tend to live longer in morbidity circumstances compared to men. Nonetheless, among the population of Southeast Asian region, older persons in Cambodia spend the longest life in unhealthy years. Although they are expected to have lengthier years of life than their counterparts

from Indonesia, Lao PDR, Myanmar, and the Philippines; the difference in duration is, on average, additional years of living in unhealthy life, and it is not economically productive or a good indicator for social development. This table should also be interpreted with caution because the trend of normal life expectancy and life expectancy free of disability in Cambodia over the years has been increasing, but it is still far behind that of its neighboring Thailand and Vietnam in terms of absolute years (United Nations, 2017; WHO Global Health Observatory Data Repository, 2018).

In terms of uncommon gender difference in unhealthy life expectancy in Cambodia, a possible explanation can be given based on the fact that males were more likely than females to experience execution, physical and mental torture, or other severe types of brutality under the KR's administration. They were more educated and holding better socio-economic status and government position – the population deemed by the regime as expendable labor supply. Therefore, it is typical that the KR's heinous acts and harsh living and working condition fundamentally have a stronger and larger impact on men and their health than that of women's. Pol Pot's horror, which still haunts them now, increases the risk of falling into poor health and morbidity particularly infectious disease due to weakened immunity and rampant poverty. Contemporarily, an insufficient number of psychologists and psychiatrists and victim's refusal to participate in long-term care for Post-Traumatic Stress Disorder by health professionals (Jegannathan, Kullgren, & Deva,

2015; Agger, 2015) are making Cambodians more prone to continue to bear this mental laceration.

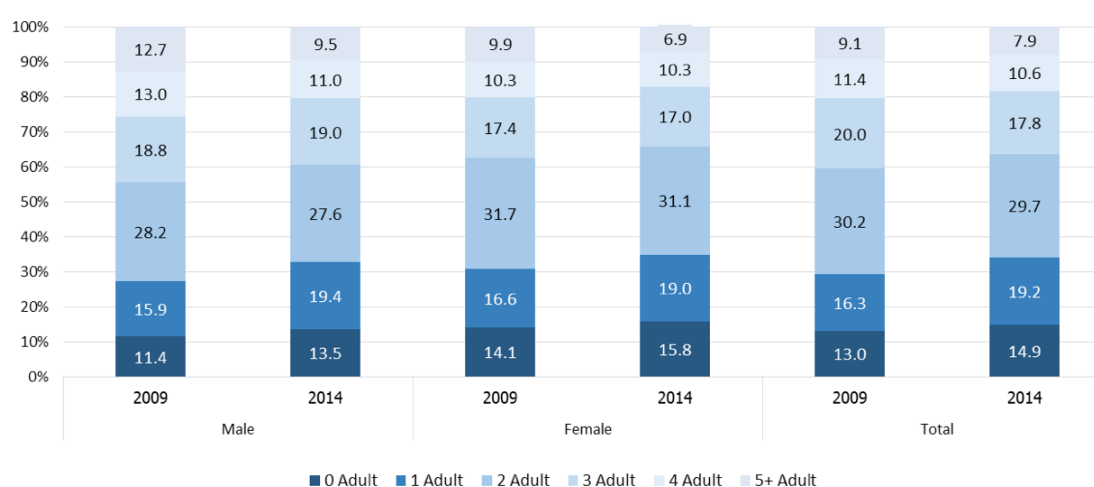
Many older women have also lost their husband or potential spouse, thus, fail to receive spousal support because females are less likely than males to be remarried after facing marital disruption or dissolution. In fact, Cambodia Socio-Economic Survey 2014 shows that out of the 58% of older persons that were married, only 40% were women. KR's atrocities resulted in a very unbalanced sex ratio precipitating a crisis in the marriage market. In this regard, Islam and others (2017) asserts that many women at that time had the tendency to marry younger and at times less educated men. Therefore, female older persons are more likely to provide support to their husband rather than being the recipient. Many others who remain single without living family members who should be the priority for assistance to ensure "aging in place". Figure 3 portrays the share of old-age adult's household by sex and number of adult who is defined as those between 15 – 59 years old living there regularly in 2009 and 2014 to capture the declining trend of number of adult members in the household who can potentially provide support.

It should be highlighted that the definition of having two or more older persons in the same household are still considered as having zero adult members regardless of whether or not the older persons are helping each other or receiving private transfer from their migrating children. However, the older persons' households with zero adult may not indicate single-person or older-persons-only

households but can be a result of migration of adult children leaving behind only young children. From the graph, it is clear that the number of adult household members is decreasing between 2009 and 2014. As a result, older adults in Cambodia are beginning to experience a living situation with fewer supporting individuals who can provide physical and material assistance. A shrinking

number of working adults within their residence can be explained by fertility decline, labor migration, and family transformation from extended to nuclear families (National Institute of Statistics, 2013). It is also a result of recent economic growth. In this regard, 16% of zero-adult older female person households in 2014 is moderately larger than that of older males.

Figure 3: Old-Age Person Households by Sex and Number of Adult Members (%) in 2009 and 2014



Source: Cambodia Socio Economic Survey (2009, 2014), author's tabulation.

Overview of Actors Involved in Care Provision

Family

Similar to Eastern Asian countries, Cambodia is family-oriented. The institution of modern Cambodian family had been a subject of significant influence throughout the 20th century such as the French colonialism and the Khmer Rouge's radical inculcation. During the Pol Pot administration, young children were separated from their parents or families and placed in groups to diminish cultural emphasis of family solidarity. This was

done to brainwash children, rub off the "capitalist dirt" from their body, and turned them into "the true communists" and spying instruments against their own parents, family members, or other people in their communities who would criticize the regime (Chea & Kobjaiklang, 2017). KR's attempt on social reconstruction had negative influence on family arrangement, yet it has kept surviving to the extent that the severely diminishing effect was reversed as soon as the KR's domination collapsed. The Khmer family returned to its long-established formation, but new trends of household transformation can be observed due to modernization and the country's re-engagement

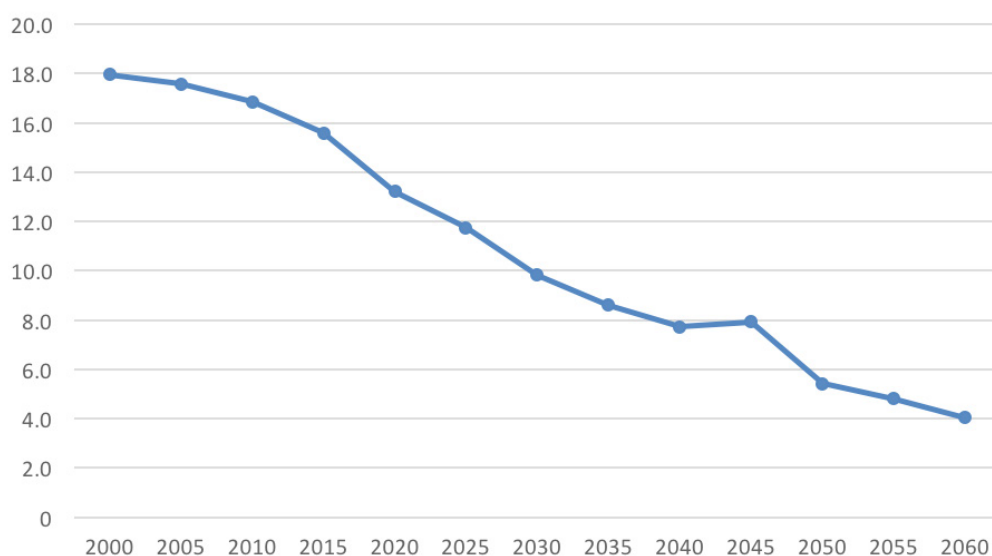
with the global economy (Demont & Heuveline, 2008).

Family is presently the primary actor and a core source of all kinds of support. Its role has been to nurture protection and care for its members to cherish the essential value of filial piety in Buddhism, the official religion and practiced by 97% of population (National Institute of Statistics, 2013). Therefore, most social welfare provision and psychological well-being consolation are principally maintained by family and, to some extent, by the state such as public education and healthcare. As parents provide custody for younger generation when they are young, children also need to secure their parents during old age. Older Cambodians would co-reside and depend almost entirely on their adult children for material and physical support (Zimmer et al., 2006). However, older adults usually become caretakers of their grandchildren allowing adult children to participate fully in employment and reduce the burdens of childrearing.

Cambodia does not have a culture of son preference. Old-age parents typically co-reside with the child who has the highest socioeconomic status although conventionally, the youngest daughter is held responsible for looking after older parents (Chea & Kobjaiklang, 2017). This is done to honor them and uphold normative standards, but she will be bequeathed the family homestead. Nonetheless, the situation is deteriorating corresponding to sudden demographic transformation. Furthermore, it is also skeptical if

recent economic growth and lifestyle changes will make the flow of filial support for old generation erode. In lieu of which, 71% of total household in the country has no living old-age adults whereas having only one and two older persons within the household consists of 20% and 8.5%, respectively. The “three or more old-age persons in household” comprises only 0.2% of all household (National Institute of Statistics, 2014).

Figure 4 displays the potential support ratio (PSR). PSR is calculated using the number of working-age population between ages 15 to 64 years who potentially can provide support divided by people aged 65 years and above who are more likely to not be able to support themselves, i.e. needing care and financial aid. According to the graph, from 2000 – 2015, the ratio dropped from 18 potential support sources per older persons to roughly 16, but the decline will be more rapid in later years. Out-migration also aggravates PSR in the rural area if we separate between regions, for magnitude of working denizens in the cities will see an increase due to in-migration of labor forces. In this sense, it is, to a degree, a signal for socio-economic failure that needs to put every effort to cope with. The emerging demographic byproduct migration itself produces is detrimental to old-age security because in the context of Cambodian rapid population aging, migration will prompt an uncertain future of family care provision for older persons increasing the risks toward their well-being. They may also have to take care of migrant’s young children.

Figure 4: Potential Support Ratio per Person 65+

Source: Adapted from United Nations (2017). Medium variant projection.

Without an old-age survey, we have limited understanding if the older population is receiving appropriate care they are supposed to get from their adult children such as financial assistance or physical care. Zimmer & Khim (2013) observed that only 76% of migrant households with at least one aging persons received remittances in 2011. However, this does not mean that older people living in non-migrant households would get regular material aids either, for solidarity does not automatically exist when family members share the same roof. On the contrary, it is not separated by distance as long as the members keep their relationship. Distance may terminate physical care, but migrants still can provide emotional and financial resources. There is a growing concern that many old-age individuals have been abused or neglected by their co-residing relatives even in the Asian countries where the tradition has given them high respect (Cooper, Selwood, & Livingston, 2008; WHO, 2008). Solidarity may be an important aspect to keep family members to assist one

another in prudent long-term and keep undesirable incidences in check.

Government and Development Partners

Cambodia is in the transitional period for health and social protection reform. The health sector is one of the prioritized dimensions for development since 1995. The annual budget toward improving public health care has been increased over the years corresponding to the growing economy. In 2017, health funding constitutes 8.5% of total government expenditure which amounts to about 5 billion USD. This amount was fourfold compared to that in 2008, but only around 95% of the approved budget was implemented annually (Bureau of Health Economics and Financing, 2015). The Ministry of Health (MoH), which was established in 1993, has been trying to address healthcare provision problems and strengthen the system and infrastructure which was left in dire state, to the extent that only 25 medical physicians survived

the violence (Heng & Key, 1995). Between 1980 – 1981, about 11,230 health workers were recruited by the government, but initial restoration of health sector was placed on quantity rather than quality of medical staffs who were trained haphazardly without international accreditation or standard so that they could assume position in 1,225 health posts (Annear et al., 2015). Therefore, the qualification of many medical personnel under such scheme was largely questionable. As a result, Cambodian people continue to face geographical and socio-economic barrier to health services not only in term of quality but also quantity. In previous decades, there has been an increase in health specialists, but it is not proportional to the increasing population.

Initially, public health care services were fully subsidized by the government, but in 1996, as part of the reform, a nominal user fee has been imposed to generate revenue, to reduce government expenditure, and to increase personnel's motivation to work since 60% of revenue is allocated as personnel's additional income. The fee is exceptionally low and charged based on the number of treatments performed while the people living in poverty are officially exempt from all charges. However, this also deprives public facilities of income that they need to maintain their services and staff's salary. Thus, few doctors and nurses are willing to work in rural areas where many people are not subject to user fees. Furthermore, because their wage is low, care provider's income is usually supplemented by working at the fast-growing

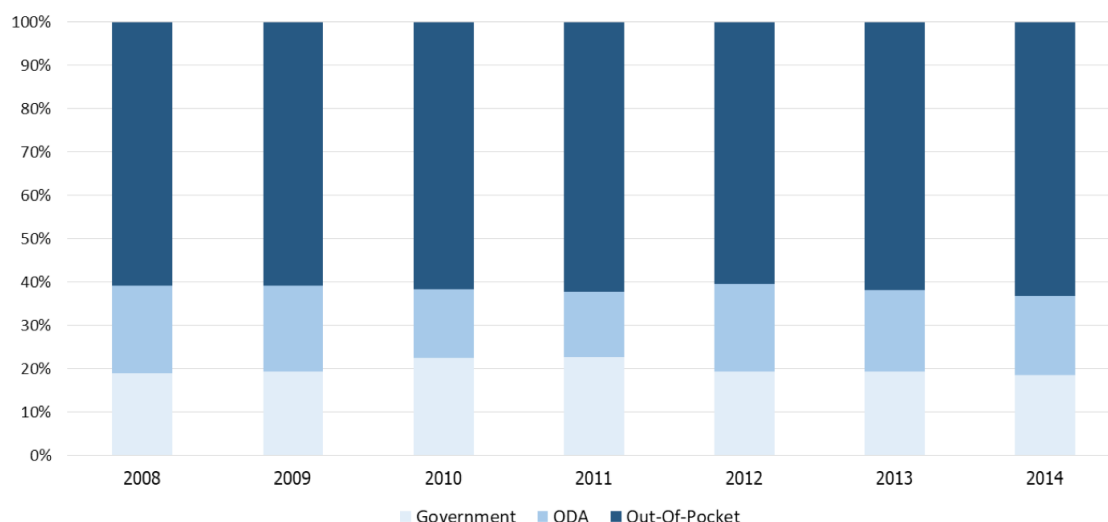
private hospitals or clinics which tend to be more lucrative if they were located in big cities. In addition to that, problems of public health care system are lack of caregivers during the working hours and impolite attitudes towards poorer patients. Certain essential medications are also frequently unavailable or insufficient. Therefore, patients must purchase them individually from private pharmacies. On the other hand, private practitioners are generally more attentive and available but also more expensive. Moreover, patients normally bypass the first-line health centers and seek direct treatment at the referral hospital without any referral making their journey costly and time-consuming, so they tend to suffer even more financial hardship.

Institutional factors are also major reasons the middle and upper class conventionally seek significant medical treatment in Bangkok and Singapore respectively (Annear et al., 2015). This leads to unnecessary yet deemed important spending, but it creates barriers for the older population and those with disability to seek oversea services. As a consequence, the share of out-of-pocket money to total health expenditure is high whereby fees to private healthcare providers covers the most of such expenses. In 2014, total health expenditure was 5.8% of GDP, the highest in ASEAN region and vastly funded by households (Bureau of Health Economics and Financing, 2015; World Bank Databank, 2018). Using qualitative data, Chea (2016) corroborates that for rural residents, who had suddenly fallen impoverished, the biggest cause of their destitution or indebtedness is associated

with health care by having to pay exorbitant rate for treatment. Figure 5 illustrates share of total health expenditure between 2008 and

2014. Out-of-pocket expense remains fluctuating though national budget has gradually increased.

Figure 5: Share of Total Health Expenditure Between 2008 and 2014



Source: Bureau of Health Economics and Financing, Ministry of Health (2015).

Note: ODA stands for Official Development Assistance.

To deal with high expenditure, the Health Equity Fund (HEF) was developed in 2000 by the MoH. It has been financed by the Cambodian government together with various local and international organizations or institutions. The beneficiaries are those living under national poverty line who are holders of the “Poor ID” and entitled to a reimbursement mechanism at the public hospitals so that they are provided healthcare free of charge and the facilities still earn revenue to supplement staff’s income. In 2014, HEF’s coverage was almost 90% of all poor population, and full insurance was to be achieved by the end of 2015 (Bureau of Health Economics and Financing, 2015). However, it covers less than 20% of Cambodian population, and some among those poor patients still need to spend money for other

ancillary healthcare provision in the private facilities to which are referred by public practitioners or medication from private pharmacies. Thus, this health scheme only lessens financial burden but does not eliminate it entirely.

Besides HEF, voluntary health insurance schemes namely the Community-Based Health Insurance (CBHI) and the Private Health Insurance, is also available. The latter is a private companies’ business but regulated by the Ministry of Economy and Finance. Its members are people with substantial income and being employed in the formal private sectors which purchase premiums for them. The former insurance, CBHI, is administered by a not-for-profit NGO since 1998 and only for those working in the informal sector

and living above the poverty line to offer them a risk-sharing method. Despite almost two decades of establishment, as of 2014, there were only 139,971 memberships down from 455,000 in 2013 but there is a lack of existing literature indicating why the number decreased or the uptake has remained low (Bureau of Health Economics and Financing, 2015). However, Ovesen and Trankell (2017) argue that NGOs' contributions to the health sector may not necessarily reflect public interest, as some do not operate at the location where health situation is dire but where their donors direct them. Due to the concern over their ability to maintain HEF, the government has considered CBHI as an option. Although from recent trend, the effectiveness and sustainability of this scheme raise remains undetermined.

There are several other types of social health insurance available in Cambodia including the mandatory National Social Security Fund which is under the Ministry of Labor. This provides social security scheme on occupational risk, health care, and pension for formal private employees, but the coverage is still, hitherto, limited to mostly manufacturing industries. For public servants, the Ministry of Social Affairs is the unit in charge of maintaining the National Social Security Fund for Civil Servant. In addition, those with particular afflictions such as tuberculosis, malaria, and living with human immunodeficiency virus (HIV), are also eligible for free treatment in public infirmaries. These schemes aim to remove barriers to utilizing care services but, none of which is designed specifically for older persons regardless of socio-economic status. The majority of older people are

currently entitled to no pension since NSSF, which was initiated in 1955, has resumed function only after the end of the conflicts. Thus, the fund is unable to afford paying those who did not contribute previously. However, according to National Population Policy Action Plan Phase 1, 2016 – 2018, destitute old-age adults who are 70 years old and above will receive some amount of allowance from the government which will be decided in the Rolling Action Plan 2018 – 2020 of the National Aging Policy 2017 (NAP), a plan to be discussed later.

Effort to foster knowledge of life course approach to health and diseases and prepare the younger population for what they may experience when they are 60 years old, have also been prioritized and observed in the NAP which intends to encourage healthy lifestyle and behavior and regular health assessment via public campaign and school curriculum. Therefore, they can be more productive and healthier in later life and reduce the accumulative risk of non-communicable illness. Considerable attention has been continuously paid to mothers, newborns, and children who are regarded as part of vulnerable groups due to high preventable mortality rates. The said sub-groups are the concern rather than the youth although they constitute a third of the Cambodian population. This can be substantiated by the Cambodia-WHO Cooperation Strategy 2016 – 2020 which is adamant on emphasizing maternal and child death. Interestingly, the NAP also paves the way to stimulate the habit of high saving and reduced materialism to forestall poverty at old-age. This is a new evolution of

traditional pattern in Cambodia which was constantly ignored in the past.

Affordable universal healthcare for all Cambodians has remained distant from success, not to mention its quality. It can be validated by the recent Universal Health Coverage Monitoring Report in which Cambodian UHC index is scored 55 and ranked 8th in the ASEAN region (WHO & World Bank, 2017). Moreover, there is no one-stop health facility established to provide care solely for aging individuals and very few health facilities adequately meet their needs as well. However, this is understandable because even if the political and financial support has been increased annually, the MoH has been operating under limited budget which is exceptionally lower compared to other countries in the region resulting to the deprivation of the public health system.

Older People's Associations and Community Care

In the attempt to have the communities involved in old-age care and raise awareness of the challenges aging condition in the country will pose, the government organizes an annual celebration of the International Day for Aging People on October 1st through the community-based Older People's Associations (OPA). It works to improve quality of life of the older persons and for the benefit of their locality via collective activities coordinated by older people themselves intending to attract community support and promote active aging. OPA provides older persons with opportunities to continue to participate in social, cultural, and civic affairs to maintain their dignity

and well-being. In addition, it serves as a forum to discuss relevant issues, address concern over their welfare, and present it to local authority and the government. In Cambodia, the formation of OPA is required to conform with the Guideline for the Establishment and Management of Older People's Associations which was produced by Ministry of Social Affairs. It prescribes necessary criteria to establish, manage, and organize an OPA's activities so that it will become strong and sustainable to enhance inclusive local development in long-term.

Through OPA and its inter-network, all members can interact with one another to share experience and knowledge, develop solutions, and promote life course method to healthy aging in the context of "seniors help seniors" (RGC, 2017). Some members have even assisted in replicating a successful OPA in other neighborhoods. There are also NGOs, volunteers, and government personnel who come to introduce mechanism to prevent senior adult from diseases and strengthen their health by gathering older persons and their family members and give them instruction on basic health aids, homecare, and the importance of physical activities, diet, and good hygiene in household. This notion is based on an informal discussion with HelpAge Cambodia's staff and author's observation on their official website and Facebook page. In addition, OPA in Cambodia also provides a chance for income generating activities, but it is generally located in populous areas and within NGOs' target or working boundary where they could visit more often. Those living in remote rural regions, who also tend to

be more susceptible to harmful condition and poverty lack access. A plan to enhance the role of OPA in the community is essential since it is thriving and appears to be more effective and efficient than running a public campaign to promote health.

Because OPA is a sustainable way to encourage “aging in place” for a country with limited budget and culture of family value, the state tends to provide all support. Through Ministry of Social Affairs’ funding and facilitation, in early 2018, governmental OPA has been established nationwide situated within each sub-national administrative unit or the *commune* which is amounted to 1,636 across the country according to an unofficial interview with an employee from an international organization called HelpAge Cambodia which headquarter is located in Battambang Province and verbal report from official in the Ministry of Social Affairs. Nevertheless, same sources claimed that governmental OPAs are at the early stage of working to recruit members. Moreover, HelpAge Cambodia is also maintaining another 206 community-based multi-functioning OPAs in Banteay Meanchey, Battambang, and Siem Reap province, all of which are in the Northwest of Cambodia. It should be highlighted that the term “commune” and “community” used in Cambodia have slightly different meaning. While commune is a smaller administrative unit within a district with obvious borderlines that separate one from another, community suggests a local neighborhood without proper boundary. Thus, commune refers to a political entity.

For old adults without shelter, the government-funded National Center for Older People provides them accommodation and medical services for free although the government is being fostered to strengthen the role of pagodas and monasteries instead because it has been a long tradition for the Khmer to enrich their mindfulness through mediation, merit making, and building spirit at the temple with monks (Chea & Kobjaiklang, 2017). Due to insufficient professional psychologists and psychiatrists, Buddhist monks have played crucial roles in curing mental illness of many KR’s survivors (Agger, 2015). Local pagodas, which spread across Cambodia and have offered sanctuary to homeless persons, are also public spaces and places for festival celebration, funerals, and consultation among villagers regarding of their community development. Therefore, there is no reason to ignore its important position in the society to extend community involvement or not to make use of its numerous infrastructure for old-age care to redirect government’s budget toward construction of other vital structures or facilities. It should be noted that although pagodas or any religious institutions are completely independent from Phnom Penh’s control or influence, they still need to follow state’s regulation and are placed under indirect monitoring.

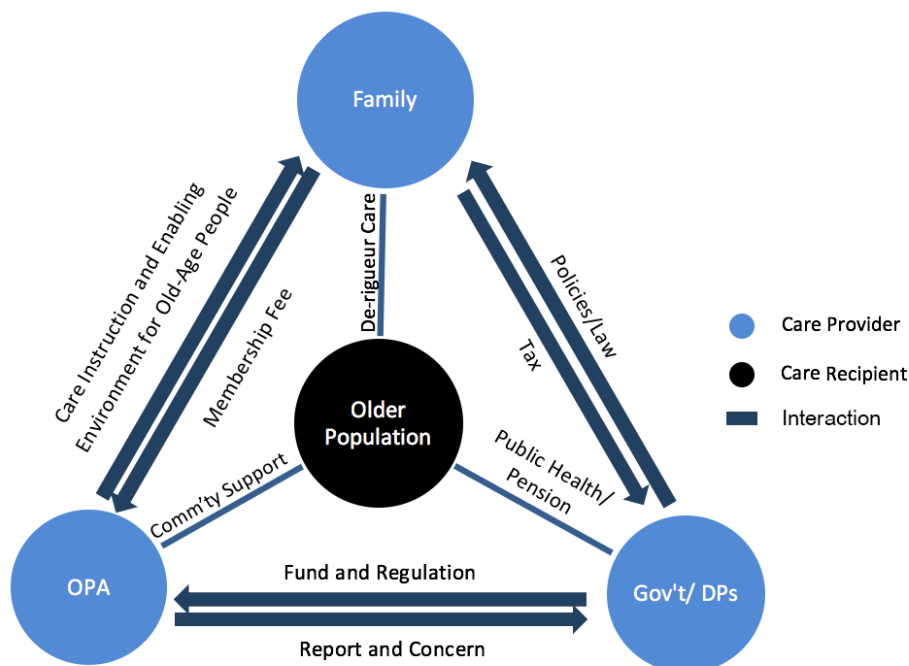
Private Sector

The private sectors in Cambodia currently play very small and trivial parts in old-age care provision and political motivation underlies some charitable contributions which plan to earn political interests and support. However, there is room for

improvement in the future, but it depends on resolution. Ultimately, based on available information, the following diagram is created to

visualize how old-age care in Cambodia is organized:

Figure 6: Diagram of Old-Age Care Organization in Cambodia



Source: Author's illustration based on the discussion above.

Note: DPs stands for Development Partners.

National Legal Framework

The growing figures of older populations and their well-being was brought to international agenda in 2002 in Madrid, Spain, which led to the adoption of Madrid International Plan of Action on Aging, to which Cambodia is a signatory, followed by the 2010 regional convention and Brunei Declaration on Strengthening Family Institution for Caring for the older persons in which ASEAN members agreed that old-age care provision should be the main responsibility of family to honor the hallmark of Asian culture of filial piety. On this account, the

Royal Government of Cambodia (RGC) has essentially placed emphasis on factoring multi-faceted aging dynamics in the holistic development planning process to mitigate its repercussions and gear itself for opportunities. The RGC has attempted to mainstream cross-cutting issues of old-age care arrangement for poor rural population and vulnerable women as highlighted in recent plans including National Population Policy 2016 – 2030, National Health Care Policy and Strategy for Older People 2016, National Social Protection Policy Framework 2016 – 2025, and National Aging Policy (NAP) 2017 – 2030 which had been

developed from the previous irresponsible and incomprehensive 2003 Policy on the Older People. The NAP 2017 is also elaborated on all existing legal framework and policies in place (RGC, 2017).

The updated policy was jointly formulated and reviewed by Ministry of Planning and Ministry of Social Affairs to align with Cambodian normative and international framework. It concentrates on three broad notions and exclusively attach importance to collective awareness of aging condition. First, the policy aims to eliminate all forms of age-based discrimination in every aspect of life including employment in which older persons are not treated on par with younger generation and hence discourages them to participate in the society. Public support is given to a concept of making appropriate use of their skills and wisdom to allow them to be self-reliant. Second, it ensures equality for women who are more vulnerable than their male counterparts and comprise vast majority of Cambodian aging population. Third, it places a high priority to promote Khmer culture of intergenerational transfer among household members to strengthen the joint family system. To guide an implementation of the NAP, the Rolling Action Plan 2018 – 2020 is being developed and carried out by relevant ministries and government agencies.

To translate strategy into concrete action and achieve a desirable outcome, the Cambodian National Committee for the Older People, which is a high-level government body established in 2011, is tasked to implement this policy by

coordinating with fifteen line-authorities and other stakeholders and involve directly with the Older People's Associations. However, monitoring on the progress and outcome evaluation will be conducted in conjunction with the Ministry of Social Affairs and Ministry of Planning, but indicators and guideline on mechanism will be determined in the forthcoming action plan. Despite the fact that it has yet to be formalized, political importance is constantly raised and given to financial security of the senior individuals and the intergenerational linkage among family members which are deemed priority issues. This can be substantiated by the objectives within the National Aging Policy 2017 – 2030 itself, which was approved in August 2017. It indicates government's strong stance against the idea of establishing more National Center for Older People which is inimical to social and cultural context of family-oriented Cambodia where traditional system of filial piety is highly valued. Furthermore, it attempts to persuade family to view old-age parents and relatives as their resources rather than a burden.

Policy direction lies on the notion of promoting home-based care which is primarily a responsibility of extended Khmer family to honor the traditional principles of intergenerational relation. The Cambodian government underscores in the NAP that school as well as adult parents ought to teach children and foster the importance of old-age care and respect, so they themselves can expect family support at old age. It further states that the most effective method of teaching is by demonstration. Hence, parents should start showing their kids moral respect and necessary provision for their

own older parents first so that children can learn by example. Aligning with the national and international contexts, promoting intergenerational transfer is necessary, which the government has constantly attempted to publicize throughout the NAP 2017 – 2030 to ensure a high degree of harmony in the household consisting of members with different ages and a conducive environment for the older population. The concept of strengthening living arrangement and kin's obligations is clearly expressed in the modern 1993 Cambodian constitution, article 47, which proclaims that *"parents shall have the duty to take care of and educate their children to become good citizens whereas children shall have the duty to take good care of their elderly parents according to Khmer customs."*

Nevertheless, for a civil-law country such as Cambodia, this is incomprehensive since it does not define lucidly how much care is considered "care". There is a specific punishment for parents who abandon their children but it does not indicate the opposite. What it means in a country which practices Romano-Germanic legal system is that the court cannot punish those who violate the law if the law does not introduce such punishment. Hence, the children's duties are largely escapable; however, there are also societal ethics and sanctions to consider. From a legal perspective, law on aging is necessary to ensure that the NAP will progress according to plan. Such actions have already been adopted in Cambodia's neighboring countries specifically Thailand which enacted the Older Persons Act in 2003; and Vietnam which has the law on the

elderly adopted on 2009. Non-development of this law can be attributed to either previously lack of interest in aging problems or slow progression toward targeted indicators in general, as no assessment of the result and effectiveness of 2003 National Policy on Older People was conducted. Nevertheless, after a decade of inadequate concern, the NAP is probably the first sign reflecting government's commitment toward improving aging population's quality of life.

With the purpose of recognizing the future impacts of issues on well-being, the government has also approved and enacted the National Population Policy 2016 – 2030 in March 2016 to expand on the previous one which was passed in 2003. The National Population Policy 2003 was set to reduce tremendous growth of population size so as to adjust age composition and distribution to meet the needs for achieving Millennium Development Goals. Therefore, primary objectives of the previous NPP were to decrease total fertility rate, maternal and child mortality and morbidity, the adverse effect of rural-urban migration, population pressure on environment and natural resources, and halt the spread of HIV. The overall objective of the new population policy is, however, to ensure persistent social development within the national and global framework through concerted efforts in maintaining steady improvement in the quality of life of Cambodian people and equitable and inclusive economic growth to alleviate poverty. In perspective, National Population Policy 2016 contains little details on older adults. Appraisal

of the first NPP action plan is due to be carried out at the end of 2018.

Policy Recommendation

The increasing proportion of older persons in Cambodia presents both opportunities and challenges for the entire society including families, communities, and government. Therefore, there is a need to factor all aspects of development in plans with respect to rapid demographic dynamics to harmonize economic growth with population aging. In this sense, critical policies to respond to such an issue have to be carried out with extreme caution by relevant ministries and government agencies to really promote crucial support for aging persons. The following policy recommendations are supplements of what were not mentioned in National Aging Policy 2017 – 2030. It concentrates on enhancing family support system which is a key contribution to achieving “society for all ages” and the sustained economic growth:

1. The government should demonstrate to adult children that there are not only costs of old-age care but also benefits of having older persons in the household. For example, older persons can offer childrearing. Thus, intergenerational transfer both upward and downward flow should be encouraged.
2. Government should provide other types of incentive to those who have older parents or relatives living in the same household. Tax incentive is one thing, but housing program seems to be very effective in countries where the price of real estate is volatile and is becoming increasingly unaffordable. Cambodia is one of them, and those who agree to take care of old-age parents should be entitled to affordable housing program and selection of location.
3. Retirement age should be extended from 60 to 65 years old. The government should try to motivate capable and willing older persons to continue to work for their own financial security. Working is also a type of physical activities which allow them to remain healthy and reduce household's burden.
4. Foster the sense of caregiving by getting university students involved in volunteering activities program in their own community or through OPA.
5. Although ethical codes sometimes carry even greater power than law or regulation and despite the fact that violating them does not necessarily mean breaking the laws, Law of Aging might still be considered to provide a mechanism against those not fulfilling obligations towards their older family members.
6. Many Cambodians remain unfamiliar with the concept of high saving, so they are likely to default to poverty at very old ages when their resources deplete. Therefore, high savings from younger ages should be made an accustomed and stimulating tradition through parents-children knowledge transference and curriculum at school. Economic literacy and bookkeeping habit should be taught from the primary education rather than at the upper secondary level as described in current curriculum.

7. Government should improve public health system not only the quality of facility but also knowledge and attitude of public caregivers who should be compelled to adhere to their work and professional ethics.
 8. Older persons, specifically those who live in the rural areas, usually have lower education level. This affects their access to information and understanding about health and available services. Administrators at the OPA should be trained regularly by the government to disseminate knowledge regarding healthcare and preventive methods to their counterparts in the community to improve accessibility.
 9. Expand the role of pagodas or other religious institutions. Government can make use of space available within the pagoda to set a forum for discussion and become shelters for homeless aging population in the community or even OPA itself. Older adults normally go to pagodas for various activities, this is the best place for gathering and spreading knowledge.
 10. Presently, there is no special transport service for older people or people with disabilities. They may be unable to use public buses, boats, or trains. Motor-taxi is the only transportation way they are familiar with, but it is greatly exposed to the risk of accident and death. Therefore, the government should provide more accessible, convenient, and cheap public transportation for old-age individuals.
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Abbreviations

ADL	Activities of Daily Living
ASEAN	Association of South-East Asian Nations
BHEF	Bureau of Health Economics and Financing
CBHI	Community-Based Health Insurance
CSES	Cambodia Socio-Economic Survey
DHS	Demographic and Health Survey
DPs	Development Partners
GDP	Gross Domestic Product
HEF	Health Equity Fund
HLE	Healthy Life Expectancy
IADL	Instrumental Activities of Daily Living
KR	Khmer Rouge
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoSF	Ministry of Social Affair
NAP	National Aging Policy
NIS	National Institute of Statistics
NGOs	Non-Government Organizations
NSSF	National Social Security Fund
ODA	Official Development Assistance
OPA	Older People's Association
PSR	Potential Support Ratio
RGC	Royal Government of Cambodia
UHC	Universal Health Coverage
UN	United Nations
WHO	World Health Organization

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China

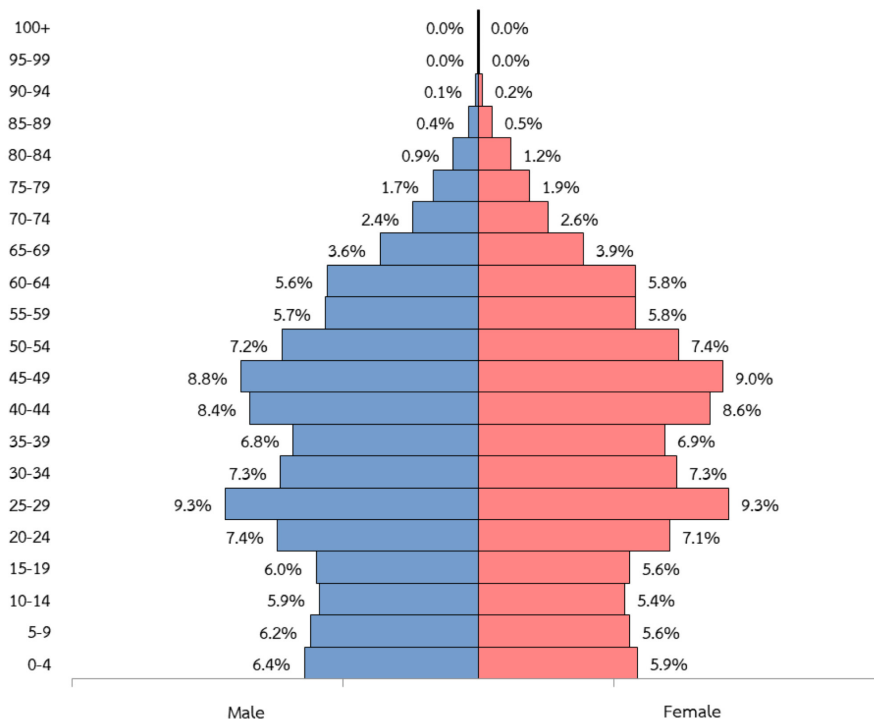
Dang Ngoc Hoang Truc

Introduction

The People's Republic of China has a large population size representing 18.47% of the total

world population in the year 2017. In absolute terms, the country has the highest population count compared with all other societies in the world (Worldometers, 2017).

Figure 1: China's Population by Age Group, 2015



Source: United Nations (2017).

According to the UN's World Population Prospects (2017), the shape of China's population pyramid 2015 shows that the country is an aging population with a smaller bar at the bottom, the bulge in the middle, and a narrow shape at the top of the

pyramid. The aging index, one of the important indicators indicative of the trend of population aging, is calculated as the number of persons 60 years old or over per hundred persons under age 15 (Department of Economic and Social Affairs (DESA),

2002). The aging index in China is 86.89 % in the year 2015. It means that the ratio between older persons and the population under 15 years is nearly 1:1. This raises concerns whether the Chinese economy will continue to be burgeoning.

Overview of Population Aging and Care Needs

There are numerous issues concerning the population of China; among them is the remarkable development of aging that is incomparable to any country regardless of the level of development. This demographic change is a result of three components: an increase in life expectancy which is at 74.5 years for both sexes combined by 2015 due to the decline of mortality across ages where the crude death rate (CDR) had decreased from 23.1 in the 1950s to about 6.0 (United Nations, 2015). Further, the decrease and persistence of low fertility whereby the total fertility rate (TFR) had dropped to 1.48 in 2000. The cause of aging in China is the marked perception of China being a country that rigorously enforces policies to control the fertility of its population. This is most pronounced with *the One-child Policy*. The consequence of this policy is that the country has more than 150 million families with only one child which represented more than two-thirds of all families in 2010. In addition to the rapidly declining proportion of its young population, imbalance in the sex ratio at birth is also an issue. It is the effect of having the one-child policy in conjunction with the patriarchal structure embedded in the Confucian belief system (Feng, Cai, & Gu, 2013). These risks and vulnerabilities borne of the unbalanced population structure since the 1970s

may jeopardize the well-being of the older persons (Feng et al., 2013).

According to Jackson and Howe (2004), based on United Nation population projection in 2003, there were eight working-age adults in China for every older person aged 60 years in 1950. Whereas, there are only approximately 4 working-age adults for each older person by the year 2020. If current demographic trends were to continue in the next 30 years, it is estimated that the number would decline to just two adults for each older person. (Jackson & Howe, 2004).

Additionally, there have also been changes in family structure and components highlighted by the decline in family size. This family transition in conjunction with living arrangement is caused by the strong influence of urbanization and globalization all over the world. With the remarkable period of rapid economic growth involving the shift in governance from a centrally planned to a market-based economy, China has become the second largest economy and is increasingly playing an important and influential role in the global economy (The World Bank, 2017). Zimmer and Kwong (2003) acknowledged that the shrinkage of family size corresponds to changes in social structure, coupled with changing income and increasing urbanization that will affect the nature of support in China (Zimmer & Kwong, 2003). China's society is influenced by Confucianism where children are expected to take care of parents in their old ages. In Confucianism, filial piety means respectful treatment of parents and older adults in the family; it also implies a

three-year mourning period after the death of an older family member (Timothy, 2013). Therefore, if the family structure changes, support for Chinese older persons becomes a challenge due to a reduced number of children compared to the past. For instance, this situation could lead to a 4-2-1 family situation, with four paternal and maternal grandparents, two older parents, and only one adult child (Quanbao & Jesús, 2011).

Health Status of Older Persons

With regard to general health status, the World Health Organization (2015) reported the 10 leading causes of death of Chinese people were stroke (23.7%), ischemic heart disease (15.3%), chronic obstructive pulmonary disease (10.3%), trachea, bronchus, lung cancers (6.1%), liver cancer (3.96%), stomach cancer (3.3%), road injury (2.8%), hypertensive heart disease (2.5%), diabetes mellitus (2.3%), lower respiratory infections (2.1%). Stroke was the leading cause of death amongst these causes, killing 2,331,300 people in 2012 (World Health Organization, 2015). Besides, for persons in group 60-69 years and 70 years and over, the reported cause of death by non-communicable diseases was more than 90% and 95% in the year 2012, respectively (Amuthavalli, 2015). Furthermore, the incidence of chronic disease is projected to increase further by 2030, as reported by Wang et al. (2011). They emphasize the stark expected increase in the number of people aged 40 and older with at least one non-communicable disease: from 79,563,965 people in 2010 (the original figure) to 136,706,478 by 2020 and 181,257,958 by 2030 (Langenbrunner, Marquez, & Wang, 2011).

Regarding gender differences, according to a report on aging and health by World Health Organization (2015) Chinese women tend to live longer than men: the average life expectancy at birth was 44.6 years for both men and women. Meanwhile, WHO estimates that by 2030, the life expectancy of women will be 79 years and for men only 76 years. Interestingly, the report also claimed that the gap in life expectation at birth between the sexes in China will widen, while the gap in high-income countries is expected to shrink (Amuthavalli, 2015). Opposed to the positive aspect of Chinese women's longevity, a study by Zeng in 2014 on the oldest-old, i.e. those who are 80 years and over, used longitudinal data for the years 1998, 2000, and 2002 and came to the conclusion that women are at a disadvantage in terms of socio-economic conditions and health status. It was also observed that women in rural areas had higher active life expectancy than those in urban areas. Another observation was that the oldest-old females who had delayed childbearing were also found to have had increased likelihood of better health status in their final years of life compared to others. Moreover, positive thinking is also a factor that determines gains toward longer lives (Zeng, 2004).

With regard to Activities of Daily Living (ADLs), research of Wang and Zheng (2009) showed that, in general, older persons who live alone or only with their spouse are more likely to have higher risk of functional impairment than older people who live with relatives or children. In addition, married older people are less likely to undergo difficulty of activities of daily life, and are at lower

risk of death than single older people. Another observation was that those with health insurance had lower risk of death than their counterparts who had the same dependency level of ADL. Type of caregivers has been observed to play a significant role on faster recovery and lower risk of death among older persons, especially when such care is received from spouses, children, kin or relatives compared to non-familial caregivers. This is explained by the values and definitions about traditional families in Confucian ideology in Chinese society, where older persons' happiness increases correspondingly to the rise in the number of descendants in the family. The main caregivers for older people are their spouses, children, and relatives. Unrelated persons are considered older persons caregivers of lower quality than older peoples' families. Therefore, when older persons are taken care of by their spouses, children and relatives, they will have better mental health and higher confidence in society. Under such conditions, their physical health recovers faster than of those who face psychological isolation due to lack of love and care from family (D. Wang, Zheng, Kurosawa, Inaba, & Kato, 2009).

Overview of Actors Involved in Care Provision

The majority of older people in China depend on family support that stems from filial piety, a cultural trait among Confucianism societies where it is assumed that children tend to their parents' needs in later life (Kwon, 1999; Wang et al., 2009). However, household structures and living

arrangements have been observed to transform along with the drastic changes in the age structure of the population whereby the number of young people has fallen sharply while the number of older adults had increased rapidly. The number of traditional family caregivers has been decreasing and consequently, the participation of government and private sectors has emerged and expanded rapidly in the form of long-term care services for older persons. In particular, the role of government is to promote and provide home and community-based aged care. However, these services are scattered and exist only at a few locations, and those that do exist are concentrated only in cities and towns, while almost none exist in the countryside. In contrast, nursing homes or institutional older adult care by the private sector are expanding rapidly in urban areas (Feng, Liu, Guan, & Mor, 2012).

Government / State

Generally, the provisions by the state in all aspects of life are continuously decreasing especially in terms of social welfare and all forms of community care. This is due to economic reforms and tightening fiscal policies. The country's economic restructuring became explicit with trade liberalization in 1979 when there was a shift from being centrally controlled to implementing free market reforms on foreign trade and investment. It allowed the entrance of private sectors in all issues and needs of life (Morrison, 2014). Simultaneously, population aging has been developing leading to challenges in the provision of care for older persons due to the reduction of public and cooperative sectors in the country.

The central government has been encountering dilemmas on stimulating locally-sourced provisions for older-person care across communities (Bartlett & Phillips, 1997).

China's government has been unable to establish and develop a specialized care system. For instance, public general hospitals are capable of specialized treatments for both infectious diseases and non-communicable diseases. Therefore, older patients then have to visit those general hospitals that lack a geriatric-care section and they are expected to follow the same processes as regular adult patients. Most of these older patients have multiple chronic diseases requiring them to visit different departments to receive various diagnoses and treatments from different physicians. This has raised medical expenditures and delayed treatment time for older patients while also increasing their risks of polypharmacy and iatrogenic diseases (Cheng, Rosenberg, Wang, Yang, & Li, 2011).

Before the 1980s, there were hospitals or clinics where older persons could access health services. For example, the Chinese government had residential care facilities (RCFs) where basic physical care was provided but lacked the social and emotional dimensions of care and the usual patients in these facilities are older persons without children, those with disabilities, as well as those with no immediate family members. However, China has experienced rapid growth in the residential care industry since the late 1990s and RCFs have expanded to cater to self-funded clients, improved mental health, emotional, and

social support services. The principal reason why older persons moved into these RCFs is that they are unable to receive care from their adult children because of their respective schedules. Many older residents report they prefer to stay in RCFs due to better living conditions. Their psychological well-being is improved as well because of access to social activities compared to when they reside at the homes of their adult children in cases where their children live far away for working or studying purposes. A prominent shortcoming remains though; there is disparity among social classes in accessing these care home services. Poorer older adults have fewer options for nursing homes compared to those from richer backgrounds or retired government official because of the high costs of selected facilities. Older persons with lower socioeconomic statuses are also able to access nursing homes if they accept to choose nursing homes that have lower hygiene, personal privacy, employee service attitudes, and weaknesses in the quality of services. We will return to this content in more detail below in the section on the role of the private sector (Zhan, Liu, Guan, & Bai, 2006).

Family

Most older persons receive financial support from adult children. They also receive care support for activities of daily living and instrumental activities of daily living from family members. However, only 8% of older persons have adequate financial resources. This observation corresponds with Chinese older persons' living arrangements from census information in 2000 where it was indicated that 64% of people aged 65 years and over live

with their children, 24% live only with their respective spouses, 10% live alone, and 2% have other arrangements (Yi & Wang, 2003). Therefore, adult children maintain a primary role in the care of older persons in the family.

Private Sector

Under the law of the People's Republic of China on Protection of the Rights and Interests of the Elderly issued in the year 1996 and revised in 2012, family members were to become the main source of care for older persons (National People's Congress of the People's Republic of China, 1996, 2012). In response to the rule of law, there are developments in investment from both international and local companies in care facilities for older people where services have varying costs and quality of care. Such services mostly revolve around older persons who are unable to receive direct care from their adult children (Feng et al., 2012; Robila, 2014). An example for this is when adult children are unable to visit their parents; they can acquire help online by hiring someone to visit their household. One such service is through *taobao.com*, one of China's major online platforms. There are more than 30 types of services connected to visitations where costs range from 10 yuan (US \$1.60) to 5,000 yuan (US \$814.30) (China Society For Human Rights Studies, 2013b). There is also an emergence of some prestige homes that have received the widespread respect and admiration of the community on the basis of the perception of their achievements or quality of older population care (Bartlett & Phillips, 1997).

Residential care facilities (RCFs) have increased in number and developed rapidly in recent years because of private sector efforts. They are an alternative choice to traditional family care among big cities and center areas in China. The typical structure of each RCF is a specific physical and social environment that has the purpose of enhancing older residents' physical and psychological well-being. Fortunately, most of the residents are satisfied and feel happier with their lives in RCFs compared to staying at home and receiving care from family members. However, there are also some who feel isolated and depressed upon relocation. Whether this is the case depends on the characteristics of each individual in terms of their personality, attitudes toward aging, the quality and type of services at older homes; support of family members is also a crucial aspect. These factors play an important role in adapting to the life in the RCFs as well as older adults' well-being (Cheng et al., 2011).

Non-government Organizations (NGOs)

In conjunction with the integrated efforts of the national government, local government units, and private companies whose focus is on the care of the older persons, international organizations have also been involved, particularly HelpAge International. It is a global network of organizations working toward the promotion of the rights of older persons to have healthy and secure lives. HelpAge International currently has projects in impoverished areas of rural Shaanxi, Sichuan, and Hunan Provinces aimed at strengthening community-based associations of older people to identify and address their needs particularly on income

security and healthcare. Other aims of the projects they conduct is reducing older people's social isolation by building community social networks as well as providing a platform between older people's associations and relevant authorities to coordinate better health services in communities (HelpAge International Organisation, 2017a, 2017b).

There are also local non-government organizations such as the Society of Geriatric Medicine, the Society of Geriatric Rehabilitation, and the End of Life Care Society, as well as academic institutions at the national level, i.e. gerontology institutes and geriatric associations. Charitable organizations in different provinces also operate including the Shanghai Sunshine Rehabilitation Center which belongs to the hospital of Tongji University, and the Leling Elderly Care Organization that is a community organization run by volunteers. The Shanghai Sunshine Rehabilitation Center plays a supplemental role for older person's health systems through the establishment of support networks and the development and implementation of specific geriatric training programs for various types of care providers including primary care practitioners and informal family caregivers. The Leling Elderly Care Organization in Beijing has cooperated with the United Nations Development Programme (UNDP) and the United Nations Volunteers (UNV) program to inaugurate the Spring Shoots Programme with the main purpose to build network community older adult care which can adapt to every Chinese local context (Chen, Yu, Song, & Chui, 2010; Shanghai Sunshine Rehabilitation Center, 2017; UNDP China, 2010)

Important Issues Related to Care Needs and Provision

Similar to other countries in the world, China is also facing several challenges as its population is aging. Two of the major short-term and long-term issues that need government intervention and policy change are urban-rural discrepancies of older persons' care, and selected aspects of feminization of aging.

Rural and Urban Older Population

Although the average urban population growth rate was 3.1% from 2010 to 2015, approximately 45% of Chinese are still residing in rural areas in 2015 (World Statistics Pocketbook, 2017). However, there are disadvantages of the older population living in rural areas compared to their counterparts in urban areas. Almost all urban older persons do not need to continue working after retirement because of their high pension levels. In contrast, traditionally, poverty has always existed in rural areas that has driven older people to remain in the labor force; this applies mostly to older men (Prince et al., 2016). Moreover, only a limited number of older persons migrate with their children to urban centers while the majority of older persons have to live alone once their children migrate to urban areas for work and leave them behind without a care network for them at old age. In addition, there are disadvantages when it comes to health care for the older population because the average annual income of agriculture workers is less than one-third of the income of urban workers; this situation might affect their ability to pay for health related expenses (Flaherty

et al., 2007; Xue & Gao, 2012). Zhang & Goza (2006) also determined that rural older adults have serious and urgent challenges due to the lack of options of family care in comparison to urban older persons, resulting from the one-child policy and the migration of children to urban areas (Zhang & Goza, 2006).

With regard to the level of support provided by adult children, a study by Guo and Colleagues (2009) evaluated the level of personal assistance, financial, and spiritual support (which is measured by a variable indicating whether at least one child is cited as a confidant) available to rural parents whose children had emigrated out of the household. The authors observed that emigrated sons tend to provide more financial and mental support than emigrant daughters (Guo, Chi, & Silverstein, 2009). In contrast to the previous study on the support of emigrant children, Lei (2013) used data from the Chinese General Social Survey in 2006 to analyze the urban-rural differences in intergenerational support from non-migrant children. The author found that daughters were likely to provide more financial and parental care than sons in urban households. Such difference was not observed in rural areas (Lei, 2013).

Besides, looking beyond the future prospects of the older population in China, OECD Local Economic and Employment Development (2013) has stated that the system of public services for older persons in China is still underdeveloped because urban planning, urban development, or infrastructure construction take older persons not or only to a limited degree into account. Regarding

rural areas, in particular, there is almost no service for the older persons. Therefore, older persons face greater challenges in their daily lives (OECD Local Economic and Employment Development, 2013).

Feminization of Aging and Its Challenges

According to the World Health Organization (2002), there is feminization of older populations when female life expectancy is higher than male's (World Health Organization, 2002). This may be considered an issue with Confucian societies where women's societal value is undermined compared with males who are esteemed within the family and in the community (Timothy, 2013). In China, the percentage of female older persons was higher than of males in 2016; 8.3% and 7.9%, respectively (National Bureau of Statistics of China, 2016). There is a variety of risks among the older female population because of the patriarchal structure embedded in Confucianism norms. Women would have lower levels of education, employment, and wage; this encompasses households where women are expected to follow decisions of the husband and male relatives (Rosenlee, 2006). There is also difficulty in being remarried upon the death of a spouse that is caused by the ethical standards that are set for women in Confucian society. Similarly, there is low percentage of remarried women after their dissolution of marriage.

Another expectation as dictated by social customs is that females are to assume the responsibility of taking care of family members ranging from the oldest to youngest generations. Therefore,

once females reach older ages, the risk of experiencing financial insecurity is increased because of the probable lack of pension allowance. Regardless if they would want to continue being part of the workforce, it becomes difficult to find employment because their qualifications are lacking or relatively lower than those of males. Aside from financial insecurity, psychological and emotional issues such as depression might be experienced by older females in China because they tend to live alone (Singh & Misra, 2009).

Laws and Regulations on Care Provision

China's basic pension scheme is limited to those working for governments and large companies. 25% of the nation's labor force is covered by this pension plan. And within that proportion of the workforce, 45% are in the urban areas and are mainly employees as compared with those who work in the dominant non-public sectors such as agriculture in rural areas (Jackson & Howe, 2004). This particular disparity between rural and urban populations in China affects the differences between healthcare support and patient's expenditure. China has deployed two different healthcare schemes to provide preventive and curative services in rural and urban areas. Central, provincial, and local governments provide funds for hospitals at varying levels. Regarding urban areas, the cost of health care is included in public-health and government-health types of insurance if the household head is working for public agencies and state factories; or labor-health insurance if they work for non-state companies.

The patient would still have to pay a registration fee during every visit to the hospital, whereas in rural areas, the cost of health care is included in the cooperative-type healthcare program with the resource support coming from many sectors: the local government, farmers and communes, as well as collective management units (Robila, 2014).

As mentioned above, in 2012, China amended the Law on Protection of the Rights and Interests of the Elderly 1996. Accordingly, Article 18 stipulated that *"family members shall care for the mental needs of the elderly, and shall not ignore or cold-shoulder the elderly. Family members living apart from the elderly shall frequently visit or greet the elderly. Employers shall, in accordance with the relevant provisions of the state, ensure the rights of the supporters to have the family visit leave"* (National People's Congress of the People's Republic of China, 2012). Based on this law, there is a slogan for communities: *Care for senior citizens: Visiting parents*. Adult children should visit or keep in touch with older family members on a regular basis, whether through writing emails or making calls (China Society For Human Rights Studies, 2013a). The key component of this law is that family members shall not have permission to ask older persons to do any work in order to receive care. Also, older parents can approach the adult child's employer or even the judicial court if they, the children, are unable to fulfill this role stipulated in the law. This results in a continuous deduction of their salary toward the fund for older person's care (National People's Congress of the People's Republic of China, 1996,

2012). However, this law encounters an issue for society whereby the child who is a sole offspring would have to bear a large financial burden when they must provide care and support for all older family members which is intensified when the said child is married and would have to tend to his and the spouse's family members (Robila, 2014).

Specific thrusts were being conducted in conjunction with developing the law. In 2009, the National Development and Reformation Department and Civil Affairs Department proposed a model of *Family providing primary care; community serving as a back-up, and institutional care being only a supplement* with the guiding principle of older person care services development. The Chinese government also announced in 2013 its intention to develop and improve the care services for older population in the country by the year 2020. This is to be achieved by seeking to build a new older person care service system based on in-home care activities and community service provision. The government also encourages researchers and scholars to have the initiative on developing a long-term care system for older adults. An allocated financial grant, together with tax breaks, is accessible to academics who will contribute to policy making (Hui, 2016).

Policy Recommendation

As a country undergoing rapid developments with regard to the structure of its population as well as its economy, it has to be acknowledged that China is not the first country to experience population aging. This context allows their society

to gain lessons from other countries through collaborations from researchers and scholars. If the government further develops policy measures for older persons, the society may benefit from actualizing active aging. To express the process for achieving this vision, WHO has adopted the term *active aging* with its concept and rationale is "Active aging is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (WHO, 2002, p.12).

With regard to home care or nursing homes, the financial support should be increased for childless older people to enhance their access to such facilities because the current components of the market economy where increased quality equates with much higher costs (Zhan et al., 2006). Aside from encouraging and facilitating the development of the nursing home industry, the government must improve its role in the management of service quality and the regulation of costs of these facilities because older persons are considered a vulnerable group. They might be subjected to various forms of violence and exploitation especially among those with declining mental health. Furthermore, new and innovative older care services should also be promoted including adult daycare centers, meal delivery, and home care.

Working toward the improvement of the quality of life of older persons in China, the government should build smart cities for improved accessibility particularly for those with disabilities, i.e. providing barrier-free convenience in buildings. This has to

be encouraged among local governments for them to build such amenities in public areas as well as at private homes to allow older persons to live independently.

China needs to be proactive and timely in the development of policies to adapt to the challenges, constraints, and limitations inherent in aged care, as well as to fill the gaps of social welfare for the older population, while at the same time maintaining the goal of sustainable economic growth specially when the labor force participation and structure relating to the dependency ratio is decreasing sharply (Hui, 2016). Based on the longevity dividend theory, the synthesis of gains from many social aspects such as economic, health, and societal benefits through slowing of the population aging process thus eliminates the expensive costs of health care (Olshansky, Perry, Miller, & Butler, 2007; Olshansky, Beard, & Börsch-Supan, 2012). Therefore, it is recommended that policymakers invest toward the health condition of all persons by: (i) conveying health messages on various media directed at young people in the society; (ii) designing community health promotion programs, such as *friendly parks* that are equipped with adequate equipment accessible to all, as well as sports programs online which can be guides on personal fitness to be done at homes, offices, and outdoors; (iii) attracting scientists and researchers in the field of biomedical research to develop drugs to fight premature aging and improve physiological health for all ages; and lastly, (iv) building a healthy spiritual life for the older persons in rural areas where there is limited entertainment and recreation services.

Finally, the government should encourage older persons to develop a positive perspective about aging by prolonging their working age. Since the 1950s, the official retirement age for males has been 60 years in any sector; 55 years for females in white-collar employment, and 50 years for females in blue-collar work (Giles, Wang, & Cai, 2011). This will result in older persons earning income and continuing to contribute to the household economy rather than becoming dependent on their children and other young members of the family. Lee and Xiao (1998) reported that according to the social development of the modern society, there is a rapidly increasing emotional gap among family members from the stresses of their individual lives especially from financial concerns. Children with higher socioeconomic status tend to continue having close relations with their parents unlike those with poorer backgrounds (Lee & Xiao, 1998). This leads to emotional deficiency and poorer mental health among the older persons with lower socioeconomic status.

Prospective Themes on Aging Research

There are many projects and surveys that explore aging issues in China. However, most of these surveys were conducted during the 1990s. The information may be dated, such as the People's Republic of China National Survey of the Elderly, 1991; the China Survey on Support Systems for the Elderly, 1992; the Shanghai Survey of the Elderly in the Process of Aging, 1996; and the China Research Center on Aging Data Compilation

of the Survey on China's Support for the Elderly, 1994.

Longitudinal data that are accessible are more recent. An example is the Chinese Longitudinal Healthy Longevity Survey (CLHLS), 1998-2012, which provides information on health status and quality of life of older persons aged 65 years and older in 22 provinces of China. The study was conducted to determine the factors of healthy human longevity and oldest-old mortality. It specifies representation of the oldest population namely nonagenarians and centenarians. Demographic and background variables in the survey include: sex, ethnicity, place of birth, marital and childbirth history, living arrangement, education background, main occupation before age 60, and sources of financial support (Institute for Social Research (ICPSR)-University of Michigan, 2015).

The government, the community, children, families, private companies, and national and international non-governmental organizations in charge of older population care need to perform more studies addressing various themes to better understand the needs of older persons in terms of care in China such as (1) evaluate the impacts

of social media and entertainment services on well-being and life satisfaction among older persons in order to improve and apply new service systems which can optimize and enhance quality of mental health and overall life satisfaction of older Chinese; (2) Conduct a large-scale public opinion survey of both the older persons and young people in assessing the appropriateness of the retirement age regulation that has been promulgated by the government for nearly 70 years to build a reasonable retirement age in order to meet the labor supply of older persons and the labor market demand from urban and rural areas; (3) Explore the differences in responsibilities and attitudes toward older adults care among stakeholders, such as the central government, local governments, private companies, and international and domestic NGOs, as well as differences in accountability, morale of the community and society as children, relatives, neighbors, and older people among themselves. From that, develop projects and programs that fit the needs and orientations of each target to optimize solidarity and achieve the most comprehensive and highest benefits for the older population in moving the aging society forward in the future.



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Indonesia

Mujiyadi Benedictus

Overview of Population Aging in Indonesia

The number of older persons in Indonesia, i.e. those who are aged 60 years and over, is sizable. This is in relation with improvement of food consumption and also the enhancement of healthcare awareness. According to the Social Welfare Data and Information Centre of the Ministry of Social Affairs, the total number of older persons in 2016 is estimated to be almost 26 million (Pusdatin Kesos, 2015).

Data from the Statistic National Board of Indonesia show that the total older population in Indonesia is 25.48 million comprising 8.03 % of the total Indonesian population (Badan Pusat Statistik (BPS), 2017). It is estimated that the total number of older persons will be 36 million by the year 2025. Furthermore, the United Nations stated in 2013 that based on the number of older persons in Indonesia, it ranks number 108 of all countries in the world. It is then estimated that by the year 2050, the Indonesian older population could become the 10th largest in the world.

Table 1: Development of Number and Share of Older Persons in Indonesia, 1971 to 2020

No	Year	Population	%
1	1971	5,306,874	4.5
2	1980	7,998,543	5.5
3	1990	11,277,577	6.3
4	1995	12,778,212	6.6
5	2000	15,262,199	7.3

Table 1: (continued)

No	Year	Population	%
6	2005	17,767,709	8.0
7	2010	19,936,895	8.5
8	2015	23,992,553	9.8
9	2020	28,822,879	11.3 (predicted)

Source: BPS (2017).

Based on the 2014 National Census which is locally known as *Susenas 2014*, there are 16.08 million households with at least one member who is 60 years and older representing 24.50% of all households in Indonesia. The number of female older persons is larger than the number of males with 10.77 million older women compared to 9.47 million older men in 2014. The number of older persons living in rural areas are as many as 10.87 million, which is more than the number of older persons living in urban areas at about 9.37 million. The value of the older-person dependency ratio of 12.71 indicates that every 100 people of productive age must support about 13 older persons. The older-person dependency ratio in rural areas is higher than in urban areas, at 14.09 and 11.40, respectively. Comparing sexes, more older women need to be supported by the population of working ages. The dependence ratio of older women, 13.59, is higher than that of older

men which is 11.83. Most older persons live together with their extended family. 42.32% of older persons live with three generations in a single household, living with their children or children and grandchildren; or with their children or parents and parents-in-law. A total of 26.80% of older persons are living with their nuclear family, while those living only with their partner represent 17.48%. Those who deserve attention are those who live alone or a single older-person household. As many as 9.66% of older persons live alone and must meet their food, health and, social needs independently.

Data shows that life expectancy in Indonesia varies across provinces by over 10 years. It is lowest in West Nusa Tenggara with 63.25 years and highest in Yogyakarta with 74.56 years (Table 2).

Table 2: Life Expectancy Across Provinces in Indonesia, 2016

No	Province	LE	No	Province	LE
1	Jogyakarta	74.6	18	West Java	68.6
2	DKI Jakarta	74.4	19	South Celebes	68.6
3	Bali	73.3	20	West Celebes	68.6
4	North Sulawesi	72.6	21	Bengkulu	68.3
5	Riau Islands	71.6	22	Nagroe Aceh Darussalam	68.2
6	East Kalimantan	70.8	23	South East Celebes	67.9
7	Central Java	70.8	24	Banten	67.8
8	Central Kalimantan	70.7	25	Papua	67.5
9	Riau	70.7	26	Maluku	67.5
10	North Sumatera	70.3	27	West Papua	67.4
11	South Sumatera	69.7	28	East Nusa Tenggara	67.3
12	Bangka Belitung Islands	69.7	29	Gorontalo	67.2
13	East Java	69.3	30	South Kalimantan	66.7
14	Lampung	69.3	31	Central Celebes	66.5
15	Jambi	69.1	32	North Mollucas	66.4
16	West Kalimantan	68.9	33	West Nusa Tenggara	63.3
17	West Sumatera	68.8	34	North Kalimantan	Na

Source: BPS (2017).

Issues Related to Older Persons

The total population of older persons in Indonesia was 18.1 million in 2010 and increased to 18.78 million in 2015 (Ministry of Social Affairs Data and Information Centre, 2015). Among the total older population, there are 2,848,854 who are categorized as neglected older persons. Neglected persons are those who attain inadequate basic needs fulfillment, including biological, psychological, social, and spiritual needs. These older persons live in inadequate dwelling, consume insufficient food, and possess scant clothing. They may also stay with families and receive little care from their children or even other relatives. Moreover, they have less support in terms of spiritual needs.

It is common understanding that every human being has several needs namely: (1) physiological needs such as food, clothing, housing, and health and psychic; (2) need for a sense of security and tranquility, both inward and outward, such as the need for freedom and independence among others; (3) social needs or the need to communicate with others; (4) need for self-esteem or recognition; and (5) self-actualization needs which are the needs for physical, spiritual, and intellectual abilities based on one's own experience with the eagerness to live and have a purposeful life. These needs exist from the beginning of life. For older persons, they should be in a stable state but the level of fulfillment of such needs depends on each individual and their respective family. These needs, if unmet, will result in problems relating to a decrease in the level of independence of older persons. However, due to some limitations, it remains that neglected older

persons have not had enough support to fulfill their basic needs in their daily life.

Models of Services for Older Persons

Protection for Potential and Non-potential Older Persons

In general, there is no significant difference between the services provided to potential and non-potential older persons, except for the kind of services. Potential older persons are those who are given opportunity to receive education, training, and job opportunity. They can remain productive economically and socially. Non-potential older persons are the ones who are helpless. They obtain social protection and health services, as well as access to various public facilities.

Models of Service for the Potential Older Persons

The number of potential older persons continues to increase over time along with improvements of the health of older persons. Such potential older persons are differentiated into older persons with sufficient education (minimal secondary-school attainment) and older persons with low education and even no education. Some developed countries consider older persons as labor resource for jobs with service functions that require no great physical involvement, thoroughness, and long-distance travel. For example, being social workers and volunteers who provide service to the community. Toward the services for the potential older persons, there are six parties directly involved in this model of government: non-government organizations, communities and

community organizations, the family, the private sector, the college, and social workers. When this model was initiated, older persons gained access to services that provide support in training and mentoring, economic development, tools and funding assistance, health services, and integrated services for older persons with what is called a *posyandu* who acts as medium to interact with fellow older persons with potential.

Model of Service for the Non-potential Older Persons in Shelters

Beyond institutions owned and managed by the government, in the community, there are some shelters which are managed by the private sector. Reasons why older persons are living in the shelters are for example that there is no family who could support them, or that the family wants the older person to live in the shelter, or the older person him- or herself wants to do so. In the first instance, the state is directly responsible for providing a government-administered assistance for the survival of the shelters. In addition, there are also private nursing homes that also require the participation of all stakeholders. There are at least four types of assistance that should be provided to the shelter: protection assistance, infrastructure support, cost assistance, and health care assistance. The problem that has emerged and continues to grow is that the funds provided by the government for these non-potential older persons services continue to decline while the number of older persons who need to be served and their needs is increasing. Therefore, the role of other stakeholders, especially the community through the role of groups, should be improved.

Model of Service for the Non-potential Older Persons that are Home-based

Those older persons who live with their family have greater opportunity to interact with their environment. In this model, the role of family and government is very central both at the micro- and macro-level. At the micro level, the role of family and community are social protection, protection of facilities and infrastructure, and the protection of living and health costs through home care and community care. At the macro level, the roles of the government are especially to guarantee coverage of costs, to secure public facilities, infrastructure and legal aid, and to ensure health insurance. It is also within the government's roles to encompass social services, health offices, district health services that are called *puskesmas*, and health personnel. These roles include services for special older-person out-patients (geriatric clinics) and special older person in-patients (Older persons wards).

Overview of Actors Involved in Care Provision

Government

1. *Ministry of National Development Planning (MNDP)*

The MNDP has to coordinate the master design preparation among several agencies and also to monitor all programs operated.

2. *Ministry of Social Affairs (MSA)*

The MSA has the responsibility in tending to of social services, both in institutional and non-institutional forms. There is a Directorate level that has the role of setting the program,

budgeting, and monitoring all activities related with services for older persons.

3. *Ministry of Health (MOH)*

The MOH has the obligation to establish programs and to monitor all health services for older persons from the national to district level.

4. *Ministry of Education and Culture (MEC)*

This MEC is obligated to set up a policies and programs that provide services toward realizing older persons' potentials according to their skills and abilities.

5. *Ministry of Religion Affairs (MRA)*

The MRA is tasked to have policies and programs that provide services for older persons concerning spiritual activities.

6. *Ministry of Communication and Information (MCI)*

The MCI has to publish all information related to services for older persons.

7. *Ministry of Home Affairs (MHA)*

This MHA attends to administrative business. This includes its responsibility to coordinate all civil administrative business on provincial and municipal levels.

8. *Central Board of Statistic*

This institution has to support all data being used for activities; from planning to implementation in central and local areas.

9. *Provincial agency*

10. *District agency*

Social Organization

1. *National level*

There is a committee called *Dewan Nasional Indonesia untuk Kesejahteraan Sosial* or the

National Committee for Indonesian Social Welfare that was established as the coordinating body of various social organizations at the national level.

2. *Provincial level*

There is a board called *Badan Koordinasi Kegiatan Kesejahteraan Sosial*, the Provincial Coordinator for Social Welfare Activities, that was established as coordinator of various social organizations in provincial level.

3. *District level*

This office is the *Koordinasi Kegiatan Kesejahteraan Sosial* or the Office for Social Welfare Activities whose role is to coordinate of varies social organization in district level.

National Committee for Older Persons

Monitoring Programs and Activities

The National Committee for Older Persons is an independent board established by the President based on the Act number 13 in 1998. The Committee has the task to monitor all programs and activities that are held by the government itself as well as social organizations. Recently, the Committee has been composed of nine members: representatives from universities, former minister, senior staff members of social organization, and senior government official.

Bridging Among All Parties

All parties who have been active in offering services for older persons should work in conjunction and provide their best services for the older population. However, in some cases, these parties have been facing problems. Some parties have certain reasons to support only their own cause. In such cases,

there is conflict of interest which is why it is seen important to have a board to coordinate and monitor those parties to optimally provide for all older persons. All parties should participate and contribute to serve the older population based on the guidelines set by the government.

Tasks of Parties Involved

In the framework of improving social welfare for the elderly, the central government that is represented by the Ministry of Social Affairs through the Directorate of Services and Social Rehabilitation of Elderly has several activities, including:

1. The elderly service program regarding shelters providing various services such as day care services, and cross subsidy services. There are 237 shelters whereby three (located in Bekasi, Makassar, Kendari) shelters belong to the Ministry of Social Affairs, 70 to the provincial government, and 165 to private parties or the community.
2. Service programs beyond shelters that cover home care services (6 units), foster care, day care services (6 units), and economic productive support (assistance and guidance).
3. Institutional programs such as networking among national and international agencies; inter-sectoral coordination, organizing the National Elderly Day (HLUN) and International Lifelong Day (HLUIN); and coaching and institutional empowerment of older persons.
4. Protection and accessibility, including the Social Security for Older Persons and those whom being neglected from 2006 to 2009, Trauma Center (5 units), social accessibility,

emergency services, and interagency management networks.

These activities are implemented to achieve:

- (1) family and community support for older persons' lives,
- (2) protection and social security systems that improve the lives of the older population,
- (3) job opportunities and activities to actualize themselves within the family and community;
- (4) a social climate that encourages older persons to engage in religious and spiritual social activities; and
- (5) the accessibility of older persons to public facilities and services. The national programs are subsequently delivered into local programs.

Concomitant with the central government, the provincial governments have the task to create further regulation and services that follow the central policy. At this level, services for older persons also can be divided into institutional and non-institutional types consisting of home care and community care. At the institutional level, the role of the local government is very important, especially in forming regulations and other policies that support the improvement of the welfare of older persons. One of the provinces that is very responsive to the welfare of older persons is East Java which has made Regional Regulation No. 5 of 2007 on Older Persons' Welfare. This regulation was then transmitted to various districts and cities in East Java. In addition, budget support is done

with several activities. First, conducting home care test that is the service of older persons in their own family. Second, having older persons' social security in the form of cash assistance for unproductive and neglected older persons. Third, older-persons assistance. Fourth, transmuting laws to local regulations. Fifth, establishing Community Health Centers that provide convenience for older patients. Lastly, providing public facilities such as special stairs that facilitate the mobility of older persons who require assistive devices; handles on each side or corner of the wall, and special sidewalks, to name a few. This kind of regional government support provides novelty for the handling of older persons especially those who are abandoned.

The handling of older persons by the government includes several important activities: (1) provision of data of older persons including the number of older persons and whether the older persons' condition is still potential or not up to the potential that can be developed; (2) preparation of a work program to improve the welfare of older persons who integrate various related agencies so that the handling is not partial and overlapping or even not handled at all; (3) construction of special facilities in public places, including queuing arrangements for older persons; (4) provision of financial support for the welfare improvement program for older persons; (5) preparation of laws and regulations in regions that support the central government's efforts to improve the welfare of older persons; (6) transmittance of legislation that has been drafted so that all regional stakeholders can participate in its implementation in the field;

and (7) provision of support to community for both institutionalized and non-institutionalized types through direct roles in the community environment.

Acts and Regulations

The Act of Republic of Indonesia number 13/1998 concerning older persons welfare services

The Act of Republic of Indonesia number 23/1992 concerning health services

The Act of Republic of Indonesia number 39/ 1999 concerning human rights

The Act of Republic of Indonesia number 11/ 2009 concerning social welfare services

The Act of Republic of Indonesia number 23/ 2014 concerning local government

Agreement between the Ministry of Home Affairs and Ministry of Social Affairs number 78/1993 and number 39/HUK/1993 concerning non-government organizations

The Ministry of Social Affairs Regulation number 67/HUK/2006 concerning older persons home care

The Ministry of Social Affairs Regulation number 86/HUK/2010 concerning the organization and management in Ministry of Social Affairs

Services for Older Persons

Shelter of Elderly (called PSTW)

The duties and functions of the PSTW comprise the provision of services and rehabilitation to older persons who need these services in order to solve social problems as well as to obtain a better level

of living. PSTW explicitly mentions that these institutions refer to the duties and functions as mandated by Minister of Social Decree number 106/ HUK/ 2009. In operation, the institutions can develop a service model which should not contradict the applicable law.

Regularly, the shelters provide a variety of services: physical needs services (dormitory, food, and clothes among others); religious services (spiritual guidance); social services (individual and social group work); work skill services (both as a hobby and economically oriented); psycho-social services; health services; recreation activities; and also funerals services.

Day Care Services

In terms of care services during daytime, the clients do not reside in shelters. Beneficiaries continue to reside in their own family homes but they can stay in shelters during the day. They are coming in the morning and go back home in the evening. This kind of service is similar to the shelter system, except for aspects of dwelling: social services; psychological services; religious services; physical and health care; safe rest place; re-creative services and hobby activities; referral services, information, and transport services.

Community-based Services

In terms of home care services, the main services have come from the families where older persons reside which may include their children and relatives. However, the government supports families through supplemental food, health services, and social guidance.

Conditional Cash Transfer (CCT)

Older persons who become the recipients of CCT assistance are those aged 70 years and above. Older persons have healthcare and daily needs, which can add to the family's needs. CCT for older persons has aimed to ease the burden of the family economy. Supporting the family with whom the older persons reside has impacts on the older persons themselves.

Trauma Centre

This is a service for any older person that has experienced a traumatic event, both physical and psychological. Every shelter provides trauma intervention that aims to provide the best service for those who need this support.

Nursing Care

Elderly nursing care is a service in institutional types of facilities conducted through day-to-day activities by professionals (social workers, nurses, doctors, or psychologists) with several functions including rehabilitation and protection as well as care.

The goals of nursing care include:

- 1) Identifying basic health problems of older persons including mental health
- 2) Knowing the degree of independence or disability of older persons
- 3) Providing relief for older persons that may be in the form of mobility, basic care for those who are bed-ridden, as well as feeding
- 4) Understanding older persons' conditions in terms of psycho-social dimension and health

- 5) Accompanying older persons with mental disorders including depression and dementia
- 6) Providing complementary therapies both individually and in groups. This includes therapies such as aroma therapy, massage, acupressure, cognitive therapy, music therapy, hypnotherapy. Therapies are suggested based on the condition and according to the abilities of older persons
- 7) Training older persons in the use of tools and devices
- 8) Referring older persons to related service institutions as needed in terms of health, legal, and social facilities
- 9) Providing welfare to companions

Nursing care services are conducted through institutional base (in the orphanage) and are implemented in the form of:

1) *Accompaniment*

Nursing care assistance is delivered when the older person is in a state of illness, has impaired movement, is bed-ridden, and has barriers in accessing resources needed

2) *Social care*

Social care is a form of social service that requires care for a longer duration. The forms of social care for older persons are those that may revolve around activities of daily living (ADLs)

3) *Basic older persons' needs fulfillment*

This includes caring for older persons who are sick, have disabilities, and are bed ridden

4) *Consultation and counseling*

5) *Telephone service*

6) *Information services*

7) *Service for older persons who are near death*

8) *Funeral services*

Family Support

The government has prepared Prosperous Family Cards for the older population. Currently there are 150,000 older persons over 70 years who are less able. They receive social assistance amounting to IDR 2,000,000 per year.

This program is implemented with the consideration that there is a value-oriented system that should keep parents within their families. If older persons are admitted to the PSTW, there is an impression that the family is disrespecting their parents. On the other hand, the number of homes and their capacities remain inadequate.

Recommendations

The existing program and activities, both of which are being conducted by the government and community, do not match with the growing number of older persons. There should be activities that can act as complementary programs to reach a larger number of beneficiaries especially those residing in rural and remote areas that may have limited access to such services.

Services to older persons should be managed by involving many parties, both public and private. The government needs to encourage the private sector to allocate some of its Corporate Social

Responsibility Funds for improving the welfare of older persons by: (a) becoming a permanent donor in nutritional services for non-potential older persons especially those who are abandoned, vulnerable, and in institutions; (b) providing assistance in the form of capital and training to potential older persons to initiate or develop their business; and (c) providing health services on a regular basis through the *Posyandu*.

There needs to be a review of Law Number 13/1998 concerning Older persons Welfare with the aim of the revision to consider the present

condition. It is necessary to encourage the provinces, districts and municipalities to develop regulations on the improvement of older persons' welfare. Increasing the welfare of older persons should be pursued by involving all stakeholders. The budget for services, protection, and empowerment of older persons needs to be improved because eventually, every human being will become an older person.

Models of protection and social services for older persons need to be implemented in order to be useful for improving their welfare in the future.

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Japan

Hai Yen Thi Nguyen

| Executive Summary

One of the most common questions in providing care for older persons is “Who will look after Japan’s older person?” The synergy between families, communities, government, NGOs, and the market is probably the most appropriate answer to the above question. In the current situation of Japan, it is usually the daughter or daughter-in-law. This becomes a challenge because they may have a need to develop themselves professionally if they desire it especially when the working situation in Japan is considered whereby even more than 10 hours a day may be required. If they have to bear the responsibility of taking care of older adults, they will lack the time for other social relationships and for their own well-being. One solution is to hire a professional caregiver or use a nursing home; the costs of these options have been addressed in order to limit the prospective financial burden on individuals as well as on society overall. There is a probable issue with the inability to have enough people working in the care sector, particularly attending to the older persons. The current policy system for older

persons in Japan has not changed much since 2007. And while there are aspects that can be improved, it can clearly be stated that the organization of care for older persons in Japan - with regard to access, cost, and equity - provides a lot of insights for other countries to learn from (Ikegami & Campbell, 2004).

| Introduction

Japan is known for being among the countries with the largest populations in the world with 126.93 million in 2016 (Statistics Bureau, Ministry of Internal Affairs and Communications, 2017). The country is also among the leading countries in the world in terms of both onset and rapidity of aging. In the 1980s, 9.1% of its population was aged 65 years and over and this proportion increased to 27.3% by 2016 (Statistics Bureau, Ministry of Internal Affairs and Communications, 2017). Japan is currently considered to be a “*super-aging society*” (Muramatsu & Akiyama, 2011). With the number of older persons rising steadily and total fertility at a persistently low level, Japan faces a severe aging challenge that affects many societal areas. The focus on this

chapter is centered on older-person care whereby it is being addressed through the contribution of individual families and the local and national welfare systems.

Overview of Population Aging and Care Needs

In this section, information about the current situation of older persons in Japan is provided as well as the overall situation of care needs in Japan.

Population Aging and Its Persistence in Population Projections

According to the Annual Health, Labor, and Welfare Report in 2016, the momentum of aging in the country had been remarkable. In the period from 1970 to 1994, the age structure of the population of Japan transformed whereby the share of the population 65 years and over increased from 7% to 14%. In perspective, France developed to such levels in a span of 115 years (from 1864 to 1979) and 72 years (from 1942 to 2014) for the United States of America. The proportion of older persons continued to increase from 17.4% in 2000 to 27.3% in 2016. Further on, population projections for 2050 indicate that older people will compose 37.7% of the total population. This prompted even the government to adopt the term “super-aging society” (Cook & Halsall, 2012; Ibe, 2000; Statistics Bureau, Ministry of Internal Affairs and Communications, 2017).

Aging progression varies between urban and rural areas, and even between cities in Japan. The

population in urban areas is aging faster than in the countryside. In large cities, the rate of aging is faster still than in smaller cities. According to a report by the Ministry of Health, Labour and Welfare in 2016, it is predicted that the number of older persons will decrease in cities with populations of less than 50,000 persons and increase in larger cities in 2020 (Ministry of Health, Labour and Welfare, 2016).

Living Arrangement

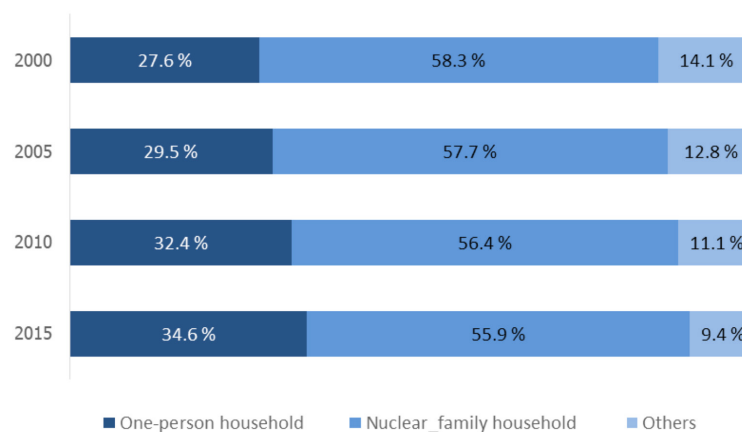
Older persons in Japan desire to have an intergenerational living arrangement and this attitude has been persisting for a long period (Brown, Liang, Krause, Akiyama, Sugisawa, & Fukaya, 2002). However, more and more often it has been unrealized under the change of industrial society and lifestyle where the majority of the younger population leave their parental homes mainly because of employment. As a consequence, the number of older persons living alone has been increasing (Katsuhiko, 2016; Saluter, 1994). Living arrangements of older persons have changed significantly between 1960 and 2005. In the 1960s, about 90% of older persons lived with their children. With the advent of economic and social change, this share started to decline, representing only 50% in 2005 and it is forecast to decrease further. At the same time, in the period between 1960 to 2005, the proportion of older persons living with their spouses increased from 5% to 32% and living alone from 4% to approximately 15% (Hotta, 2007).

The factors that contribute to the reduction of the proportion of older people living with their children

are economic and social in nature. Economic factors include economic structure change, increase in participation of women in the labor force, and the financial independence of older persons. Social factors on the other hand involve changing social norms and developing a care system for older persons from both the private and public sectors (Raymo & Kaneda, 2003). Socioeconomic and health conditions affect living arrangement of the older population in Japan. The results of a study for the period from 1987 to 1996 with a sample of 2,200 Japanese older persons aged 60 years and above showed that older persons with chronic diseases were more likely to live with a married child or spouse, whereas if self-rated health is categorized as poor, older persons are more likely to live with single children (Brown et al., 2002).

The number of older persons living alone has been increasing annually, reaching 6.24 million people in 2015, 58.0% of whom reported difficulties earning a living (Ministry of Health, Labour and Welfare, 2016). The trend of older Japanese living alone will continue, given that social isolation phenomenon, called hikikomori in Japanese, is increasing in prevalence. This phenomenon is characterized by older people living alone without contact with children and friends (Steptoe, Shankar, Demakakos, & Wardle, 2013; Teo, 2009, 2013). When looking at all households, not just those of older persons, one sees a decline in the share of nuclear-family households over time. Meanwhile, the share of one-person households has been increasing from 27.6% in 2000 to 34.6% in 2015 (Figure 1).

Figure 1: Household Structure (All Ages) in Japan from 2000 to 2015



Source: Statistics Bureau, Ministry of Internal Affairs and Communications (2017).

Research by Toyota (2006) showed that living overseas in older ages is increasingly popular. The total number of Japanese living abroad has been increasing over time, from 289,990 persons in 1970 to 1,143,357 in 2010; yet, there is lack of an accurate number of Japanese retirees living overseas (Thang, Sone, & Toyota, 2012). This

group is also referred to as 'long-stay' retirees. Those single and married older Japanese who choose to live the rest of their lives in other countries, such as Thailand, often have an upper-middle social background. The expensive cost of medical care and nursing care in Japan is one of the reasons why older persons spend retirement

abroad (Toyota, 2006). This situation will be portrayed in more detail later in this chapter.

The Health Status of Older Persons

Japan has the highest life expectancy (LE) in the world with 86.8 years for females and 80.5 years for males in 2017 (World Health Organization, 2017). In 2016, there were about 65,692 centenarians, i.e. persons over 100 years of age (Yamanaka, Ueda, & Matsuda, 2017). This development is the result of the improvement of social systems related to health, nutrition, and education (Goodman, 2006). Previous studies have shown that Japan not only has a high life expectancy but also high healthy life expectancy (HLE) (Mathers, Sadana, Salomon, Murray, & Lopez, 2001; Salomon, Wang, Freeman, Vos, Flaxman, Lopez, & Murray, 2012; Yong & Saito, 2009). In 2010, HLE for men worldwide were 59 years and for women were 63.2 years, compared to HLE of Japanese males and females of 70.6 and 75.5 years, respectively (Salomon et al., 2012).

In a comparative study of health between Korea and Japan, it was found that only 6% of Japanese older persons had been hospitalized during the past six months while the rate of hospitalization was 10% in Korea (Lee & Shinkai, 2003). Regarding mental and physical health, older adults in Japan are healthier than older persons in developed countries such as USA and France in 2012 (Sano & Yasumoto, 2014). Studies have shown that the rate of communicable diseases among older Japanese is lower than the non-communicable diseases. The most common non-

communicable diseases of older Japanese are ischemic heart disease, osteoporosis, hypertension, depression, dementia, cancer, diabetes and obesity (Ishii, Ogawa, & Akishita, 2015).

Within the Japanese society, the prevailing factor that affects older persons' health is socioeconomic status (Kagamimori, Gaina, & Nasermoaddeli, 2009; Muramatsu & Akiyama, 2011). Gender is also a source of disparity. Depression is more likely to be reported among females than males (Okamoto & Tanaka, 2004). Yet, in general, the perception of health of females is better than of males. When analyzing factors associated with women's health, it was found that women who are older, single, lower educated, unemployed, and reside in rural areas have lower self-rated health perception and physical functioning (Lee & Shinkai, 2003). Gender differences also exist in the need for old-age care. Japanese males tend to depend on their wives while older women often depend on the care of their children. This is related to women having higher life expectancy than men, therefore they are more likely to become widowed and to need their children for support and care (Ogawa & Retherford, 1993).

The value system and beliefs in Japanese culture have also influenced the perception of health of older persons. One fundamental concept that relates to health and happiness is "ikigai" which encompasses the joy and goal in life and having a life worth living (Tanno, Sakata, Ohsawa, Onoda, Itai, Yaegashi, & Tamakoshi, 2009). The effects of ikigai on Japanese older males and females have been shown to help reduce the risk

of cardiovascular mortality as well as mental and behavioral conditions including anxiety and depression (Tanno et al., 2009).

Current Care Needs

For older persons in the country, current care needs focus on Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Under Japanese law, if older adults need support, they must secure a document granted by the Care Needs Certification Board. Care-needs certification is divided into seven levels which depend on the level of assistance the person may need. For example, Support Level 1 or 2 is provided to persons who require support for ADLs (Asahara, Momose, & Murashima, 2003; Ozawa & Nakayama, 2005; Tsutsui & Muramatsu, 2007). In addition to addressing the physical health status, the mental health of older people is also monitored using indicators that measure social isolation of the older Japanese. These monitoring instruments are The Life Satisfaction Index A (LSI-A), Geriatric Depression Scale (GDS), and the Ando-Osada-Kodama (AOK) Loneliness and Social Support Scale (Saito, Kai, & Takizawa, 2012).

Overview of Actors Involved in Care Provision

Care is a process between the provider and the recipient of care. In this study, the term ‘care’ involves care for older persons to address their medical, financial, and emotional needs among others. Within the framework of this report, we focus on the role of five institutions that address care needs of older Japanese: families,

communities, government, non-government organizations (NGOs) and the private sector.

Families

Families have traditionally been the main source of care for older persons. Japan was considered as having an “*ie*” family structure. “*ie*” refers to the family or household where three generations live together and bears a hierarchy based on seniority and gender (Sano & Yasumoto, 2014). In 2011, this family structure has immensely declined and is being replaced by the nuclear family. Three-generation households account for 10% of all households compared to over 33% in the 1960s (Sano & Yasumoto, 2014). Due to this, the government of Japan formulated a new program in 2000 called “long-term care insurance” (Muramatsu & Akiyama, 2011) for the older population bearing the slogan “from care by family to care by society” (Tsutsui & Muramatsu, 2005) in order to reduce the burden on family members with regard to caring for older persons (Muramatsu & Akiyama, 2011). The decline in the family’s role in caring for older persons has made the role of government essential (Tsutsui, Muramatsu, & Higashino, 2013).

This responsibility of caring for older parents by family members is based on the cultural aspect of filial piety. As with the household structure shift, filial piety had been observed to stagnate from 1963 to 1986. Nevertheless, in 1987 filial piety began to decline because of the transformation of socioeconomic and demographic conditions (Ogawa & Retherford, 1993). This development coincides with another demographic shift whereby

the proportion of adult children who remain single has been increasing. This led to an increase in the number of older persons living with an unmarried adult child.

Caring for older persons by family members is considered challenging. Relatives in the family experience the pressure of caring for older persons with the expense of time, finances, and personal well-being for long periods of time. Mental and emotional issues arise among these care providers. It was observed that the consequences associated with older person care is depression and may subsequently lead to commitment of suicide. In 2012, about 200 incidents of suicide across the country were related to such pressure (Sano & Yasumoto, 2014).

There has been a shift between sexes in care for older persons in Japan. In the past, most of the responsibilities for caring for an older family member rested with wives and daughters-in-law. Recent reports indicate that there has been a shift in this care model whereby it is appearing to abandon its recognition of being “women’s work” as men have begun to engage in this task (Long & Harris, 2000). Males account for 17.9% in 1986 and 22.7% in 2004 of all caregivers for older adults in Japan (Sugiura, Ito, Kutsumi, & Mikami, 2009).

Communities

The ‘community’ as a social unit in Japanese culture is considered important (Ono, 2004; Saito et al., 2012). For older person care, communities are an important link to achieving the success

of the healthcare programs. Research has shown that there is a positive impact of community support on the health of older people (Oyama, Goto, Fujita, Shibuya, & Sakashita, 2006).

The number of older people who commit suicide in Japan has been increasing annually, such as in the case of Nagawamachi in Aomori. The main cause is that older persons are suffering from depression, and the suicide rate among older males is higher than among older females. The key program to averting suicides is the national prevention program where community members are providing support to older persons (Ono, 2004).

However, further developments have to be done because it has been observed that there are gaps with such community-based interventions (Oyama et al., 2006). Japanese older persons have a high sense of independence and prefer to receive less help from others. Based on local culture, receiving community support is a form of shame; it is even considered a social stigma (Garon, 2002). Developing a community network for older people to communicate with other locals is instrumental toward better physical and mental health. Gender differences should be noted though in planning these community-based programs. Older females are more likely to join and receive help from the community than older males. Women also tend to have a larger social network than males offering them a larger base of support (Ajrouch, Blandon, & Antonucci, 2005; Igarashi, Takai, & Yoshida, 2005).

Non-government Organizations (NGOs) and Non-profit Organizations (NPOs)

Due to the rapid aging of the Japanese population, older-person care tends to overwhelm family members. The government encounters challenges as well and therefore non-government organizations (NGOs) and non-profit organizations (NPOs) aid in alleviating such issues. There have been numerous sectoral organizations established in Japan in the 1960s that offer older person care services affordably. An example is the Luther Home whose aim is to be a home with moderate fees for older members of the organization. This type of service is known as domiciliary support center that has care services as bathing and monitoring health condition. Part of its services also is to provide transportation during emergencies as well as regular check-up at hospitals (Tout, 2013). The organization also offers a caregiver training program where family members can learn and receive advice on how to provide proper care for older persons.

Other social, sectoral programs are present such as the volunteer program of Funabashi Junior High School to support older local community members (Nakano, 2004). There is also *Niji no kai* that is a non-profit Japanese volunteer organization, which was established in 2000 to promote well-being for older Japanese (Aoyama, Dales, & Dasgupta, 2014).

To deal with a large number of older persons, the government of Japan set up *Fureai Kippu* schemes or usually called “ticket for a caring relationship” in order to enhance the support

network for senior care (Hayashi, 2012). The most notably of *Fureai Kippu* schemes is the time banking system. In short, this program allows individuals to accumulate time-credits through helping older persons and they can use them through an exchange time credit card to ask for help when they are old or sick. These credits can even be transferred to their relatives (Laratta, Nakagawa, & Bovaird, 2011). It was started with the idea of “time is money” and that a volunteer takes the time to take care of an older person now, which can be returned to that volunteer in the future. Time bank systems are a novel concept that works for both givers and receivers. “For every hour that a person volunteers in giving services to others they receive an hour of service in return” (Miller, 2008). The *Fureai Kippu* network was established in the 1980s and plays a key role in Japanese society to develop self-sufficiency in its aging population and to keep older people active. After the implementation of long-term care insurance system for older persons and the disabled in 2000, *Fureai Kippu* regimes’ role declined (Hayashi, 2012; Miller, 2008).

Government

As the number of older persons increases in Japan, policies and programs for their care become significant issues. It is a country with stable economic growth such that its GDP in 2010 ranked second in the world. This creates the potential for Japan to implement policies for its older population more effectively (Cook & Halsall, 2012).

Table 1 shows a brief summary of the development of key welfare policies for older persons in Japan from 1963 to 2000.

Welfare policy in the 1960s focused on intensive care homes for the older persons. After which, in the 1970s, a program that supplies free healthcare

was established. From the 1980s to the 1990s, the government focused on the Gold Plan to promote general health and welfare. The introduction of a long-term care policy is an indispensable necessity in Japan as with the context that has been previously discussed.

Table 1: Summary welfare policies for Older Persons in Japan from 1960s to 2000s

		Aging rate (year)	Major policies
1960s	Beginning of welfare policies for older persons	5.7% (1960)	1963 Enactment of the Act on Social Welfare Services for the Elderly - Intensive care homes for the elderly created - Legislation on home helpers for the elderly
1970s	Expansion of healthcare expenditures for older persons	7.1% (1970)	1973 Free healthcare for the elderly
1980s	"Social hospitalization" and "bedridden older persons" as social problems"	9.1% (1980)	1982 Enactment of the Health and Medical Services Act for the Aged - Adoption of the payment of co-payments for elderly healthcare, etc. 1989 Establishment of the Gold Plan (10-year strategy for the promotion of health and welfare for the elderly) - Promotion of the urgent preparation of facilities and in-home welfare services
1990s	Promotion of the Gold Plan	12.0% (1990)	1994 Establishment of the New Gold Plan (new 10-year strategy for the promotion of health and welfare for the elderly) - Improvement of in-home long-term care
1995s	Preparation for adoption of the Long-Term Care Insurance System	14.5% (1995)	1997 Enactment of the Long-term care Insurance Act
2000s	Introduction of the Long-Term Care Insurance System	17.3% (2000)	2000 Enforcement of the Long-term care Insurance System

Source: Ministry of Health, Labour and Welfare (2016).

Japan has the social insurance system as the foundation for a long-term care system. In 1983, The Ministry of Health, Labour and Welfare in Japan established annual health examinations for the whole population to prevent non-communicable diseases such as cancers, heart diseases and stroke. Under the pressure of an aging society and difficulties in balancing work and life, Japan is

required to have a program to share the task of caring for older persons with disabilities. The slogan "from care by family to care by society" was produced to ensure the right to approach institutional and community-based long-term care services of older Japanese persons as well as asserting the responsibility of government in caring for them (Campbell & Ikegami, 2000; Eto, 2001).

On April 1, 2000, the Japanese government established a mandatory program involving long-term care insurance (LTCI) in order to supply home care service and institutional services for all older people (Campbell & Ikegami, 2000; Long, Campbell, & Nishimura, 2009; Tsutsui & Muramatsu, 2007). People will have to pay premiums from age 40 on and get benefits when they reach the age of 65 years based on the level of physical and mental disability. LTCI will pay about 90% of the cost of treatment. People have the right to choose services and providers, but they are prevented from receiving cash for family care (Campbell & Ikegami, 2000; Tsutsui, 2010).

In order to receive LTC, the older person must have a certification granted by the Care Needs Certification Board. The board is composed of nurses, doctors, social workers, and physical therapists with at least 5-year experience. Results from the evaluation committee will be divided into seven levels to assess the physical and mental health of the older persons, i.e. for those who have a care-needs certification level 1 or 2, the expected need for support is on ADLs (Asahara et al., 2003; Ozawa & Nakayama, 2005). The Care Needs Certification system has been deemed effective in Japan (Tsutsui & Muramatsu, 2005).

Even with the success of the program LTCI, there are limitations to it such as lack of control on expenditure and also the extent of the role of central and local governments. This led the government to introduce two aspects of reforms in 2005 to the LTCI program: “charging nursing

home residents hotel cost” (Tsutsui & Muramatsu, 2007) and providing more services to improve the physical and mental health of older people such as providing lectures for the community to prevent lifestyle diseases, training for volunteers in care skills for older people and day services where nurses visit patients who suffer from depression and dementia in order to provide consultation and guidelines at home (Tsutsui & Muramatsu, 2007).

Issues are still observed as a study has found that there are inequities in allocating insurance resources to older people with certain disabilities in Japan, particularly those with dementia of the Alzheimer’s type (DAT); and vascular-type dementia (VD) (Arai, Zarit, Kumamoto, & Takeda, 2003). The Government-Certified Disability Index (GCDI) underestimates the impact of DAT. The system has obstacles for older persons with this disease when approaching LTCI.

Among the older population, some choose to reside in other countries upon their retirement. It is estimated that dental diseases, hypertension, and musculoskeletal disorders are the three top chronic diseases that Japanese older persons who have retired in Chiang Mai receive treatment for either in Thailand or Japan during the previous year (Miyashita, Akaleephan, Asgari-Jirhandeh, & Sungyuth, 2017). Thailand is a typical destination along with Hawaii in the United States, Canada, Australia, and Malaysia, among others. There are at least 3,000 older Japanese that are staying long-term in Thailand,

mainly in Bangkok, Chiang Mai, Chiang Rai, and Phuket. In the 1990s, a program was introduced to adapt to the increasing needs of long-stay retirees overseas by a public interest corporation authorized under the Ministry of International Trade and Industry (MITI). This is a replacement program for “Silver Columbia Plan 92” which was established by MITI in 1986. The Long Stay Foundation is the first company to offer long-stay retirees overseas services in 1992 to adapt to the needs of older Japanese who want to live abroad longer during old age (Ono, 2008, 2010). By 2025, the baby-boomer generation in Japan will turn 75 years of age, which will contribute to the pressure on Japan’s older person care system. The government is expected to establish ‘the community-based integrated care system’ program which reforms of the long-term care insurance system to ensure the provision of healthcare, nursing care, expansion of home-based medical care, housing and livelihood support for older persons (Morikawa, 2014; Tsutsui, 2014).

The success of policies in Japan depends on social norms, gender ideologies, and culture (Long & Harris, 2000). The main task of long-term care insurance system in Japan is toward the independence of older people in daily living rather than simply providing personal care. Policies bear the thought of “long-term care is needed to be the right of all older people to meet their need” (Sano & Yasumoto, 2014).

The Current Financing for Elder Care

With the state of aging in Japan, its government has to cope in terms of allocating the national budget toward welfare schemes that concentrate on older person care. In 2017, spending on social security amounted to 33% of the total budget, while education spending accounted for 5.5%, national defense for 5%, and public works for 6% (Oku, Ichimura, & Tsukamoto, 2017).

A previous study has also shown that Japan allocates more funding for its older population than any other country. When comparing between Japan and Sweden in terms of spending for their respective older population, the former allocated 46.4% of its budget while Sweden allocated 34.9% (Oku et al., 2017)

While older persons in Japan need support for their physical and emotional healthcare, they also need support for their financial well-being. The financial resources of the older population come from three main sources: support from children/relatives, support from the government and personal savings. At younger ages, Japanese people prepare for old age through savings, paying taxes to the government and possessing private insurance. Savings are high among older adults, especially among the 60-to-69-year old age group which accounts for the highest savings at 21.18 million yen. Generation X, those in the 30-39 age-group, was recognized as having the highest debt due to buying property (Table 2).

Table 2: Saving and Debts for Different Age Groups in Japan in 2016 (in Million Yen)

	Average	<29	30-39	40-49	50-59	60-69	70+
Yearly income	7.2	4.9	6.3	7.4	8.4	6.3	5.9
Saving	13.0	3.1	6.1	10.4	17.0	21.2	19.9
Financial institutions	12.4	3.0	5.9	9.8	15.9	20.9	19.8
Demand deposits	3.4	1.6	2.7	3.3	3.5	4.5	4.9
Time deposits	4.4	0.9	1.7	2.9	5.8	8.5	8.4
Life insurance, etc.	3.1	0.4	1.2	2.6	4.5	4.9	4.0
Securities	1.5	0.2	0.3	0.9	2.2	3.0	2.8
Non-financial institutions	0.6	0.0	0.2	0.7	1.1	0.3	0.0
Debts	7.8	5.0	12.3	10.4	5.8	1.9	0.8
Housing and/or land	7.2	4.6	11.8	9.7	4.9	1.6	0.5
Other than housing and/or land	0.5	0.3	0.3	0.5	0.7	0.2	0.1
Monthly and yearly installments	0.2	0.2	0.2	0.2	0.3	0.2	0.2

Note: Two-or-more-person households.

Source: Statistics Bureau, Ministry of Internal Affairs and Communication (2017).

Financial support from the government is very important to older adults, especially those with low education, living alone, unmarried, unemployed, and having ill health. According to the Family Budget and Price Report in 2017, for non-working older person households in Japan, the main source of income came from social security benefits, which accounted for 84.2% of total income. Non-working Elderly Households were defined in the report as households with two or more members and a household head of 60 years or older (Statistics Bureau, Ministry of Internal Affairs and Communications, 2017).

Health Promotion

In order to maintain the health of older people better, Japan has several programs to develop their health. These programs focus on the promotion of lifestyle change through exercise, among others, to prevent related illnesses including diabetes and obesity. One example is the event that was held on September 3, 2017 called “Emergency Medicine Day 2017” (Ministry of Health, Labour and Welfare, 2017) which was an avenue to share information to the public about emergency cardiopulmonary resuscitation. Such public health events are publicized in mass media and on the ministry’s website.

Important Issues Related to Care Needs

One of the most important issues for care for older persons in Japan is prevention of social isolation which is defined as not communicating with friends, neighbors (non-family members), not leaving the house and not going out for the purpose of working or shopping for at least six months (Alan R Teo, 2013). Studies of Saito et al. in 2009 and in 2010 observed that the percentage of older persons suffering from social isolation increased from 10.4% in 2009 to 28.7% in 2010 in Japan (Saito, Shimizu, Yamaguchi, & Takei, 2009; Saito et al., 2012). The further risk of social isolation is its probable progression toward loneliness, depression and the general lower perception of well-being. People tend to make friends and set up their social network at school and at their workplace therefore upon retirement, establishing such a social network becomes difficult (Saito et al., 2012). Addressing this dilemma, the government of Japan promulgated a program in October 2006 to prevent social isolation and upon evaluation, it has been shown that the program resulted in a positive effect on loneliness and subjective well-being but bears no effect on depression (Saito et al., 2012).

There is a shortage of labor in Japan and labor migrants can help in providing care to older persons. Beginning in 2008, Japan signed economic partnership agreements with three Southeast Asian countries including Indonesia, the Philippines, and Vietnam about receiving

foreign nurses and care workers in Japan (Hirano, 2017). Foreign nurses and care workers are required to pass a test in Japan within four years of their first arrival in Japan. From 2008 to 2009, the Japanese government planned to have 1,000 nurses from Indonesia to Japan, but the actual numbers until 2010 were 212 nurses and 266 care workers due to a lack of proper qualifications. In addition, cultural and language differences may become a barrier between the older adult and the caregiver (Hirano, 2017; Ogawa, 2011).

Social norms, gender ideologies, and values are factors that influence policy of care for older persons from government, community, and NGOs (Ikegami & Campbell, 2004). Thus, the Japanese government should pay attention to these factors when they set up programs for older person care.

Policy Recommendations

Countries in the process of aging consider Japan as a model for solving matters related to aging populations (Nakane & Farevaag, 2003). Care for older person policies in Japan are generally working well but there are a number of shortcomings that need to be addressed. One notable aspect is the burden on care providers. Research shows that caring for older persons is a long-term engagement that may require leaving gainful employment. Family members as care providers are subject to physical and mental stress. The Japanese government then may have to consider allocating welfare for family- member care providers; one possibility would be to compensate family members financially for their care work or

flexible work schedule for caregivers (Colombo, Llena-Nozal, Mercier, & Tjadens, 2011). This will ensure the long-term sustainability of this intra-household care especially in the current situation of the country where there is a lack of human resources to care for older persons (Arai & Washio, 1999).

Death in Isolation

A prominent issue among older Japanese people is death in isolation or solitary deaths, which describes the situation where people are dying alone, without care and are discovered after a long time. The term was first used in Japan in 1970 and then became more popular in 2000s (Nomura, McLean, Miyamori, Kakiuchi, & Ikegaya, 2016). A study in Osaka from 2010 to 2012 indicates that older people who were 60 to 69 years old and who were living alone had the highest risk of solitary death (Morita, Nishi, Furukawa, & Hitosugi, 2015). As described earlier in this chapter, the change in household composition towards a nuclear family structure is paralleled by an increase in one-person households (Statistics Bureau, Ministry of Internal Affairs and Communications, 2017). This change in family structure is leading to an increase in the number of older people living alone without any family care. According to the National Institute of Population and Social Security Research, there were 2,000 deaths in isolation among older persons in Tokyo in 2011 (Sano & Yasumoto, 2014). This requires a policy for this target group to support their well-being in old age.

One-person Households

The number of one-person households in Japan is increasing, especially among the older subpopulation. Studies indicate that people who live alone are less happy than those living with others and living in isolation may affect psychological health and well-being (Yeung & Cheung, 2015). At the same time, households with only one older person pose particular challenges for care provision which have to be dealt with.

Further Recommendations

In the coming years, overseas retirement will increase particularly in Southeast Asia. Japanese older persons are able to afford the lower cost of living and health care, they can obtain long-term visa, and are able to experience cultural similarities. Therefore, the Japanese government needs supportive policies for older people who retire overseas. A program set up by the Japanese government for oversea retirement in 1985 has received criticism from the media, as well as the international community, who said that Japan is trying to export older people to other countries. In the 1990s, a company named Long Stay Foundation set up a program to promote and provide information about retiree overseas trips with the slogan enjoy a second life. Differences in language and culture lead to difficulties for older Japanese to integrate into new places (Ono, 2008; Thang et al., 2012).

In conjunction, the Japanese government also needs to coordinate with governments of destination countries for Japanese older people to be able to integrate into their destination. Oral health problems

among older persons are considered chronic problems due to lifestyle. Lifestyle-related diseases such as diabetes and obesity need to be identified early, therefore encouraging people to participate in a comprehensive annual health check is necessary to prevent these diseases.

One of the unique characteristics of Japan is that there are many natural disasters occurring

each year such as earthquakes, tsunamis, landslides in part because of the geographic location of Japan along the Pacific Ring of Fire and thus being vulnerable to disasters. Therefore, special policies, particularly for older persons that live alone and/or have care needs and hence are most vulnerable should be provided to help them before, during and after disaster strikes.



| Abbreviations

ADLs	Activities of daily living
DAT	Dementia of the Alzheimer's type
GCDI	Government-Certified Disability Index
GDP	Gross Domestic Product
HLE	Healthy Life Expectancy
IADLs	Instrumental Activities of Daily Living
LE	Life Expectancy
LTCI	Long-term Care Insurance
MIC	Ministry of Internal Affairs and Communications
MITI	Ministry of International Trade and Industry
NGOs	Non-government Organizations
NPOs	Non-profit Organizations
VD	Vascular-type Dementia

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Introduction

Lao People's Democratic Republic, Lao PDR, also known as Laos has participated in the issue of aging at an international level in a number of contexts including the Madrid International Plan of Action on Aging. This reveals the need to reflect on issues relating to how older persons live today. Advancing public policy that meets the requirements of older persons is the aim and this can be achieved through the contribution of scientific evidence that facilitates the estimation of future needs.

Support and services for older persons in Lao PDR are provided through government programs. Only a small minority of the older population is covered by old age pensions, virtually all of whom were formerly employed in the formal sector. Pension benefits are provided within the contributory social security system under the recently established National Social Security Fund (NSSF). There are currently no social assistance pensions. As a result, people outside the formal sector and without NSSF membership are left without pension coverage in old age. Most assistance and support is provided to those older

persons who are in most need, i.e. the poor, the frail, and the disabled.

In Lao Culture, the propensity is to care for older persons by keeping them healthy and allowing them to stay with family as long as possible. This is not only more cost effective from the government's point of view; it also conforms to the wishes of the vast majority of older people themselves.

Overview of Population Aging and Care Needs

Population aging is anticipated to be the dominant demographic trend in Lao PDR. The age profile of the population has changed over the past 10 years and is projected to change even more significantly in the coming decades.

Fertility and mortality are the two components of demographic change that determine natural population change. The main force underlying the projected aging of the population is the fall in fertility rates that has occurred since 2005, as well as an improvement in life expectancy. Fertility in Lao PDR as measured through the crude birth rate fell

from 35 per 1,000 population in 2005 to 28 per 1,000 population in 2015.

The aging of the population is the inevitable consequence of the fertility transition. Life expectancy at birth is about 65 years for females and 62 years for males (2015). In 2005 an estimated 5.8% of the population was aged 60 or older. By 2015, the Lao population and housing census indicated that the proportion of the population aged 60 years and older was 6.5% or 422,276 older persons (National Statistics Centre 2005; Lao Statistics Bureau 2015).

The aging of the population has yet to become an issue for Lao PDR. The proportion of persons above age 60 years is still low and will only begin to rise rapidly after 2020. Even in 2050, the proportion in Lao PDR will be lower than currently in Thailand (Jones, 2015).

Health Status of Older Persons

Lao PDR has initiated some activities to promote health of older persons. These activities include free health assessment during the international day festival of the older persons as well as education on risks from certain unhealthy behaviors. Lao PDR has not yet strengthened special nutrition, physical exercise, and healthcare education programs for older people. Moreover, there is no system that ensures universal coverage of health services for the older population which is the most effective way of ensuring access of the older people to comprehensive health care.

Lao PDR has yet to establish a long-term care (LTC) system because older persons benefit from a tradition of informal care by families and friends to underpin home care. In the future, Lao PDR will be facing a challenge since changing family structures will entail a reduction in the ability of families to care for their older members.

Current Care Needs

In this report the care needs are defined as having difficulty in performing activities of daily living (ADLs). Generally, older persons need to be able to manage ADLs in order to live independently without assistance for activities such as walking, feeding, dressing and grooming, toileting, bathing, and transferring. In Lao PDR, if older persons are not fully independent because they have difficulty with ADLs, family members usually provide the assistance they require.

Overview of Actors Involved in Care Provision

Families

Lao PDR has a strong tradition of families providing care. Families are providing LTC to older persons with limitations in the ability to perform tasks necessary for independent living. Family members often assist with personal care, perform housekeeping tasks, provide emotional support, manage difficult behaviors such as wandering, aggression, and hallucinations, deal with healthcare providers, manage finances, coordinate care, and deal with uninvolved or unhelpful family members.

The help and support of family members make it possible for parents to live at home longer. Most family members think of it as doing what comes naturally when one is a wife, husband, daughter, son, or having any family relation. However, family members may have very low skills for caring for their older family members. This may require learning new skills to care for loved ones who are old. Moreover, family members also help older persons understand the consequences of their decisions related to medication, finances, or advanced directives in daily living.

Communities

In Lao PDR, there is no care provision by the community regarding work, income, retirement, and environmental adaptation to facilitate the older population.

Government

There are currently no care provision schemes specifically for the older population except for pensions as part of the contributory formal social security system. Currently, an estimated 8.47% of older persons receive such a pension¹. As such, there is a lack of basic income security for the vast majority of older persons who are not eligible for formal social security pensions. This mostly involves those who spent their economically active years in the rural informal sector.

In the formal social security system, the pension age is set at 60 and 55 years for males and females respectively, under the condition of a

minimum working period of 25 years and minimum contribution period of 15 years. The pension age and minimum working period can be reduced by five years in case of disability, or in case of having continuously worked for 5 years in hazardous environments. Early retirement for health reasons is possible by up to three years if the worker has at least 25 years of contributions (Law on Social Security, No.34/NA, 26 July 2013).

The civil servant social security scheme under the NSSF is currently a pay-as-you-go system without accumulated reserves. In the initial design of the program, contributions were supposed to be allocated into off-budget reserve funds. However, the government/ employer contributions are currently only provided in accordance with expenditure needs for benefit payments for each year. All contributions are used for benefit payments of the respective year.

There are special pension benefits for revolutionary veterans, i.e. national heroes and fighters in the revolutionary war. They are entitled to a special benefit. These benefits are stipulated in Prime Minister Decrees No. 241 of 2007 on the privileges towards persons with outstanding performance and good contribution to national revolutionary tasks.

Non-government Organizations

In Lao PDR, there is no service and support provided to the older population by the

¹ National Social Security Fund (NSSF). www.nssf.gov.la (2018)

non-government sector. However, over the past few years, HelpAge International has initiated several programs to support the older population by working closely with Lao Women's Union. Soon, such programs run by HelpAge International will likely finish (HelpAge International, n.d.).

| Prospects for Care Needs

Care needs are very important for daily living of older persons. There is a deep, interesting, and constructive policy conversation underway nationally on how to best provide for care needs and to make the best use of social care resources to meet the needs of the growing older population of Lao PDR.

Current care needs demonstrate the likelihood of having unmet needs according to types of activity. Older persons are less likely to receive support for difficulties with personal care activities. Many older people have difficulty bathing independently, getting dressed, or using the toilet. Most of them receive assistance from family members.

| Quality of Care Provision

In general, acquiring a health condition does not necessarily mean a high level of dependency on health and care services. Many older people do not consider themselves to be living with a life-limiting long-term condition, meaning that even if they have one or more health conditions this is not perceived to have a significant

impact on their lives. Where older people do need support, the quality of support they receive and how well they are able to adapt is a crucial factor in their long-term prospects for living well and maintaining independence. Lack of appropriate treatment and support can have very dire consequences for the health of older people, particularly individuals with multiple long-term conditions or frailties who are most in need of responsive health and care services. It is important to establish the social fund or older-person fund to support the care needs of Lao PDR in the future.

| Laws and Regulations

Currently, Lao PDR has one national policy for the older population - "The National policy towards the Elderly in Lao PDR (2004)". Unfortunately, Lao PDR has no laws, regulations, strategy, or action plan directly targeting the older population.

| Policy Recommendation

1. Consider creating regulation through a law or decree on older persons
2. Renew the national policy for the elderly
3. Formulate a national strategy and action plan for the needs of an aging society
4. Establish a non-contributory minimum social pension for older people who are not covered by the formal social security system
5. Provide non-cash benefits for the older population, such as free health care, housing and transportation

6. Explore different targeting options, e.g. targeting all older adults without formal pensions or targeting only the most vulnerable: those living in poverty, older persons without family support, or those who have a disability
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Malaysia

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| Executive Summary

Malaysia is a Southeast Asian nation facing population aging at a relatively low level of national income. The country has experienced development, albeit with some regional disparities, that is consistently addressed in national development programs. The social structure is characterized by Western bureaucratic systems and pluralism. Establishments of the British colony in terms of fundamental governance structures (i.e. federal constitutional monarchy) and social institutions (i.e. health and welfare institutions) as well as the separation based on ethnicity and economic activity continue to shape the socio-cultural context. The Malaysian population is heterogeneous with diverse ethnic groups, religions and belief systems in tandem with a multitude of cultural practices and traditions that are mirrored in the heterogeneity of the older population. The nation's economic growth has been remarkable, but challenges have arisen from the growth of the older population and the consequent increase in the need for care and social protection. As this industrialized nation enters the third stage of the demographic

transition attributed to a faster decline in birth rates in comparison to the decline in death rates, changes are evident in the population landscape.

Rapid population aging means that the nation must be innovative to respond to this dramatic change. Along with the demographic transformation, there are accompanying social changes that affect the ability of the family to provide care and support for older adults. The continued increases in longevity not only increase the health and economic vulnerabilities of older persons, but also affect the capacity of the family to provide intensive physical care. Family size and composition are also changing: families are smaller, members are highly mobile, and more generations are present. The middle-aged, working population who are currently sandwiched in their role of supporting the younger and older generations in the family will have to be given due consideration in the policy. Due the increasing demands for old-age support and long-term care, the family cannot be expected to sustain these functions without policy interventions and supportive programs or services.

Key stakeholders in multisectoral support for the older population in the federal or central government are the Ministry of Women, Family and Community Development, Ministry of Health, and the Ministry of Housing and Local Government. These ministries determine the regulatory structure (laws, policy and guidelines), allocate funding, and provide major programs and services for the older population. The Department of Social Welfare under the Ministry of Women, Family and Community Development provides residential care and non-residential support, while the Ministry of Health provides primary, secondary and tertiary level care for older persons at minimum or affordable charges. The Ministry of Housing and Local Government oversees physical planning and local services. The second tier of government at the state level regulates Islamic family law and provides some support for the elderly through the state welfare departments and Islamic welfare instruments (e.g. *zakat/tithing*, *waqaf*). The growing demand for care and protection by the older population requires more inclusive and innovative approaches that enable all Malaysians to remain healthy and contribute actively to the society. Age and gender integration as well as multisectoral collaboration will be crucial for long-term sustainability.

Background

The first section describes a combination of physical, historical, socio-cultural, and economic factors that has contributed to the development of institutions, policies, and programs related to care and protection for older persons in Malaysia.

Physical Context and Regional Differences

Malaysia is a country located in Southeast Asia, with a total land mass of 330,803 square kilometers that is divided into two separated areas. The Peninsular or West Malaysia situated to the south of Thailand and north of Singapore whereas East Malaysia is located on the island of Borneo bordering Brunei and Kalimantan, Indonesia. Sabah and Sarawak, which are sizeable in land area but lower in population density. Despite improvements in the transportation system, geographic factors such as remoteness and the South China Sea remain as physical and psychological divide between the people of the Peninsula from those of Borneo (Bedi, 2013). It was also argued that this distinction has caused development to reach the people in Sabah and Sarawak in a much slower pace affecting social interaction and integration between the regions (Bedi, 2013). In the recently announced national budget for 2018, Sabah and Sarawak received the largest allocation to develop and improve infrastructure including highways, broadband internet connections, and access to clean water (Chu, 2017).

Together with Sabah and Sarawak, the federation of Malaysia was formed in 1963. The federation currently consists of 13 states and three federal territories of which 11 states and two federal territories, namely Kuala Lumpur and Putrajaya, are in Peninsular Malaysia. The federal territory of Kuala Lumpur remains as the nation's capital city whereas the federal administrative center was relocated to Putrajaya, as the new home of federal government ministries and the host to the nation's

diplomatic activities (Moser, 2010). The federal territory of Labuan is in an off-shore island in Sabah. All the federal territories fall under the purview of the Ministry of Federal Territories and administered by the city administrative office, such as Kuala Lumpur City Hall or corporations like the Putrajaya and Labuan Corporations (Siddiquee, 2013).

Several studies reported that the geographically uneven pattern of development promoting regional disparities in physical and socio-economic development has continued to exist, particularly between urban and rural areas. Studies have pointed out the dominance of urban growth centers in terms of population density and drawing in interstate migration, as well as agglomeration of private sector investments in urban areas that gave rise to relative regional differences in income, living costs, access to healthcare and information, and quality of life (Abdullah, Doucouliagos, & Manning, 2015; Hashim, 1998; Masud & Haron, 2008; Mohit, 2013; OECD, 2016a; Siwar, Ahmed, Bashawir, & Mia, 2016; Wegelin, 2012). The primary focus on rural development schemes also mirror the poverty eradication strategies in the economic development policies due to the fact that a large majority of the population are the rural poor (Mansor & Ab Rashid, 2016).

Key physical factors in the development of social protection system are regional disparities and level of urbanisation. The overarching goal of the regional development, as stressed in the Malaysian Development Plans which is consisted of an attempt to redress economically imbalanced

development with a particular focus on income disparity and other welfare indices between ethnic groups, economic activities, and consequently between states and regions (Hassan, 2017). Malaysia's definition of an urban area is premised along the lines of population size (i.e. a combined population of 10,000 or more) and economic activity of the population (60% of population is involved in non-agricultural activities) (Siwar et al., 2016). It was reported that the level of urbanization rose from 34.2% in the 1980 to 71% by 2010 and is expected to continue resulting in more people relocating to major cities on the west coast of Peninsular Malaysia and in Sabah and Sarawak (Siwar et al., 2016; Yaakob, Masron, & Masami, 2010).

Historical Context

The British colonies of Borneo and Malaya provided the foundation for the Western-style bureaucratic administration in Malaysia (Poole, 2009). Malaysia practices constitutional monarchy, alongside a federal parliamentary democracy based on the English or Westminster system of government (Aboo Talib, 2016). Legacies of the colonial regime also remain in the established institutions and policies that are retained in the federal type of political system and the government (Yaakop, 2010).

Ethnic pluralism was also initiated during the British rule which later gave rise to a socially fragmented landscape and unequal multi-ethnic society beginning in the 1920s (Aboo Talib, 2016; Aziz & Yussoff, 2012). This social fragmentation can be attributed to the practice of geographical separation

based on ethnicity and economic activity that continue to shape ethnic relations (Poole, 2009).

Another important legacy of the British colonial practice inherited which was subsequently adopted in the country's efforts to eradicate poverty is the social protection programs. Mansor and Ab Rashid (2016) reported that the Chinese and Indian laborers who came to Malaysia had relied on informal social security structures afforded by their own clans, ethnic groupings, or employers. In 1951, Malaysia's Employees Provident Fund was established cater for the growing pressure from strong trade union movements followed by another landmark development in 1971 of the development of the Social Security Organization (SOCSO), providing employment-related injury schemes and invalidity pension. The introduction of the New Economic Policy in 1971, along with the establishment of the institutions, had shaped the foundations of social protection in Malaysia.

Socio-cultural Context

With a local population size of 31.7 million persons or 89.7% of the total population and almost 3.3 million non-citizens, which is the remaining 10.3% in 2016, Malaysia is among the world's 50 most populous nations in the world (Department of Statistics Malaysia, 2016). The Department of Statistics Malaysia reported that the Malays and Bumiputera (other indigenous groups) make up about 67.4% of the total Malaysian population, followed by the Chinese (24.6%), Indians (7.3%) and others (0.7%) (Department of Statistics Malaysia, 2015). As discussed by Tey and his

colleagues (2016), the population of Malaysia is comprised of some of the largest ethnic groups in the world, namely Chinese and Indians, in addition to Malays and Bumiputera that make up the largest group in the country. The people of Sabah and Sarawak are linguistically distinct and culturally diverse. Ethnic groups of Ibans and the Kadazan-Dusun represent 30.3% and 24.5% of the total population in Sarawak and Sabah respectively (Department of Statistics Malaysia, 2015).

Islam is the official religion of the country, but other religions are also practiced. Since ethnic and religion are intertwined in the Constitution, ethnic Malays are generally Muslims. Other ethnic groups practice Christianity, Buddhism, Hinduism, Sikhism, folk religions, and animism (Saw, 2007). According to David (2017), while Bahasa Malaysia is the official national language, there is a range of spoken and written languages (including English as a second language) as well as dialects in each ethnic group. The salience of language in a multilingual context of Malaysia is reflected in the differing medium of instruction in national schools in contrast to vernacular schools along with the language shift from one generation to another in the families of minority ethnic groups (David, 2017).

Given the multicultural, multi-religious, and multilingual cultural landscape, there are converging and diverging cultural conventions related to family life and caregiving. The roles and responsibilities of family members are embedded across all religious beliefs in addition to the strongly held cultural values of filial piety and family-centered care (Hossain, 2014; Ismail, Tan, & Ibrahim, 2009;

Masud & Haron, 2014). In contrast, some authors have argued that parenting and child socialization tend to differ by socioeconomic status (Yunus & Dahlan, 2013) rather than ethnic group, given the collectivist nature of the society (Keshavarz & Baharudin, 2009).

The governance structure is divided into three tiers—the federal, state, and local. A concurrent jurisdiction between the federal and state government takes effect in areas including housing and housing provisions, public health, town and country planning, and also welfare (Loh, 2014). Nevertheless, due to the wide-ranging federal powers, centralized federalism continue to dominate the political discourse including substantial federal interventions in the functions of state governments and local authorities (Loh, 2010). The traditional rulers (sultans), who were present in nine of 13 states, were identified as the “Heads of Islam” within their respective states in the constitution whereas the king is the highest Islamic authority in the remaining four states and the federal territories.

An area where there is a significant distinction in the society is the family law. Families in Malaysia are subjected to different statutory and legal authorities, with Islamic (Syariah) legal framework governing the Malays and Muslims families and a corresponding civil code that applies to the non-Muslims families in Malaysia (Nor, Abdullah, & Ali, 2016). This parallel legal system affects the family life matters, among others, pertaining to marriage and divorce, custody and care of a child following divorce, as well as inheritance. Thus, there is

constitutional precedence of the federal law over state law, except in matters regarding Islamic law.

Economic Context

Malaysia’s economy used to be dependent on raw natural resources including tin, rubber, and palm oil however, it is transformed to more diversified and open economy in the industrial and service sectors (OECD, 2016a). In 2015, Malaysia’s GDP in USD was \$296.3 billion (World Bank, 2017). As such, the country is considered to be a middle-income country for 46 years with 19 years in the upper tier (OECD, 2016a, 2016b; World Bank, 2017). It seems Malaysia has remained in the upper-middle income tier the longest and not being able to progress to high income due to the middle-income trap (Hill, Yean, & Mat Zin, 2013; Ong & Hamid, 2010). The aspirations to become a high-income nation is still on its track despite growing internal and global fiscal challenges. Efforts to confront the challenge of maintaining economic growth against the rapid pace of aging must be met with serious reforms to boost productivity and foster inclusive development (OECD, 2016a).

Based on a recent survey of household income and basic amenities, the Department of Statistics Malaysia (2015) released a report indicating that both the median and mean household incomes has increased from 2012 to 2014. The median monthly income demonstrated a growth rate of 11.7% annually from RM3,626 in 2012 to RM4,585 in 2014. The mean household income also showed a growth from RM5,000 in 2012 to RM6,141 in 2014 at a 10.3% increase per annum. The report also indicated that the growth rate in mean and

median household income was also higher in rural compared to urban areas.

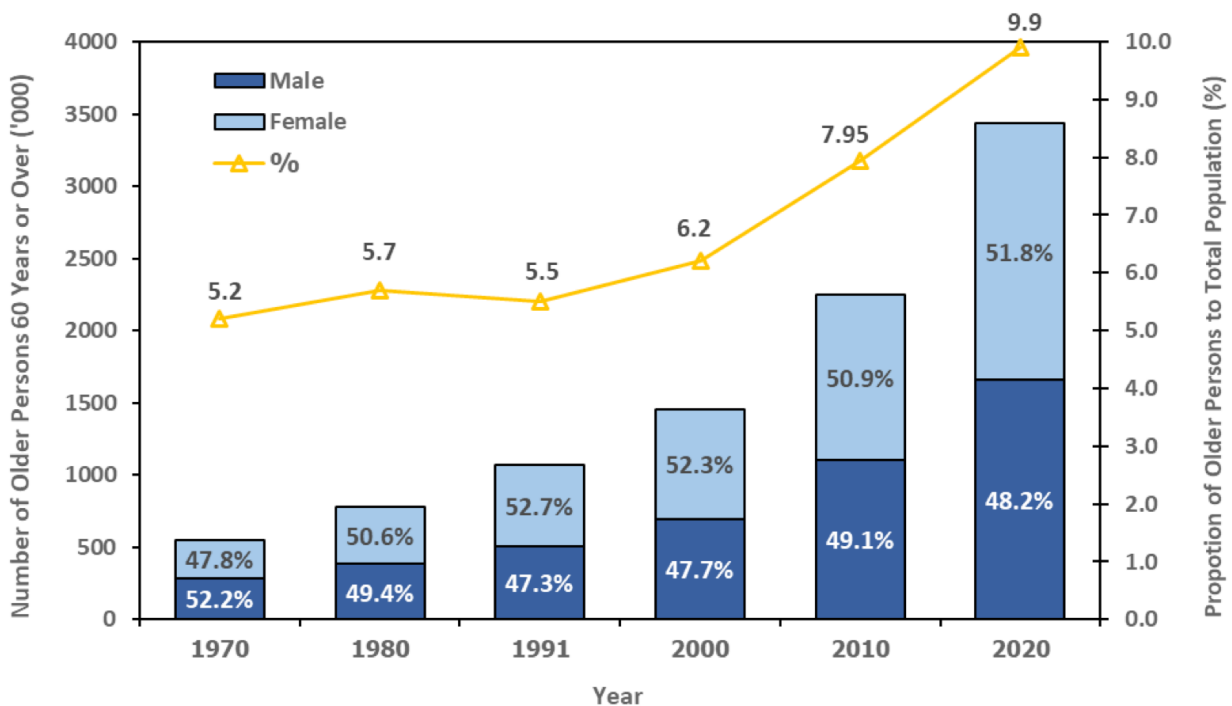
According to the report by Khazanah Research Institute (2016), population aging impacts the Malaysian economy at the macro and micro levels. At the macro level, the Malaysian economy is to be affected in relation to the end of the demographic dividend. At the micro level, the Malaysian households may not be able to afford longer life expectancies without interventions through social policies in areas such as the redefinition of the age of retirement, reforms in financial practices to ensure old-age security, and reorientation of the health systems towards preventative rather than curative measures to reduce healthcare burden. Against this backdrop, this paper presents an overview of Malaysia's changing demographic and socioeconomic

contexts that shape the needs for long-term care (LTC) among the older population. The following sections provide an overview of demographic and social transitions that shapes the needs for LTC.

Overview of Population Aging and Care Needs

Malaysia is now at the third stage of demographic transition characterized by having a more rapid decline in birth rates compared to death rates (Hamid, 2012). During the 1970s, Malaysia had a relatively high rates of birth and death but then, in the 1990s, it had experienced a more rapid decline in birth and death rates which led to the shrinking of young population and growth of the older age group (Khan & Narayan, 2014).

Figure 1: Older Persons in Malaysia by Sex, 1970-2020



Declining fertility and mortality accompanied by increasing life expectancy at birth have resulted in not only rapid but also transformative demographic transition. As presented in Figure 1, the absolute number of older persons (defined as individuals

aged 60 years and above) in Malaysia has grown from 546,000 in 1970 to 2.25 million in 2010. It is estimated to further increase to 3.44 million in the next decade as illustrated in Table 1 (Department of Statistics Malaysia, 2012; Pala, 2005).

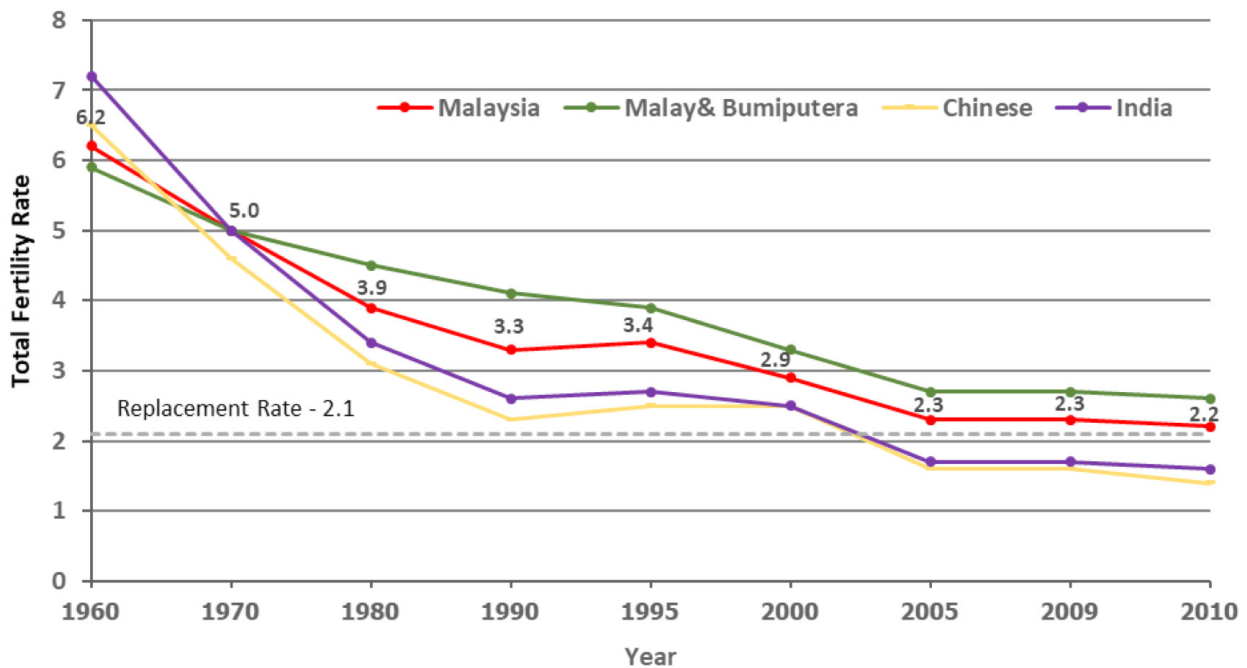
Table 1: Growth of Older Malaysian Population, 2010-2040

Age Group	2010	2020	2030	2040
Number of older persons ('000)				
60 to 69	1,361.5	2,098.0	2,805.9	3,341.0
70 to 79	642.7	947.8	1,485.7	2,002.1
80 and over	244.4	604.5	604.5	952.2
Total	2,248.6	4,896.1	4,896.1	6,295.3
Percentage of older persons				
60 to 69	60.6	61.0	57.3	53.1
70 to 79	28.6	27.6	30.3	31.8
80 and over	10.9	11.5	12.4	15.1
Total	100.0	100.0	100.0	100.0

Lower Birth Rates and Total Fertility Rates

The delays in marriage and childbearing has resulted in fewer children and older mothers, as the national Total Fertility Rate (TFR) reached replacement levels in 2010 (Figure 2) (Department of Statistics Malaysia, 2015). It is evident that the population age structure, like many other aspects of life in Malaysia, differs significantly among the three major ethnic groups (cf. Table 2). The Malaysian Chinese are aging at a much faster rate than the Malays and Bumiputera due to differences in fertility, mortality, and migration patterns (Chai

& Hamid, 2015). The mean age of first marriage was the oldest among the Chinese in at 27 years old in 2010, compared to 25.4 years and 26.1 years for the Bumiputera and Indians respectively. The total fertility rate of the Malaysian Chinese reached replacement levels as early as 2001 and they have enjoyed the longest life expectancy when compared to the other ethnic groups. As a majority of the Malaysian Chinese and Indians reside in urban areas, the experience of aging can also vary significantly from the predominantly rural Malays and Bumiputera.

Figure 2: Total Fertility Rate for Malaysians and Different Ethnic Groups, 1960-2010

Increasing Life Expectancy with Variations Across Gender and Ethnicity

Improvements in life expectancy contribute to the growth in older population with more people surviving into older ages. Life expectancy at birth had risen from 61.6 years in 1970 to 74.7. The population's median age has increased to 27.8 years in 2016 due to improved living conditions and quality of life. Economic prosperity, in conjunction with improvements to public health, education, and employment, has led to increasing longevity. Greater access to food that are safe

and nutritious, the control of infectious diseases, more sanitary condition, and other non-medical social improvements in the last two centuries have vastly improved life expectancy (Lindsay & Merrill, 2014). Like other countries around the world, Malaysian women are more likely to live longer than men. Life expectancy at birth for females in 2014 was 77.2 years and 72.5 years for males. On average, someone at the age of 60 in 2014 can expect to live for another 18 to 21 years.

Table 2: Population in Malaysia by Age Group and Nationality, 2005 and 2015

Nationality	2005			2015		
	0-14	15-59	60+	0-14	15-59	60+
Total (in Thousands)	8,039.5	16,230.8	1,775.5	7,822.1	18,518.1	2,248.6
Malaysian	7,744.9	14,700.3	1,726.0	7,667.6	16,414.2	2,182.4
Malay & Bumiputera	5,553.5	9,416.4	977.3	5,625.9	10,808.3	1,242.8
Chinese	1,551.9	3,953.8	621.6	1,451.5	4,201.0	778.0
Indian	524.0	1,181.4	114.0	495.9	1,278.6	150.4
Others	115.5	148.7	13.1	94.3	126.5	11.4
Non-Malaysian	294.4	1,530.6	49.0	154.5	2,103.7	66.2
Percent	30.9	62.3	6.8	27.4	64.8	7.9
Malaysian	32.0	60.8	7.1	29.2	62.5	8.3
Malay & Bumiputera	34.8	59.1	6.1	31.8	61.1	7.0
Chinese	25.3	64.5	10.1	22.6	65.3	12.1
Indian	28.8	64.9	6.3	25.8	66.4	7.8
Others	41.7	53.6	4.7	40.6	54.5	4.9
Non-Malaysian	15.7	81.7	2.6	6.7	90.5	2.9

Source: Department of Statistics Malaysia (2014a, 2015).

Speed of Aging

The aging transition from being an aging (7% of the total population is aged 65 years and over) to an aged population (14% are 65 years and above) is expected to happen in 23 years or so (2020-2043) (Kinsella & He, 2009; S.-H. Lee, Mason, & Park, 2011).

A highly compressed demographic transition has given rise to concerns about older person care and social protection (Abd Samad & Mansor, 2013; Baginda, 1986; Clark, Ogawa, & Mason, 2007; Mafauzy, 2000; Mohd, 2014). This situation poses a challenge to developing countries like Malaysia which must cope with the aging phenomenon with limited resources available. The challenges of the aging population are made more complex due to

the heterogeneity of older Malaysians i.e. based cohort, sex, ethnicity, location and socio-economic status (Hamid & Chai, 2013).

Typology of Older Malaysians

Older Malaysians have heterogeneous backgrounds that shape their experience of aging. However, a large majority of older Malaysians have the potential to contribute towards the society and economy. While the health and social welfare programs have maintained support for the growing number of vulnerable older people, such programs may not be sustainable in the future. Therefore, there is a need to address the different typology of older Malaysians and to match services to the level of health and socioeconomic status (Table 3).

Table 3: Percentage of Older Malaysians According to Health and Economic Status

Typology of older persons	Percent	Service needs
Poor and disabled	4.6	Welfare approach
Not poor and is disabled	8.5	Affordable services
Poor and able	25.8	Income generating programs
Not poor and is able	61.2	Potential to contribute to society

Source: Unpublished data: Hamid et al (2017).

Overview of Actors Involved in Care Provision

Care and social protection for older persons exists at the nexus of family and intergenerational support network, government (public), businesses (private), and the civil society (community-based).

Family and Intergenerational Support Network

Cultural values such as filial piety influenced families to commit to provide for the needs of different generations (Alavi, Sail, Idris, Abu Samah, & Omar, 2011; Ismail et al., 2009). It is associated with the notion of interdependent lives. The

relationship between different generations in the family causes for material transfers and non-material transmission including knowledge and values (Chong, Mohamad, & Er, 2013; David, 2013). Communication and understanding between the generations could be considered as an aid to remove stereotypes and establish intergenerational solidarity (Abdul Aziz & Yusoooff, 2012; Wok & Hashim, 2013).

As the life expectancy improves among older adults, the care from family members could face a crisis because of: (i) loss of traditional support structure (ii) opposing responsibilities and limited resources among adult children to provide care for young and older dependents (the mean income for adults age 40-59 is RM1373.13) and (iii) higher vulnerability of older adults to chronic diseases and disability as they age and, thus, a possible demand for more complex care.

The tendency of family members to provide emotional, informational, financial, and physical support is influenced by current social changes within the family and the community. When children move out of the house to live in other areas because of employment or getting married, neighbors come to play the principal role in providing support to community-dwelling older persons (Yahaya, Momtaz, Hamid, & Abdullah, 2013). Older adults with chronic illnesses and disabilities, especially older males, were found to be at-risk of unmet needs for support (Momtaz, Hamid, & Ibrahim, 2012). Unpublished findings from research datasets (2008, 2010, and 2011) at the Malaysian Research Institute on Ageing

(formerly known as the Institute of Gerontology) confirmed that:

- 1) The highest expectations of support are from adult children after which is the spouse. 86% out of a subsample of 1,277 older adults, stated that they received support from their children.
- 2) Married older females with formal education and higher income level tend to receive more social support.
- 3) Personal income and marital status were significant factors affecting social network size and frequency of contact with children.
- 4) More than half of older adults who co-reside with their adult children did not pay for any household expenses. A study found that older persons continue to share their resources (e.g. grandparenting, cooking meals, doing house work, financial support) to the family.

The research results confirmed that providing support to others, as opposed to receiving it, has a higher potential benefit on older adults' health (Momtaz, Ibrahim, & Hamid, 2014). Therefore, the relationship and influence of active exchanges between older adults, the family (e.g. support and caregiving) and the community (e.g. volunteering) should be further explored.

The presence of children along with the potential source of social and financial support for elderly parents are considered as important factors regarding care for older adults. As families transformed from extended into nuclear form to fit the current economic conditions and modern

lifestyles, the family size faced a considerable decline. Simultaneously, co-residence between older adults and their children remains as a norm (Sulaiman & Masud, 2012). Longer life expectancy and high cost of housing also caused a change in family composition to become multi-generational (Antonucci, Birditt, Sherman, & Trinh, 2011; Izuhara & Forrest, 2013). The family should adapt to changing social circumstances to increase the possibility of its survival, for example, through structural adaptation as in 'beanpole families' which have more surviving family members but with smaller number from each generation (Aziz & Yusoff, 2012) and functional adaptation by 'women in the middle' (Jones & Leete, 2002), who continue to offer protection and care to older members despite shifting social conditions.

Economic growth and urbanization promote economic values that sometimes contradict interdependence and collective responsibility (E. Lee, Ong, & Smith, 1973). These changes possibly generate modern pressures on the individual and family. Moreover, families tend to highly invest in their children's education for social mobility and allow the younger generation to pursue career opportunities in urban areas which change the nature and relations in large family networks. These situations may need the reconstruction of family ties and negotiation of family roles and responsibilities. Increased educational chances and larger chance of participation for women in the formal labor force also mean a decline in the pool of traditional carers in the family system, and consequently, increase the demand for alternative care providers for older adults (Chee & Barraclough,

2007). Therefore, there is an urgent need for more community-based support and services to respond to the growing demands for LTC. A continuum of care linking health and social care is fundamental in meeting the various care needs of older adults. A multi-sectoral support for the older population is reflected in the way the state, civil society, and the private sector are involved in the planning and delivery of support services for older adults.

Federal Government

The government, through the Ministry of Women, Family and Community Development (MWFCD) and the Ministry of Health (MoH) are major providers of public-funded services and regulates major functions such as social welfare and public healthcare facilities and services. The MWFCD is a federal ministry that plans and implements social policies and oversees direction of the government ministries and agencies in achieving the goals of gender equality, family development, and a caring society. The MWFCD, through the Department of Social Welfare, provides institutional (residential care) and non-institutional services (financial assistance, activity centers) for older persons. Apart from providing primary, secondary, and tertiary healthcare, the MoH is also actively involved in monitoring the National Health Policy for Older Persons (2008) and more recently, in the development of the new Private Aged Healthcare Facilities and Services Act.

The Ministry of Housing, and Local Government (MUWHLG) provides for the affordable housing schemes, regulates various areas pertaining to physical planning and housing, and guides local

government agencies in delivering municipal services and maintaining recreational and socioeconomic facilities.

National Development Plans

Development planning at the national level is guided by the Five-Year Malaysia Plans (FYMP), the National Physical Plan (NPP), and national policies in various sectors that are endorsed by the Cabinet. Malaysia (formerly, Malaya) has experienced a succession of eleven development plans since 1950 and the latest is the Eleventh Malaysia Plan (2016-2020). Ultimately, the national development planning operates within the specified goals of Vision 2020 and the Third Outline Perspective Plan 2001-2010 (Federal Department of Town and Country Planning, 2010). Throughout these consecutive five-year development planning, swift and rather inclusive development has managed to reduce some of the country's regional inequality. However, the gap remains large and continues to extend (Hassan, 2017; Hutchinson, 2016; OECD, 2016a).

Social Policies, Programs and Services

In response to population aging, the government has designed policies which aim to ensure the well-being of older persons and the special consideration toward this portion of the population in the inclusive national development approach. The National Policy for Older Persons became effective in 2011 providing the agenda and action plans for relevant ministries and various tiers of the government. Along with it, the National Family Policy 2012 also highlighted intergenerational solidarity within the family. Social welfare programs

for older adults include institutional care, financial assistance, activity centers with capacity to transport older adults to certain places, and assistive devices or aids.

Rumah Seri Kenangan are publicly funded shelter homes for older adults who do not have any family and financial support. A report by the Department of Social Welfare (2014) stated that there are 14 government funded old persons' homes, known as *Rumah Seri Kenangan* (RSK) and *Rumah Warga Tua* (RWT), which offer shelter and protection for 2,553 residents. These homes offer satisfactory care and support in the form of rehabilitative and counselling services for the residents (Visvanathan, Zaiton, Sherina, & Muhamad, 2004). Eleven of the *RSKs* are in Peninsular Malaysia and Sarawak and there are three *RWTs* in Sabah. There are two *RSKs* in Sarawak located in Kuching and Sibu. The facilities were undergoing reconstructions and residents were temporarily relocated to other nearby welfare institutions while the project was being completed (Lim, 2016).

The residents of these homes must fulfil the admission criteria including being Malaysian citizens aged 60 years and above who do not have the means to support themselves. They also must have good mental well-being (i.e., be free from any mental illnesses) and do not have any contagious diseases. The lack of family support is normally the main factor affecting the decision to stay or be admitted to the old persons' homes. For older adults who are poor but have family members to provide care for them, a financial assistance

scheme is present locally called the *Bantuan Orang Tua* whereby the older person receives RM300 per month. This amount for financial assistance is to be raised to RM350 as per the 2018 budget of the government.

The Department of Social Welfare also runs two homes for the chronically ill (*Rumah Ehsan*) and two social rehabilitation centers for beggars and the destitute (*Desa Bina Diri*) which are not age-specific facilities.

Senior citizen centers (*Pusat Aktiviti Harian Warga Emas*) provide for the elderly in the community with some centers having a van for transportation (*Unit Penyayang Warga Emas*). Additionally, the federal government offers financial assistance for poor elderly (*Bantuan Orang Tua*) alongside other financial support by the State government and other religious or charity bodies. Lifelong learning programs are also popular among older adults promoting their engagement in active and productive activities in later life.

Besides providing primary, secondary, and tertiary healthcare the MoH is also actively involved in monitoring the National Health Policy for Older Persons (2008). And more recently, in the establishment of the new Private Aged Healthcare Facilities and Services Act. The new Act was gazetted in March 2018. Until the new law is enforced, the present regulatory mechanism distinguishes by types of facility with regard to registration. Private healthcare facilities and nursing homes are licensed by the MoH while the

old persons' homes are to be registered with the Department of Social Welfare.

Other government agencies and departments such as the Civil Service Department, Armed Forces Fund Board, Employee Provident Fund, and the Social Security Organization handle the government- or employment-related social security programs and schemes. The government also offered some tax reliefs for Malaysian citizens, through the Inland Revenue Board of Malaysia, for the medical and healthcare expenses of parents (limited to RM5,000) or for parental care (RM1,500 for one parent) borne by the adult children. As population aging has entered the political discourse in Malaysia, gender issues have always been dominant in the social security system regarding health, financial support, and welfare. With the longer life expectancy of women and the cumulative shortcoming over the lifespan, adding the demographic dimension piqued the issue of quality of life and the needs social protection and LTC for the growing segment of the population.

Social Protection Schemes for the Elderly

A variety of programs and schemes under public health, welfare, employment, and education systems, in addition to rural and urban development plans in poverty eradication comprise Malaysia's social protection system (Hamid, Ibrahim, & Chai, 2013). There are gaps in the current system of social security which provide basic protection through contributory and non-contributory schemes. The system provides for healthcare and primary needs for livelihood in old age but does not necessarily address the need for LTC. Furthermore,

the financial assistance is not a substitute for LTC and there is still a robust focus on the family to cater support and care, regardless of whether it is going to be provided by the family network or paid formal services. Over the long term, these programs and schemes will not be sustainable in view of the rapidly aging population that is expected to become double and even triple in magnitude in the next few decades. So, there is a need to increase the social protection floor and LTC for older adults and to use innovative methods that empower the distribution of care burden and cost-sharing of care across individuals and family, community/ voluntary sector, the market, and the government. The government is reviewing the institutional arrangements of social security programs/ schemes and care services. Also, the regulatory mechanisms for the emerging aged care industry is being consolidated through a new act which bonds the regulation private nursing homes and care centers for older adults under a single body.

Role of State-level Administration, Local Governments, Communities, and Other Not-for Profit Players

State governments, who have full control over the Islamic affairs, have played their roles and efforts to cater the need of care for elderly in their local community. For instance, Islamic Department of Selangor (JAIS) under *Lembaga Zakat Selangor* has funded two care institutions namely *Bait al Mawaddah* and *Rumah Orang Tua Darul Salamah*. *Bait al Mawaddah* is a residential facility that is purposely built to provide care for poor and neglected, hence vulnerable, older

Muslims. *Rumah Orang Tua Darul Salamah* is a short-term stay and transit care that emphasized lifelong education for Islamic religious studies, so-called *pondok*. As an attempt to enhance the quality of care, these facilities are equipped with facilities such as clinic, rehabilitation, *musolla* (prayer area), garden and dining areas. As mentioned before, these forms of facilities commonly highlighted the Islamic concept namely *Baiti Jannati* (My home, My Heaven) which consist of six elements such as promoting happiness, cultivating intellectual capacity, providing health care, enhancing Islamic way of life, providing comfort, and ensuring that the home is filled with strong love and family bonds.

Next, local governments in Malaysia largely fall under the purview of the state governments but the federal ministries, specifically the Ministry of Housing and Local Government and the Ministry of Federal Territories have an oversight in expressing, performing, and monitoring all laws related to local government. There are three types of local government with a range of responsibilities reflecting their size and capacity: city councils (in the Federal Territory of Kuala Lumpur and in Sabah and Sarawak), municipal councils, and district councils. The scope of authority is related to urban planning, the development of basic facilities and infrastructure, monitoring development, public health, waste management, business licensing, maintenance of peace and landscape, and improving the local economy. The local authorities stem their income from taxes, non-tax revenue, and federal or state government allocations. Nevertheless, due to

centralized federalism or the periodic intervention of the federal ministries, the local governments' functions remain to be diluted within other levels of government (Berman, 2017).

As presented in Table 4, selected peak organizations on aging and the older persons are incorporated in social policy practices as representatives in the National Advisory and Consultative Council for Older Persons (NACCOP).

Table 4: Organizations on Aging and Their Roles

Organizations	Major roles
<i>Majlis Pusat Kebajikan SeMalaysia (MPKSM)</i>	• Institutions for poor older persons without family relations (<i>Rumah Sejahtera/ Pondok Sejahtera</i>)
Central Welfare Council of Malaysia	• Senior activity centers (<i>Pusat Aktiviti Warga Emas</i>)
National Council of Senior Citizens Organisations Malaysia (NACSCOM)	• Senior citizens clubs • Lifelong learning • Old folks' homes • Day centers
<i>Persatuan Kebajikan Usiamas Malaysia (USIAMAS)</i> Goldenage Welfare Association Malaysia	• Advocacy • Home help (collaboration with HelpAge Korea)
Gerontological Association of Malaysia (GeM)	• Home visits • Intergenerational initiatives • Research and training
Alzheimer Disease Foundation Malaysia (ADFM)	• Day care center for Alzheimer's Disease patients • Caregiver support groups Training • Recognized as part of the clinical management of dementia (Dementia Clinical Practice Guidelines, Ministry of Health, 2009)
<i>Majlis Kebajikan dan Pembangunan Masyarakat Malaysia (MAKPEM)</i> National Council of Welfare and Social Development Malaysia	• Advocacy • Training for caregivers and home help volunteers

These peak organizations were also partners in the implementation of the National Policy on Older Persons (2011) and the National Healthy Policy on Older Persons (2008). They were also allocated funds to run activities or programs by department

or ministry (i.e. Ministry of Women, Family and Community Development or Ministry of Health) or in collaboration with other government and non-government agencies. These organizations and their affiliates continue to be recognized and

privileged in acquiring government funding, but the activities/ programs tend to be geographically limited in reach and scope.

The community is represented by a spectrum of civil society actors on aging in Malaysia. Based on a recent engagement of the Malaysian Institute of

Ageing with the third sector on the 12th of October 2017, it was found that there were many individual actors with important roles with regard to aging and the elderly. We have identified a core role of the actors, but their actual activities may not necessarily be limited to these roles (Table 5).

Table 5: Selected Civil Society Organizations on the Aged and Aging

Research institutions	<ul style="list-style-type: none"> • Malaysian Research Institute on Ageing (MyAgeing™) • Social Security Research Centre (SSRC) • Community Rehabilitation and Ageing Research Centre (H-Care) • USM-RIKEN International Centre for Ageing Science (URICAS) • Gerontech Lab
Professional bodies	<ul style="list-style-type: none"> • Gerontological Association of Malaysia (GeM) • Malaysian Healthy Ageing Society (MHAS) • Malaysian Society of Geriatric Medicine (MSGM) • Society for Anti- Aging, Aesthetic and Regenerative Medicine Malaysia (SAAARM)
Retiree associations	<ul style="list-style-type: none"> • <i>Yayasan Pesara Malaysia</i> • <i>Persatuan Pesara Malaysia</i> • <i>Kelab Pesara Malaysia</i> • Various civil service retiree associations, i.e. former teachers, police, firefighters, armed forces, veterans
Disorder/ Disease/ Health support	<ul style="list-style-type: none"> • Alzheimer Disease Foundation Malaysia (ADFM) • National Stroke Association of Malaysia (NASAM) • Malaysian Parkinson Disease Association
Senior citizen clubs	<ul style="list-style-type: none"> • NACSCOM • Senior Citizens Association • Selangor and Federal Territory (SECITA) • Aged United to Organize Rest & Recreation (AUTORR) • Various local senior citizen's clubs • Various health clinic associated senior citizen's clubs • Various neighborhood-based senior citizen groups (<i>Rukun Tetangga or Jawatankuasa Kemajuan dan Keselamatan Kampung</i>)
Advocacy / welfare groups	<ul style="list-style-type: none"> • MPKSM • USIAMAS • MAKPEM

Table 5: (continued)

Learning / education groups	<ul style="list-style-type: none"> • University of the Third Age (U3A) • al-Jenderami • Modern pondok/ <i>pesantren</i>
Faith-based groups	<ul style="list-style-type: none"> • Little Sisters of the Poor • Than Xiang • Hindu Sangam • Darul Insyirah
International groups	<ul style="list-style-type: none"> • Rotary • Lions • Salvation Army • Tzu Chi

The discussion and deliberation of issues among the civil society organizations highlighted several issues of the existing structure and modus of operandi of civil society organizations. Many senior citizen associations are not registered and do not collaborate with each other. Even registered groups may be dormant or inactive in the engagement of older adults. The third sector on aging does not present its resources nor share experiences to achieve some intra or inter-sectoral alliance. The focus on monitoring and quality of care is still on residential facilities and services, not daycare or mobile care. Service providers need to join in as an emerging voice for the older care industry. Still, there is a gap in public funding, independent capacity, and service coverage to be bridged. Absence of common understanding on the issues involved and failure to respond to the new opportunities for civil society growth. These issues indicate the need for the aggregation and harmonization of civil society organizations at the national level to encourage a collaboration and more efficient responses to the needs of older population.

Elder Care Services by Profit and Not-for Profit Providers

Services by the for-profit and not-for-profit providers cater for families looking for support to care for older adults requiring long-term healthcare and daily physical assistance. Residential care for older Malaysians was originated by charity and faith-based organizations, and in the recent years has become a demand capitalized by businesses. The private sector plays an essential role in providing medical care, health and nursing for the physically-dependent older person. Alternatively, the government-subsidized, hence more affordable, charity-type residential care institutions were primarily shelters and homes for older persons. The private healthcare facilities and the nursing homes were regulated by the MoH while the shelters and the homes for older persons were registered with the Department of Social Welfare. Another private sector role is in private financing of retirement. As part of the Government's Economic Transformation Program to drive the growth of

the nation's private pension industry, the Private Retirement Scheme (PRS) was introduced in 2012 to promote retirement savings. With the approval by the Securities Commission Malaysia, this scheme was recognized as the third pillar of voluntary saving scheme under Malaysia's multi-pillar pension framework, protecting members' interests and educating the public on retirement planning. Other initiatives by the private sector include concessions in service fees and preferential treatment (e.g., special lanes, parking, resting areas) for retirees or older persons.

The scope of civil society falls primarily in the provision of shelter and necessities for the poor older persons who have no family members or have nobody to support them. There were roughly 110 Rumah Sejahtera providing shelter for some 1,200 older adults. Besides, there were up to 400 more welfare and shelter homes (not necessarily age-specific) accommodating around 14,000 persons. Results from a phone survey showed that 28% of the residential older-person care providers included the not-for-profit organizations, comprising charitable, faith-based and voluntary groups. These providers cater to about 37% of the older population living in institutions (e.g. homes for older persons, older-person shelters or nursing homes) with an average size of 40 residents. 62% out of the 392 residential care providers reported the collection of fees, 38% received public donations, and 20% obtained government grants. Besides residential care, the civil society also has a principal role in community-based services including senior activity centers,

clubs and associations serving older persons who are physically independent or socio-economically disadvantaged.

The voluntary or not-for-profit sector normally provided no or minimal care (supervision), but with the aging and increasing disability of the residents, the providers have had to increase their scope into low (supervision and trained personal care) and high care (round-the-clock trained personal care and nursing). Many of them did not have the capacity to deal with the increasing level of care. They were unable to expand their functions without funding or grants and consequently, these institutions had to increase their financial ability by diversifying their income streams including income from asset rentals, corporate donations, fundraising activities, running their own gift and thrift shops, and nominal payment for services and training. The older and superior organizations with a lot of assets and connections might have the advantage over smaller associations/ groups in this aspect. Furthermore, it was also found that organizations that incur a fee for the service could no longer get government funding even though the fee was not set at a market rate or to create profit. It is significant to note that there is some common misunderstanding of 'for-profit' and 'not-for-profit' in the current situation. Therefore, residential aged care providers are facing a strain in their resources but simultaneously, there was a lack of incentives for the voluntary or not-for-profit providers to enlarge their level and scope of services.

Important Issues Related to Care Needs and Provision

There are the major trends that have been taking place concurrently have potential to influence care of the elderly.

Increase in Longevity

An important trend in care is the greatly accelerated rate of increase in the oldest-old population, that is those who are most vulnerable and in need for social care and support. Demographic and epidemiological changes have also influenced the capacity of informal carers to offer care for older family members. Longer life expectancy and high disability rates due to co-morbid conditions among older Malaysians have pushed family members to their limit and increased the demand for formal LTC services that could manage the changing health circumstances of older adults (Ambigga, Ramli, Suthahar, Tauhid, Clearihan, & Browning, 2011). At the same time, there is the intensifying burden of social protection and demands for care services that came to the attention of the government. Longevity also required a supportive

and assistive environment to sustain their functional capacity and mobility in the community. Thus, age-friendly environment is one of the important component that should be emphasized to fulfil the need resulted from longevity.

Changing Family Size and Composition

As the patterns of fertility and mortality changed, increased educational and employment opportunities, as well as evolving migration trends have profoundly influenced the family. According to the figures from the 1991, 2000, and 2010 censuses, the percentage of extended family households have alleviated around 20% in the past two decades (Table 6). However, the average household size, has continue to decline from about five persons in 1991 to four persons in 2010. Although the decline in family size can be attributed to decreasing fertility rates, the falling number of household members are more influenced by factors relating to housing design and costs (pricing), urban living and congestion (density), as well as changing consumer and familial values (privacy).

Table 6: Household Type and Average Household Size, Malaysia, 1991, 2000 and 2010

Type of Household	1991		2000		2010	
	%	AHS	%	AHS	%	AHS
Single person household	7.4	1.0	7.1	1.0	8.3	1.0
Unrelated member household	2.9	4.4	3.5	4.3	5.2	3.7
Nuclear family household	64.5	4.8	65.4	4.5	62.8	3.9
Extended family household	22.6	6.2	20.3	6.2	20.5	6.8
Other related members' household	2.6	3.3	3.6	3.6	3.2	3.2
Total Private Households	1,694,091		4,777,576		6,341,273	
Average Household Size	4.8		4.6		4.2	

Source: Department of Statistics Malaysia (1995, 2004, 2013a).

Co-residence and Sandwich Generations

A high proportion of older Malaysians continue to co-reside with their adult children and/or other family members. With social changes and modern lifestyle demands, the family adapts itself by changing its structure and activities to accommodate new roles and functions. These trends have challenged the capacity of adult children—particularly those who belong to the sandwich generation—in caring for young children and aging parents. Adult children in their middle ages are also facing a period marked with tremendous changes in life and transition in personal achievement and lifestyles. Mid-life is seen as the time of balancing responsibilities of parenthood, caregiving, and also the peak of career development and advancement.

Economic and Social Vulnerabilities

Globalization and rapid socioeconomic growth and development toward becoming a developed nation by year 2020 have brought a significant impact on the quality of life of the Malaysian older adult population. Older persons who were advantaged in their earlier life stages would have better asset accumulation than those who were disadvantaged (Tengku Aizan, 2015). However, findings show that older Malaysian had poor saving behavior for their old age and lack of income security (Hamid & Masud, 2011). As older Malaysians tend to live longer, they may outlive their saving. Thus, poverty might be a risk on the social and health in later life.

Mobility of Families and Presence of Non-family Caregivers in the Household

Large-scale international internal migration and in-migration emerged as a result of urbanization and industrialization. Internal migration was

largely within the state (61.3%) followed by inter-state (28.5%) (Department of Statistics Malaysia, 2013). By inter-state migration, younger population tracks educational and employment prospects in urban areas, leaving behind older persons in the rural areas. In 2010, the total number of international immigrants was 2.4 million (8.0% of total population). However, in the last two decades, foreign domestic workers have been hired to take over the caregiving role of families (Tan & Gibson, 2013).

Demands of Work and Family Life

The large-scale entry of women – and not only young women – into the workforce is also a social change. Majority of middle-aged women (i.e., the principal caregivers to the aged) now work. As the phrase “women in the middle” suggests, such women are in middle age: in the middle from a generational standpoint, and in the middle whereby the demands of their several roles compete for their time and energy. Time constraints, lack of energy, and numbers of commitment are presented as a three common barriers in performing multiples roles and commitment towards family activities (Sabil & Marican, 2011). Additionally, care burden has increased due to the cultural and filial responsibility towards taking care for frail parents and extended parenthood were common practice in our society for middle-aged group (Wong, Awang, & Jani, 2012). Increase in the caregiving roles and responsibilities to care for a parent in addition to childcare add to the burden on women, especially those in formal work (Dare, 2011). These barriers may have an impact on family relationship and

contribute expressively towards work-family conflict (Wong et al., 2012). Older parents are expecting to live with their children rather than in an institution and receive caregiving and financial support from their children (Alavi et al., 2011).

Access and Affordability of Quality Health and Long-term Care

Even though healthcare coverage is universal with minimum fees, access is still limited by location and those who are able to afford out-of-pocket expenses (private health and long-term care) (Barracough, 1999). In addition, most Malaysians are not covered by private health insurance.

| Policy Recommendations

1. Changing people’s mindset and the focus on promoting health and financial wellbeing across the lifespan to ensure good health and income security in old age.
2. Age and gender inclusive policy approaches to promote age- and gender-integrated society, including the recognition of care work and roles of both males and females in family care.
3. Strengthening intergenerational solidarity in family and community, emphasizing the different care needs across the lifespan.
4. Due to the socio-economic and health differences of older population, policies must be designed according to the typology of older Malaysians and their level of care needs.
5. Transforming work culture and environments geared toward a longevity economy.

6. Facilities and services should be made more accessible and affordable for the majority of older Malaysians by experimenting with different models of service delivery.
 7. Strengthening the capacity of civil society organizations in providing care for the older persons.
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Myanmar

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Introduction

Populations are aging in many societies as consequence of demographic transition with regard to lower fertility and reduced mortality. With aging populations, the world is paying attention to active aging defined as the process of optimizing opportunities for health, participation, and security to enhance quality of life as people age (Beard, Officer & Cassels, 2015). Myanmar, one of the poorest and least healthy countries in Southeast Asia, is also facing the increasing pace of aging mirroring a rapid fertility transition. Since the first quasi-civilian government has started political and economic transition, Myanmar has been increasingly receiving attention to achieve better quality of life of older persons by implementing related care provision programs in collaboration with international non-government organizations (INGOs), non-government organizations (NGOs), and community-based organizations (CBOs). In spite of initiating the care provision programs, families still remain the mainstay of the social, financial, and instrumental support for the older persons. The study is carried out with the objectives to collect comprehensive information on the role of families and local and

national support systems when it comes to care of older adults and to provide evidence for better understanding of gaps in care provision. The study focuses on the people ages of 60 years and over and interchangeably uses the older persons, older people, and older adults.

Population Aging and Care Needs in Myanmar

Asian countries are facing a change in dependency ratios and population structures with tremendous demographic shifts. Nowadays, it cannot be denied that population aging is the priority of social agendas in Asia. Like other Asian countries, Myanmar's population is aging while fertility is rapidly declining. The country's total fertility rate has dropped from 6.1 in the 1960s to 2.25 by 2010-15 (United Nations, 2015). The 1973 census has reported that the proportion of the population aged 60 years and older was slightly over 6%, but it has gone up to 7.9% by 2010 (United Nations, 2011). According to the 2014 Myanmar Population and Housing Census, the total population of Myanmar was 50.3 million people whereby the population aged 60 and older was 4.5 million or

8.9% of the total (Department of Population, 2017a). An increase in the older population has been occurring at an average annual rate of 2.4% over the past 40 years while the total population growth rate was 1.4%.

It is projected that while the total population would be growing at an increasingly slower rate, the older population will be increasing at a faster rate (Department of Population, 2017b). During the period of 2015 to 2050, although the total population tends to increase at an annual rate of less than 1%, the older population will be accumulating at 3% and higher until the period of 2030 to 2035. Besides, Myanmar is projected to have a large proportion of older persons reaching 15.5% by 2035 and 20.2% by 2050. During the period of 2045 to 2050, the older population will still be growing at about 1.7%. Increase will be even faster in the population at age 80 and above with about 5% or more between 2025 and 2040. Whereas the number of children stays fairly constant until it starts to decline from 2035 onwards, the number of people at the working ages continues to rise but at a slower rate. This will bring about that the growth in the prime working ages will be more than children by 2050 and ultimately result in the proportion of the older population being larger than that of the younger population. Those figures indicate that families will face challenges in taking care of older people in the near future.

In terms of current household living arrangements of older Burmese people, the thematic report on the older population has described that vast

majority of them live in conventional households and that it is rare for an older person to live in an institution (Department of Population, 2017b). The thematic report considered the living arrangement forms with eight classifications: living with a child with or without grandchildren and other residents; living alone; living only with a spouse; living with grandchildren without the adult children, although other family members may live in the house; living with a sibling but not a child; living with other relatives but not a child, grandchild or sibling; living with non-relatives only; and a final category of household arrangements that could not be classified.

According to the said thematic report, about three-quarters of the older population co-reside with a child (Department of Population, 2017b). Reports of men living with children are higher than women. It is also found that although there are older adults who are living alone or with a spouse only, the figures for those categories were relatively lower compared to those co-residing with a child. Women are more likely to live alone than men. It is worthy to note that co-residence with a child was the most common household arrangement in both urban as well as rural areas (Department of Population, 2017b).

According to the statistics presented by the thematic report, other living arrangement categories represent a relatively low proportion: older people living with a grandchild and no children but possibly living with others; living with a sibling, no children, no grandchildren but possibly living with others; living with other relatives, no children, no

grandchildren, and no sibling; and living with non-relatives only (Department of Population, 2017b). Therefore, it can be generalized that living with a child/children is the most common living arrangement form while other living arrangement forms are less common. It can be said that older persons living in conventional households is a striking feature of Myanmar society, similar to other ASEAN countries.

In the Myanmar religious and cultural context, younger people have been taking care of older people as a noble practice. Traditionally, the society gives older persons meaningful roles as advisors within family as well as community. Furthermore, in Myanmar where people live with extended families, family plays a very significant role in determining the well-being of older persons. The country has witnessed rapid economic expansion in recent years since economic and political reforms have been initiated since 2010 (Teerawichitchainan & Knodel, 2016). With rapid economic expansion, family members are increasingly engaged in jobs and younger people are migrating for work. This may result in traditional family care system likely eroding whereby looking after the older people will become burdensome for younger family members.

Approximately a quarter of the older people have reported that they have at least one form of disability that affects their seeing, hearing, walking, remembering and concentrating abilities (Department of Population, 2017b). In addition, a survey of older people's use of health care services in five Myanmar Townships found that more than half of the respondents aged 60 years and older

had some or even many difficulties when they move around (Rajan & Seerupa, 2016, as cited in Department of Population, 2017b). Accordingly, most of the older persons can be considered as those having care needs.

Concerning the health status of Older Burmese, Knodel (2014) observed that only a third of older persons reported that their overall health was good or very good. Health status of older people of Myanmar is lower compared to neighboring Thailand (Knodel, 2014, as cited in Teerawichitchainan & Knodel, 2016). The proportions of older Burmese who reported poor health status increased significantly with age, from 17% to 32% between those aged 60–64 and those aged 80 years and older (Knodel, 2014).

According to the 2012 survey of older person, 22% of the older respondents have reported that they were not able to perform at least one of the five activities of daily living (ADLs) – i.e. bathing, dressing, eating, toileting, and laying down – on their own. Besides, nearly 51% reported that they have at least one form of five functional limitations: walking 200-300 meters, lifting 5kg, crouching/squatting, using fingers to grasp/handle, and walking up and down a set of stairs. Of the respondents, 28% indicated they have difficulty to independently carry out at least one of five instrumental activities of daily living (IADLs): doing household chores; using or counting money when shopping or paying for something; taking medications such as taking the right portion or at the right on time; using transportation such as buses, boats, trains,

motorcycles, cars or trucks; and making a phone call. Teerawichitchainan and Knodel (2016) have described that 57% of the older respondents asked during the 2012 older person survey had at least one of the overall 15 difficulties and were consequently considered to represent those in need of long-term care (LTC).

The Department of Social Welfare (2014) presented that of all older people, more than 10% or about 500,000 may be vulnerable. Of the vulnerable group, 30% were being looked after by their extended families and therefore, the remaining 70% should be considered as those who need attendant care.

Care Providers

Family

In Myanmar, the vast majority of older people live in conventional households and traditional family care is a central care system. Such care is much important because older parents want to spend time with their family members rather than other care providers. They always expect family member's care especially when they feel physically or mentally ill and the family plays a significant role in promoting the older persons' well-being. In Myanmar, where the share of out-of-pocket payment for health services is extremely high, it is undeniable that family has been a main provider of financial and instrumental assistance for the older adults in poor health conditions especially those with LTC needs (Teerawichitchainan & Knodel, 2016; Grundy et al., 2014 as cited in Teerawichitchainan & Knodel, 2016). Thus, family-

based care can be considered as an intrinsic caring model in Myanmar context.

Government

The Myanmar government is keen on investing in social protection programs directed at the vulnerable groups in society. The Department of Social Welfare (DSW) under the Ministry of Social Welfare, Relief, and Resettlement (MSWRR) is implementing social welfare services including care of older persons on behalf of the state. Homes for the Aged is one of the care models provided by the DSW throughout the country. The DSW provides resources such as rice, cash for food, clothes, and salary of the administrators of the Homes for the Aged every year as well as technical assistance like training courses for voluntary care givers (Department of Social Welfare, 2014). Homes for the Aged are located in the following 13 areas across the country: Kachin, Kayah, Chin, Sagaing, Tanintharyi, Bago, Magway, Mandalay, Mon, Rakhine, Yangon, Shan and Ayeyarwaddy (Department of Social Welfare, 2012). There were 71 registered Homes for the Aged established by social and religious organizations in different places across the country which housed 2,300 older persons (Department of Social Welfare, 2014). This subsequently increased to 78 registered homes across the country attending to 3,402 older residents (HelpAge International, 2015, as cited in Department of Population, 2017b). These homes are taking care of the older persons aged 60 and older who are facing social problems. Regardless of race and religion, necessities such as food, shelter, and health care are provided for older persons (Department of Social Welfare, 2012). The

Homes for the Aged are an important care model for the older adults because they will be the homes for those who are in need but without a care provider or even completely abandoned.

Another care provision of DSW is Day Care Center for the Aged. There are two daycare centers located in Yangon. One of them is being run by the DSW with the objectives of reducing social loneliness because some of the older people have sufficient financial means but they are in need of social support (Department of Social Welfare, 2014). The center is taking care of more than 100 older adults.

In the center, the older adults can be involved in group activities; do their hobbies like reading, painting, playing musical instrument, signing, chatting with other peers; taking meditation and so forth. The daycare centers can be considered an important model for older adults who feel socially and/or emotionally lonely. The center will provide services to older persons such as social and health care; old-age development; recreation programs; lifelong learning programs; and health promotion and nutrition programs.

Additionally, the state initiated a social pension, which was the first national, universal social protection scheme in 2017 with the purpose to ensure income security for people of older ages to empower them to meet their needs and to ensure access to health services (Shoon, 2017). Social pension is a cash benefit program and persons aged 90 years and over are being provided 10,000 Kyats (about 9 USD) per month every three months.

As mentioned above, the Myanmar government is very keen to invest in social protection programs for the vulnerable groups including the older population. The state is also paying attention to achieving improvements in the health status of the older population by implementing a healthcare program under the umbrella of the Community Health Care program. According to Han (2012) and the Ministry of Health and Sport [MoHS] (2014), the healthcare program is being implemented with the objectives of promoting the health of older adults and increasing accessibility of geriatric services.

To establish those objectives, the program intends to have at least 20% of the ambulatory services required by older adults to be provided by geriatric clinic services through primary health care in the project townships (Han, 2012; MoHS, 2014). These geriatric clinics opened by the Township and Station Hospitals and Rural Health Care Centers provide the specific care to the older people every Wednesday. It also encourages home-based geriatric care through families, health volunteers, and both local and international NGOs. The program provides advocacy and training to health personnel, voluntary health workers, family members, and community volunteers. Apart from those health services, the clinics also provide oral care and eye care to the older adults including cataract surgery, distribution of free eye glasses, and general dental treatment. Prevention of falls is also emphasized. They offer referrals to the township hospitals as well.

In terms of health promotion, the clinics for older persons have been undertaking the following

health promoting activities: demonstrating physical exercises; encouraging to do exercises regularly in groups like Tai Chi which is beneficial for the older adults in terms of prevention of heart disease and prevention of falls; screening procedures for high blood pressure, diabetes, heart disease, and other prevalent diseases like osteoporosis and cancer; initiating treatment depending on availability; referring to the appropriate tertiary health centers; providing rehabilitative program; providing vaccination program for pneumonia and influenza for the older adults at risk; and lastly, providing nutritional counselling and health education to the older adults as well as caregiver. The clinics also serve as recreational center which can reduce loneliness (Han, 2012). According to Han (2012), the health care program for older adults has been implemented in 20% of all townships which equals to 88 townships across the Regions and States. This program is being expanded by four townships every year.

The MoHS has been implementing the program in the project townships in collaboration with local NGOs like Myanmar Mother and Children Welfare Association (MMCWA), Myanmar Red Cross, Fire Brigade, Myanmar Women Federation (MWF), Voluntary Home Care services from Social Welfare Department and various local and international NGOs (Han, 2012).

Non-government Organizations (NGOs)

A volunteer-based home care program introduced by the Republic of Korea (ROK) in Myanmar in 2004 is a care provision model provided by

NGOs. It is a replication of the model of the Republic of Korea and other ASEAN countries, namely ROK-ASEAN Home-care Model. The main objective of the project is to improve the health and social condition of poor and lonely older people in order for them to attain better living status. The program is being implemented in collaboration with NGOs like the National YMCA and other local NGOs under supervision of DSW (Department of Social Welfare, 2014). Its benefit is LTC services at home (International Labor Organization (ILO), 2015). The activity is to take care of lonesome older persons by well-trained volunteers in the home setting. This model is considered a cost-effective model because it is an easy way to take care of the older adults (Han, 2012; Department of Social Welfare, 2014). This program was caring for approximately 30,000 older people (Han, 2012). As previously mentioned, the members of the community voluntarily look after each other as a form family spirit based on Myanmar tradition and culture; thus, there may not be much difficulty to establish and sustain a community-based care system. Another strength is that this care model can fill the gap for those older adults who are left alone when their family members go outside for work or due to other reasons preventing them from receiving any care of the family members. Hence, the model plays an important role in providing care for older adults.

In addition to the ROK-ASEAN model, another care model being practiced by a local NGO is the Day Care Center located in Yangon. It is being operated by the Myanmar Medical

Association (MMA) with the objectives of supporting elderly doctors aged 70 and above in three different aspects: financial, social, and services (Han, 2012). Its main activities are daycare center development and preparation of a home-based physiotherapy care project. It is also carrying out other functions like research programs, academic training programs, and the publication of a newsletter.

Community

In addition to the aforementioned care provision programs, other international bodies are also providing community-based care programs. These are Older Person Self Help Groups (OPSHGs) and rural development on aging (Department of Social Welfare, 2014). HelpAge International introduced OPSHGs in collaboration with DSW in 2009. The OPSHGs programs are being piloted in the four geographical regions of Ayeyarwaddy, Mon, Kayin, Yangon, and Mandalay; with the main objective of improving livelihoods among older people and their families. The beneficiaries are provided a package of in-kind and cash transfers and services, including LTC provided by volunteers. Each village has one OPSHG committee with five sub-committees, consisting of older persons aged 60 years and above, that determine how to spend the funds. Its membership is voluntary. The functions of OPSHGs are fund raising, income generating ventures, and health care services.

The older-person health care programs are part of OPSHGs. Those programs are providing

monthly mobile medical units, health awareness to older people and their communities on communicable and preventable diseases, and capacity building for local government health workers to older adults in the community. With the purpose of reducing poverty in rural areas, the program is creating job opportunities and supporting income generating activities of older people and their families. In this model, OPSHGs members receive home visit of a volunteer, can take loan and health care. Besides, the OPSHGs members aged 70 or 80 years and above are being provided with a social pension, in cash as well as in kind. Cash support is provided to every older adult member aged 70 or 80 years and above and regular non-cash support to the older persons with financial hardship. The conditions to receive a social pension vary across villages: In some villages, a social pension is provided to all the members at age 70 and above while other villages are providing it to those aged 75 and above; between ages 70 to 80; 80 and older; or at least 100 years old. Moreover, the amounts provided by different OPSHGs are also different. In terms of regular non-cash support, the older persons with financial hardship are supported with rice and oil. Occasionally, non-cash support like glasses, medicine (mostly vitamins supplements), food, clothing and so forth is provided to all of the older members at specified ages. In addition to those provisions, OPSHGs also conduct social and cultural activities like the annual Old People's Festival.

Since the care model of OPSHGs provides LTC as well as economic support, this can increase

self-esteem of the older people by promoting active social participation and also making them active and healthy. Thus, its role should be considered very important in ensuring the older persons' well-being.

In addition to OPSHGs, HelpAge International introduced the model of Rural Development on Ageing by adapting Village Development Committee (VDC) model. The program provides a non-contributory community transfer, both cash and in-kind. It is a wider community approach, which pays attention to income generation, livelihood activities, and vocational training among other things (ILO, 2015). Generally, its activities are similar to the OPSHGs' ones.

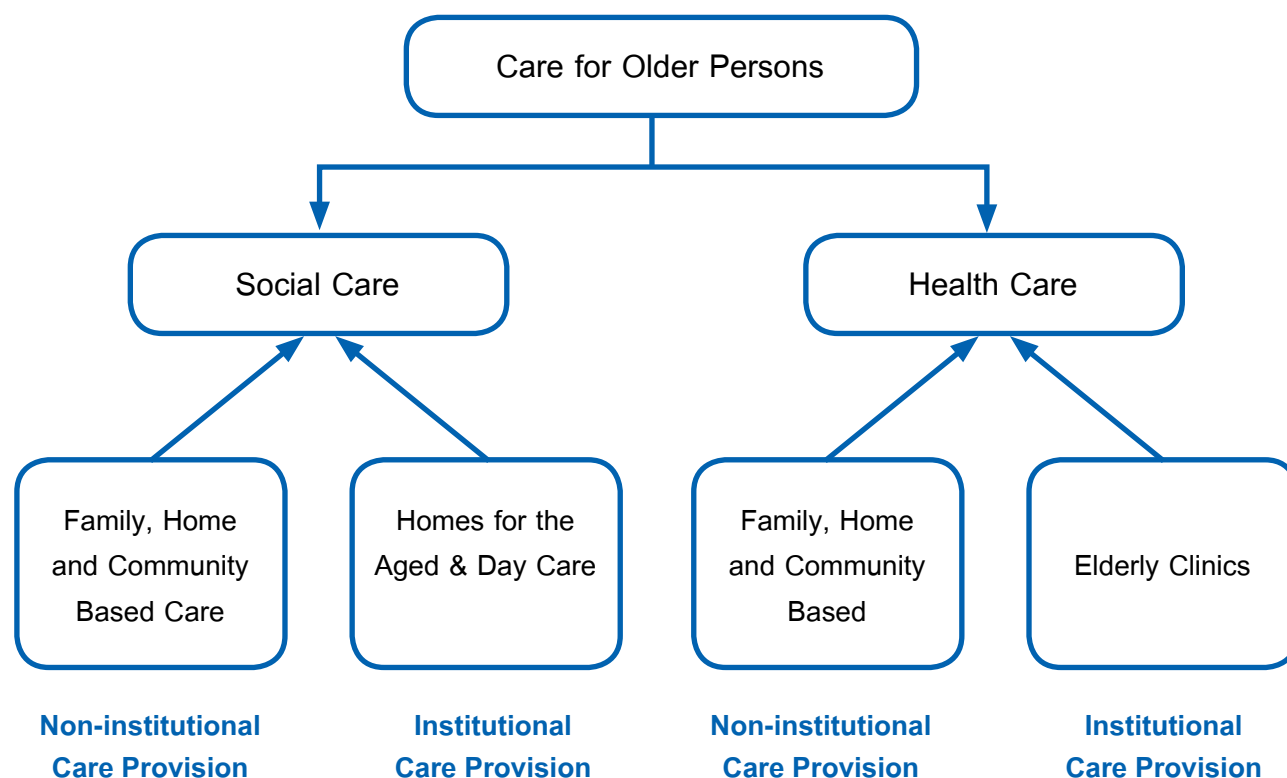
Apart from those actors, other national bodies are providing the care for older adults. The National Aging Network is one of the care bodies. In 2014, it was formed with the lead of the Department of Social Welfare and named "National Aging Network". There are 11 network members: Myanmar Council of Churches (MCC), HelpAge International, Little Sister Home for the Aged, Myanmar Baptist Churches Union (MBCU), National YWCA, Nway Htwe Lat

Group (Warm Hands Group), Save The Aged, Thabarwa (Natural) Center, Sesar Yeik Home for the Aged, Support Group For Elderly Doctors (SGED) and National Federation. These network member organizations are carrying out the care for older adults with different caring activities.

Private Sector

No information about private (non-profit as well as profit) care actors are provided by any existing literature which the author could access. This may be because particular private health care system, whether non-profit or profit, for the older people has not been officially implemented yet.

It can be seen that the different caring actors are taking care of older adults by practicing various care models. Since the state cannot provide the care for older adults nationwide yet, those care models introduced by INGOs and NGOs can play an important role to close this gap (Figure 1). In the context of Myanmar, all of those care models are considered appropriate, cost-effective, and fruitful (Department of Social Welfare, 2014).

Figure 1: Care System of Older Persons in Myanmar

Note: This is the author's interpretation of existing literature on care models.

All in all, contributory cash benefit programs, non-contributory cash benefit programs, and social care services are being provided to the older persons but with limitations. However, those programs are being implemented only in some areas, not universally. Not only the government but also non-governmental and civil society organizations are providing these programs. It is clear that government as well as INGOs and NGOs are the main actors in providing care to the older persons. And last but not least, the family plays a very significant role in taking care of the older people and is the major care actor.

Financing Schemes

Care of Older Persons

Care provision programs for the older adults are being financed in different schemes. Homes for the aged are being funded by the general government (ILO, 2015). OPSHG are being co-funded by the government and HelpAge International. Similarly, Rural Development on Aging is being also co-funded by the government and HelpAge. Home care programs are being co-funded by the general government budget and HelpAge International, World Vision, Global Vision, Young Men's Christian Association, Young Women's Christian Association, and Myanmar Maternal and Child Welfare Association.

It should be noted that social care services provided in pilot areas are being financed by the state and INGOs.

Health Care of Older Persons

The Myanmar government has not yet implemented the universal healthcare program for older adults nor any official policy or program to provide LTC for older persons (Teerawichitchainan & Knodel, 2016). In spite of increasing spending on health, the share of payments for health services that is out-of-pocket is still high (Latt et al., 2016). However, Myanmar is gearing to secure Universal Health Coverage (UHC) as part of its Vision 2030 in order that everyone in Myanmar can achieve the healthcare services they need without consequences of financial hardship. The report on health in Myanmar (2014) describes that the country is attempting to strengthen its health financing systems so that all people can have access to services without suffering any financial barrier when paying for them.

The reports concerning the healthcare system for older adults show only that MoHS was implementing health care programs for older adults in pilot areas but does not provide any clear evidence that the state is providing a particular healthcare financing scheme for older adults by subsidizing healthcare expenses. The report on healthcare in Myanmar expresses that the government health expenditures through tax-based financing will be increased for all dimensions (MoHS, 2011). Social health insurance under the social security board will be expanded. Health financing schemes financed

by GAVI HSS assistance (Hospital Equity Fund, MCH Voucher scheme and township-based health protection scheme) will be covered by the tax-based financing, CBOs, and donors for which beneficiaries are the poor.

It can be concluded that the country has not established the healthcare financing scheme for older adults and also no particular fund for the care for older adults, and the future plans to strengthen the health financing scheme do not mention any specific scheme for older adults although they pay particular attention to the scheme for other groups like for example the Maternal Child Voucher scheme.

Gaps in Care Provision

As previously mentioned, 500,000 older persons, which represent more than 10% of the older population overall, may be vulnerable; and 70% of those vulnerable older persons should be considered as those who are in care needs. In fact, the Homes for the Aged are providing care to 3,402 older residents. Existing studies have further presented that OPHGs are providing services to only a small fraction and the proportion of older adults who receive the service is 0.16% (Teerawichitchainan & Knodel, 2016). Home-care programs are being implemented only in selected geographic areas which are being facilitated with the older people project. Those programs have not been universally active yet, remaining in the pilot stage. With regard to day care centers, there are only two centers providing daycare and both of them are located in Yangon. The gap between

the needy population and those who are receiving care is identifiable.

There is no UHC financing scheme yet but the country is trying to improve the financing scheme with future plan. It is found that there is no plan to implement the particular health care financing scheme for older persons although attention is paid to other groups like Maternal Child Voucher scheme. In terms of prospects to meet the care needs, the National Social Protection Strategic Plan is promising to implement OPSHG programs nationwide. Furthermore, the Department of Social Welfare (2014) suggested the plans to be described as follows: 1) to form the National Committee for Older People; 2) to raise awareness on taking care of older people; 3) to implement programs for older adults in line with the National Plan of Action for Older People; 4) to establish a trust fund for older people; 5) to organize help for community-based home care services; 6) to carry out OPSHGs program widely; and, 7) to develop day care centers for Older People nationwide.

The care programs for the older adults focus on only those who are socially as well as financially vulnerable. In this regard, the possible gap is that private care models, which may support the older adults who are from high-income families and can afford to purchase the care services, remain uncommon. One of the probable gaps is insufficient skilled manpower.

Challenges Related to Care Provision

The challenges or issues related to care provision are effective coverage area, equity, and quality services. Some geographical areas in Myanmar where a variety of ethnic groups are living still remain hard-to-reach areas due to political unrest and conflicts or the remoteness of the location. Consequently, availability of the older-adult care programs is very limited in those hard-to-reach areas (ILO, 2015). Moreover, the health care services are not available in very remote and underdeveloped areas. Those can lead to a risk of geographical inequity. In other words, the care programs for older adults do not have national coverage yet.

Since Myanmar cannot provide UHC as well as particular healthcare financing scheme for older adults, the family as a unit has been mainstay for financial and instrumental support to the older persons. As result, the poor older persons will have financial hardship to access the health care.

In regards to LTC needs, it is to be remarked that few programs address this issue and infrastructure required cater to the needs of dependent persons in old age is missing (ILO, 2015). One attempt to close that gap is the Home Care Program. The care is not delivered by professionals, which may hinder the quality of service for difficult cases. According to Department of Social Welfare (2014), one of the challenges of the care for the older persons is to promote more resources and to have skilled human resource for community-based care

provision for the older adults. Besides, geriatric medicine has not strengthened yet. There is also limited consolidated monitoring of programs (ILO, 2015). In addition to those issues, low awareness on active and healthy aging concepts is one of the issues related to care provision for the older adults.

Laws and Regulations Related to Care for Older Adults

The 58th World Health Assembly recommended a wide range of actions for Member States and WHO, adopting resolution WHA 58.16 on “Strengthening active and healthy ageing” (Han, 2012). It suggested that policies and programs that promote healthy and active aging need to be developed, implemented, and evaluated.

In the 2008 Constitution of the Union of Myanmar, Article 32 (a) states that the Union shall take care of mothers and children, orphans, children of fallen defense services personnel, the aged and disabled (Han, 2012).

In the December of 2016, Older Persons Law was enacted with the aims to improve the health and social care provided to the older adults and well-being. The law is composed of 17 Sections: 1) Wordings and Definitions; 2) Objectives; 3) Forming Myanmar Aging Committee and its Role and Responsibilities; 4) Forming Local Organizations and their Responsibilities; 5) Older Persons’ Rights; 6) Supporting and Caring the Parents and Children’s Responsibilities; 7) Supporting and Caring the Older Persons and General Role and Responsibilities; 8) Earning Regular Income; 9) Social and Health Care

for Older Persons; 10) Creating Environment which the Older Persons can stay comfortable; 11) Older Persons’ Participation in Community Activities; 12) Issuing and Holding Aging Identity Card; 13) Establishing Homes for the Aged and Providing Care Services for Older Persons; 14) Issuing Registration Card to Social Organizations; 15) Raising Fund, Maintaining and Spending; 16) Crimes and Punishments; and 17) General. Section 9 describes that Myanmar Aging Committee to be formed for establishing the objectives will support social and health care to the older persons in collaboration with the respective ministries and perform the universal health coverage with Ministry of Health and Sport. Besides, to create a place that can provide sufficient care to the older persons, the committee has to support any family member or volunteer who will look after the older persons and also encourage the community in an appropriate way. By-laws are being drafted for the laws and will cover such matters as a family’s duty of care, government services for the older adults, and formation of self-help groups (Frontier Myanmar, 2017).

It is to be noted that the development of National Policy on Aging and National Action Plan on Ageing has been underway.

Other Related Laws and Regulations

According to the Social Security Law (2012), the insured civil services after retiring or the insured after receiving invalidity benefit and superannuation benefit under sections 33 and 35 have the right to enjoy medical treatment in accord with the stipulations if it is involved with the followings: (a) being a person who had paid contribution for 180

months and above and (b) being a holder of identity card for retirement issued by the Township Social Security Office after retirement.

The Social Security and Law (2012) established social security old age pension scheme for the employees of company who have already been at pension age and have contributed for at least 12 months and were registered to the Social Security Board. This law considers only companies with at least five workers and takes into account unpaid apprentices, permanent employees, and temporary staff. In this scheme, the employer and employee each contribute 3% of the worker's salary into the disability benefit, superannuation benefit, and survivor's benefit fund. It is an expensive scheme. Although this social security old-age pension scheme is established, it has not been active yet.

Policy Recommendations

After transformation of politics and the economy, the government reengaging international society has started to pay attention to the older adults' well-being as evidenced in its constitution, social protection strategic plan and commitment to a range of international conventions, including the 2002 Madrid International Plan of Action on Ageing. Moreover, the government has shown interest to invest the programs which are improving the older adults' welfare and policy makers are getting attention to formulation of policies on aging. Thus,

the study provides the recommendations so that the policy makers get attention in formulating policies related to the care system for older adults:

- 1) To reinforce traditional family care system which is the most appropriate and effective in Myanmar context
- 2) To strengthen OPSHG's which is also the relevant to the Myanmar context by encouraging local government
- 3) To build capacity for the care volunteer of older adults
- 4) To strengthen geriatric care services by sustaining the existing health care activities for older people by providing continuous support
- 5) To raise awareness on active and healthy aging concepts to family, community, care volunteers and other institutional care actors
- 6) To promote awareness raising for development of healthy public policy
- 7) To establish sustainable source of fund for the care system for older people

The possible limitations to take action some of those recommendations are as follows:

- 1) Difficulty to involve care volunteers for older adults in the long run
- 2) Insufficient health personnel for geriatric services, especially in rural settings
- 3) Increase of the government budget

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Philippines

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Overview

The Philippines is one of the most populated countries in the world and ranks as the second most populous member state among the Association of Southeast Asian Nations (ASEAN). According to the 2015 Census of Population (POPCEN 2015) conducted by the Philippine Statistics Authority (PSA) the population was 100,981,437 as of August 1, 2015, representing an increase of 8.64 million compared to the population of 92.34 million in calendar year 2010 and an annual growth rate of 1.72%.

Like most developing nations, the Philippines is a country in transition in socioeconomic development, demography, and epidemiology. An increase in life expectancy, mortality reduction,

and fertility reduction, brought about by advances in medical technology and medical care as well as improved socioeconomic conditions, led to the forecast of population aging by 2030 (Department of Social Welfare and Development & Department of Health, 2007).

Past Trends and Distribution of Older Persons

Older persons, i.e. individuals aged 60 years and above, accounted for 7.55 million or 7.48% of the total population in 2015. In 2015, there were 1,318,289 more older persons compared with the 2010 Census of Population and Housing (CPH) count of 6,230,480 persons as seen in Table 1. Older females represent a higher share than older males.

Table 1: Population Age 60 and Over, by Sex, Census 2010 and 2015

Census Year	Both Sexes	Male	Female
01 May 2010	6,230,480	2,754,055	3,476,425
01 August 2015	7,548,769	3,334,212	4,214,557

Source: Philippine Statistics Authority (2010, 2017a).

Comparatively, Regions IV-A and III and the National Capital Region (NCR) had the largest numbers of older persons whereby the share of the older population among the total population was 13.34%, 11.65%, and 11.28%, respectively. Whereas, Autonomous Region in Muslim

Mindanao (ARMM), Cordillera Administration Region (CAR), Region XIII, and Mindoro, Marinduque, Romblon and Palawan (MIMAROPA) had the lowest number of older persons with shares of 1.49%, 1.76%, 2.63%, and 2.88%, respectively.

Table 2: Population Age 60 and Over by Sex and Region, 2015

Region	Both Sexes	Male	Female
National Capital Region	851,214	360,523	490,691
Cordillera Administrative Region	133,093	60,653	72,440
Region I	493,195	207,456	285,739
Region II	283,678	126,198	157,480
Region III	879,439	384,376	495,063
Region IV-A	1,007,160	431,422	575,738
Mindoro, Marinduque, Romblon, and Palawan (MIMAROPA, Region IV-B)	217,155	99,140	118,015
Region V	458,438	199,015	259,423
Region VI	443,667	186,860	256,807
Region VII	493,259	216,217	277,042
Negros Island Region	394,349	174,979	219,370

Table 2: (continued)

Region	Both Sexes	Male	Female
Region VIII	383,844	174,418	209,426
Region IX	254,534	119,293	135,241
Region X	327,994	151,972	176,022
Region XI	344,530	163,796	180,734
Region XII	272,427	127,166	145,261
Region XIII	198,645	91,898	106,747
Autonomous Region in Muslim Mindanao	112,148	58,830	53,318

Source: Philippine Statistics Authority (2017a).

Future Increases in Older Persons

The older population increased with an average annual growth rate of 3.7% between 2010 and 2015. During the period from 2000 to 2010, the older persons' annual growth rate was recorded at 3.2%.

The older population is expected to double from 7.55 million in 2015 to 14.25 million in 2030 (Table 4). It is projected that by 2045, almost 16% of the population will be age 60 and older.

Table 3: Annual Growth Rate for the Population Age 60 and Over, Census 2000, 2010 and 2015

Reference Period	Annual Growth Rate
2000-2010	3.2 %
2010-2015	3.7 %

Source: Philippine Statistics Authority (2010, 2017a).

Table 4: Projected Population Age 60 and Over, 2010-2045

Year	Both Sexes	Male	Female
2010	6,261,500	2,768,600	3,492,900
2015	7,639,300	3,413,200	4,226,100
2020	9,508,800	4,287,200	5,221,600
2025	11,717,100	5,314,300	6,402,800
2030	14,246,100	6,483,400	7,762,700
2035	16,833,100	7,669,600	9,163,500
2040	19,654,200	8,964,800	10,689,400
2045	22,595,700	10,298,900	12,296,800

Source: Philippine Statistics Authority (n.d.).

Note: The 2010 Census-based Population Projections was in collaboration with the Inter-Agency Working Group on Population Projections.

Marital Status of Older Persons

In 2015, 57.9% of 60+-year-old Filipinos were married while 6.47 were never married and a large number were reported as widowed (30.63%) as seen in Table 5. The rest of the older population was categorized as in common-law/live-in marital arrangement (3.12%), divorced/separated (1.84%) and with unknown marital status (0.04%).

Among single older persons, the majority (66.45%) were females. Similarly, among widowed individuals, the proportion of females (78.66%) was also higher than of males (21.34%).

Literacy Rate among Older Persons

A person is considered literate if he or she is able to read and write a simple message in any

language or dialect (PSA, 2017a). In 2015, the literacy rate among the older population was recorded at 95.35%. It was slightly higher among males (95.59%) than among females (95.15%).

Engagement in a Gainful Activity

In 2015, 41.99% of older persons were engaged in a gainful activity during the 12 months preceding the census. Males represent almost two thirds of older persons engaged in a gainful activity (64.46%) (Table 6).

In October 2017, the total population of those 15 years old and over who were in the labor force was reported at 42.7 million. The total population of those 55 years old and over in the labor force in 2017 was estimated at 6.20 million, 55.29 thousand persons higher compared with 6.15

Table 5: Total Population 60 Years Old and Over by Marital Status, 2015

Marital Status	Population	Percentage
Single	488,599	6.5
Married	4,370,602	57.9
Widowed	2,311,992	30.6
Divorced/ Separated	139,202	1.8
Common-Law/ Live-in	235,256	3.1
Unknown	3,118	0.0
Total	7,548,769	100.0

Source: Philippine Statistics Authority (2017a).

million in 2016 (PSA, 2017b). 55 years was mentioned in the previous statement because there is no disaggregated data of 60 years old and over in the Annual Labor and Employment Estimates.

By major occupation group, older persons engaged in skilled agricultural forestry and fishery comprised the largest group representing 37.65% of the total, followed by elementary occupations with 15.75%, managers with 13.48%, and services and sales workers with 10.46% (Table 7).

Table 6: Gainful Workers 60 Years Old and Over by Sex, 2015

Sex	Gainful Workers 60 Years Old & Over	Percentage
Male	2,043,089	64.5
Female	1,126,317	35.5
Total	3,169,406	100.0

Source: Philippine Statistics Authority (2017a).

Table 7: Gainful Workers 60 Years Old and Over by Major Occupation Group, 2015

Major Occupation Group	Gainful Workers 60 Years Old & Over	Percentage
Managers	427,116	13.5
Professionals	88,589	2.8
Technicians and associate professionals	100,789	3.2
Clerical support workers	63,400	2.0
Service and sales workers	331,560	10.5
Skilled agricultural forestry and fishery workers	1,193,130	37.7
Craft and related trades workers	279,145	8.8
Plant and machine operators and assemblers	178,382	5.6
Elementary occupations	499,049	15.8
Armed forces occupations	2,167	0.1
Other occupation not elsewhere classified	5	0.0
Not reported	6,074	0.2
Total	3,169,406	100.0

Source: Philippine Statistics Authority (2017a).

Poverty Incidence among Filipino Older Persons

“Poor” as defined by the National Economic and Development Authority refers to individuals and families whose income falls below the poverty threshold and/or who cannot afford to provide, in a sustained manner, their minimum basic needs of food, health, education, housing and other essential amenities of life. The PSA report on the country’s official poverty statistics for the basic

sectors for 2015 provided estimates of poverty incidence using the income and sectoral data from the merged Family Income and Expenditure Survey (FIES) and Labor Force Survey (LFS). As presented in Table 8, poverty incidence is stated in NSCB Resolution No. 2 series of 2007 and it refers to the proportion of families or individuals with per capita income or expenditures less than the per capita food threshold among the total number of families/individuals.

Table 8: Poverty Incidence Among Older Persons, 2006, 2009, 2012 and 2015

Year	Poverty Incidence
2006	16.9
2009	16.1
2012	16.2
2015	13.2

Source: Philippine Statistics Authority (2017c).

Filipino older persons have a poverty incidence of 13.2%. It was reduced by three percentage points from its previous estimate of 16.2% in 2012.

Recent data from the DSWD National Household Targeting System for Poverty Reduction (NHTS-PR) for the year 2015 showed that 1.2 million or 4.17% of older persons were identified as poor out of 5.1 million households or 28.7 million individuals under this program, 52% of whom are males.

Living Arrangements

The traditional system of social support for older persons in most developing countries in Asia is anchored on living arrangements for the elderly and based on co-residence with adult children (Knodel & Ofstedal, 2002). Based on data from the 2007 Philippine Study on Aging, 71% of respondents reported that they were co-residing with a child, regardless of whether the spouse or other relatives were also in the household (Cruz, Gonzales, Natividad, & Saito, 2007). The 2007 Philippine Study on Aging also shows that men, the younger elderly, the currently married, and those with higher education are more likely to live

with unmarried children, regardless of whether the spouse or others are present. Women, the older elderly, those not currently married, and those with lower education are more likely to live with married children, again, regardless of whether the spouse or others are present.

Only 4.5% live alone, while 10% live with others only (no spouse or children). More women than men live alone, while more men live with their spouse in a two-person household, a difference that is partly accounted for by the lower life expectancy of men resulting in more widows than widowers. In the 2007 CPH, 372,129 older persons were recorded to be living on their own. They comprised 6.7% of the total 5.5 million older adults. Of this number 22.5% were 60-64 years old, 23.2% were 65-69 years old, and 21.7% were 70-74 years old.

Health Status of Older Persons

Statistics have shown that life expectancy at birth in the Philippines has been improving. The estimated life expectancy at birth in 2015 was recorded at 68.41 years (Table 9). Since the year

1990, life expectancy at birth of females has been recorded higher compared to males. In 2015, the computed life expectancy at birth for females was 71.95 years and they were expected to live almost seven years longer than males whose life expectancy was estimated at 65.04 years.

Average life expectancy at birth in the Philippines in the 2035-2040 is projected to reach an average of 75.68 years. Women are projected to live to about 78.34 years while men were expected to live 73.01 years (Table 10).

Table 9: Life Expectancy at Birth by Sex, 1990-2015

Year	Life Expectancy at Birth		
	Both Sexes	Female	Male
1990	65.3	68.1	62.6
2000	66.7	69.8	63.7
2007	67.5	70.8	64.3
2008	67.6	71.0	64.4
2009	67.7	71.1	64.4
2010	67.8	71.2	64.5
2011	67.9	71.4	64.6
2012	68.0	71.5	64.7
2013	68.1	71.6	64.7
2014	68.3	71.8	64.1
2015	68.4	72.0	65.0

Source: United Nations (2015).

Table 10: Projected Life Expectancy at Birth by Sex, 2000-2005 to 2035-2040

Year Interval	Female	Male
2000-2005	70.1	64.1
2005-2010	71.6	66.1
2010-2015	73.1	67.6
2015-2020	74.3	68.8
2020-2025	75.5	70.0
2025-2030	76.5	71.0
2030-2035	77.5	72.0
2035-2040	78.3	73.0

Source: Philippine Statistics Authority (n.d.).

Note: The 2000 Census-based Population Projection was in collaboration with the Inter-Agency Working Group on Population Projections.

Based on the computed life expectancy at age 60 in the 2015 Global Age Watch Index by HelpAge International, the average number of years that Filipinos at age 60 are expected to live is 17 years, assuming that age-specific mortality levels remain constant. However, in reference to healthy life expectancy at age 60, the average number of years that Filipinos older persons are expected to live in good health is 14 years (HelpAge International, 2015).

Older Persons with Disability

The 2010 CPH revealed that 1.443 million persons or 1.57% of the Philippine population had a disability. The recorded figure of older persons with a disability was 407,614, which comprised 28.26% of the total number of persons with disabilities (PWDs) (Table 11). Of the total number of older persons with disability, more than 57% were females.

Recent data (2015) of NHTS-PR show that there were 74,936 poor older persons with disabilities.

Table 11: Older Population with Disability by Age Group and Sex, 2010

Age Group	Total	Male	Female
60-64	88,719	44,278	44,441
65-69	75,207	35,973	39,234
70-74	79,535	35,422	44,113
75-79	63,334	25,849	37,485
80-84	50,314	18,506	31,808
85 and over	50,505	16,084	34,421
Total	407,614	176,112	231,502

Source: Philippine Statistics Authority (2010).

Mortality

In the Philippines, more than five persons died for every 1000 population in 2014. This is equivalent to 568,418 registered deaths from all causes across ages. As can be seen in Table 12, male deaths were higher than female deaths from infancy to

adulthood except at ages 80 years and over. More than 56% of total deaths (320,653 cases) are accounted for by death of older persons (PSA, 2017a). Incidence of death among old age is higher among males than females with 52% and 48%, respectively.

Table 12: Mortality by Age and Sex, 2014

Age Group	Both Sexes	Male	Female
All Ages	568,418	326,847	241,571
Under 1 year	21,856	12,642	9,214
1- 4 years	9,920	5,423	4,497
5- 9 years	5,388	3,041	2,347
10-14 years	5,011	2,939	2,072
15-19 years	8,512	5,560	2,952
20-24 years	11,844	8,012	3,832

Table 12: (continued)

Age Group	Both Sexes	Male	Female
25-29 years	13,349	9,191	4,158
30-34 years	15,986	10,913	5,073
35-39 years	18,648	12,404	6,244
40-44 years	23,902	15,765	8,137
45-49 years	30,224	19,739	10,485
50-54 years	37,623	24,473	13,150
55-59 years	45,121	29,510	15,611
60-64 years	51,430	32,842	18,588
65-69 years	53,007	33,016	19,991
70-74 years	53,437	30,920	22,517
75-79 years	55,628	28,465	27,163
80-84 years	48,869	21,575	27,294
85 years & over	58,282	20,171	38,111
Not stated	381	246	135

Source: Philippine Statistics Authority (2015).

The Philippine Health Statistics (PHS) showed that pneumonia is the number one cause of death among older persons with 38,422 registered deaths followed by cerebrovascular diseases and acute myocardial infection at 36,385 and 29,922 registered deaths, respectively (Table 13). The

other leading causes of death among older persons are diabetes mellitus, chronic lower respiratory diseases, disease of pulmonary circulation, hypertension (with and without heart involvement), and tuberculosis of respiratory system (Department of Health, 2013).

Table 13: Leading Causes of Death Among Older Persons Aged 60 Years and Over, 2013

Causes of Death	Total Number of Deaths	Death Rate per 100,000
Pneumonia	38,422	558.7
Cerebrovascular diseases	36,385	529.1
Acute myocardial infarction	29,922	435.1
Diabetes mellitus	17,681	257.1
Chronic lower respiratory diseases	17,444	253.6
Disease of pulmonary circulation & other forms of heart disease	17,033	247.7
Hypertension with heart involvement	13,585	197.5
Tuberculosis of respiratory system	11,096	161.3
Other forms of ischaemic heart disease	11,491	167.1
Malignant neoplasm of other & unspecified site	7,717	112.2
Nephritis,nephrotic syndrome and nephrosis	7,400	107.6
Hypertension without heart involvement	7,155	104.0
Malignant neoplasm of trachea, bronchus and lung	5,713	83.1

Source: Department of Health (2013).

In a study on the health expenditure of the elderly relative to the National Health Account by Racelis, Russo & Mason (2003), it is mentioned that older persons are “relatively heavy consumers of personal health care (22%) and relatively light consumers of public health (5%)” (as cited in Alcid & Sanchez, 2016, p.7). The study also showed that 62% of health expenditures of Filipinos in the age groups 50-64 years, and 65 years and above came from their own pockets. This reveals the relevance of the mandatory coverage of all older persons in the national health insurance program of PhilHealth as provided for by Republic Act No.10645.

Social Protection System for Older Persons

Republic Act No. 9994 or the Expanded Senior Citizens Act of 2010 aims to protect the rights and provide additional privileges to older persons in the areas of employment, education, health, social services, access to public transportation, and provide incentives for individuals or non-government organizations (NGOs) caring for or establishing homes, residential communities or retirement villages solely for older persons. Incentives for individuals or NGOs are in the form of realty tax holiday and prioritization in construction or maintenance of roads leading to the said home, residential community, or retirement village.

Additional entitlements of older persons are the following social protection programs: a) Mandatory health insurance coverage for all older persons; b) Social Pension for indigent older persons amounting to PhP 500.00 (where US\$ 1 = PhP 53.1 as of writing); c) Social Safety Nets in the

forms of food, medicine, and financial assistance to help cushion the adverse effects of economic crisis, disaster, and calamities; and lastly, d) Contributory Pensions by the Government Service Insurance System (GSIS) and Social Security System (SSS) for retiring older persons.

Care Needs of Older Persons

“Care needs” is not officially defined in the Philippines. Instead, as defined in National Economic and Development Authority (NEDA)-Social Development Committee Resolution No. 1, series of 2007, the Philippines adopts the definition of social protection which is “policies and programs that seek to reduce poverty and vulnerability to risks and enhance the social status and rights of the marginalized by promoting and protecting livelihood and employment, protecting against hazards and sudden loss of income, and improving people’s capacity to manage risks.”

The components of social protection are: a) Labor market programs; b) Social Insurance; c) Social Welfare; and d) Social Safety Nets. However, for the purpose of this report the definition from the National Framework for NHS Continuing Healthcare will be used as stated below.

Healthcare Need

The Department of Health (DOH) as the health arm of the Philippine government is responsible for the general regulation and supervision of the country’s health system. In response to the current healthcare needs of the country, the DOH has developed the *Philippine Health Agenda 2016-2022: All for Health towards Health for All*. The Philippine

Health Agenda 2016-2022 is the guide for the health sector in the medium term and a statement of commitment of the DOH in order to achieve the three goals of the sector. These are the Financial Risk Protection, Better Health Outcomes, and Responsiveness of the Health System. Financial Risk Protection is about enabling Filipinos to access healthcare services without spending beyond their capacity to pay. Better Health Outcomes is about making Filipinos live longer lives free of disease. Responsive Health System covers the non-health-enhancing aspects of the health system including respect, gender and cultural-sensitivity, and prompt service. These health sector goals are contributory to the Philippine Development Plan by protecting the population from external shocks and enabling them to be more productive, thus leading to economic growth (DOH, 2016).

To ensure healthcare needs for older persons, the Philippine health services give emphasis on disease prevention, rehabilitation, and health promotion of older persons. At present, the DOH is implementing a health development program for older persons to promote and improve their quality of life. In terms of financial freedom in accessing the healthcare services, all older persons are covered by the national health insurance program called PhilHealth to achieve universal healthcare.

Social Care Need

The DSWD as the social welfare arm of the government ensures that social care needs for older persons are provided. A comprehensive Long Term Care Program for Older Persons is one of the programs being implemented to protect the welfare

of our older population. There are also other modes of interventions to respond to the social care needs of the sector: 1) Residential Care Services; 2) Community-based services for older persons; 3) Home Care Support Service; and 4) Volunteer Resource Services. In addition, the DSWD provides social pension program for indigent older persons and social safety nets in the forms of food, medicine, and financial assistance nationwide to address the needs of individuals in crisis situation including the older persons.

Overview of Actors Involved in Care Provision

Family

The Filipino family is described as a closely-knit, extended family with up to three (3) generations living in one household (Abejo, 2004). It is common for families to take care of their older members. According to Abejo (2004), “Filipino elderly have been dependent on their children or co-resident kin for economic, social, and physical support” (Abejo, 2004, p.3). Carlos (1999) mentioned that respect for older persons is a trademark of the local socio-cultural context since the society puts premium on preserving their dignity and traditional familial care and support for the elderly is still widely practiced among Filipino families. It is the living arrangements of the elderly that provide a picture of their well-being.

National Government Agencies

In accordance with the Local Government Code (LGC) from 1991, the responsibility of the delivery

of health and social services was devolved from the national government agencies to the local government units (LGUs). This includes programs and services for the welfare of the elderly. After the devolution, the national government particularly the DSWD shifted its role to the formulation of policies and plans; development and enrichment of existing programs and services; and registration licensing and accreditations of individuals, agencies, and organizations implementing social services. It also implemented statutory and specialized programs which are not yet devolved to the LGUs (Executive Order No. 221 issued in 2003).

As part of its regulatory services, the DSWD ensures the fulfillment of the quality assurance in the management of Social Welfare and Development Agencies (SWDAs). The DSWD sets standards along registration, licensing of NGOs, and accreditation of service providers while the SWDAs implement social welfare and development programs and services which includes the agencies catering to older persons.

In support to the devolved programs and services at the LGUs, the national government provides directions and technical assistance to ensure the rights of and protection for older persons. The national government also provides resource augmentation for the devolved and retained community-based programs and services for older persons. For the DSWD, resource augmentation is the provision of manpower, funding, facilities, and supplies to LGUs, NGOs, POs, and other social welfare and development intermediaries to enable them to deliver basic social services.

On the implementation of the statutory and specialized program, the national government implements the following protective and promotive programs and services for older persons:

A. Residential Care Services

Through DSWD, this is a 24-hour facility that provides long-term or temporary multidisciplinary care to older persons who are abandoned by their families or with no significant others to provide the needed supervision and supportive care. The services that are provided include social services, health and medical services; psychological services, skills training, group work activities, dietary services, homelife or group living services; spiritual services, and provision of assistive devices. There are four existing residential care facilities that are being managed by the DSWD. For calendar year 2016, the number of older clients served was 843. The total funding allocations for the four facilities was PhP 59,382,417.54 and the amount utilized was PhP 43,890,265.68.

B. Assistance to Individuals in Crisis Situation (AICS)

AICS is the provision of assistance to individuals and families in crisis situation, which include but are not limited to medical, transportation, burial, referral, and counseling services. AICS is being provided through the Crisis Intervention Unit (CIU). For 2016, a total of 106,456 older persons were provided monetary assistance by the DSWD. The total

amount granted to said beneficiaries was PhP 278,581,605.00.

C. Social Pension for Indigent Older Persons

Pursuant to the eligibility criteria determined by the DSWD, indigent older persons shall be entitled to a monthly stipend amounting to PhP 500.00 to augment the daily subsistence and other medical needs of older persons. The program started in 2011 through Republic Act 9994 or the Expanded Senior Citizens Act of 2010. The target beneficiaries of the program are the frail, sick or those with a disability; also those with no regular income or support from family and relatives, and without pension from private or government institutions. From 2011 to 2014, only those 77 years old and above were included in the program, but in 2015 the age requirement was lowered covering those who are 65 years and older. In 2016, those 60 years old and above indigent older persons can also avail the program.

Since 2011, recipients of the Social Pension program have significantly increased due to the expansion of age coverage for indigents. As of December 2016, there are 1.3 million indigent older persons are enrolled in the program comprising 95.6% of the target beneficiaries of the social pension program.

D. Contributory Social Insurance

Through the SSS and GSIS, a contributory social insurance is being provided for their respective members and beneficiaries against

the hazards of old age, disability, and death. The GSIS is a social insurance that covers government workers. Its members are entitled to an array of social security benefits such as life insurance benefits, separation or retirement benefits, and disability benefits. On the other hand, SSS covers employers, regular employed and regular self-employed members in the private sector. It also covered self-employed farmers and fisherfolks, agricultural workers, overseas workers, non-working spouses, household helpers, and self-employed individuals with a net income of at least PhP 1,000.00 per month under the expanded self-employed program.

There are also employees who have separate retirement schemes under special laws. These are the members of the judiciary and constitutional commissions and uniformed members of the Armed Forces of the Philippines and the Philippine National Police, including the Bureau of Jail Management and Penology and the Bureau of Fire Protection.

Aside from the DSWD, other national government agencies and institutions are involved in the provision of care needs of elderly are the DOH, PHILHEALTH, and COSE, among others. Their programs include:

A. The Department of Health (DOH)

The DOH, in coordination with LGUs, NGOs, and POs for older persons, institutes a national health program that provides an

integrated health service for older persons. It trains community-based health workers to be among older-person health personnel to specialize in the geriatric care and health problems of older persons.

Under the Health Development Program for Older Person, the DOH implemented the following programs:

1. Older Persons Immunization Program
2. Provision of Pneumococcal and Flu Vaccines to Indigent Older Persons
3. Establishment and provision of basic health services
4. Formulation of policies and guidelines pertaining to older persons
5. Provision of information, capacity building and health education to the public and manpower dedicated to older persons

In addition, the Philippine health agenda is aiming for *All for Health Towards Health for All*. The health system aspires financial protection, better health outcomes, and responsive health system for all Filipinos.

B. Mandatory PhilHealth Coverage

All older persons shall be covered by the national health insurance program of PHILHEALTH. The LGUs where the indigent older persons reside allocate the necessary funds to ensure the enrollment and lifetime coverage of their indigent older persons, in accordance with the pertinent laws and regulations.

C. National Center for Geriatric Health

This is the first geriatric hospital in the Philippines solely intended for specialized geriatric medical services. The hospital also provides training to medical professionals and allied medical professionals in addressing the complex needs of older persons.

Local Government Units

As mentioned earlier, the responsibility on the delivery of health and social services for elderly was among the responsibilities of the LGUs. Being in the frontline or service delivery, the LGUs through Local Social Welfare and Development Offices (LSWDOs) are responsible in the implementation of the following welfare programs for older persons:

A. Senior Citizens Center

A day center facility with recreational, educational, health, and socio-cultural programs designed for the full enjoyment and benefit of the older persons in the cities or municipalities. It serves as a facility for the provision of community-based educational services such as the learning network of older persons and sheltered workshop for older persons. The SCC aims to provide opportunities for the older persons to participate in economic and social development activities giving them a sense of fulfillment and self-esteem. It also serves as a place where older persons share their knowledge, expertise, experiences, time, and financial resources to help other needy people and provide a venue for the social,

recreational, and other needs that would suit the energy levels, abilities, and interests of the older persons. In 2010, 948 senior citizen centers were established and are functional in 16 regions.

B. Strengthening the Organization of Senior Citizens Association

This is aimed at strengthening existing organizations of people aged 60 years old and above. In 2011, there were 1,087 cities/municipalities with established Federation of Senior Citizens' Associations of the Philippines (FSCAP).

C. Local Policy Issuances

The Sangguniang Bayan (Town Council), the legislative body of the municipality, leads the enactment of local ordinances and approves resolutions for older persons.

Community

The Philippine recognized the important role of the community in improving the living conditions of the older persons. National policies of the Philippine ensure the representation and active participation of older persons in their communities. The following are the mechanisms that ensure the active role of community in care provision:

A. Senior Citizens' Organizations (SCOs)

SCOs serve as mechanisms to forge unity within the sector. They also serve as their voice, articulating and advancing their needs and aspirations within the frame of their socio-cultural, economic and political rights. SCOs

work together with Office for Senior Citizens Affairs (OSCA) in managing SCO under the supervision of the City or Municipal Social Welfare and Development Organization (C/MSWDO).

B. Office for Senior Citizens Affairs (OSCA)

Based on RA 9994, OSCAs were established and headed by older persons. The OSCA head is in charge of managing the day-to-day operations of the center as well as in monitoring the implementation of the provisions of the law for older persons. OSCA provides the link between SCOs and local government services. OSCA encourages participation of older persons in local governance. The OSCA have the following functions:

1. Plan, implement and monitor yearly work programs for older persons;
2. Draw up a list of available and required services which can be provided by older persons;
3. Regularly maintain a quarterly update of the list of older persons and issue national uniform individual identification cards and purchase booklets, free of charge, which shall be valid anywhere in the country;
4. Serve as a general information and liaison center the needs of the older persons;
5. Monitor compliance of the provisions of the Senior Citizens Act particularly the grant of special discounts and privileges to older persons;
6. Assist older persons in filing complaints or charges against any person (natural or judicial), establishment, institution, or

- agency refusing to comply with the privileges under the Act before the Department of Justice (DOJ) or the provincial, city, or municipal trial courts;
7. Assist and coordinate with the concerned person (natural or judicial), establishment, institution or agency in investigating fraudulent practices and abuses of the discount and privileges exclusively granted to older persons;
 8. Establish linkages and work together with the accredited NGOs, POs, and the barangays (villages) in their respective areas.

NGOs and Private Sector Partnership

While the government continues its efforts to introduce programs for the older persons, the NGOs and other CSOs play an important role in the improvement of the welfare of older persons. As of March 2017, there were 157 NGOs working with older persons.

A. Non-government Organizations (NGOs)

Coalition of Services of the Elderly (COSE)

COSE is one of the NGOs in the Philippines working with older persons to address the key issues such as poverty and exclusion that confront their sector and to ensure that all generations of Filipinos will have more secured ageing. The following are focus areas of work of COSE:

1. Older People Organization Formation

Currently, COSE works with 402 organized groups of older persons in 17 provinces in the Philippines. COSE envisions that

this will lead to a national movement of older persons.

2. Health and Nutrition

Working to address and improve older person's health and help health providers face the challenges of ageing Filipinos.

3. Disaster Risk Reduction and Management and Emergencies

Implement an inclusive community-based Disaster Risk Reduction Program, HelpAge-COSE Typhoon Yolanda Program and sharing expertise in older people-inclusive disaster risk reduction.

4. Group Homes

Houses for abandoned older women, who are still capable of doing things to continue living freely, were established in partnership with the DSWD.

5. Advocacy

Ensuring the participation of older persons and inclusion of their issues in the development of public policies and programs.

6. Age-friendly city/communities

COSE advocates to institutionalize the recognition of LGUs that are making exemplary programs and services for their older constituents. It recognizes the initiatives of local government unit and the community itself in establishing measures and mechanisms conducive for older persons and at the same time motivates them to remain productive and actively participate in community activities while protecting their rights and welfare. In the Philippines, these initiatives are further

reinforced and strengthened through the Philippine Plan of Action for Senior Citizens (PPASC). Age-friendly municipalities/cities in the Philippines can receive an award every five years. In 2014, five municipalities/cities were awarded age-friendly communities.

and valued as productive members of society in a dynamic process unique to themselves; and are beginning a life of unlimited possibilities. Its mission is to create possibilities for their value-added life through scientific research, training and education, and specialized services.

B. Private Organizations

1. Business Mirror with United Bayanihan Foundation

This foundation has the Dangal (Dakilang Adhikain ng Ating Lahi or the Noble Goals for the People) Awards for Elderly Care. This is part of Business Mirror corporate social responsibility program. The awards recognize the noble efforts of older people who, despite their age, still choose to serve other older citizens in communities through different initiatives (De Barras, 2014).

2. SM Super Malls

This company began hiring older persons in October 2013. It launched its Senior Citizens Community Service Program which is part of its corporate social responsibility.

3. Public-Private-Partnership (ADB, LGUs and CSOs)

Cash for work and conditional and unconditional cash transfer for older persons were initiated in Samar and Leyte.

4. National Institutes of Health – Institute on Ageing

The Institute on Ageing envisions that Filipino elderly enjoy a healthy body, mind, and spirit; are being treated with dignity,

The Philippine government remains steadfast in its efforts to address the needs and various concerns of older persons, securing cooperation and collaboration work with various stakeholders and potential partners towards the achievement of common goals – the care and protection of older persons. Convergence is the main strategy to implement older-person programs. Convergence is defined as directing complementary and synergetic programs or interventions through multi-sector, inter-agency, inter-governmental, and private sector cooperation to specified recipients which are poor households, families, individuals, and communities (DSWD, 2014).

For the older-person sector, a National/Regional Coordinating and Monitoring Board (N/RCMB) has been established at the national and regional level. N/RCMB is an inter-agency coordinating and monitoring mechanism mandated to perform the following:

1. Formulate a National and Regional Plan of Action for Senior Citizens in coordination with concerned government agencies and other stakeholders;
2. Develop an effective monitoring and reporting system towards an efficient and consistent implementation of the law;

3. Develop and institute effective and innovative approaches and methods with which to address emerging concerns of the older persons;
4. Coordinate the programs and projects of the concerned agencies;
5. Coordinate the conduct of nationwide or regional information and education campaign and other advocacy activities on RA 9994;
6. Monitor the conduct of orientation, training and other capability building programs to maximize the contributions and participation of older persons;
7. Coordinate the conduct and evaluation of the plan of action, research and documentation of good practices and disparities for policy and program development.

It is composed of representatives from DSWD, DILG, DOJ, DOH, DTI and five representatives from accredited NGOs for older persons.

Enabling Laws and Policies on Older Persons Care Provision

International Plans and Agreements

At the international level, the Philippine government is one of the signatories to the Kuala Lumpur Declaration on Ageing: Empowering Older Persons in ASEAN. The Philippine government adopted concrete actions towards the empowerment of senior citizens, including the promotion of a shared responsibility approach in preparation for healthy, active, and productive ageing by supporting

families and care providers and workers and strengthening communities in delivering care for older persons.

The Philippines also actively participated in the conceptualization and adoption of other international plans such as the Madrid International Plan of Action on Ageing (MIPAA) 2007, Macau Declaration on Ageing for Asia, and the Pacific 1998 and the Shanghai Implementation Strategy 2002.

Philippine Policy and Legislative Framework on Senior Citizens Care

Older persons in the Philippines have traditionally received due care and concern from their families and the state. This is reflected in Article XV, Section IV of the 1987 Philippine Constitution, which states “it is the duty of the family to take care of its senior citizen members while the State may design program of social security for them.” Also, Article XIII, Section 11, provides that “The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all people at affordable cost. There shall be priority for the needs of the underprivileged sick, elderly, disabled, women and children. The State shall endeavor to provide free medical care to paupers.”

Anchoring from the international commitments and Philippine Constitution, the following national policies and legislative initiatives were enacted to promote and protect the rights and welfare of the older persons:

A. Republic Act 10911 (Enacted on July 21, 2016). “The Anti-Age Discrimination in Employment Act.”

The law seeks to promote equality in employment opportunities and in treatment in the workplace by promoting the employment of individuals based on their competencies irrespective of their age. Among others, it prohibits employers from forcibly laying off and imposing early retirement on employees because of old age.

B. Republic Act No. 10868 (Enacted on June 23, 2016). “An Act Honoring and Granting Additional Benefits and Privileges to Filipino Centenarians, and for Other Purposes” or “Centenarians Act of 2016.” It gives a “Letter of Felicitation” from the Philippine president and a “Centenarian Gift” in the amount of PhP 100,000.00 (US\$2,083.33) to Filipino citizens in the country or abroad who reach the age of 100 years. It also declares the first Sunday of October as the National Respect for Centenarians Day as part of the annual observance of the Elderly Filipino Week from October 1-7.

C. Republic Act No. 10645 (Enacted on November 5, 2014). “An Act Providing for the Mandatory PhilHealth Coverage for All Senior Citizens”, Amending for the Purpose Republic Act No. 7473, As Amended by Republic Act No. 9994, Otherwise Known as the “Expanded Senior Citizens Act of 2010”. PhilHealth, the national health insurance program, is mandated to cover all older persons removing the provision that older persons must be indigent to qualify for coverage.

D. Republic Act No. 9994 (Enacted on February 15, 2010). “An Act Granting Additional Benefits

and Privileges to Senior Citizens”, Further Amending Republic Act No. 7432, otherwise Known as “An Act to Maximize the Contribution of Senior Citizens to Nation Building, Grant Benefits, and Special Privileges and for Other Purposes.” This law further adds objectives that, among others, underscore the recognition of the rights of the elderly to take their proper place in society and the role of the family, community, and the government; provide for a comprehensive health care and rehabilitation system for senior citizens with disability so they can achieve “a more meaningful and productive ageing” (Section 2e). RA 9994 broadens the coverage of government assistance to older persons in the areas of employment, education, health, social services, access to public transport, and incentives to individuals and non-governmental organizations that own and manage institutions caring for senior citizens; and have set up residential communities and retirement villages solely for senior citizens.

E. Republic Act No. 7876 (Enacted on February 14, 1995) “Senior Citizens Center Act of the Philippines.” The law mandates the establishment of a senior citizen’s center in all cities and municipalities to serve as a venue for educational, recreational, social and health programs and activities for senior citizens. The DSWD in coordination with other government agencies, NGOs and POs shall provide the necessary technical assistance in the form of social and recreational services, health and personal care services, spiritual services, livelihood services and volunteer resource services.

F. Presidential Proclamations and Executive Orders

1. Presidential Proclamation No. 470, Series of 1994, declaring the first week of October of every year as “Elderly Filipino Week.”
2. Presidential Proclamation No. 1048, Series of 1999, declaring a “Nationwide Observance in the Philippines of the International Year of Older Persons”.
3. Executive Order No. 105, series of 2003 – ‘Approving and Directing the Implementation of the Program “Provision of Group Home/Foster Home for Neglected, Abandoned, Abused, Detached and Poor Older Persons and Persons with Disabilities” to promote community-based housing program for neglected, abandoned, abused, and unattached senior citizens.

G. The Philippine Plan of Action for Senior Citizens (2011-2016). As the successor plan of the Philippine Plan of Action for Senior Citizens 2006-2010, the PPASC 2011-2016 continued the achievements of the former while enhancing the strategies and mechanisms for more responsive actions given the emerging challenges faced by the older persons. This plan aims to ensure giving priority to community-based approaches which are gender-responsive, with effective leadership and meaningful participation of older persons in decision-making processes, both in the context of family and community. The PPASC 2012-2016 adopts the following three priority directions laid down by the Shanghai Regional Implementation

Strategy on Ageing: 1) Senior Citizens and Development, 2) Advancing Health and Well-being into Old Age, and 3) Ensuring Supportive and Enabling Environment.

Currently, the Philippines is preparing for the successor National Plan of Action for Senior Citizens 2017-2021 (PPASC 2017-2022). The plan will anchor on the global and national developments, such as the SDGs, Ambisyon Natin 2040 (Our Ambition 2040) and the PDP 2017-2022 of the Philippine government.

| Care Financing Schemes

The Philippine health system is funded from a mix of sources. For instance, the NHIP fund sources are coming from the contributory schemes from formal and informal sectors. However, finance health insurance for the poor, a sponsored program, is from public programs and general fiscal revenues based on the RA 10351 or the Sin Tax Reform Law.

For statutory and specialized national programs (e.g. social pension and centenarians gift), the national government are allotted budget. The General Appropriation Act also mandated all government agencies to allocate funds for Programs and Projects Related to Senior Citizens and Persons with Disability.

At the LGU level, financing is fragmented across provinces, municipalities and cities, with each LGU financing its own facilities. LGUs receive: a) part of the taxes from the national government; b) the

internal revenue allotment (IRA); and c) other revenues of the LGUs allocated to the sector such as PhilHealth capitation and reimbursements and grants from external sources (Cetrangolo, Lago, Lazaro, & Carisma, 2013).

Important Issues Related to Care Needs and Care Provision

Poverty is Perceived as an Obstacle to a Secured Old Age

Filipino individuals and families face various types of risks that are associated with global and economic instability, climate change, health-related shocks, political disruptions, or other unexpected events that cause losses in income and assets (PDP-Chapter 11, 2017). Older persons are particularly vulnerable and are exposed to risks that may bring hardships and temporary setbacks and prolonged crises. Absence of social insurance, particularly in the informal sector and other sectors with high poverty incidence will lessen the capacity of individuals to respond against hazards of old age and disability. The SSS redefined its strategies to reach out the members of the informal sector, however, the enrolment rate remains low.

Social pension is one of the government programs for the indigent older persons. However, the value of social pension remained small at PhP 500.00. According to HelpAge, expenditure on social pensions in the Philippines remains low at only around 0.1% of GDP (HelpAge International, 2016). But increasing this amount needs to consider the increasing population of older persons and the need to ensure that sufficient budget is available to cover

the indigent older persons. Also, restrictive definition to qualify as indigent older persons hinders access to the social pension program. Section 3 of RA No. 9994 refers to an indigent older person as “any elderly who is frail, sickly or with disability, and without pension or permanent source of income, compensation or financial assistance from his/her relative to support his/her basic needs.”

Deteriorating Health Status of Older Persons

With the rise of the ageing population is the increase in the demand for health services by the elderly. The elderly tend to be at a higher risk of developing disabilities and contracting diseases. Older persons account for 56% of total deaths in the Philippines. Major causes of death are communicable diseases and they remain a public health concern in the Philippines. In addition, non-communicable diseases like dementia are also challenges for maintaining health and physical functioning among older Filipinos. The majority are still unaware of dementia. Another challenge is the inequity in access to health services and medical services especially the older persons living in Geographically Isolated and Disadvantaged Area (GIDA) and disaster prone areas. (Philippine Country Report on Active Ageing, 2016).

Another major important issue is the inadequate financing for health services by LGUs. Local government units spending on health is around 7% of total government health expenditure from 2013 to 2014 (Cabalfin, 2016). The allocation depends largely on the priority of the local chief executives. Inadequate financing results in

inequalities in health service delivery, and consequently, affecting the health status of the older persons.

Occurrence of Elderly Abuse

The World Health Organization (WHO) has defined elder abuse as “a single repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.” Older Filipinos suffer from different kinds of abuse: neglect, abandonment, and physical, verbal, emotional, and financial abuses. As has been reported, it happens in home and in institutions and many cases of elderly abuse in the Philippines are either improperly reported or not reported at all to the authorities (Carlos, 1999). Although there was no exact data on the prevalence of elder mistreatment in the country, the occurrence of abuse, violence, neglect, and exploitation of older persons is very likely possible (Philippine News Agency, 2017).

Data Gaps Constraints Decision-making for Older Persons

Due to the limited and inadequate administrative and survey data on older persons, proper decision making can be hampered affecting the implementation of care needs interventions. There is a need to establish a data bank on older persons that will provide statistical information on the population. An updated national survey relating to older persons (i.e. older persons as victims of abuse and affected by emergency situations and latest data on living arrangements) needs to be established.

A number of laws and policies for older persons has been issued and implemented in the Philippines. However, there is limited study conducted on the effects of these laws and regulations. There is a need to ensure that older persons' concerns are included in the research agenda of the government and other stakeholders to ensure its mainstreaming in effective and responsive policy.

Moving Forward and Recommendations

Improve Pension System and Universal and Transformative Social Protection for Older Persons

Given the limited income opportunities because of age, an effective pension system will provide adequate income security to older persons. Financial security in later life is important particularly to support the health and other needs of older persons. Income for older persons contributes to their quality of life which will also contribute to active ageing (Philippine Country Report on Active Ageing, 2016). There is a need to strengthen contributory schemes of the national pension system to ensure that benefits of older persons are enough for their health and income needs in the future. The existing mechanisms must also review and assess to encourage enrollment of people in the informal sector as well as older persons.

It was also observed that large portions of older workers engaged in agricultural and fishery sectors, wherein these two basic sectors belong to families

with income below the official poverty threshold. The annual per capita poverty threshold in the Philippines during 2012 was estimated at PhP 18,935.00 (US\$ 357). In order to ensure sustainable income despite of climate and disaster-related risks, it is important that small farmers and fisherfolks, especially the older persons provided with agricultural insurance, gain easy access to affordable formal credit and continue to implement community-based employment programs for those whose income is irregular and who are vulnerable to fiscal shocks.

For indigent older persons with no regular source of income, the Philippines is aiming to cover 100% of poor older persons by pension and to have universal and transformative social protection that will benefit the entire population. Universal pensions avoid exclusion and improve coverage to ensure all poor older persons will be reached. Part of Philippine initiatives is to review the Senior Citizen Law to tackle adjustments in social pension and redefine the inclusion criteria to improve coverage.

Healthy Aging

Philippine health services should give emphasis on disease prevention, health promotion, and wellness of mind, body, and spirit. Health services should include preventive, curative, and rehabilitative health care services in all-government and private hospitals, local health facilities and other community-based care facilities. There is a need to address the healthcare requirements of older persons especially with special needs such as older persons belonging to minority groups, with

disabilities, and those in GIDA and disaster-prone areas. Also, provision of specialized geriatric services for older persons need to be strengthened. To improve nutrition and health for all, the Philippines seeks to guarantee care at all life stages, ensure access to functional service delivery network, and sustain financing for health through universal health insurance.

A. Guaranteed Care at all Life Stages

Better nutrition and health outcomes are expected by providing care and services to the well and the sick at all life stages, from infancy to old age. There will be a focus on specific communicable diseases (HIV/AIDs, tuberculosis, and malaria) and non-communicable diseases (cancer, diabetes, and heart disease), both of which will be addressed along with their risk factors. In addition, health promotion for all interventions will be pursued to increase awareness of health entitlements. Vulnerable populations including older persons will be prioritized in the provision of services to ensure equity in access. Specific and targeted interventions will also be provided such as annual health visits for the vulnerable populations.

B. Ensured Access through Functional Service Delivery Networks

Service delivery networks (SDNs) will be expanded and strengthened to allow more people to reach health facilities and avail of needed services. Additional resources will be provided for health facility enhancement, human resources for health, and health supplies.

C. Sustained Health Financing

The NHIP will continue to provide financial risk protection to ensure that every Filipino will be a PhilHealth member. New benefits packages will be developed and existing ones may be expanded to lower the members' out-of-pocket costs.

Institutionalizing Care Needs of Older Persons

There is a need to lobby the following priority legislative agenda of the Philippine Government to institutionalize the care needs of older persons:

A. Anti-Senior Citizens Abuse Act

Prevalence of older person mistreatment in the country needs urgent response that will improve the reporting mechanism and determine appropriate intervention. National and local government interventions on older-person abuse shall be institutionalized with the passage of a law regarding elderly abuse. The proposal aims to finally define and penalize older-person abuse for the unique offense that it is, in the same tradition as other types of domestic violence like those against women and children. The measure not only focuses on punishing certain prohibited acts but also on developing strategies to prevent and reduce the incidence of abuse toward older people through affirmative acts of advocacy and awareness-raising, as well as provision of specialized trainings and support for family members taking care of their older members, including reporting procedures at a Community HelpDesk and referral protocols for victim support services.

Relative to this initiative, the DSWD has pilot-tested a project called Reporting System and Prevention Program for Elder Abuse Cases (RESPPEC) in selected regions in the Philippines in 2017. RESPPEC is a community-based project, which strengthens partnership and networks between and among the older person sector, stakeholders and partners to ensure holistic and efficiency delivery of services to respond to elderly abuse. The objective is to establish a local reporting system or mechanism in the management of cases regarding abuse of older people.

B. Long-Term Care Act

This act seeks to go beyond healthcare needs as merely access to medication and hospital services, but to a National Long Term Care Program Framework which addresses the needs of older people who have, or are at high risk of, significant losses in physical and/or mental capacity, especially in the growing prevalence of dementia and Alzheimer's amongst the older population. Following along the lines of DOH's efforts of developing a comprehensive and integrated national healthcare program for older persons, the measure should aim to provide an older person the means to maintain a level of functional ability consistent with their basic rights, fundamental freedoms, and human dignity through the following:

- 1) Social protection for older persons;
- 2) Advancing health and well-being including Home Care and Hospice and palliative care; geriatric training for the family and

community level, and mobile health services;

- 3) Creation of an enabling and supportive environment like Day Care Centers and home nursing for the elderly. As such, the proposal calls for a multi- and interdisciplinary intervention whose implementation does not fall on just one government agency's mandate, i.e, DOH, but will involve others like DSWD, DOLE, and DTI among others, where their active participation must be emphasized in this recommendation.

C. Family Care Act

A laudable act which seeks to bring back equality and justice to family caregivers. The proposal is about granting additional exemptions to individual taxpayers taking care of minor dependents, aging parents, and persons with disabilities similar to the "Head of the Family" status the Tax Code used to allow before it was amended. It is a clear and concrete anti-poverty scheme which will have significant impact since it eases the financial burden of supporting multiple dependents. The proposal works both as an incentive and as a compensation aimed to promote the Filipino value of taking care of older people and seeks to alleviate the burden of having a sick loved one by providing for "Compassionate Care Leave Benefits" so that they can legally take time off from work to provide care for their loved ones who are critically ill or are in declining health.

To further strengthen the provision of care for older persons, the following are among the initiatives of the Philippine Government:

1. The Philippines through the DSWD and in coordination with the ASEAN Republic of Korea is implementing the ASEAN Active Ageing Cooperation Project which is primarily a research endeavor that seeks to increase awareness on the plight of older persons and look at related programs and services of the 10 ASEAN member states that respond to the concerns of the ageing population in the ASEAN Region.
2. The Philippines is currently leading the establishment of the ASEAN Family Network. It aims to contribute to the efforts of ASEAN member states and continuously strengthen the families in the region as the basic unit of society, aid the policy makers on how to best support appropriate social welfare provision and thereby raise the impact of interventions for the most vulnerable families. The Philippine government also included in its development plan the establishment of a Council for the Welfare of Older Persons. A government body that will coordinate the formulation, implementation, and monitoring and evaluation of policies, plans and programs for older persons.
3. The Creation of a Commission for Senior Citizens and passing of Magna Carta for the Older Persons has to be lobbied. Since 1995, a call to have a Commission for Senior Citizens and a Magna Carta

for the Older Persons is being raised in different fora and discussions. With these mechanisms in place, the government can ensure responsive service delivery to older persons through a more effective policy development, planning, and program implementation.

4. There needs to be a development of Philippine Plan of Action for Senior Citizens (PPASC) 2018-2022. The Philippine government is currently developing the PPASC 2018-2022 that will serve as a blueprint for policy-makers, planners, and program implementers in

promoting and protecting the rights and welfare of Filipino older persons. The PPASC 2018-2022 is consistent with the framework of all other sectors, is anchored on the *Ambisyon Natin 2040* (Our Ambition 2040) and PDP 2017-2022. It is also centered on achieving the following three (3) identified goals for the sector: 1) Development and Empowerment of Senior Citizens Ensured; 2) Health and Well-being of Senior Citizens Advanced; and 3) Supportive and Enabling Environment for Senior Citizens Ensured.



Abbreviations

COSE	Coalition of Services of the Elderly
CPH	Census of Population and Housing
DSWD	Department of Social Welfare and Development
DOH	Department of Health
DOJ	Department of Justice
GSIS	Government Services Insurance System
LFS	Labor Force Survey
LGUs	Local Government Units
LSWDOs	Local Social Welfare and Development Offices
NEDA	National Economic Development Authority
NHTS-PR	National Household Targeting System for Poverty Reduction
OSCA	Office of Senior Citizens Affair
PHS	Philippine Health Statistics
POs	People Organizations
POPCEN	Census of Population
PPASC	Philippine Plan of Action for Senior Citizens
PSA	Philippine Statistics Authority
PSY	Philippine Statistical Yearbook
RA	Republic Act
SCC	Senior Citizen Center
SCO	Senior Citizens Organizations
SSS	Social Security System
SWDAs	Social Welfare and Development Agencies

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Republic of Korea

Yongho Chon

Executive Summary

To cope with the increasing long-term care needs of older people as a result of population aging and persistent low fertility rate, the South Korean government introduced a new long-term care insurance system in 2008. This becomes an historic development of social care services for older persons in the Korean context since there were limited number of long-term care service providers only for the poor elderly as a social assistance.

The aim of this chapter is to examine how the long-term care services for older persons are provided in recent years and how the main actors of family, state, market, community have been involved in the provision of the services in Korea. In addition, the challenges for the main actors' roles of providing care services and some suggestions to tackle the issues are presented.

It is found that care roles for the elderly of the family, state, market, and community have changed significantly. The role of family has declined in elderly care provision and this was one of the

significant reasons for the introduction of new long-term care insurance. The new long-term care insurance (LTCI) system becomes a factor of the notable expansion of care role of the state and market. The role of state has been strengthened since it is concerned with the overall issues of LTCI system and developed its systems and management. Since the government has adopted the policies of marketization of care, the roles of market, in particular for-profit-service providers, have been emphasized as direct service providers. However, the care role of community has been different between rural and urban areas.

The four main players of care provision for older persons have faced the following challenges: the role of family has been predicted to be getting worse as a result of the lowest fertility rate and the state has struggled to provide good quality of care services. A number of market failures such as illegal and inappropriate behaviors of service providers have been prevalent and the role of the community is likely to decrease. To cope with the challenges, the state should actively be involved in the issues rather than leave them untouched in the market.

Introduction

Care of older persons has been traditionally the role of family members in the Republic of Korea (hereafter Korea). In particular, the eldest son's wife was to provide care to older family members. Under the strong influence of filial piety within Confucianism in East Asian countries, many people believed that looking after their parents during old age was their natural, moral duty as adult children (Chon, 2014). Since family was mainly in charge of taking care of older members, the state did not develop the proper welfare care service system despite the rapid economic growth since the 1960s. The only exception was the limited home care service as a form of social assistance. However, this family-based older person care system has been gradually eroding as a result of the changing economic and social situations such as industrialization, urbanization, individualism, and the weakened filial piety of Confucianism in Korea. The new changes led to the need for the development of formal care services by state. Since the early 2000s, Korean society and its government started to realize the significance of the demographic challenges brought by low fertility and population aging and to discuss the introduction of the institutional care service system for the elderly by the state. After discussions among policy makers and stakeholders, the Korean government decided to introduce a number of social care services for the elderly in particular a long-term care insurance (LTCI) system in 2008. This is a historic development of formal social care services for the elderly in the Korean context and this has brought about significant developments of the state and market as key actors of providing care services.

In Korea, there are broadly four institutional health and social care service systems under the laws as follows: (1) primary, secondary, and tertiary medical centers provide medical services under the National Health Insurance Act, (2) community health centers promote public health and prevent diseases under the Regional Public Health Act, (3) the LTCI system provides a number of social care services including visiting nurse service under the LTCI for the Elderly Act, and (4) a number of preventive services for older persons who are ineligible to receive the LTCI services with low level of care needs; whereby such services include complex care services for the elderly and basic services for the single elderly under the guidance of the Ministry of Health and Welfare.

This chapter focuses solely on the third point mentioned above - the LTCI system which was newly introduced as a universal compulsory national insurance in 2008 and provides mainly a number of social care services for the elderly. Therefore, care needs are defined as needs for the elderly or adults in need of long-term care (LTC) who have difficulties in managing their daily lives on their own as a result of old age or age-related diseases such as stroke and dementia. LTC is generally composed of health and social care services, however, 'social care services' such as supporting daily lives are mainly provided under the Korean LTCI system.

The aim of this chapter is to examine how the LTC services for older persons are provided in recent years and how the main actors, namely the family,

state, market, community have been involved in the provision of the services in Korea. The challenges of the main actors' roles with providing care services and recommendations to tackle the issues are discussed as well.

Social Changes and Care Status of Older Persons in Korea

Korea has been undergoing significant changes to its population owing to rapid aging of the society and having one of the lowest fertility rates in the world which was at 1.17 in 2016. Korea is considered an 'aged society' in 2018 as over 14% of the population is now aged 65 years and over. Furthermore, it has been projected that Korea will become a 'super-aged society' by 2025 whereby over 20% of the population are older persons (Statistics Korea, 2016). It will take only eight years to undergo the transition from aged society to super-aged society which is by far faster than what is observed in other Western developed countries, including Japan (Statistics Korea, 2016).

Owing to the notable economic growth and the improvements of the nutrition and medical services, people have been living much longer than in previous decades. The life expectancy of the population increased from 62.3 years old in 1970 to 82.1 years old in 2015 (Statistics Korea, 2017a). In particular, the baby-boomers who were born from 1955 to 1963 after the war will reach 65 years soon and they are about to occupy one of the largest population age groups.

With this, the traditional belief of family-based care has eroded. Whilst the proportion of people who replied that 'Elderly parents should be supported by their family members' decreased from 89.9% in 1998 to 30.6% in 2016, the proportion of people who replied that 'Society and others should take care of the elderly parents' increased from 2.0% to 50.8% during the same period (Statistics Korea, 2017a; Kim, 2017). It suggests that many people believe that state rather than family should escalate its effort and role in providing care services for older persons. Therefore, it has been becoming increasingly difficult to expect for adult children, especially from some middle-and low-income groups, to care for their elderly relatives (Sunwoo, 2003: 15). For instance, the households of older people have greatly changed. Around half of older persons (49.2%) replied that they lived with their adult children in 1998. However, in 2017, the said figure declined to 23.7% (Chung et al., 2017). Although the proportion of older people living with their adult children is still higher than that of other developed countries, the overall number of households of older people in Korea appears to follow the trend of those developed countries since the proportion of older people living alone or with their spouse has been increasing rapidly.

Although people live longer than in the past, older people suffer more from a number of chronic diseases. In terms of health status of older people, it was observed in 2017 that 89.5% of older people interviewed suffered

from chronic diseases (Chung et al., 2017). Among them, 16.5% of older people had one chronic disease, 22.0% had two of such diseases, and 51.0% have had three or more. The most prevalent chronic diseases among the older population were high blood pressure (59.0%), osteoarthritis or rheumatism (33.1%), diabetes (23.2%), backache or sciatic neuralgia (24.1%), hyperlipidemia (29.5%), and osteoporosis (13.0%). It is notable that many older people in Korea suffer from mental diseases as well. It was found that 21.1% of older people interviewed suffered from depression which was assessed utilizing the Short Form of Geriatric Depression Scale (SGDS) in 2017 (Chung et al., 2017). Older females (24.0%) and older persons without spouses (29.2%) were more likely to suffer from depression than males (17.2%) and those with spouses (16.5%).

The Introduction of New Long Term Care Insurance in 2008

Since the early 2000s, the South Korean government realized the seriousness of population aging and the weakened care role of family members for the elderly relatives. It decided to introduce a new LTCI system for the elderly which was initially proposed by the

former President Daejung Kim who was in office from 1997 to 2002. The old LTC system as a social assistance program was problematic since it covered only a small number of poor older persons. The kinds of services offered were home visitations and nursing home facilities only and the quality of service was meager since most of home visiting services were provided by paid volunteer workers who had undergone a short training period. The main service providers were the small numbers of not-for-profit providers which regularly received government subsidies. Given the social changes as noted above, the old LTC system was unable to meet the increasing care needs of older people.

After discussions about the new scheme of LTCI system such as finance, kinds of services, and copayment rate, the National assembly passed a new law named 'Long-term care insurance for the elderly' in 2004 and the new LTCI system was implemented in July 2008. Although there were some oppositions to its introduction and disagreements of the schemes among stakeholders, the contents of the new institutional system were formed relatively easily by policy makers and stakeholders. The main characteristics of the LTCI system are presented in Table 1.

Table 1: Main Characteristics of LTCI System in Korea

Aim of LTCI	To improve the quality of life for older people who are not able to manage their daily lives because of old age or chronic diseases and to reduce the care burden placed on family members by providing social care services
Financing	<ol style="list-style-type: none"> 1. Contributions of LTCI: Compulsory for all adults registered under the National Health Insurance Service (NHIS) 2. Central and local taxes 3. Service users' co-payments: 15% (domiciliary services) or 20% (institutional) of their costs
Kinds of Services	<ul style="list-style-type: none"> - Domiciliary services: Home visiting, visiting bathing, visiting nurse, short-stay respite care, welfare equipment (e.g. stick, bath chair) - Institutional services: small nursing home (less than 10 older people), nursing home (more than 9 older people)
Roles of Insurer	NHIS (central and local branches): setting and levying contributions, managing finances, assessing and issuing grades, overseeing services, evaluating service providers
Population coverage	<ul style="list-style-type: none"> - Unconditional for those aged 65+ - Conditional for adults aged under 65 with age-related diseases (The disabled are registered with the NHI but excluded from the LTCI services since there is a separate social support service for them)
LTCI Beneficiaries	7.5% of older people aged 65 or over (519,850) in 2016
Eligibility evaluation	Standard assessment of a 52-item questionnaire (body function: 12 items, cognitive function: 7 items, behavior change: 14 items, nursing treatment: 9 items, rehabilitation: 10 items)
Eligibility levels and scores	Eligible benefits grades 1 (Critical, 95 or over), 2 (Substantial, 95-75), 3 (Moderate, 75-60), 4 (low, 60-51), or 5 (lower and the elderly with dementia only, 51-45)

Source: Chon (2018, p.223).

In terms of financing of the new LTCI system, there are three main sources of LTCI income: (1) insurance premium which is collected every month based on means-tested schedule by the NHIS, (2) co-payment of service users where

15% of total costs for domiciliary service users and 20% for institutional service users, and (3) central and local governments taxes. As a social assistance scheme, the co-payment of the poorest elderly is free and the second poorest

pay half of the copayment rate. The central and local governments taxes provide for the LTCI finance. The taxes should provide around 20 % of the expected LTCI premiums income annually.

In terms of services, older people should take an assessment procedure which aims to categorize their eligibility to receive the LTCI services (Chon, 2013). Firstly, any elderly person or family member should apply for the LTCI services at the local NHIS branch. Then, the staff of that local NHIS branch visits the household of the applicant, collect necessary information, and assess needs using a standardized assessment checklist of 90 items. In particular, the staff representative checks the 52 items which focus on the functional assessment of the activities of daily living (ADL), cognitive function, behavior change, and nursing treatment and rehabilitation, and subsequently decides on the level of support the older person needs from the care workforce. The result is used as the grade of the of the older person assessed. If the older person receives a score from 1 (critical) to 5 (lower, dementia only), that person is eligible to use the LTCI services. However, if the elderly person receives a grade of A, B, or C, that person is ineligible to access the services.

Care Diamond: The Roles of Four Main Actors in Elderly Care Provision

Applying the care diamond framework by Ochiai (2009) to the Korean elderly care provision, the

main actors identified to be involved are the family, state, market, and community. However, there have been significant changes within each actor's role in the past decades as discussed in the following.

Family

The family, including relatives, has been playing a key role in taking care of its older members. Although formal social care services have been provided by the LTCI, family and relatives who are informal care providers have been providing significant social care services.

However, this structure and function of the family has been changing fundamentally which negatively affects the care role of family (Kim, 2017). Firstly, there has been a rapid increase in small and nuclear families where the average number of family members decreased from 3.1 in 2000 to 2.5 by 2015. In particular, single households of unmarried, divorced, and single older persons have notably increased as a common type of living arrangement. The proportion of single-older-person households relative to the total number of older person households increased from 20% in 1990 to 33.5% in 2016 (Statistics Korea, 2017a). It is notable that the proportion of single households of those aged 80 years or over increased from 10.1% in 1990 to 26.5% in 2016, and 47.5% of older people aged 70 years lived alone in 2016 (Statistics Korea, 2017a). This suggests that more older persons have difficulties in receiving care services from their adult children than in previous years.

Owing to the active participation of women in the labor market, the dual-earner family model rather than breadwinner model has been prominent. The country has the highest poverty rate of older people among OECD countries which stands at 49.6% in 2013 (Statistics Korea, 2017b). Related to this is that around a third of older people (30.5%) were part of the labor market of Korea in 2016 (Statistics Korea, 2017a). With the limited coverage of National Pension system and the declining private transfer by adult children in Korea, many older people have to maintain gainful employment to support themselves. Therefore, not only male older persons (41.1%) but also females (23.2%) participate in the labor market (Statistics Korea, 2017a). It suggests that an increasing number of older people have to shoulder the costs of care services by themselves rather than family members.

Finally, the caring attitudes of family and relatives have been changing as a result of prevalent individualism and the weakened filial piety aspect within Confucianism (Son, 2011). Many young people nowadays argue that the state and society should play more active roles in caring for older persons rather than family members (Statistics Korea, 2017a). This situation suggests that while the number of older people in need of LTC has been significantly increasing as a result of population aging, the role of families to provide

personal care for their older members has been unrealized. Moreover, what remains is the equally lacking socialization-type care by the state. This will have brought about the deficit of care (Kim, 2017).

State

With the introduction of the new LTCI, the responsibilities and role of state have been emphasized. The government and the insuring body (NHIS) have been involved in managing the LTC systems and dealing with emerging issues in the field. When the LTCI system was introduced, the adequacy of the overall LTC schemes was the main issue. However, as an increasing number of older people have begun using the LTCI services, the issues related to the quality of services such as care workforce and the regulation of service providers have emerged as well.

Prior to the introduction of the LTCI, only around 1% of the older population (38,000 persons) in 2008 used the LTC services which was finally supported by the government. This number increased to around 7.5% of older people, or 520,043 persons, with the advent of the new LTCI system in 2016 as shown in Table 2 (National Health Insurance Service (NHIS), 2017).

Table 2: Trend in the Number of Older Persons, Applicants, Recipients of Eligible LTCI Grades and Beneficiaries, 2012 to 2016

	2012	2013	2014	2015	2016
Number of older people	5,921,977	6,192,762	6,462,740	6,719,244	6,940,396
Applicants	643,409	685,852	736,879	789,024	848,829
Those receive the eligible grades(proportion of all older people)	341,788 (5.8%)	378,493 (6.1%)	424,572 (6.6%)	467,752 (7.0%)	519,850 (7.5%)
Beneficiaries	369,587	399,591	433,779	475,382	520,043

Source: National Health Insurance Service (NHIS). (2017), author's calculation.

Although there have been a number of limitations regarding the quality of services, the systematic training of care workers has been implemented and the quality of service would improve.

After the new LTCI was implemented, the role of the insurer, NHIS, has been strengthened as well. The Ministry of Health and Welfare has been involved in institutional macro-level issues, the NHIS has coped with many of the meso- and micro-level issues. In particular, the number of NHIS staff to assess the needs of applicants and to issue the eligibility grades for them has been significantly increased in order to cope with the increase in the number of older people who applied for the LTCI benefits. In addition, the NHIS has been in charge of evaluating the service providers regularly.

The new president, Jaein Moon, has strongly emphasized the responsibility of the state to take care of the elderly with dementia. Therefore, dementia relief centers and special service providers are being established. The introduction of a new type of LTCI service only for those with mild dementia, which is called 'cognitive support grade', is going to be introduced in 2018 (MHW, 2017). Although the state is not a direct service provider in the LTCI, its role has been strengthened in the process of designing and managing the LTCI system.

Markets

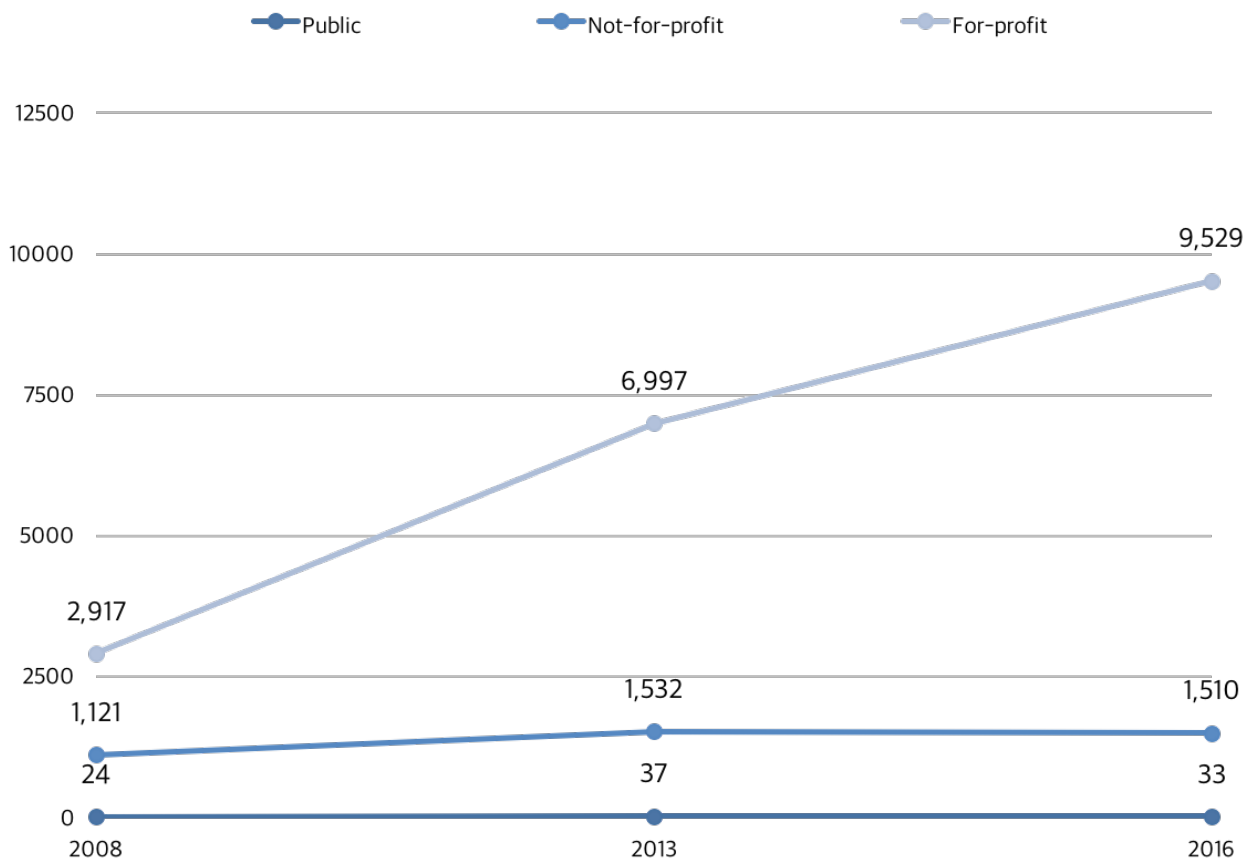
The role of the market has been increasing along with the institutional expansion of the LTC services. This is primarily because the Korean government has adopted the policy of 'marketization of care' denoting government measures that allow, support, or facilitate the participation of for-profit and not-

for-profit providers in the care market and promote the market principles of competition and choice (Brennan et al., 2012: 379). To facilitate the marketization of care, the deregulatory and market-oriented policies have been actively sought around the introduction of new LTCI (Chon, 2014).

Prior to the introduction of the new LTCI system, there had been few public-based service providers and also a small number of not-for-profit providers which received government subsidies. However, these were inadequate relative to the increasing needs of older people. Different LTC service providers and the care workforce were urgently needed to introduce this new LTCI system. This prompted the government to adopt the policy of

marketization of care rather than the establishment of public-based service providers and care workforce under the strong path dependency of cost containment of the residual Korean welfare state. Therefore, the government opened the LTC market to for-profit forces which was prohibited to the public and not-for-profit forces and urged them to establish new LTCI service organizations by easing entry requirements (Chon, 2014). This approach has been very successful in terms of the rapid increase in the number of LTCI service providers. Whilst the public sector has been stagnant in older-person-care provision, the for-profit sector has been keenly participating in the LTC market.

Figure 1: Number of Home-Visit Service Providers According to Ownership, 2008 - 2016



Source: National Health Insurance Service (NHIS). (2017).

For instance, in terms of home-visit service which is the most popular service among the LTCI services, as Figure 1 shows, there were 24 public home visit service providers in 2008 but only 33 in 2016. However, there has been a huge increase in the number of for-profit home-visit service providers from 2,917 in 2008 to 9,529 in 2016 (National Health Insurance Service (NHIS), 2017). There is only 0.3% of public home-visit service providers and 13.6% (1,510) of not-for-profit providers but, the majority, which is 86.1% of providers, were from the for-profit sector. Similarly, the number of public-based institutional service providers such as nursing homes was 73 in 2008 and slightly increased to 105 in 2016. For-profit institutional service providers increased notably from 832 to 3,675 during the same period (National Health Insurance Service (NHIS), 2017). 70.9% of providers were from for-profit sector while only 2% were public-based institutional service providers. The for-profit sector dominates the Korean LTCI market and that of public sector is very marginalized. The not-for-profit sector has been in charge of 38.3% of institutional service and 15.3% of domiciliary services in 2016.

Prior to the expansion of older-person care service, the role of not-for-profit sector was absolute since the for-profit-service providers did not provide elderly care services. Social welfare organizations have been key providers of welfare services but they have long been amalgamated to the government subsidies with limited financial autonomy and independence (Park et al., 2016). The role of non-governmental organizations (NGOs) had been restricted in care provision since they have mainly been involved in

political and local issues and have limitedly provided welfare care services.

This rapid increase of the number of private service providers was possible since the Korean government explained very actively the merits of introducing new service providers with very low entry requirements of new LTCI system by showing the rapid population aging in Korea. Through this, many individuals believed that they could generate profits through the new service organizations. With the rapid increase of LTCI providers, many older people are able to access the services and the objective conditions of exercising choice of service providers by clients and their care providers had materialized (Chon, 2014).

Community

In terms of role of community in care provision for the elderly, there has been notable difference of roles between urban and rural areas. In rural areas, it appears that local residents to a certain degree know and support each other well. Older people tend to gather and meet at the community halls or senior citizen centers and spend their leisure time with other residents. There still is the sense of community spirit whereby local residents take care of each other when there is such a need. However, even though the government has adopted policy of marketization of care, the number of LTCI service providers in the rural areas remains inadequate. The for-profit home-visit service providers have been reluctant to establish their organizations in rural areas as they have to incur higher costs to travel to each home with an older person in remote areas. They also encounter enormous difficulties in recruiting care workers.

Therefore, older persons in rural areas have been relatively excluded from the use of LTCL services. In urban areas, it seems that the situation is the opposite. Many local residents do not know much each other and the spirits of community have dwindled in many areas. However, there are many places for the elderly such as welfare centers and senior citizen centers. Some of the older people can spend their spare time there and make friends and participate in leisure programs. Such facilities mainly enable social participation of older people and their roles in term of elderly care are limited. In addition, there are many LTCL service providers in the urban areas since many for-profit service providers opened their organizations. Therefore, many urban elderly are able receive the LTCL insurance services.

Despite better access to the LTCL services, social isolation of older persons has emerged as a serious social issue in Korea. A number of older persons keep to their houses. They rarely head outside and they refuse to use services or other types of support. This appears to originate from a number of complex issues such as poverty, family dissolution, bad health, and inadequate welfare system access. This leads to the vicious circle of health deterioration such as early decline of activities of daily living, depression, fast progression of diseases, and early death or suicide.

Challenges of Main Actors in Care Provision

Family, state, market, and communities have been playing important roles of providing care of older people. However, a number of following challenges

with respect to the four sectors have emerged since the introduction of the new LTCL system in Korea.

Family

The government provides socialized care services through the introduction of new LTC system to cope with the declining care role of family. Despite this, the role of family and relatives still play significant roles in taking care of older members since the amount of benefits of LTCL services is insufficient. For instance, home-visiting service, which is the most popular among LTCL services, is limited to three hours a day at most; their family members have to take care of the elderly for the remaining hours. However, given the weakened caring role of family members, how far they will keep taking care of the elderly is uncertain in the future. With the lowest fertility rate of 1.17 in 2016 in Korea (NSO, 2017), it is likely that the number of family informal caregivers will be significantly reduced while the number of older people in need of LTC will continue to increase as a result of the rapid population aging.

Despite this, the institutional support for informal care providers is at a basic level such as in the form of being allowed to take leave from employment for informal family caregivers taking care of elderly with dementia. Developed countries such as Sweden, Finland, Netherland have endeavored to support the informal caregivers through the caregiver allowance, tax reduction, pension credit, paid leave, flexible working hours, and even counseling to support them in maintaining their role in taking care of older persons (Courtin, Jemai, & Mossialos, 2014). In Korea, although the need for such policies has been gradually recognized by the policy makers, they are

wary of the prospect of the rapid increase of welfare budgets for the informal caregivers.

State

The need for proper, quality services have increased as many older people have the experience of using the LTCI services. However, the quality of LTCI services remains to be problematic. As Table 3 presents, 23.4% of institutional service providers in 2015 and 12.8% of domiciliary service providers in 2016 have received the lowest service grade of “E” which represents “Very poor”.

The shortage of and demanding working conditions for care providers and the unstable market have negatively affected the quality of services as will be discussed later. Without the fundamental change of LTCI system and operations to cope with the challenges, such issues cannot be resolved with ease.

In addition, many local authorities have been passive in conducting their roles as regulators in the processes of whether to allow the entrance of the new service providers notwithstanding legal requirements. Local authorities have believed that the NHIS is mainly in charge of the LTCI system and they lack the number of public officials to properly conduct such a regulatory role in the field.

Moreover, although the current financial situation of the LTCI system shows surplus in terms of the aggregate allocation, it is likely that the LTCI budget will experience a deficit in the future as the number of LTCI user will increase significantly as a result of the rapid population aging. To cope with this, the government will have to increase the amount of insurance premiums resulting in financial burden to the state and younger generations.

Table 3: The Trend of the Results of Evaluation of LTCI Service Providers, 2011- 2016

Year	2011	2012	2013	2014	2015	2016
Service provider	Institutional	domiciliary	Institutional	domiciliary	Institutional	domiciliary
Total	3,027	8,963	3,347	8,150	3,623	4,916
A (excellent)	319	900	337	808	508 (14.0%)	1,222 (24.8%)
B (good)	645	1,890	340	815	737 (20.3%)	1,487 (30.2%)
C (fair)	1,277	3,701	1,676	4,079	831 (22.9%)	993 (20.1%)
D (poor)	649	1,858	664	1,634	697 (19.2%)	584 (11.8%)
E (very poor)	137	614	330	814	850 (23.4%)	630 (12.8%)

Market

A number of market failure issues have emerged in the LTCI market. Many service providers have been involved in committing unlawful and illegal behaviors such as false billings to the NHIS and exemption of co-payments under the low price of LTCI services (Chon, 2014). Although governments have continuously inspected such behaviors, there is difficulty in thoroughly examining the many service providers. As a result, an over-supply of providers appears to lead to such inappropriate situations (Chon, 2013, 2014). Therefore, it has been criticized that older people in the LTCI have become the means to generate financial resources for the service providers. The state has been tightening the regulations of providers in the market against the inappropriate behavior of service providers. However, the LTCI service providers have gathered their forces and lobbied members of the National Assembly and the Ministry of Health and Welfare to protect their interests.

In addition, a number of structural challenges of the LTC market such as the dominance of for-profit providers and the high turnover and shortage of care workforce persist. Many for-profit providers in the LTCI market have endeavored to reduce their expenses on care workforce to maximize their profits and survive in the competitive market. However, it is reported that for-profit providers were more likely to give lower salary to their home-visiting care workers than not-for-profit providers (Nam et al., 2013). This low salary along with low social perception and demanding working conditions of care workers have led to the high labor turnover and shortage. Although many

middle-aged women expect to obtain proper jobs to make their livings, many of them believe that care work is not decent work but a demanding, low-paid job. Therefore, many care workers have been reluctant to work in the LTC sector. This is the reason why many LTCI service providers have enormous difficulties in recruiting and retaining young and experienced care workers and the mean age of care workers is increasing where over 80% of care workers are aged 50 years and over in Korea. Since taking care of the elderly is very demanding work where they need to deal with the basic and diverse daily needs of older people such as washing and changing of body position; care workers in relatively advanced middle ages would have enormous difficulties in providing good quality services (Nam et al., 2013).

Community

As noted above on the predicament in the rural areas, the spirit of community persists and the local residents have looked after each other. However, given the high proportion of older people and low proportion of young and middle-aged people, it is predicted that around 30% of the population of local cities will disappear in twenty years (Ma, 2017). The need then for the provision of LTC services for the local elderly will be significantly increased. However as mentioned previously, the number of LTCI service providers has been very limited and the young and middle-aged people who can take care of the elderly will persistently decrease. Therefore, the role of community in rural area will be significantly reduced in the foreseeable future.

In the urban areas where there is decreasing social relationship among local residents and the rapid increase of single elderly household, it appears that social isolation will continue to be an issue. Although the different levels of governments have developed certain services and welfare systems for the single elderly, such as safety check services, it is uncertain how far the state can cope with the serious challenges.

Conclusion and Policy Recommendations

To tackle the challenging issues of the increasing LTC needs of older people, the South Korean government has recently socialized LTC through the introduction of a new LTCl system in 2008. This has become a historic development of social care services for the elderly in the Korean context.

The caring role of family has continually decreased and the introduction of new LTCl has become the decisive factor of the significant expansion of the roles of state and market when applying the care diamonds perspective into the current situation in the country. The role of the state has been strengthened since it has concerned itself with the overall issues of LTCl system and developed its systems and management in a proper manner. Since the government has adopted the policies of marketization of care, the roles of market with particular attention on for-profit-service providers have been emphasized as direct service providers. The role of community however has been different notably between rural and urban areas. The spirit

of the community in rural areas has been alive and residents take care of each other including the older persons. This has dwindled in urban areas on the other hand.

In terms of challenges the four main players of care provision have faced: firstly, the role of family has been predicted to continue to decline as a result of the persistently low fertility rate and the weakened sense of filial piety of people. Despite this, the supporting policies for the informal family caregivers have only been in the initial phase. Secondly, the state has struggled to provide proper quality of care services as a result of the shortage of well-trained care workers and unregulated market. Thirdly, for-profit providers have dominated the LTCl market. The number of market failures such as illegal and inappropriate behavior have persisted rather than the merits of markets; this has been associated with the poor quality of services. Finally, the role of community is likely to decrease further as a result of the declining number of young and middle-aged population who can care for the older population.

The state should manage the LTCl market through the appropriate regulations of and evaluation measures for service providers and implement active policies to tackle fundamental challenges. For instance, in order to attract young and middle-aged care workers, the training system and the attitude toward care workers should be fundamentally changed. Moreover, the active policies for the informal caregivers should be developed as well.

Furthermore, the government should create a novel way to recover the role of community in urban areas. For instance, to facilitate social relationships and social capital among residents, some local authorities such as Metropolitan Seoul, have vigorously implemented 'community building projects' which aims to boost the promotion of

social relationships among local residents. There is also the 'visiting community center' which is when public officials visit children and older people, assess their needs, and provide tailored-services to them. In a similar vein, the central government should find good models to recover the community spirit.



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Singapore

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Executive Summary

Singapore is undergoing a rapid demographic transition which is accompanied by changing health and social care needs. As a result, Singapore is exploring care strategies and policies to ensure its population is able to access effective and quality care in a sustainable manner. The current report is analyzed using the proposed domains from the care for the elderly in ASEAN+3 Secretariat: 1. Demographic and epidemiologic transitions, 2. Organization of care for older adults, 3. Role of actors in providing care, 4. Health and long-term care financing, 5. Policies, laws and regulations on care for older adults and 6. Challenges in care provision for older adults and strategic considerations in Singapore. As the pace of ageing is gathering momentum in Singapore, there are increasing policy responses and strategies in investing in older adults, family and the community; developing resources for care, integrating health and social resources; and in aligning healthcare financing to meet the needs of its older population.

This report takes the definition of long-term care (LTC) provided by the World Health Organization

(WHO) which defines LTC as the provision of care services to help chronically ill and functionally disabled people maintain a good quality of life with the highest degree of independence, personal fulfilment and dignity by combining medical, nursing, and social care services (World Health Organization, 2000).

Demographic Transitions and Challenges in Singapore

Life Expectancy Gains and Shifting Population Structure

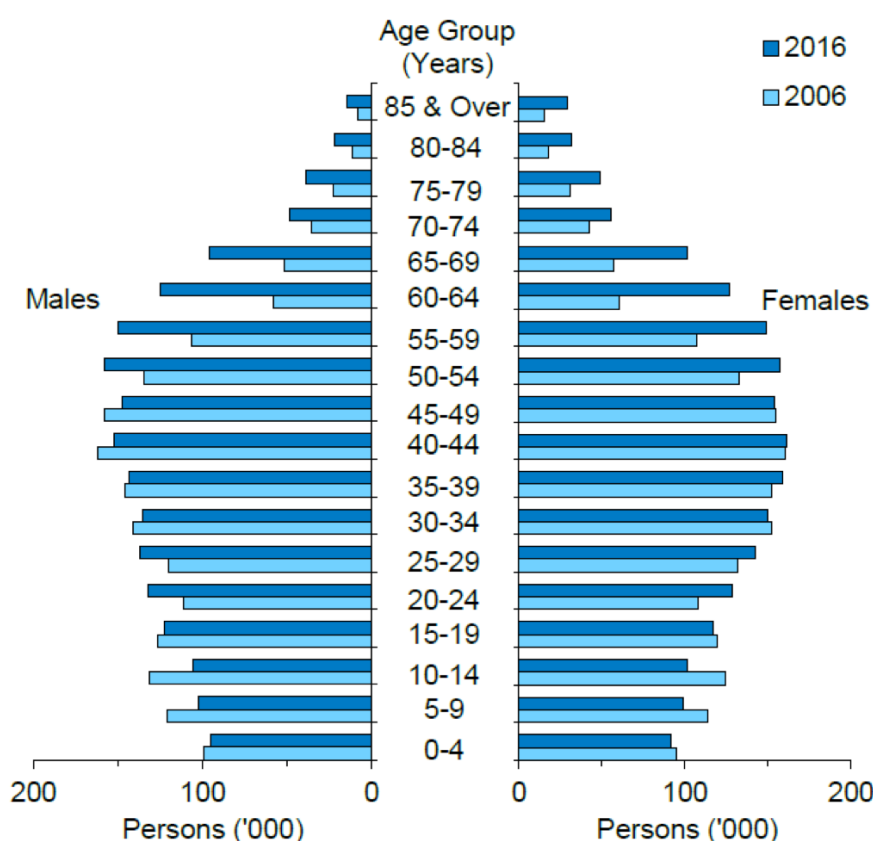
Singapore's population is aging rapidly. In 2016, Singapore's total residents were 3.93 million, and residents aged 65 years and above constituted 12.4% of the population (Figure 1) (Department of Statistics & Ministry of Trade & Industry, 2016). The population of older adults is predicted to double by 2030, with one older person in every four Singaporeans (Ministry of Health, 2016a; Peh, Ng, & Low, 2015). The current trend of population aging is due both to Singapore's increasing life expectancy and declining total fertility rate (TFR). In 2015, the TFR was 1.24 births/female, compared to 3.07

in 1970 (Department of Statistics & Ministry of Trade & Industry, 2016). With the current TFR below replacement level, the old-age support ratio (OASR)¹ for the country is predicted to decline further from 5.4 in 2016 to 2.1 by 2030 (Department of Statistics & Ministry of Trade & Industry, 2016; Department of Statistics, Ministry of Home Affairs, & Immigration & Checkpoints Authority, 2016).

Singapore's life expectancy at birth was 82.7

years in 2015, compared to 80.1 years in 2005 (Department of Statistics & Ministry of Trade & Industry, 2016). The life expectancy gains between 2003 and 2013 was at a higher rate of 3.3 years, compared to 2.8 years from 1990 to 2002 (Department of Statistics & Ministry of Trade & Industry, 2016). In addition, life expectancy at age 65 years has also increased to 20.6 years in 2015 (compared to 18.7 years in 2005) (Department of Statistics & Ministry of Trade & Industry, 2016).

Figure 1: Population Structure of Resident Population



¹ Old-age support ratio defined as the ratio of the working-age population (20 to 64 years old) per older person aged 65 years and above.

Health of the Population and Health Expenditure

The increase in longevity for Singapore's residents is accompanied by an increase in healthy (life) years. The 2013 Global Burden of Disease (GBD) Study ranked Singapore as one of the highest for Health-Adjusted Life Expectancy (HALE)² at birth. Singapore residents are expected to spend 70.75 years (males) and 73.35 years (females) of their life free of disease and/or injury, which is 10.16 and 9.22 years above the world's average for males and females, respectively (Murray et al., 2015).

In a decade, Singapore has experienced a faster rise in HALE than life expectancy, suggesting good health outcomes among its population. Bloomberg Global Health Index 2017 ranked Singapore as

the second most efficient health care system and the fourth healthiest country in the world (Bloomberg, 2017a, 2017b). Singapore also has a relatively low total expenditure on healthcare compared to other high-income countries. The country's total health expenditure is 4.9% of GDP compared to 8.9% for OECD countries (Table 1) (OECD, 2015; Tan, Tan, Bilger, & Ho, 2014; World Bank, 2017). In the budget highlight of 2010 by the Ministry of Finance, an estimated 0.1% of GDP, or 3% of the country's national health expenditure, was spent on long-term care (LTC) (Ministry of Finance, 2010). This compared to OECD countries, which on average spend 1-2% of GDP on LTC³. The paper also projected a likely increase in expenditure for LTC to meet the needs of Singapore's aging population (Ministry of Finance, 2010).

² Health-adjusted life expectancy is an estimate of the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

³ Data obtained from OECD Health Data (2008).

Table 1: Singapore's Health Expenditure, 2014

Singapore (2014)	
Health expenditure, total ⁴ (% of GDP)	4.9
Health expenditure, private ⁵ (% of GDP)	2.9
Health expenditure, public ⁶ (% of GDP)	2.1
Health expenditure, private (% of total health expenditure)	58.3
Health expenditure, public (% of total health expenditure)	41.7

Source: World Bank (2017).

Shifting Family Structure and Smaller Household Size

Singapore faces a shift in family structure with smaller household size and an increased proportion of married couples with fewer or no children (Department of Statistics & Ministry of Trade & Industry, 2016). The proportion of households with children declined from 59% in 2005 to 54.3% in 2015 (Department of Statistics & Ministry of Trade & Industry, 2016). One in four (26.6%) of these households reported the heads of the household to be 65 years and older. There is also an increase in the number of single-elder households and households of older couples with no children or children living apart from them (Department of

Statistics & Ministry of Trade & Industry, 2016; Ministry of Social and Family Development, 2015b).

There is a downward trend in multi-generation households in Singapore. Although most of older adults in Singapore reported living with family, a substantial number (29%) reported living with friends, other kin or an unrelated individual. In addition, almost one in five older adults 65 years and older reported to be living alone (Hock, Ser, & Teng, 2013). Younger working Singaporeans also have increasing opportunities to be globally mobile. For 2016, around 213,400 Singaporeans worked or lived overseas, compared to 157,800 in 2004 (Department of Statistics, Ministry of Home

⁴ Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.

⁵ Private health expenditure includes direct household (out-of-pocket) spending, private insurance, charitable donations, and direct service payments by private corporations.

⁶ Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.

Affairs, & Immigration & Checkpoints Authority, 2016). This increasing shift in family structure and smaller household size will put increasing strain on the availability of family support and informal caregiving for older adults.

Epidemiologic Transitions and Emerging Needs

Increasing Chronic Disease and Disability Burden

Rapid population aging in Singapore has resulted in a fast, epidemiologic shift from acute to chronic diseases. In addition, older adults are more vulnerable to multiple chronic diseases, and they experience higher rates of disability that creates dependency and may require more help from others. The increase in morbidity and disability is accompanied by a shift in health and social care needs.

Using Disability-Adjusted Life Years (DALYs)⁷ as a summary measure, around 400 thousand years of healthy life were lost due to premature deaths and ill health in Singapore in 2010; with ischemic heart disease (IHD) and diabetes as the leading cause of DALYs in the resident population (Ministry of Health, 2014c; Murray et al., 2015). Older adults aged 65 years and above contributed a significant

35.5% of the entire burden of disease and injury. In terms of specific causes of DALYs for this older age group, IHD, stroke and Alzheimer's and other dementias were the leading contributors (Table 2).

The Ministry of Health (MOH) Singapore uses the ability of an individual to perform Activities of Daily Living (ADLs) as a measure of disability. Findings from a simulation study on LTC published in 2013 projected that the number of resident Singaporeans 60 years of age and older, with at least one ADL limitation, will double from 27,900 individuals in 2012 to about 57,300 in 2030, and most will reside at home (Ansah, Matchar, Love, Malhotra, Do, Chan and Eberlein, 2013). Of the older adults projected to be ADL disabled, 36% are expected to have one or two ADL limitations (mild disability) while 64% are projected to have three or more ADL limitations or be severely disabled (Ansah et al., 2013). With increasing trends in disability burden, the country is expected to have increasing numbers of older adults who require physical assistance with significant contributions of care hours from caregivers. This will impact the support and time needed from caregivers. The average family eldercare hours⁸ needed is projected to increase from 29 hours per week to 41 hours per week by 2030 (Ansah et al., 2013).

⁷ DALY is the summary measure used to give an indication of overall burden of disease. One DALY represents the loss of the equivalent of one year of full health.

⁸ Family eldercare hours are hours of eldercare (care for ADLs and IADLs) directly provided by family members.

Table 2: Ten Leading Specific Causes of DALYs in Those Aged 65 Years and Above by Gender, 2010

Rank	Overall (DALYs = 141,710)	% of Total	Males (DALYs = 68,968)	% of Total	Females (DALYs = 72,742)	% of Total
1	Ischaemic heart disease	16.0	Ischaemic heart disease	16.9	Ischaemic heart disease	15.1
2	Stroke	10.7	Stroke	10.2	Stroke	11.2
3	Alzheimer's & other dementias	8.1	Lung cancer	7.2	Alzheimer's & other dementias	10.3
4	Lower respiratory tract infection	5.8	Chronic obstructive pulmonary disease	6.3	Lower respiratory tract infection	5.9
5	Diabetes mellitus	5.4	Alzheimer's & other dementias	5.8	Diabetes mellitus	5.2
6	Lung cancer	5.2	Diabetes mellitus	5.6	Vision disorders	4.0
7	Chronic obstructive pulmonary disease	3.9	Lower respiratory tract infection	5.6	Lung cancer	3.3
8	Vision disorders	3.7	Colon & rectum cancer	4.0	Colon & rectum cancer	3.2
9	Colon & rectum cancer	3.6	Vision disorders	3.4	Breast cancer	3.1
10	Nephritis and nephrosis	2.1	Liver cancer	2.6	Nephritis and nephrosis	2.5
% DALYs accounted for by the top 10 specific causes		64.5		67.6		63.8

Note: Total may not add up due to rounding.

Source: Singapore Burden of Disease Study (2010).

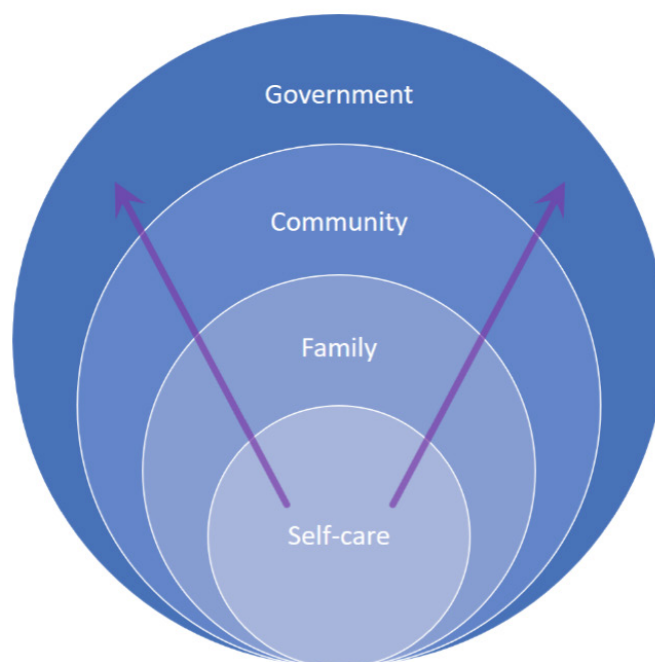
Organizing Care for Older Adults

Underlying Philosophy for Care

Singapore emphasizes self-care as the first line, followed by family and community care before the government is engaged (Figure 2) (Mehta & Wee, 2004; Ngiam, 2004). Singapore views care to be

a personal responsibility and the family as an extension of personal care (Lim, 2012). The family's involvement in caring for older relatives is consistent with the Asian philosophy of 'familism' and filial piety (Chin & Phua, 2016; Teo, Mehta, Thang, & Chan, 2006).

Figure 2: The ‘Many Helping Hands’ Approach Adopted by the Singapore



Provision of Care and Long-term care for Older Adults

In Singapore, multiple stakeholders are engaged in supporting families to provide care for older adults including the community, government, Voluntary Welfare Organisations (VWOs) and the private sector (Table 3). Traditionally, the government took on the role of funding, directing and regulating the care services, while VWOs and private care providers managed the provision of LTC services (Chin & Phua, 2016; Mehta & Vasoo,

2002). However, increasingly there is some blurring of roles in line with Singapore's plans to integrate acute and community services and to provide more efficient and patient-centric care (Ministry of Health, 2016g). There is increasing government involvement through acute hospitals and regional health systems into extending and providing post-discharge home care services and through community hospitals for rehabilitative and intermediate care (Chia, Abraham, Seong, & Cheah, 2012; Lee et al., 2015).

Table 3: Overview of Actors and Their Roles in Care Provision in Singapore, 2017

	Roles in Care Provision							
	Framework and Regulation	Financing	Types of Services					
			Acute Care	Intermediate and Long-term care				
				Residential/ Institutional Care	Non-residential/Community-based care			
					Centre-based	Home Care		
						Medical	Nursing	Personal/ Emotional
Self, Family		+					+	+/+
Community and VWO		+		+	+	+	+	+/-
Government	+	+	+	+	+	+	+	
Private Sector			+	+	+	+	+	+/-

Note:

+ the actor has a role in the type of care provision in older adults.

- the actor does not have a role in the type of care provision in older adults.

Box 1. Typology of Formal Care in LTC

Medical and nursing care described for LTC and home care predominantly delivered by skilled medical doctors, nurses and paramedics and can include administration of medication, wound dressing, to more complex care in enteral tube, and urinary catheter. Some countries include preventive and rehabilitative services. Social care needs based on personal care or Activities of Daily Living (ADL) including feeding, bathing, personal hygiene, ambulation and Assistance care or Instrumental Activities of Daily Living (IADL) including performing housework, preparing food, handling finances, taking transportation, care in day centres, and meals delivered at home is generally care delivered by low-skilled workers. The main aim is to help dependent older adults to remain at home and the package offered by different countries varies. At minimum most packages include care in ADL Assistance services or IADL are only covered as benefits in a limited number of countries.

(OECD, Eurostat, WHO, 2011. A system of Health Accounts, OECD Publishing)

Role of Actors Providing Care in Singapore

A. Family and Surrogate Caregivers

In Singapore, an older adult's family plays a large, and arguably the most important role in the care and support. Families provide physical (instrumental), emotional and financial support. The survey on informal caregiving 2010 found that the majority caregivers of older adults aged 75 years and older were their children (77%) and spouses (16%), with reported average caregiving time of 38 hours/week (Chan, Ostbye, Malhotra, & Hu, 2013).

Caregivers were also more likely to be female (60%) than male. With rising education level and labor force participation among women, many families are turning to a market-based and family-centered option by hiring foreign domestic workers (FDW) as surrogate caregivers. One in two caregivers reported having the support of an FDW specifically to help with care. However, only 45% of FDW reported having any experience or formal training in caring for older adults (Chan et al., 2013).

1. Emotional and Physical Support

In a survey about the perception and attitudes towards aging and older adults in 2013, 96.5% of respondents between 50 and 74 years agreed that family support was the key to successful aging (Mathews & Straughan, 2014). Many older adults reported having regular interaction with their family, including both physical and emotional support. The HDB household survey in 2013 reported that almost half of the married children visited their older-aged

parents at least once a week (Housing & Development Board, 2014). Societal attitudes towards the older adults in Singapore are positive and more than 90% of respondents 70 years or over felt they had a close-knit family (Ministry of Social and Family Development, 2015).

2. Economic Support

As older adults are more likely to have complex medical and social care needs, future spending by households is expected to be stretched with increasing challenges in healthcare and LTC spending with aging. The majority (82%) of economically inactive older adults reported having received financial support from their children and one-third of those older than 65 years relied on their children to pay their medical bills (Housing & Development Board, 2014). The care expenditure and needs of these older adults had impact on finances of the whole family, which led to the expressed concerns on financial adequacy among the surveyed informal caregivers from all socioeconomic status (Chan et al., 2013).

B. Community and Voluntary Welfare Organizations

In line with the 'many helping hands' approach, Singapore has a range of formal LTC services to supplement care provided by the families. Community and VWOs have been taking an important role in supporting older adults in Singapore by providing a wide range of services and developing innovative models of LTC for older adults in service delivery, including case management and at different levels of care for home, community and residential-based services

(Mehta & Vasoo, 2002; Ministry of Health, 2016a). Approximately 70% of LTC services in Singapore are delivered by the VWOs (Tan, n.d.). In Singapore, VWOs are typically set up as societies and companies limited by guarantee or trusts, exclusively for charitable purposes (Ministry of Social and Family Development, 2017). Majority of VWOs originated from religious organizations or charitable foundations.

Other roles that VWOs play in caring for the older population in Singapore include health promotion for the relatively well and able older persons and in providing for care in the community for those in need and for those who are looking for support, companionship and activity to enhance their lives (Agency for Integrated Care, 2016b; Caregiving welfare association, 2017; Healthy Ageing Association, 2014; Singapore Silver Pages, 2017).

C. Government

In Singapore's health system, the public sector hospitals are the major provider of healthcare (Ministry of Health, 2017b). The government's role is mainly in providing the framework, infrastructure and resources needed to support the direction services will take (Chin & Phua, 2016; Mehta & Vasoo, 2002). The current framework focuses on three key shifts in the healthcare system to provide affordable and sustainable health care as Singapore faces an aging population with vision statements by the Ministry of Health (MOH) in Moving beyond healthcare to health; Beyond hospital to community and Beyond quality to value (Ministry of Health, 2017g).

Organizing Care: Moving Towards Integrated Care with Service and Policy Integrators

Singapore recognizes that older adults have higher complex LTC needs and the provision of LTC requires a coordinated strategy combining medical, nursing and social care services to address the wider impact of population aging (Peh et al., 2015; Wong, 2013). In order to promote comprehensive care for older adults, the government looked at creating coordinating agencies and increasingly on both structural and policy measures to facilitate coherence integrating the provision of LTC for older adults.

1. Agency for Integrated Care (AIC)

AIC was established in 2009 to facilitate placement of sick older patients to nursing homes and chronic sick units (Agency for Integrated Care, 2016a). Later, its role expanded to discharge planning and transitioning patients from hospital to community. Currently, AIC is the national level LTC care integrator and works with community care agencies and partners to develop services, manpower and improve quality of health and social care services to support the aging population. They are responsible for processing the services application, coordinating and referring patients and families (caregivers) to appropriate services by giving information on care services, support and financing options.

2. Community Case Management Service

Older adults with complex social and health care needs are supported by Community Case Management Services (CCMS). The service is overseen by AIC and operated by VWOs, The CCMS case managers provide needs assessment

and coordinate care plan to ensure the older adults have access to the right services to age well in place. (Agency for Integrated Care, 2017; Le Berre, Maimon, Sourial, Guériton, & Vedel, 2017)

3. Regional Health Systems (RHS)

RHS⁹ were set up from 2007 to create a regional health and wellness ecosystem comprising of public and private health, as well as social, care providers. Each RHS manages and integrates care within its region to achieve patient-centric care. RHS are responsible for care across the continuum (from preventive health to end-of-life care), and are responsible for publicly funded healthcare institutions including polyclinics, acute hospitals and community hospitals that cater to their populations' total care needs. Each has also established partnerships with VWOs and/or private sector providers in the primary care and ILTC sectors (Ministry of Health, 2017e).

4. Ageing Planning Office (APO)

The Ageing Planning Office was formed in 2011 under MOH to oversee the planning and implementation of strategies to address the needs of Singapore's aging population, including strategies towards successful aging (Government of Singapore, 2016; Peh et al., 2015). It co-ordinates at Ministry level and on an implementation level to drive forward initiatives on successful aging, aged care services and supports the Ministerial Committee on Ageing (Government of Singapore, 2016; Mehta & Vasoo, 2002).

D. Private Sector

In Singapore, private sectors play a major role in providing LTC (approximately 30% of LTC services) (Tan, n.d.). Although most of these services are catered to full-paying individuals, in April 2003, accredited private nursing homes reserved a proportion of their beds for individuals eligible for MOH subsidies, allowing more private-sector participation in the public funded LTC sector (Ministry of Health, 2017d).

Organizing Care: Healthcare Services and Facilities

A. Primary Care and Acute Care

There are 18 publicly funded polyclinics operated by Regional Health Systems (RHS) across Singapore that offer family medicine for acute and chronic disease management, health promotion and immunization. These comprise 20% of the primary health care service, whereas 80% of it is provided by private general practitioner (GP) clinics. In contrast, the costlier hospitalization care is mostly provided by the public sector (80%) (Table 4) (Ministry of Health, 2017a; Ministry of Trade & Industry, 2017).

Although private GPs comprise most of the primary healthcare system, a disproportionate number of older adults visited primary care in publicly funded polyclinic (29%) compared to GPs (11%) (Ministry of Health, 2010, 2014b). Since the private sector GPs play a larger role in primary care provision, there are also increasing attempts to bring partnering GPs into providing more chronic care to older adults.

⁹ The three RHS are the National University Health System overseeing the Western region, the National Healthcare Group overseeing the Central region, and Singapore Health Services overseeing the Eastern region.

Table 4: Primary Care and Acute Healthcare Facilities

	2014		2015		2016	
	Public	Private	Public	Private	Public	Private
Acute Hospitals	8	9	9	9	9	9
Primary Care Facilities	18	1,868	18	1,933	18	2,017

Source: Ministry of Health (2017a).

B. Intermediate and Long-term care (ILTC)

Sub-acute and community care for older adults in Singapore can be broadly divided into residential (institutional) or non-residential (community-based) services. These are provided primarily by VWO and private operators (Mehta & Vasoo, 2002; Ministry of Health, 2017d).

C. Residential/Institutional Care

In Singapore, residential ILTC services include community hospitals, chronic sick units, nursing homes, and inpatient hospices (Table 5) (Ministry of Health, 2017d).

Table 5: Residential Intermediate and Long-term care Services in Singapore

Type of Long-term care	Description
Sheltered Homes	Provide residential care and social-recreational services for older adults who are independent functionally but have no or little family support.
Community Hospitals	Provide intermediate care for those fit for discharge from acute hospital but who need further rehabilitation or convalescence prior to returning home.
Chronic Sick Units	Provide skilled nursing and medical care on long term basis for individuals suffering from medical conditions with long term complications.
Nursing Homes*	Provide services to meet the needs of residents who require assistance with activities of daily living and/or daily skilled nursing care, and who are unable to be cared for at home. The services include medical care, nursing care, rehabilitative services and dietary services.
Inpatient Hospice	Provide medical, nursing and psychosocial care for those in the terminal stages of their illness.

*Some nursing homes also provide shorter term respite care services

In 2016, there were 69 nursing homes in Singapore, of which 13 are publicly operated, 26 are operated by non-profit, and 30 are run by the private sector (Agency for Integrated Care, 2016b). The number

of nursing home beds are steadily increasing from 10,968 beds in 2014 to 13,022 in 2016 (Table 6) (Ministry of Health, 2017a).

Table 6: Intermediate and Long-term health care Facilities

	2014	2015	2016
No. of Residential Intermediate and Long-term care Facilities			
Community Hospitals	6	7	8
Nursing Homes	65	71	69
Inpatient Hospices	2	2	2
Total No. of Beds	12,174	13,790	14,858
Community Hospitals	1,065	1,464	1,663
Nursing Homes (including Chronic Sick Units)	10,968	12,185	13,022
Inpatient Hospices	141	141	173
No. of Non-Residential Long-term care Facilities			
Centre-based Care Facilities	68	81	88
Home Care Providers	14	17	21
Home Palliative Care Providers	5	7	7

Source: Ministry of Health (2017a).

Older adults have both the highest admission rates and lengths of stay in Singapore (Table 7) (Ministry of Health, 2017c). In an effort to improve care for older geriatric patients, in 2003, the MOH required every public hospital to provide basic clinical geriatric care (Wong & Landefeld, 2011). The government also aims to move from hospital

to community care with the expansion of community hospital facilities. There are currently eight community hospitals¹⁰, with plans to build two new community hospitals co-located with acute hospitals over the next three years to provide more sub-acute and rehabilitation care.

¹⁰ The eight community hospitals include one privately funded one. The other seven are publicly funded and are either VWO operated or RHS operated.

Table 7: Hospital Admission Rates per Thousand Resident Population, 2016

Age in years	Public Sector	Private Sector	Total
0-4	199.2	127.0	326.2
5-9	37.0	11.0	47.9
10-14	31.8	5.8	37.6
15-19	31.4	6.4	37.8
20-24	39.1	9.3	48.4
25-29	44.8	23.6	68.4
30-34	51.1	38.8	90.0
35-39	47.1	30.7	77.7
40-44	48.8	22.9	71.7
45-49	64.0	19.1	83.1
50-54	83.9	17.1	101.0
55-59	110.7	17.7	128.4
60-64	143.3	19.9	163.2
65-69	192.0	22.6	214.5
70-74	272.0	32.1	304.2
75-79	370.5	41.0	411.6
80-84	513.3	61.3	574.6
85 and over	681.4	88.5	770.0

Notes: These data exclude normal delivery and legal abortion – data from MediClaim system.

D. Non-residential/Community-based Care**1. Centre-Based Care**

These centers provide daytime care services for older adults based on physical and social needs on a long term basis including rehabilitation (physiotherapy or occupational therapy), basic nursing care, and maintenance of physical and mental health through social support (Ministry of Health, 2017d). These include day care, day rehabilitation and dementia day care centers. Most are organized by VWOs with MOH subsidies based on means-testing, a method used to determine the amount of subsidy each person needing care is eligible based on monthly household income per person. There are also efforts by MOH to integrate the social and health care services by developing Active Ageing Hubs (AAHs) and Senior Care Centres (SCCs) (Ministry of Health, 2015b, 2016g). There are attempts to co-locate these facilities within public housing estates and community centers to improve access to care, and within nursing homes to facilitate the integration of care (Ministry of Health, 2016g).

2. Senior Activity Centres

MOH oversees the Senior Activity Centres (SAC) which are typically operated by Voluntary Welfare Organisations (VWO). These centres are located at void decks of public housing flats. SACs provide free social and recreational services for older adults and monitor frail/homebound older adults within the public housing.

3. Home-Based Care

Home-based care provides services to meet the clinical and social needs of frail and homebound older adults and to support caregivers (Table 8) (Ministry of Health, 2017d). Majority of home care providers are VWOs, with a smaller contribution from the private sector (Ministry of Health, 2017d). More recently, RHS has been increasing their roles in providing care transitions for their complex older patients from hospital to home in nursing, medical and rehabilitative care at home.

Table 8: Home Care Services for Homebound Older Adults in Singapore

Home Care Service	Description
Home Medical Care	Provides medical consultation at home for older adults with chronic conditions or disabilities
Home Nursing Care	Provides nursing services for older adults with chronic conditions or disabilities which include wound care, nasogastric tube change
Home Therapy	Provides rehabilitation services including physiotherapy, occupational therapy and speech therapy
Home Personal Care	Provides assistance with ADLs and/or iADLS, such as house-keeping, personal hygiene, medication reminders
Home Palliative Care	Provides end-of-life care by a multi-disciplinary team of doctors, nurses and social workers, to terminally ill patients and their families

Table 8: (continued)

Home Care Service	Description
Escort/Transport services	Provide and arrange transport to medical appointments
Meals-on-wheels	Daily hot meals provided to home

Source: Ministry of Health (2017d).

E. Expansion of Places in Residential and Non-residential LTC Services

In the past five years, publicly-funded aged care capacity has substantially increased. Committee of Supply (COS) in MOH in 2016 has projected further increases in capacity for nursing homes, community and home care by 2020 (Table 9) (Ministry of Health, n.d.-a). Efforts are made in strengthening home and community care options to help older adults avoid institutionalization, and to age at home and in the community.

There are also plans to expand options in home care services and eldercare centers, in general, and specifically for mental health and palliative care with the 5-year Community Mental Health master plan for 3,000 dementia-specific day care and nursing home beds by 2021 (Teo et al., 2006). In the National Strategy for Palliative Care, the government has plans to increase capacity and to provide quality palliative care including larger financial support for hospice care services (Lien Centre for Palliative Care, 2011).

Table 9: Planned Capacity Expansion of Places Available in Aged Care Services

	End 2011	End 2015	By 2020	% Increase between end-2011 and end-2020
Acute Hospitals	6,900 beds	8,100 beds	9,500 beds	38%
Community Hospitals	800 beds	1,400 beds	2,900 beds	263%
Nursing Home Care	9,400 beds	12,000 beds	17,000 beds	80%
Community Care	2,100 day places	3,500 day places	6,200 day places	195%
Home Care	3,800 home places	6,900 home places	10,000 home places	163%
Palliative Home	3,800 places	5,150 places	6,000 places	58%

Source: Ministry of Health (n.d.-a).

Organizing Care: Life Course and Socio-ecologic Approach

Older Singaporeans are encouraged to assume personal responsibility for their health, particularly in living healthy lifestyles as this plays an important role in maintaining health and quality of life. This is especially relevant to the current increase in life expectancy in Singapore. It is recognized that a healthier lifestyle with fewer risk factors such as sedentary behavior, obesity and smoking has the potential to stop or retard the development of non-communicable diseases (NCDs) like heart disease and diabetes. According to the Singapore Burden of Disease Survey 2010, approximately 70% of the burden of death and ill health was caused by NCDs (Ministry of Health, 2014c). Hence, health promotion is an important component to improve the awareness and attitudes towards a healthier lifestyle and empowering self-care as a preventive measure and maintain health and independence in aging.

A. Health Promotion and Preventive Health

A key focus for care in older adults is to empower them to remain healthy. The Ministry of Health has launched a National Seniors' Health Programme for older adults to encourage them to remain active and healthy by promoting health education and preventive health services (Ministry of Health, 2016a). These include campaigns to increase awareness of nutrition, falls, stroke, physical activity and dementia specifically for older adults (Health Promotion Board, 2017).

Other initiatives include the Screen For Life (SFL) program to improve accessibility to health screenings for chronic disease like cardiovascular diseases and preventable cancers namely breast, cervical, and colorectal cancer (People's Association, 2017a, 2017b). At the community level, People's Association (PA), a statutory board to promote racial harmony and social cohesion, has implemented Wellness Programmes since 2008 to encourage those over 50 to remain physically, mentally and socially active by participating in community-based physical activity and social programs (People's Association, 2017b).

B. Aging in Place

Aging in place is defined as the ability of an individual to live in one's own home and community safely, independently and comfortably, regardless of age, income or ability level. Current policies emphasize both successful aging and aging in place in the community. This is also in line with older adults' preference to age in place (Ministry of Health, 2016f; Pink, 2016).

Programs are in place to foster a society where older adults live full, active and meaningful lives with an emphasis on lifelong learning and volunteering. Examples of these social programs administered by The Council for Third Age (C3A) include: The National Silver Academy (NSA), a network of educational institutions and community-based organizations offering learning opportunities to older adults; and the Silver Volunteer Fund, which aims to empower volunteer organizations to offer more volunteer opportunities in the community for the seniors (Council for Third Age, n.d.).

There are also increasing efforts to mobilize the community to support health and social care for older adults. Overseen by the Ministry of Health (MOH) and its Agency for Integrated Care (AIC), the Community Networks for Seniors brings together different stakeholders in a community – voluntary welfare organisations (VWOs), the People's Association's (PA) grassroots organisations, regional health systems and government agencies – to jointly engage and support our seniors. The objectives are to promote active ageing among seniors to keep them well, extend befriending services to seniors living alone, and sew up health and social support for seniors with needs.

In organizing care around the older adult, Singapore is beginning to look at the notion of a 'care continuum', which includes elements of public health policies of preventive measures, active aging, autonomy promotion and empowerment, social assistance, healthcare and even end-of-life or palliative care. There is also the potential for controlling the demand and costs for care of dependency in older adults by increasing the focus on prevention of functional decline, and health promotion programs.

| Healthcare and LTC Financing

Introduction

Singapore uses a combination of mandatory medical savings, insurance and financing schemes, and grants to accomplish the goals of healthcare financing to ensure individuals have access to effective acute, chronic and LTC services and financial protection for older people (Table 10).

This mixed financing system has multiple tiers of protection that are anchored on individual and family responsibility, followed by support from the community, with public assistance as the last resource in ensuring healthcare access and affordability. The first layer of protection, government subsidies, is available for everyone to offset healthcare cost, and is based on eligibility (Figure 3). For publicly funded acute hospital care, government subsidies are provided based on ward class chosen (up to 80%) and further tiered based on a patient's means, with higher subsidies for lower-income Singaporeans. Intermediate and long-term care (ILTC) subsidies are based on household means-testing and the specific ILTC service utilized. Those who are eligible can obtain up to 80% subsidy for ILTC services in the community (Ministry of Health, 2015e).

Table 10: Financial and Funding Schemes for Older Persons in Singapore

Scheme/Subsidy	Eligibility in financing	Type	Purpose(s)
Mandatory Savings & Insurances			
a. Medisave	All	Mandatory national savings program	Acute and intermediate care
b. MediShield Life	All	Mandatory Insurance	Acute and intermediate care
c. Medifund	All sources of financial aids exhausted	Endowment fund	Acute, intermediate and long-term care
d. ElderShield	All automatically enrolled at 40 years with an opt-out option ≥ 3 ADL limitations, and ≥ 40 years old	Severe disability voluntary insurance Cash pay-out of: S\$300 for 5 years, or S\$400 for 6 years	Long-term care
Financing Schemes & Grants			
a. Interim Disability Assistance Programmed for Elderly (IDAPE)	Those ineligible for ElderShield, and Low income, and ≥ 3 ADL limitations	Cash pay-out of: S\$150 for 6 years, or S\$250 for 6 years	Long-term care
b. Pioneer Generation Disability Assistance Scheme (PioneerDAS)	Be a Pioneer ≥ 3 ADL limitations	Cash pay-out of: \$100 per month	Long-term care
c. Senior Mobility and Enabling Fund (SMF)	Low income citizens aged 60 years and above Needs-based assessments	Varies, depending on household means-test results	Subsidy for assistive devices, home healthcare items, transport services to MOH-funded eldercare and dialysis centres
d. Enhancement for Active Seniors (EASE)	Household member ≥65 or Household member between 60 and 64 years with ≥1 ADL limitation	Variable subsidised cost	Elder-friendly home improvement in HDB flats
e. Caregivers Training Grant	Care recipient ≥ 65 years old, certified to be disabled, or is using disability services of an accredited VWO	S\$200 per year	Support caregivers to attend training to better equip themselves with caregiving skills
f. FDW Grant	≥ 3 ADL limitations	S\$120 per month	Offset FDW levy and employment
g. FDW levy concession (Persons with Disabilities)	≥ 1 ADL limitations	S\$60 (instead of S\$265)	Subsidise FDW employment
h. Eldercare fund	VWO nursing homes and other ILTC services	Endowment fund	Subsidise VWO nursing homes and ILTC operating costs to help low- and lower-middle income households

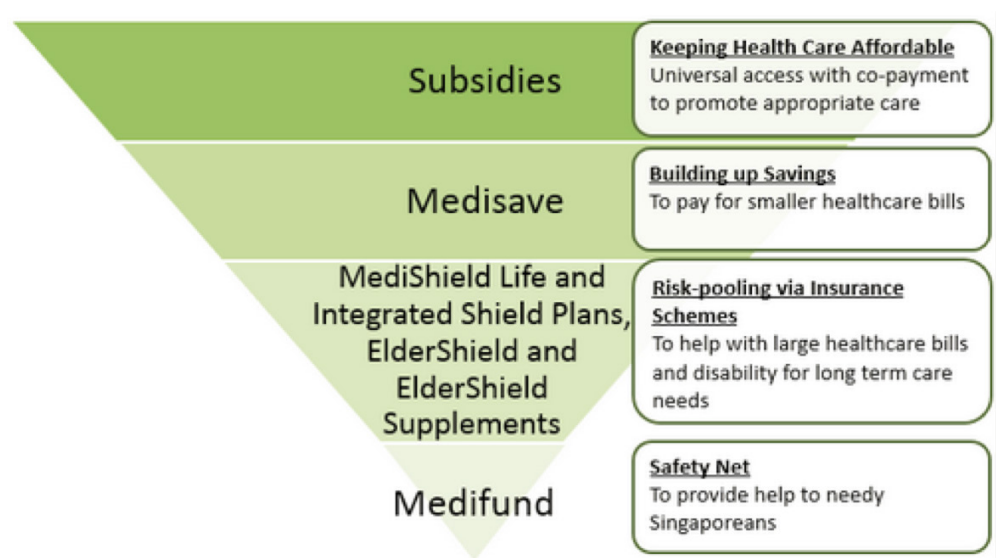
Healthcare Financing Framework

A. The 3Ms System

The next layer of protection after the government subsidies are the 3Ms – a compulsory medical savings account (Medisave), a catastrophic medical insurance scheme (MediShield Life) and a means-tested medical expenses assistance scheme

(Medifund) (Ministry of Health, 2017f). However, Medisave and MediShield Life cover predominantly acute hospitalizations, day surgeries, selected specialist outpatient expenses, intermediate care in community hospitals and selected chronic conditions in primary care and are subjected to withdrawal/claim limits.

Figure 3: Multiple Layers of Protection in Singapore Healthcare Financing



Source: Ministry of Health (2008, 2015c, 2015d, 2016d, 2017f, n.d.-b).

B. Medisave

Medisave is part of the Central Provident Fund (CPF)¹¹ scheme, a mandatory national savings scheme where both employers and employees are required to contribute a percentage of the monthly wage to the CPF account of the employees. Individuals are required to set aside savings in their Medisave accounts which can be used to pay

for both the individual and immediate family’s medical expenses after Government subsidies and insurance (MediShield/MediShield Life) pay-out (Ministry of Health, 2017f).

The use of Medisave has been progressively liberalized to help reduce out-of-pocket (OOP) payments by patients. Since 2006, Medisave

¹¹ The Central Provident Fund (CPF) is a social security scheme that allows Singaporeans and permanent residents to set aside part of their employment income as funds for retirement. Their employers are also required to contribute to the employees’ CPF account. CPF can be used to address healthcare needs, home ownership, family protection and asset enhancement.

extended cover to chronic diseases in specialist outpatients and primary care under the Chronic Disease Management Programme (CDMP) (Agency for Integrated Care, 2013; Ministry of Health, 2015c).

C. MediShield/MediShield Life

With increasing healthcare costs, MediShield was implemented in 1990 to allow for risk pooling across individuals. It was introduced as an opt-out, voluntary health insurance run by the government to help cover the increasing costs of healthcare from an unexpected catastrophic illness that Medisave was unable to cover. However, some individuals, could not benefit from MediShield due to pre-existing illnesses or their age, as coverage stops at 90 years old. Recognizing the gaps, in 2015, the government re-launched MediShield as MediShield Life, to provide all Singapore residents with universal, life-long insurance coverage and better protection from large hospital bills. Although premiums for older adults and those with the pre-existing illnesses are higher based on actuarial risk, the government provides subsidies to make premiums more affordable (Ministry of Health, 2017f). Benefits of MediShield Life include a reduction in co-payments and the ability to claim larger portions of hospital costs (Ministry of Health, 2015d).

In addition, older adults in the Pioneer Generation (PG)¹², can receive subsidies of 40% to 60% for their premiums in MediShield Life, along with

additional annual Medisave account top-ups¹³ from government of \$200 to \$800 (Ministry of Health, 2017f). Other benefits include increased subsidies in publicly-funded primary and specialist care, and private GPs. PG Ambassadors, who are made up of volunteers, go door to door to explain the benefits provided to Pioneers.

D. Medifund

Medifund is an endowment fund set up by the government as a safety net for Singaporeans who face financial difficulties with their remaining bills after receiving government subsidies and who have exhausted other means of payments and insurances (Ministry of Health, 2017f). In 2007, the government also introduced Medifund Silver to provide assistance to older adults specifically and in 2008, Medifund Silver could also be used to deliver assistance in a more targeted manner in the intermediate and LTC sector in response to the aging population (Ministry of Health, 2008, 2016d).

E. Financing Chronic and Long-term care

Similar to many countries, Singapore's current financing system provides better coverage and benefits for acute episodes of care and hospitalizations than for on-going chronic care and LTC. With an aging population, LTC needs and demands are also likely to increase, with family- or community-based informal support under growing pressure from falling fertility rates, and smaller family sizes. Although there are no

¹² Pioneer generation was defined as Singapore Citizen who was aged 16 and above in 1965 and who obtained citizenship on or before 31 December 1986.

¹³ Medisave can be used to pay annual premiums for Medishield Life.

specific data on LTC expenditure in Singapore, experiences from other countries place the expenditure of LTC as expensive and a significant burden on low-income households and especially older adults with high levels of dependency (Singapore Silver Pages, n.d.-b). In Argentina, for example, the average LTC expenditure for women aged 60 years and above is estimated to be 52% of expected value per capita family income (Monteverde, Noronha, & Angeletti, 2008). In addition to the coverage provided by the subsidies and the 3Ms, the government implemented ElderShield, a severe disability insurance scheme, to improve healthcare affordability for older adults.

F. ElderShield

ElderShield was launched in 2002 as a severe disability insurance scheme to provide basic financial protection for severely disabled Singaporeans (i.e. those unable to perform at least 3 ADLs) who need LTC by giving a monthly cash pay-out (Ministry of Health, n.d.-b). ElderShield insurance is run by three private insurance companies appointed by MOH. Singaporeans turning 40 are auto-enrolled and pay premiums through Medisave or cash annually from 40 to 65 years old (Ministry of Health, n.d.-b). Although pre-existing chronic diseases are not excluded, older adults with pre-existing severe disabilities prior to the enrolment are excluded from ElderShield. An ElderShield Review Committee has been convened to review and recommend enhancements to ElderShield (Chua, 2017).

G. Financing Schemes and Grants

1. Interim Disability Assistance Programme for the Elderly (IDAPE)

For needy and severely disabled older adults who were ineligible for ElderShield in 2002 because they had exceeded the maximum entry age or had pre-existing disabilities, the Interim Disability Assistance Programme for the Elderly (IDAPE) provides cash payouts to qualified individuals with per capita household monthly income of S\$2,600 or below (Ministry of Health, 2016b). For example, a citizen who needs maximal assistance with three or more ADLs and whose household income is below \$2,600/month, will be given a monthly payout for up to 72 months to assist with OOP expenses in medical or nursing care, or in hiring a helper or FDW (Ministry of Health, n.d.-c).

2. Pioneer Generation Disability Assistance Scheme

Older adults from the “pioneer generation”, citizens who were aged 16 and above in 1965 and who obtained citizenship on or before 31 December 1986, who are moderately to severely disabled can receive \$100 a month in cash, regardless of household income, to help with their OOP care expenses.

3. Eldercare Fund

The demand for nursing home care continues to increase with the rapidly aging population. Recognizing the need to secure the future affordability of nursing care for households of low- and lower middle income, the Eldercare Fund was established in 2010 under the Medical and Care Endowment Schemes Act. The interest income from the Fund is used to provide operating

subsidies to VWO nursing homes and other intermediate and long-term healthcare services. However, the Fund does not fully replace community support, and VWOs continue to raise funds from the public in helping the less privileged (Medical and Elderly Care Endowment Schemes Act of 2000, 2001; Ministry of Health, 2000).

4. Other Schemes and Grants

a. Housing

The government has also introduced several older-person-friendly initiatives to incentivize families to take more responsibility in the care of their parents. The Ministry of National Development Singapore and the HDB introduced the Proximity Housing Grant in 2015 (Jo, 2016). Married children who are buying apartments close to their parents are given up to SGD 20,000 under the Grant.

b. Chronic Health and Primary Care

Community Health Assist Scheme was introduced in 2012 to subsidize for primary care and dental care at accredited GP and dental clinics (Ministry of Health, 2014a). Medisave can also be used for 19 chronic diseases¹⁴ under the Chronic Disease Management Programme (CDMP) (Ministry of Health, 2015c). In addition, with the rise of living expenses and medical costs, older adults whose children are low income earners themselves can apply for ComCare Long-Term Assistance Scheme with cash allowance and recurring specialized needs, such as healthcare consumables (Ministry of Social and Family Development, 2016).

c. Disability Assistance

The Seniors' Mobility & Enabling Fund (SMF), provides older Singaporeans aged 60 years and above means-tested subsidies to offset the cost of assistive devices (such as wheelchairs, walking frames), home healthcare items and transport services to MOH-funded eldercare and dialysis centers (Singapore Silver Pages, n.d.-c). The Enhancement for Active Seniors (EASE) scheme is also available to older adults and families to make their homes in public housing friendlier and safer for older adults (Housing & Development Board, n.d.).

d. Human Resource Assistance

With the declining fertility rates and more women entering the workforce, FDWs have become an alternative for older adults' care provision at home (Chan et al., 2013). A comprehensive program was introduced to train FDWs to improve the quality of care. Families with dependent older adults are given Foreign Domestic Worker Grant and lower concessionary levy to lower the cost of hiring FDW to care (Ministry of Health, 2016g).

H. Tiering of the Subsidies through Means-testing and Eligibility

Providers approved by MOH for subsidized LTC services have eligibility rules based on assessments using physical disabilities and means-testing. Singapore uses 3 ADLs disabilities or more for financing eligibility for cash payouts in ElderShield,

¹⁴ The CDMP covers diabetes mellitus, hypertension, hyperlipidemia, stroke, asthma, chronic obstructive pulmonary diseases, schizophrenia, major depression, bipolar disorder, dementia, osteoarthritis, benign prostatic hyperplasia, anxiety, Parkinson's disease, nephrosis/nephritis, epilepsy, osteoporosis, psoriasis and rheumatoid arthritis.

IDAPE and PioneerDAS (Table 10). The means-testing approach for these LTC services is based on household means-testing and those falling below a set threshold of household income are eligible for publicly funded LTC benefits and subsidies based on a tiered approach (Ministry of Health, 2015e). Those who do not qualify for the means-tested subsidized LTC services are still able to access and purchase LTC services without subsidies.

Policies, Laws and Regulations of Care for Older Adults

Evolving Policies on Care for Older Adults

1960s-70s: Social care and protection of vulnerable older adults

Since the independence of Singapore in the 1960s, the provision of care to older adults focused on social care and social protection. Initially, care institutions were run by VWOs to provide basic shelter and care for the homeless, financially needy and vulnerable older adults. In the 1970s, a number of Homes for the Aged were started that provided both basic shelter with the addition of nursing care for the aged sick (Singapore Christian Home, 2013; Sitoh, 2003; Villa Francis, n.d.).

1980s-1990s: Inclusion of health, and financial security and development of a successful aging framework

In anticipation of a demographic transition, Singapore started to take a more comprehensive look at policies to meet financial, social and health needs of older adults. In June 1982, The

Committee on the Problems of the Aged was appointed. It addressed the contributions of older adults in the workforce and listed alternative employment options for older adults. Community organizations and VWOs were asked to provide a wider range of welfare, medical and social services to assist families to care for the weaker and dependent older adults (Ministry of Culture, 1984).

Later in 1998, an inter-ministerial committee was formed to expand on the earlier policies to include the nuclear family and the community. The Inter-Ministerial Committee (IMC) was formed to ensure that all levels of society were well prepared for the challenges and opportunities of an aging Singapore. Supported by the then Ministry of Community Development, Youth and Sports (now the Ministry of Social and Family Development or MSF), the committee centered on “Successful Ageing for Singapore” and produced a report on 78 recommendations (Ministry of Social and Family Development, 1999). The development of a National framework centered on “Successful Ageing for Singapore” was formulated based on the principles of well-being and the development of older adults as well as to ensure an enabling and supportive environment. In addition, recommendations were made towards a more integrated health care model and community-based care approach. Employment for older adults, public housing and public transport systems were also reviewed for better participation and accessibility for older adults. To address the needs of the

aging population in different stages of maturity of the Singapore society, the Committee on Ageing Issues (CAI) was set up in 2004. The CAI placed a new emphasis on maintaining a high quality of life for a new cohort of older adults from the baby boomer generation and recognized the importance of infrastructural accessibility as well as the collaboration involving the three sectors of public, private and people to achieve the long-range view of “Successful Ageing for Singapore” (Committee on Ageing Issues, 2006).

2000s – 2017: Coordination within Ministries and implementation of “Successful ageing” policies to include all levels of society

In 2002, as part of a global initiative, Singapore also adopted the concept of Society of All Ages introduced by the Madrid International Plan of Action on Ageing to prepare all levels of the society for the challenges and opportunities of an aging society. To coordinate various ministries efforts in providing a holistic approach towards aging, the Ministerial Committee on Ageing (MCA) was established in 2007 (Ministry of Community Development Youth and Sports, 2007). The MCA launched the City For All Ages (CFAA) project in 2011 to encourage local communities create “senior-friendly communities” to support the aging population (Singapore Business Review, 2011). Later, in 2015, MCA unveiled an ambitious \$3 billion national blueprint, the Action Plan for Successful Ageing

along three key thrusts: (i) at the individual level, to help Singaporeans stay active physically, cognitively, economically and socially; (ii) at the community level, to build a cohesive society and foster inter-generational harmony; (iii) at the city level, to build an age-friendly city that enables older adults to live actively and age-in-place confidently. (Ministry of Health, 2016a). The Action Plan was developed after extensive consultation with over 4,000 stakeholders including members of the public, students, government agencies, academics, local governments and businesses. The plan also marks the national movement to shift the negative paradigm of aging from one that is associated with illnesses and disabilities, to a positive one that is filled with opportunities (Ministry of Health, 2015a).

The Action Plan for Successful Ageing also incorporated the role of research and innovation to redefine the future experience of aging and new care models through the National Innovation Challenge (NIC) by increasing multi-disciplinary translational research. This resulted in the establishments of research institutes with a specific focus on older adults and aging. These include the national Geriatrics Education and Research Institute (GERI), the university-affiliated Centre for Ageing Research and Education (CARE) and the Ageing Research Institute of Society and Education (ARISE) (Ministry of Health, 2016e).

Table 11: Timeline of Policy Response in the Care for Older Adults Between 1980 to Present

Year	Policy	Recommendations
1982	The Committee on the Problems of the Aged	<ol style="list-style-type: none"> 1. To alter accepted ideas and attitudes of society towards old age from negative to positive 2. To change entrenched practices and attitudes towards retirement 3. To create more job opportunities for older people 4. To enable older workers to continue a normal active life through earlier contributory superannuation schemes 5. To monitor the physical and mental health of those over 60 6. To foster greater filial piety and responsibility for children and relatives 7. To grant assistance in tangible forms for more homes to be established for the aged who are in need 8. To consider introducing legislation requiring certain religious activities to be licensed with the stipulation that they must set up homes for the aged
1998	The Inter-Ministerial Committee (IMC)	<p>Consists of 6 areas with 78 recommendations:</p> <ol style="list-style-type: none"> 1. Social integration of the Elderly To improve transport resources and facilitate community-based services 2. Health Care To study the health care needs and review standards for service delivery 3. Financial Security To fine-tune the CPF system and encourage public education on financial planning 4. Employment and Employability To increase training and employment opportunities 5. Housing and Land Use Policies To make homes and environment elder-friendly and support extended family living 6. Cohesion and Conflict in an Ageing Society To promote extended family ties
2004	The Committee on Ageing Issues (CAI)	<ol style="list-style-type: none"> 1. Elder-friendly housing <ul style="list-style-type: none"> • Provide different housing options • Help older adults to monetise their housing assets 2. Barrier-free society <ul style="list-style-type: none"> • Make all public housing barrier-free • All new public buses be elder-friendly 3. Holistic affordable health care and eldercare <ul style="list-style-type: none"> • Top up Medisave Accounts • Family practitioner based holistic care for older adults 4. Active lifestyles and well-being <ul style="list-style-type: none"> • Promote more programmes and services for older adults • Build on strong family ties to ensure that the family continues to be the first line of support

Table 11: (continued)

Year	Policy	Recommendations
2016	The Action Plan for Successful Ageing	<p>Key points and Initiatives:</p> <ol style="list-style-type: none"> 1. Lifelong Employability: Maximise opportunity to keep working and earning longer. Government, unions and employers to support older workers 2. Health and Wellness: National Seniors Health Programme and a new workplace health programme targeting those aged 40 or above 3. Senior learning: National Senior Academy to provide a range of learning opportunities, including intergenerational Learning programme 4. Senior Volunteerism: Aims to recruit 50 000 older adults volunteers to allow them to contribute their time and experience 5. Community Befriending: Expansion of home visit programmes to minimise social isolation in vulnerable older adults 6. Inter-generational Harmony: Co-locate Eldercare and childcare facilities; Policies to support family members living near each other; Foster respect and social inclusion 7. Aged Care: Increase home and community care, double number of community beds and increase nursing home capacity by 2020 8. Active ageing and Assisted Living: Plans for 40 new day centres for older adults by 2020, of which a quarter of these centres will be Active Ageing Hubs that provide active aging and assisted living services in new housing developments; senior-friendly housing and public spaces 9. Transport: Make public transport more affordable and convenient for older adults and improve experience and safety for pedestrians 10. Research: Investment in aging related research

Laws and Regulations

Singapore's guiding principle in health and social care emphasizes self-care as the first, which is followed by family and community care before the government is engaged in a "many helping hands" approach. The legislative Acts in Singapore were progressively introduced to ensure that the needs of the older adults are addressed in a sustainable manner and the responsibility of care decentralized to all levels of society.

A. Legislative Acts

1. Women's Charter (1961)

This Charter was passed to protect and advance

the rights of women and girls in Singapore. However, the Charter has provisions against family violence including abuse of older adults. Older adults can apply for a Protection Order from the Family Court to restrain the abuser (Women's Charter of 1961, 2009).

2. Destitute Persons Act (1989)

Under the provisions of the Act, the admission to welfare homes is statutory. Nearly nine in ten of the residents are aged above 50 (Goy, 2017). The Destitute and Shelter Support Branch (DSSB) is responsible for twelve homes which are listed as welfare homes for the care, reception and

rehabilitation of destitute persons. The homes are run by VWOs serving as managing agents for the Ministry. Basic rehabilitation provided by the homes aims to increase older adults' functional levels so that they could care for themselves. Residents with families return to their families ultimately. Thus, the welfare homes should be a temporary place for them to stay (Destitute Persons Act of 1989, 2013; Ministry of Social and Family Development, n.d.).

3. Maintenance of Parents Act (1996)

Older adults in Singapore who is of or above 60 years old and who is unable to maintain themselves adequately may apply to a Tribunal to order children pay an allowance for maintenance. The allowance could be used for shelter, food, medical costs and clothing (Maintenance of Parents Act of 1995, 1996).

4. Advance Medical Directive Act (1996)

The Advance Medical Directive (AMD) is a legal document one can sign in advance to inform one's doctor that he/she does not want the use of any life-sustaining treatment to prolong his/her life in the event he/she becomes terminally ill and unconscious and where death is imminent (Advance Medical Directive Act of 1996, 1997).

5. Mental Capacity Act (2008)

This Act was passed in 2008 and amended in 2016 to provide a regulatory framework for the protection of the mentally incapacitated. The Act introduced the Lasting Power of Attorney which is an instrument

by which a person may appoint another to make decisions for him/her in the event he/she loses mental capacity (Mental Capacity Act of 2008, 2010).

6. Silver Support Scheme Act (2015)

This Act serves as social security and protection scheme with a quarterly pay-out to supplement the livelihoods, of low-income older adults with less retirement support. Older adults will be assessed automatically on their eligibility and the pay-out per quarter could be as high as \$750 (Silver Support Scheme Act of 2015).

B. Regulations

Enhanced Nursing Home Standards

Singapore established a regulatory framework to ensure consistent, safe, and quality care for residents in nursing homes. The Enhanced Nursing Home Standards (ENHS) were based on recommendations by the Nursing Home Standards Workgroup¹⁵. The ENHS introduced in January 2014 was promulgated into a set of Licensing Terms and Conditions on Nursing Homes (NH LTCs) in April 2015. All nursing homes are mandated to be licensed under the Private Hospitals & Medical Clinics (PHMC) Act, and are required to comply with the relevant PHMC Regulations and the NH LTCs (Private Hospitals and Medical Clinics Act of 1980, 1999). MOH conducts regular, unannounced inspections to nursing homes to ensure they meet the licensing requirements and provide appropriate care to residents. The Nursing Home Visitors Programme was introduced in April 2012 where a group of volunteers visit the Nursing Homes to obtain

¹⁵ Workgroup consists of nursing home leaders, clinicians, pharmacist and therapists.

feedback on the provision of care directly from residents and family members, as well as to make general observations on the living conditions. The visitors program for nursing homes is in addition to the existing regulatory supervision and licensing inspection which is conducted before the renewal of nursing home license. Additional efforts to improve the standard of care include independent peer audits for the poorer compliance nursing home and annual regulatory forums to share best practices in safety and quality improvements.

Challenges in Care Provision for Older Adults and Strategic Considerations in Singapore

Increasing Long-term care Needs and Demands

Currently, most long term caregiving needs of dependent older adults are met informally by family members. However, the available pool of informal carers is likely to shrink due to dramatic falls in the proportion of younger adults compared to older adults, and with the shifting trend in household structure. It would be challenging for caregivers to meet the projected needs in caregiving (Ansah et al., 2016; Goh, 2011). Countries are also beginning to recognize that informal care is not without costs to caregivers, and society and health systems. As most caregivers are still in the working-age population¹⁶, they face lost income in reduced work hours, absenteeism from work, employability and productivity loss. Combined, these indirect costs are likely to have significant negative impacts at

a societal level and a macro-level in socioeconomic development (Wong, 2013). In addition, the increasing demands for formal LTC services such as day care and respite care services continue to rise in recent years.

Measuring Demand and Burden of Costs in LTC

There is inadequate data to accurately project LTC demand and burden of costs for the country. Although the OECD uses age 80 years and above (old-old) threshold to project demand of LTC, the use of a specific age threshold may not be appropriate (Francesca, Ana, Jérôme, & Frits, 2011). Currently, Singapore uses a measure of dependency in terms of ADL disability. There is some empirical evidence to suggest that ADL-based data may underestimate the need for care because it does not give due weight to cognitive and mental health problems (World Health Organization, 2002). A better indicator of LTC needs should also include projections of chronic disease and availability of caregivers. There is a lack of data on the burden of direct and indirect costs of LTC to self and family. Indicators to estimate the economic impact in costs to family and households from reduced productivity, work loss, increased health care consumption, reduced savings and increased caregiving are also important to estimate the economic burden and to project future costs. For example, the United States estimated the indirect costs of informal care to be \$450 billion in 2009 (Feinberg, Reinhard, Houser, & Choula, 2011).

¹⁶ Defined as age between 45 and 59 years.

Inappropriate and Inefficient Use of Health Care Resources

The current health care and financing system in Singapore provides better coverage for episodes of acute hospital care rather than on-going chronic and LTC. However, Singapore is beginning to move on the need to shift care to the community by increasing structural and human resources in home and LTC, and in making LTC more affordable with different financing schemes. Similar to many countries, including Japan, if older adults' LTC needs are not met, they will look to fulfil their needs in other parts of the health system leading to inappropriate use of resources and cost shifting. This is both expensive and an inefficient use of health care resources (Zhou, Vidyarthi, Wong, & Matchar, 2017). In Singapore, those 65 years and above are five times more likely to be admitted to public hospitals compared to those age 15 to 64 years (Ministry of Health, 2017c). There is also an increasing concern in the use of acute hospital beds for social and sub-acute care that could be met in the community. A study done in an acute care hospital in Singapore found that 49% of the hospital bed utilization was potentially avoidable if care could be provided in a community setting (Zhou et al., 2017). In recent years, there has been an increase in funding by MOH to shift care into the community.

Social Care Needs and Extent of Support

Most public LTC systems, including Singapore, have intense debates about both the extent of health-related social care support and extent of

the public/private mix in the provision on care. Social care needs for older adults are relevant to 'aging in place' which fulfils the wish of most older adults to continue staying at their home where they are most familiar, and providing support in the community to prevent or delay the need for institutionalization (Addae-Dapaah & Wong, 2001; Wiles, Leibing, Guberman, Reeve, & Allen, 2012). Older adults with physical or psycho-emotional needs can continue to live in the community when their social care needs are supported (Bacsu et al., 2012; Barrett, Hale, & Gauld, 2012; Wiles et al., 2012).

Strategic Transformation in LTC for Older Adults in Singapore

A. Financing of Care Packages for LTC Needs

Singapore developed a few innovative integrated care packages. The Integrated Home and Day Care packages allow older adults to benefit from a flexible mix of home and daycare services to meet their needs. Most countries can look at providing and financing LTC either narrowly as individual services for dependent individuals, or by having a broader system-level definition. Care packages are interesting developments in attempts to overcome efficiency problems caused by fragmentation in care provision and financing.

B. Increasing Alternatives in Community-based LTC

There are increasing community initiatives that aim to provide alternative residential assisted living facilities apart from Nursing Homes¹⁷. The ComSA

¹⁷ Examples include St Bernadette Lifestyle Village which offers rooms with attached bathroom, living room, dining areas, outdoor open spaces, planned activities and medical care services.

Centre at Whampoa represents a hub consisting of a multitude of amenities and services in proximity to older adults. Apart from the usual community center facilities such as a multipurpose hall, the center includes a clinic, daycare center, and services available to older adults and their caregivers to manage complex chronic conditions, and psycho-emotional problems (Kelly, 2017; Ng, 2017). There are planned innovative projects by MOH and the statutory board of the Ministry of National Development responsible for public housing, the Housing and Development Board (HDB), in “Continuing Care Precincts” in new housing developments, with the co-location of HDB flats, nursing homes and assisted living facilities so that there is a “continuum” of options from independent to assisted living and residential nursing facilities within the same community (Agency for Integrated Care, 2016 ; Ministry of Health, 2016a).

C. Integrating Community and LTC Services throughout the Health System

The traditional models of care which focus on acute hospital-based care can no longer be relevant to the shifting demographics of today’s aging population. The reorganization of the system for integration of services and process is much needed. Currently, there is increasing push for acute hospital systems to facilitate the extension of health care delivery and services from hospital to community. The strategy of integrating health and social provider systems under the RHS could harness the efficiencies in allocation and purchasing of services while improving person-centered care. However, there are challenges in attempts to align

financing with the provision of an integrated curative, rehabilitative and longer term care for older adults.

D. Sustainable Development in Integrating Long-term care

Singapore has started integrating social care and health care services at Ministry level to look at policies in care provision for older adults. The MOH and MSF work together in developing various services and programs to address physical, emotional and mental needs, in order to strengthen the integration of health and social care services for older adults in the community.

LTC system in Singapore is incrementally strengthened to ensure their long term sustainability with a mix of financing mechanisms to ensure older adults are able to access high quality LTC. Singapore has done well in increasing the capacity and resources in publicly available formal residential and home-care LTC services while supporting informal LTC by families. Currently, there is growing emphasis on home-care services and to support and build the skills of caregivers for its aging population. With an aging population, the cost of LTC is projected to increase not only for the government but also for families caring for a dependent older adult (Ministry of Finance, 2010). While means testing in LTC has its advantages, there are increasing debates on the set income threshold for eligibility to subsidized public care which could be adjusted to include more middle-income households which increasingly face higher health and LTC costs (Ministry of Health, 2012).

The main financing scheme in LTC in Singapore is the ElderShield insurance and disability schemes that pay out upon severe disability in 3 or more ADL disabilities. Improving financing support in LTC for less disabled people may slow deterioration in function and prevent premature institutionalization (Campbell & Ikegami, 2000). One way of overcoming this effect is to combine dependency standards with some consideration of the availability of family supports. Someone who is highly disabled but living with family members might require services only intermittently, while someone living alone might need more help even with a less severe disability (Brodsky, Habib, Mizrahi, & World Health Organization, 2000). There are currently no published data on OOP expenses on LTC in Singapore. An ElderShield Review Committee has recently been convened to review and recommend enhancements to ElderShield (Chua, 2017).

Conclusion

Singapore emphasizes care to be a personal responsibility and self-care as the first line, followed by family and community care as extensions before

the government is engaged. With a rapidly aging population and changing family structure, Singapore is looking to the provision and financing of long-term care. Long-term care demand and expenditure are expected to rise and the country is strengthening its service infrastructure in long-term care and the public health system is building coherence towards the integration of preventive, primary, acute, intermediate and long-term care. As the cost and expenditure in LTC are projected to rise, there are also increasing financing reforms to ensure older adults and families are able to access a more integrated, high quality, and affordable services while ensuring financial protection for older adults. The challenges are not only in meeting the current and future projections of LTC needs but also how fast to scale up LTC while maintaining fiscal sustainability. On a broader population level, there is also potential for controlling the demand and costs for care of dependency in older adults by investing in a care continuum with elements of public health policies of preventive measures, active and successful aging, autonomy promotion and empowerment, social assistance, healthcare and end-of-life care for older adults.

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Thailand

Siriphan Sasat

Introduction

Thailand became an aging society when the proportion of the population 60 years and older accounted for 10% - representing more than 6 million persons - in 2005. By 2016, that percentage had increased to 16.5% or more than 11 million persons, and it is projected that in 2021 at least one in five Thais will be aged 60 years and over (TGRI, 2016). Currently, Thailand has the highest share of an aging population among low and middle income countries in Southeast Asia and the Pacific, and is expected to have the highest aging population share in the East Asia and the Pacific by 2040 (World Bank, 2016).

There is widespread preference for a family member, especially adult children, to provide personal care (Knodel, Teerawichitchainan, & Pothisiri, 2016). However, the transformation of the society from an agricultural to an industrial economy was accompanied by smaller family sizes as a result of successful family planning which led to the reduction of the future number of potential caregivers. Compared with past expectations, women tend to work outside the house, thus, the

future caring situation for older persons in Thailand will be challenging.

This report gathered information from various sources including research reports and articles, and annual reports or reports from relevant government agencies in Thailand, such as the National Statistics Office, the Ministry of Public Health, and the Ministry of Social Development and Human Security.

Overview of Population Aging and Care Needs in Thailand

Statistics on Level of Population Aging and Living Arrangements

Living with at least one adult child has been a longstanding practice among older parents in Thailand. It has been viewed as an essential way to meet parents' needs when they require support and assistance from others. However, the proportion of older parents co-residing with children decreased steadily from 71% in 1995 to about 55% in 2014. In contrast, living alone or only with a spouse increased steadily since 1986. About 9% of older persons lived alone in 2014

and 19% lived only with their spouses (Knodel, Teerawichitchainan, Prachuabmoh, & Pothisiri, 2015).

Population Projections and Expected Population Aging

During the World Assembly on Aging held in Vienna in 1982, the United Nations defined people aged 60 years and above as the “older” population. This definition applies to both males and females. Thailand has adopted this definition as detailed in the Act on Older Persons of 2003, and in the 2010 revision (The Royal Gazette, B.E. 2553 [A.D.2010]). It had also been set that 60 years is the mandatory retirement age for civil servants (Sasat, 2011).

Findings from the 5th National Survey of Older Persons in 2014 conducted by the National Statistical Office suggested that Thailand is aging rapidly and continuously. In 1994, older persons represented 6.8% of the total population, which increased to 14.9% by 2014 as seen in Table 1. Based on the survey of older persons, it was found that there were 10,014,705 older persons in Thailand, out of whom 45.4% were males and 54.9% were females. The older population is classified into three groups; young-old, which include those aged 60-69 years old; old-old, i.e. those who are 70-79 years old; and the oldest-old who are 80 years or over. Most of the older persons in Thailand are classified as young-old, representing 56.5% of the total older population (National Statistical Office, 2014).

Table 1: Number and the Percentage of Older Population in 1994, 2002, 2007, 2011 and 2014

Year	Number of Older Persons	Percent
1994	4,011,854	6.8
2002	5,969,030	9.4
2007	7,020,959	10.7
2011	8,266,304	12.2
2014	10,014,705	14.9

Source: National Statistical Office (2014).

Population aging in Thailand differs by region. The Northern region has the highest percentage of older persons with 18.4 % followed by the Northeast with 17.0%. The Central and the Southern regions are almost the same with 13.5%

and 13.2%, respectively. The percentage of the older population in Bangkok is the lowest at 11.0% (National Statistical Office, 2014).

Health Status of Older Persons

With increasing age, numerous underlying physiological changes occur, and the risks for older people developing chronic disease and care dependency increase (WHO, 2017).

The 5th Thai National Health Examination Survey (NHES-V) in 2013 included older person health. Physical examination was performed for this survey. The Mini-Mental State Examination (MMSE) was applied for cognitive impairment and the Activities of Daily Living (ADL) instrument was applied for dependency

assessment. It was found that hypertension has the highest risk prevalence for cardiovascular disease, followed by metabolic syndrome and obesity as seen in Table 2. In terms of chronic illness, osteoarthritis, gout, and myocardial infarction were found to have highest prevalence with 22.5%, 5.6%, and 4.8%, respectively (Aekplakorn, 2014). There is evidence that chronic health problems are replacing acute illnesses. These health concerns are becoming a significant burden to public health systems globally including Thailand (Grey, 2006).

Table 2: Prevalence of Chronic Illnesses in Persons Age 60 and over

Risk for cardio-vascular disease	Prevalence	Population affected*	Chronic illnesses	Prevalence	Population affected*
Hypertension (HT)	53.2	52	Osteoarthritis	22.5	22
Metabolic syndrome	46.8	44	Gout	5.6	5.4
Obesity	35.4	34	Myocardial infarction (MI)	4.8	4.6
Hyperlipidemia	19.0	18	Asthma	4.6	4.4
Diabetes Mellitus (DM)	18.1	17	Cerebrovascular	2.7	2.6
			Emphysema	1.6	1.6

Note: *in 100,000s

Source: Modified from the 5th Thai National Health Examination Survey, 2013 (Aekplakorn, 2014).

These illnesses negatively affect the autonomy of a person. This effect varies based on the severity and the progress of diseases and may result in disability and the loss of the ability to perform the activities older persons need in their daily lives. These health problems lead to increased dependency of older persons and an increasing need for long-term care (LTC) which includes assistance in daily activities and continued health and social care.

The prevalence of dementia among the older population was 8.1%. The prevalence among females was higher than males at 9.2% and 6.8%, respectively. The prevalence of dementia increases with age. Depression is a common psychological problem in old age and the prevalence also increases with age. The prevalence of depression in males at age groups 60-69, 70-79 and 80 years and over were 3.9%, 4.2% and 5.0%, respectively, while the prevalence among females being double the prevalence of males and the average prevalence of depression in persons aged 70 years and over being 6.3% (Aekplakorn, 2014).

Falling incidences are one of the major problems among older persons. It can lead to serious injury or death, especially among the oldest-old. The total prevalence of falls within the past six months from the enumeration of the survey was 16.9%. Incidents of falls among older women were 19.9% which is higher than those of older men at 13.2% (Aekplakorn, 2014).

Overview of Actors Involved in Care Provision

Families

Thailand has practiced the tradition of family care. Research shows that the family is still the main caretaker for older persons in Thailand (Sritamrongsawat et al., 2009a). Informal systems of social and economic exchange within families are crucial for maintaining the well-being of older people. Children are the main source of income for older persons overall and very few older parents appear to be abandoned by their children as indicated that 98% live either with or next to their adult child or have at least monthly visits or phone calls (Knodel, Prachuabmoh, & Chayovan, 2013).

Public assistance to families who are unable to support older family members is still relatively limited. Several other countries have adopted policies to support families dealing the care of older persons for the latter to live independently and also to reduce the rates of admission to institutional care. To develop a comprehensive family-based care system, it is crucial to establish a system to support families and help them respond to the care needs of older persons more effectively. In addition, the capacity of the communities and the local administrative organizations must be enhanced to provide services in support of older persons and of the family carers. The Government and relevant agencies should issue such policies and strategies in order to develop and support the communities and the local administrative organizations to play

their roles and to provide the enabling environment for implementing a more practical intervention to respond to the need of older people and their carers.

Communities

People in the communities are encouraged to participate in caring for older persons. One strategy to do this is to form a volunteer group such as the Village Health Volunteers (VHV) which has been initiated by the Ministry of Public Health (MoPH) in 1997. The VHVs play an important part in the public health system as change agents on the ground, covering all age groups. In 2003, the Bureau of Empowerment for Older Persons (BEFOP) within the Ministry of Social Development and Human Security (MSDHS) has developed a pilot project on home care volunteers aiming to support older persons in the communities as well (Sasat and Chuangwiwat, 2013). Recently, in 2016, there was an initiative project on “The Development of public health long-term care system for dependent older people in long-term care sub-district.” With this project, volunteer caregivers (VCG) have been recruited from the communities and have been trained in caring for older people who need LTC. Therefore, these different types of volunteers

cover all levels of care needs of older persons from independent to dependent ones who live at home.

To determine good practices of community-based care of older persons, there are seven indicators: both formal and informal care systems are in place, strong teamwork, good use of social capital, resolving problems through community awareness, a complete database on the aging population, and availability of evaluation and monitoring systems (Yodpet et al., 2009).

Government

The government plays a key role in providing social care and healthcare for older people, depending on the level of dependency. Older people can be categorized into three groups according to WHO (2015): high and stable capacity of independence; declining capacity or mild dependency or frailty; and significant loss of capacity or moderate to severe dependency. Social and health services as well as environment also differ for each group in order to respond to their needs as seen in Table 3. These health and social services provide a life-course approach ranging from support for healthy older adults to end-of life care.

Table 3: Social and Health Services Classified by Level of Dependency

	High & Stable capacity	Declining capacity	Significant loss of capacity
Social services	<ul style="list-style-type: none"> • Senior citizen club • Old age allowance: Old age pension • Lifelong learning • Older people employment • Public welfare residential home • Housing: Senior complex 	<ul style="list-style-type: none"> • Disability allowance • Home modification • Home care volunteers elderly (HCVE) • Friends help Friends • Paid caregiver 	<ul style="list-style-type: none"> • Disability allowance • Home modification • Assist with cremation service • Paid caregiver
Health services	<ul style="list-style-type: none"> • Universal Health Coverage (UC) • Village Health Volunteers (VHV) • Promote active aging: Health promotion & Disease prevention • Primary care: Sub-district hospital, • Family doctor • Home health care 	<ul style="list-style-type: none"> • Promote community-based care • Initiate intermediate care • Provide LTC • Care manager • Volunteer caregiver • Rehabilitation • Health restoration • Palliative care 	<ul style="list-style-type: none"> • Long-term care • Care manager • Volunteer caregiver training • LTC package • Palliative and end of life care • Private Nursing home • Paid caregiver • Equipment loan
Environment	<ul style="list-style-type: none"> • Friendly environment / Universal design • Transportation for all 	<ul style="list-style-type: none"> • Assisted device innovation • Safety environment • Housing modification 	<ul style="list-style-type: none"> • Housing modification • Assisted device innovation • Safety environment

Non-government Organizations

Non-government organizations (NGOs) at the international level such as HelpAge International, Economics and Social Commission for Asia and the Pacific, United Nations (UNESCAP), International Labour Organization (ILO), and the Asian Development Bank (ADB) have played a crucial role for providing research grants to individual countries in the region in order to understand the big picture of caring systems, financing in caring for older persons, developing human resources, and developing policy as well as fostering knowledge transfer. At the local level, there are NGOs such as the Foundation for Older Persons' Development (FOPDEV) which is a not-for-profit organization with the aim to work with and for older people in the North of Thailand, especially with disadvantaged groups

in order to improve their quality of lives. The Buddy Home Care social enterprise has been initiated to develop a caring model for older persons in the community while providing care training and jobs to disadvantaged youths. forOldy is an interesting local NGO aiming to support the development of quality of life and care for older people in Bangkok. Funding for this NGO was raised through a second hand shop called Grandpa and Grandma's and donations both cash and in-kind such as medical equipment and assistive devices.

Private Sector

The majority of care providers in the private sector provide care for dependent older people whose care requires higher skills exceeding the ability of family caregivers, and also for those who lack a caregiver

at their personal home. The private sector always responds quicker to the market than the government, particularly to the needs of older people and their caregivers. As such, it is not surprising to see a large number of new long-term care facilities in the past decade. An earlier survey in 2009 found that there were 138 long-term care facilities, 34% were private sector, which the majority were for-profit organization and 49% were in Bangkok (Sasat et al., 2013). In 2018, the number of registered long-term care facilities ran by the for-profit private sector has been increased to 181 facilities in which 46.4% were in Bangkok (Department of Business Development, 2018). Although, the figure increases every year, but it is difficult to obtain the exact number of care providers due to the lack of a registration system and law enforcement.

How is Care Financed?

For health care services, all Thai citizens have health insurance since 2002. There are three health insurance schemes as follows (also see Table 4):

Civil Servant Medical Benefit Scheme (CSMBS)

It is the first scheme has been introduced the 1960s for government employees, their dependents, and retirees which covers only 5% of the Thai population. The funding comes from the government budget which means tax-based financing. The hospital payment system is fee-for-service for out-patient services, and Diagnosis Related Group (DRG) for in-patient care.

Social Security Scheme (SSS)

This scheme was introduced in the 1990s for private sector employees who comprise 12% of the Thai population. The funding comes from the contributions of three parties: government, employers, and employees.

Universal Coverage Scheme (UCS)

Introduced in 2002, this is the latest scheme to help all Thai citizens to have social health protection. It covers all those who are not covered by the CSMBS or SSS which accounts for 83% of the Thai population. It is also financed through taxes, specifically general tax revenue.

Table 4: Health Insurance Schemes in Thailand

Major Schemes	Civil Servant Medical Benefit Scheme (CSMBS)	Social Security Scheme (SSS)	Universal Coverage (UCS)
Introduced in	1960s Royal decree	1990s Act	2002 Act
Target beneficiaries	Government employees & dependents, retirees	Private sector employees:	Those who are not covered by CSMBS or SSS,
Population Coverage*	5%	12%	83%
Funding	Government budget	Payroll contribution, Tripartite	Government budget

Note: *from Srithamrongsawat (2018).

Source: Adapted from Sakunphanit (2010).

For social care, the Department of Older Persons of MSDHS has played a key role in drafting relevant policies and collaborating with other Ministries, institutions, non-government organizations, and local governments in providing care for older persons.

Is the Current Financing Scheme Sustainable?

According to the source of funding, the UCS's relies on general taxation. With the cost of health care escalating, financing becomes an issue, since the government cannot increase the tax due to the economic depression and its effect on Thai people in general. In addition, the USC has expanded from acute care to LTC in the community whereby the cost of care is even greater and may be difficult to estimate. Thus, it is unavoidable that the current financing schemes, particularly the UCS, are facing fiscal constraints.

Current Care Needs

Apart from the challenges of increasing chronic illness prevalence among older persons, the intrinsic capacity of the individual as well as the composite of all the physical and mental capacities will be reduced with age. This will affect the functional ability in old age and will lead to the increasing need to care for dependent older persons (WHO, 2015). This will also increase the need for care provision from informal and formal caregivers. The problem is a lack of inclusive data on care workers from the supply side for the benefit of human resource preparation in number and quality.

The NHES-V found that 0.5 to 20.2% of older persons have some Activities of Daily Living (ADL) limitation; which includes eating, bathing, transferring, toileting, dressing, and walking. In conjunction, 2.6 to 29.0% have some Instrumental Activities of Daily Living (IADL) limitation on mobility, communication or financial management (IADL), including using money, using a telephone, doing housework, driving, taking a public bus, and communicating with family and neighbors (Aekplakorn, 2014).

According to the study on the projection of demand and expenditure for institutional long-term care in Thailand, there would be 1.16 million older persons who will need a high level of care in 2024 or a 20-fold increase from 2004. It was also estimated that older persons with severe and profound dependency would be 1.4 to 1.9% among males and 1.7 to 2.0% among females between the period of 2004-2024 (Srithamrongsawat, et al., 2009). In addition, the 2013 health survey of older persons found that 2.0% were bedridden and 19.0% were homebound (TGRI, 2014).

Therefore, it is necessary for Thailand to be well prepared to respond to the care needs of the older population, both in terms of establishing the support systems for caregiving, financing, preparing the human resources, as well as raising awareness for social participation in providing care for older persons.

What About Future Prospects?

According to the NHES-V, the majority of older persons suffered from chronic illness and they

need a continuum of care. The care provision ranges from acute care, intermediate care, to long-term care. The LTC in the community and in institutions will be highlighted since acute care is mostly provided in specialized hospitals and have wisely been developed, so this will not be elaborated on this report. The current report will focus on the other services to meet the future care needs as follows:

Intermediate Care

Intermediate care is provided in sites involving rehabilitation services to prepare patients before returning home. The aim of this service is to enhance patients with certain levels of capacity of self-care in order to prevent disability and burden of care, to reduce bed-blocking in the acute care setting, and to reduce the number of older persons moving into a LTC facility. Unfortunately, this service is missing from the Thai health service system. Therefore, there is the need to encourage community hospitals to change their role from being a secondary hospital providing acute care service to providing intermediate care (Sasat, Choowattanapakorn, & Lertrat, 2011).

Long-term Care (LTC)

The World Health Organization (WHO) pointed out that the long-term care systems have many potential benefits beyond enabling care-dependent older persons to live with dignity, including reducing the inappropriate use of acute healthcare service, helping families avoid catastrophic care expenditure, and freeing women to have broader social roles. By sharing the risks and the burdens associated

with care dependence, system of long-term care can thus help foster social cohesion. In low-and middle-income countries, the challenge may be to build the system where does not exist” (WHO, 2015). Thailand is a middle-income country and building a LTC system is a major challenge.

The trigger for the need for a LTC system stems from various research (Bundhamcharoen & Sasat, 2008; Sasat, Choowattanapakorn, & Pukdeeprom, 2009; Sasat & Pukdeeprom, 2009; Srithamrongsawat, Bundhamcharoen, & Sasat, 2009b; Srithamrongsawat, Bundhamcharoen, Sasat, & Amnatsatsue, 2009a; Suwanrada, Sasat, & Kumrungrit, 2010).

The Second National Health Assembly which was held on 18 December 2009 has endorsed the Resolution 11 on the development of a LTC system for the dependent elderly where the terms related to LTC are defined as follows:

“Long-term care for older persons refer to all dimensions of care which include social, health, economic, and environment of older persons who have difficulty due to chronic disease or disability; partially dependent or totally dependent in daily living activities by the formal care personnel (professionals in health and social) and informal carers (family members, friends and neighbors) which include the services in the family, community and the institution”

Since then, there has been a gradual development of a LTC system in Thailand.

Community-based LTC

Families have remained to be the main support for older members with LTC needs. Volunteers play some complementary role. Senior citizen clubs usually have activities and meetings and provide assistance between members including health care and social care. Religious groups and charities also provide support to people with LTC.

In 2003 the MSDHS established the Home care volunteers service program for dependent older people. However, the care provided by volunteers was only sufficient to meet the needs of older persons who are mildly or moderately dependent (Yodpet, Sombat, & Sarobol, 2012; Labbenchakul, 2014; Lloyd-Sherlock, Pot, Sasat, & Morales-Martinez, 2017).

The Japanese International Cooperation Agency (JICA) has supported the development of community-based elderly care in Thailand. This project has been ongoing under the collaboration with the MoPH and the MSDHS since 2007. The first phase was “the Development of a Community-based Integrated Health Care and Social Welfare Services Model (CTOP)” assessed the situation on aging, policies, and welfare and social support systems in Thailand. The second phase focused on the “Long-Term Care Service Development for the Frail Elderly and Other Vulnerable People (LTOP)” and had the aim to develop evidence-based policy recommendations on LTC targeting the frail elderly (Okumoto, 2015).

In 2013, the Department of Health (DoH), Ministry of Public Health has launched a pilot project in selected provinces aiming to establish a care

management system for community-based LTC. Later in 2016, there was an initiative “The Development of public health long-term care system for dependent older people in long-term care sub-district.” The central government provided 600 million Baht through the National Health Security Office to support this project. Of this amount, 500 million Baht went to the Local Health Fund and the remaining funds were allocated to primary care units (NHSO, 2016).

Institutional LTC

Initially, the majority of residential care services for dependent older persons were found in private nursing homes, private hospitals, public welfare residential homes, and homes for poor older persons supported by charity organizations. The services ranged from basic to advanced care, including accommodation, personal hygiene, and assistance in activity of daily living, and transfers, care which required nursing skills, rehabilitation, day care, respite care, and hospice care (Sasat and Pukdeeprom, 2007). A study on demand for LTC service for older persons in Bangkok by Suwanrada, Sasat and Kumrungrit (2010) found that the main reasons of older persons for staying in nursing homes was that their families were unable to take care of them and that they needed the assistance of skilled care personnel. Most of them needed such level of care as they were bed-ridden and unable to communicate.

A survey on the institutional long-term care for older person in Thailand by Sasat et al. (2009) found that of 138 long-term care institutions; 43.5% was nursing homes; 45.5% had not been registered. In 2018, the

Department of Business Development of Ministry of Commerce (MoC) reported that there were 181 facilities which provided elder care. Two-thirds of them were personal businesses and the remaining one-third were corporations (MoC, 2018). While the Thai Elderly Promotion and Health Care Association reported that there were 132 members (Thai Elderly Promotion & Health Care Association, 2018). Thus, the exact number of facilities is still not clear due to there is no central official registration body and there is no law enforcement to register as well.

Types of Institutional LTC

A study by Sasat (2009) had classified institutional LTC in Thailand into five categories according to the objectives and the actual services provide: Residential home, Assisted living, Nursing home, Long-term care hospital, and Hospice care. In order to respond to the problems and care needs of older persons, a later study by Sasat, Choowattanapakorn, and Lertrat (2011) classified such LTC into two types namely; low care and high care:

Low or Basic Care

Low or basic care is focused on social care and welfare for older persons. It provides assistance in activities of daily living or assisted living which is not focused on care by health professionals but on assistance in eating, transferring, and using assistive devices in transferring. Most assisted living facilities do not have a medical doctor. LTC institutions which provide low care include Residential home and Assisted living.

High Care

This is the more intensive care for older persons

with chronic diseases which require nursing care and follow-up and treatment by doctors. LTC institutions which provide high care include Nursing homes, LTC hospitals and Hospice care.

Although there is no public nursing home, almost half of residents in Welfare Home for the Aged were frail and dependent. The care has been provided with inadequate staff members and equipment (Choowattanapakorn, Pothibal & Rhiantong, 2007; Sasat & Pukdeeprom, 2009; Sasat, Choowattanapakorn, Pukdeeprom, Lertrat, & Arunsang, 2013). Of 25 welfare home for the aged, 12 facilities remain administered by the MSDHS and change its name to Social Welfare Development Centre for Older Persons and 13 facilities had been transferred to administered by local authorities (Foundation of Thai Gerontology Research and Development Institute & College of Population Studies, 2012).

Integrated Health and Social Care

A number of ministries and departments are responsible for policy implementation and services related to older persons. It was often found that funding from different sources goes to the same group of older persons and research and intervention programs were duplicated. Recently, there has been an initiative involving the signing of a memorandum of understanding to work collaboratively between ministries and organizations including the MSDHS, MoPH, the Department of Local Administration, Ministry of Interior, and the National Health Security Office. The first collaborative project is focused on the quality of life of older persons.

Important Issues Related to Care Needs and Provision

Quality of Care

Quality of care refers to the extent to which service increases the probability of desired outcomes and reduces the probability of undesired outcomes given the constraints of existing knowledge (Harman, 1996). In 2015, the WHO suggested how to ensure the quality of LTC; that there is a need to orient services towards the goal of optimizing functional ability. The key actions included developing and disseminating care protocols or guidelines that address key issues regarding the establishment of three aspects: an accreditation mechanism for services and professional caregivers, the formal mechanisms of care coordination between LTC and healthcare services, and lastly, a quality management system to help ensure that the focus on optimizing functional ability is maintained (WHO, 2015).

The quality of care varies in different settings. The acute care setting has long been in service in Thailand with its own quality of care system in the form of the Hospital Accreditation (HA). However, a standard of care in LTC settings, whether in the community or LTC facilities, has yet to be developed, except in residential homes which is developed by the MSDHS. The quality of care becomes a primary concern since it is strongly related to quality of life of people. There is a need to develop a care standard in all settings in order to improve quality of care.

Registration and Issues Related to Quality of Care

Currently, neither official quality management guidelines nor comprehensive regulation for LTC is available in Thailand (Sasat & Pukdeeprom, 2009; Sasat, et al. 2013; Sasat, Wisesrith, Sakunphanit, & Soonthornchaiya, 2015). However, the promotion of quality of care for older persons has been indicated in the Act on Older Persons B.E. 2546 (A.D.2003), Section 10:

“To protect the service users for safety, care with quality which gives high importance in physical, mental, spiritual, and social”

The Consumer Protection Act also mentions;

“Quality of life of the dependent older persons is the rights of the consumers”

Moreover, in 2009, there are resolutions of the Second National Health Assembly related to health social organizations as follows:

Resolution 3.3: The institutions which provide medical and nursing services must register with the Bureau of Sanatorium and Art of Healing for monitoring the standard.

Resolution 6: Ministry of Public Health, the Nursing Council, Ministry of Social Development and Human Security and Ministry of Interior are requested to develop the standards and mechanisms at national level for the standard of care of dependent

older persons with participation from the communities, the local administrative organizations and older people as well as the monitoring of such standards to cover both the government and the private sector.

Therefore, the aim of developing the standard is not only to protect the rights of service recipients but also to prevent neglect or abuse of older persons.

Dimensions of Quality of Care

The most common framework for quality assessment is from Donabedian (1980, 1986 and 1988) who conceptualized three quality-of-care dimensions: 1) Structure, which are the attributes of settings where care is delivered; 2) Process, which determines whether or not good medical practices are followed; and 3) Outcome, which indicates impact of the care on health status. The WHO (2006) suggested that health systems should seek to make improvements in six dimensions of quality: effectiveness, efficiency, accessibility, acceptable/patient-centeredness, equity, and safety.

A study on the good practice model of the family and the community-based care in the rural area in Thailand found that the good techniques and methods were composed of nine indicators: personal hygiene, medication management, transfer assistance, bed-soar care, appropriate nutrition, feeding, excretion care, emotional stability creation, and spiritual care. The communities with good service management for older persons were characterized by seven indicators: the existence of formal care and informal care systems, strong

team work, effective utilization of the social capital, problems solutions borne of raising awareness in the communities, completed database on older persons, and the presence of monitoring and evaluation systems of the services (Yodpet et al., 2009).

A study on the model of institutional long-term care for older persons in Thailand identifies the quality of care in LTC institutions into three dimensions with respective components (Sasat, Chuwattanapakorn, & Lertrat, 2009):

1. Input factors and structure consisting of four components: policy, recruitment, availability of the medical equipment, and the selection of the materials;
2. Process comprised of six components: human resources development, multi-disciplinary care plan, referral system, holistic care, human resources management, and responsible persons for supervision, and
3. Outputs consisting of three components: monitoring and evaluation, auditing system, client's satisfaction assessment.

Quality Management and Initiative

There are studies on quality of care and care standard development for dependent older persons in long-term care facilities. For example, Sasat (2012) used the quality indicators from Sasat, Chuwattanapakorn, & Lertrat (2009)'s study to develop the *Quality Assessment Instrument* for assessing quality of care in long-term care facilities. It was applied to 37 institutional care establishments and the results revealed that the overall quality of

care was good in which the inputs and structure had high average scores followed by quality in process and subsequent outputs. The overall quality of the institutional hospice care had very high average scores followed by the hospital based long-term care. The overall quality of the assisted living facilities and the nursing homes were good and the overall quality of the residential home for older persons was moderate.

Another quality management study was *The Development of Care Standard and Service Guideline for Dependent Older Persons in Long-term Care Institution* by Sasat, Wisesrith, Sakunphanit, & Soonthornchaiya (2015). The results revealed that the appropriated care standard in the Thai context should be classified by structure, process, and outcomes of care dimensions and can be divided into seven domains and 70 standards. The structure of care consisted of three domains: physical environment, staff and management with 28 standards. The process of care consisted of three domains with 32 standards: care service, safety of care, and participation. Finally, the outcomes of care consisted of a single domain which is satisfaction and quality of care with its respective 10 standards. These standards were introduced to stakeholders through a public hearing. It was also used as the first draft for standard for LTC facilities for the Department of Support Services, MOPH.

Responsible Bodies

The quality of services in residential homes of older persons was developed in 2009. The National Committee on Welfare Extension has issued the

Regulations of the National Committee on Welfare Extension on the Standard of Social Welfare and the Rules of the Quality Assurance of the operations in Social Welfare 2009. It also included the endorsement of the indicators and the criteria for assessment of the operation standards of social welfare organizations, social workers, and volunteers. The standard for residential homes consisted of five elements: management standard, clients' health, physical environment, security system, and the internal standard system in order to control and self-assess the operations in comparison with the regulated standards.

However, a literature review showed that there is a lack of care standard and regulation for assisted-living facilities, nursing homes, LTC hospitals, and hospice care. The present standard of care depends upon professional standards which have no specificities for LTC facilities and workforce. There is also a diverse registration system for agencies providing services, both for home care service and institutional long-term care. Those private agencies that provide care for older persons are registered with the Ministry of Commerce as a general business. Therefore, the quality of care and service are still unregulated (Sasat et al., 2015).

Recently, the Health Establishment Division, Department of Health Service Support at the MoPH initiated the standard of care for older people in institutions by issuing the announcement on the standard of services for older persons in institutions to ensure management effectiveness, that preparations of the service providers meet the

needs of the older persons, and the maximization of resources for specific groups. It was suggested that the standard of care development would help to protect resident in LTC facilities more effectively (Sasat, Chuwannapakorn, & Lertrat, 2009).

At the present, the MSDHS in cooperation with MoPH has consulted with technical experts, academic, the Thai Elderly Promotion and Health Care Association, and other stakeholders to prepare regulation on registration and standard of LTC including quality management. The findings from many studies related to LTC and standard of care will contribute to the formulation of the regulation and it is planned to be enacted within the current year.

Cost of LTC

The Thailand Development Research Institute (TDRI) projected that there would be 448,466 older persons who need care in 2015 (2006). The estimated the cost of family care was 3,000 Baht/month for each volunteer which meant total cost estimates at 2.209 million Baht.

Estimates by Wongsin et al. (2014) revealed that the overall care cost incurred from home-based care of dependent persons in communities in the fiscal year 2012 was about 4.51 million Baht, and the overall cost of hiring the care team by the Local Authority Organizations (LAO) was 420,000 Baht. Considering the cost per day for the care of dependent persons when classified according to the level of care needs and regardless of the opportunity cost to the family, it was found that the cost of care per day of the mildly, moderately, and

severely dependent persons were 41, 64, and 101 Baht, respectively.

A case study conducted at the Social Welfare Development Centre by Suwanrada, Sasat, Witvorapong, and Kumruangrit, (2016) suggested that the real cost of institutional care for each dependent older person per day were on average 390 to 400 Baht for all categories (373-383 Baht for mild to least dependents, and 433-461 Baht for moderate to higher levels of dependency).

Under the assumption that 2-25% of those with severe and profound dependency would be admitted in institutions then the costs incurred would be 908 - 11,354 million Baht respectively in 2009. The costs would increase to 2,766 – 34,573 million Baht in 2024 (Srithamrongsawat et al., 2009).

Equity to Care

Since the National Health Security Act has been enacted in 2002, 99.8% of the Thai population have health security today. Nevertheless, the equity to care is still an issue, due to the existence of three health security schemes (Civil Servant Medical Benefit Scheme, Social Security Scheme, and Universal Health Coverage Scheme). Different health security schemes have different law and regulation basis, funding management, and care packages which have led to inequity in accessibility. There is also no central unit to work for policy and no regulator to ensure that people receive efficient and quality of services and the same care standard (Institute for Population Social Research, 2016).

Although all Thai citizens have social health protection, it is only in acute care settings while LTC remains to be out-of-pocket spending. At the moment, only private nursing homes exist for persons who need higher levels of care, thus, only persons who can afford to pay for such services can access them. They are also the ones who can afford to hire home helpers and to pay for any other services. It has been found that extending the roles of LAOs and village volunteers will increase the capacity and accommodate the increasing demand of care in older persons (World Bank, 2015).

Accessibility

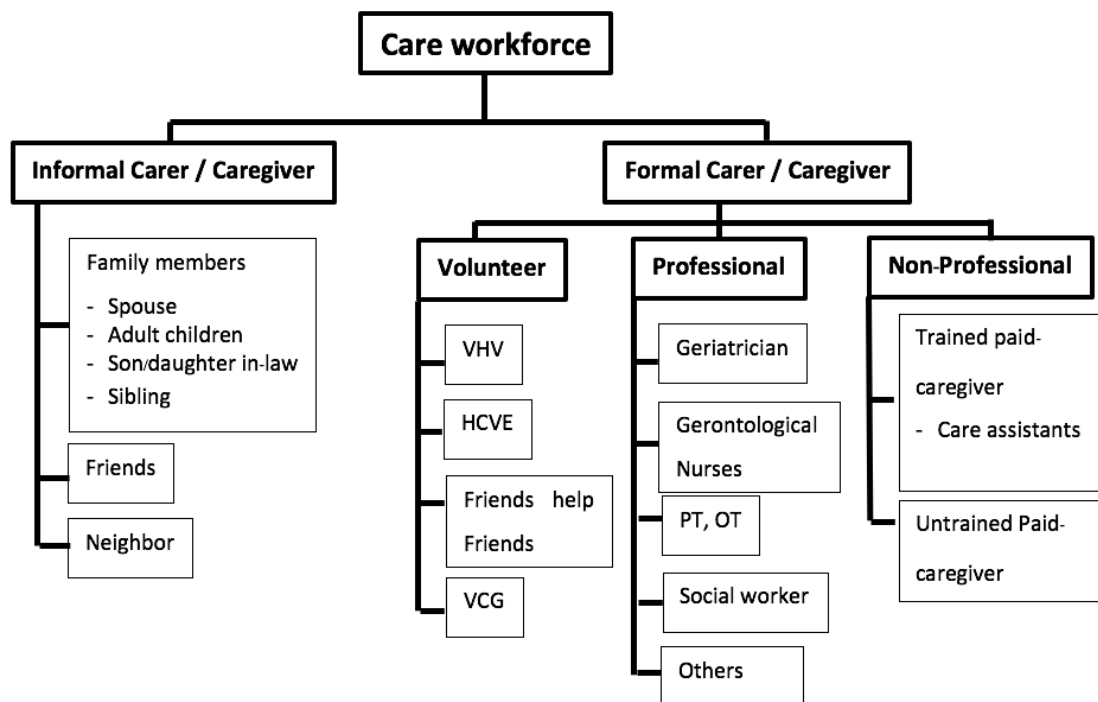
The majority of the acute care hospital under the MoPH provide the green channel for the fast-track service for persons aged 60 years and over and also carry out discharge planning and specific caregiver skill training in order to be able to provide care after discharge from the hospital. Recently, the three social health protection schemes launched benefit packages for intermediate and palliative care (TGRI, 2016).

Due to a shortness in the number of beds in acute care hospital, even the sicker patients are discharged back home, facing care challenges. While LTC has recently become available to most dependent older persons who need care at home, it is for the most part a service system to provide assistance to family caregivers to provide care at home, but not sufficient for older persons who have no caregivers and need more care almost 24 hours per day. There are only public residential homes that are available for those who are destitute, have

no family, or are unable to live with their family happily. However, there is no public place to accommodate those who have moderate to severe dependence, such as assisted living or nursing home.

Human Resources

There are several types of people who provide care for older people, depending on social context, problems and needs for care, caring condition, and policy influences. Care workforces can be categorized into two major groups, formal carers/caregivers and informal carers/caregivers (Alzheimer Research Centre, 2003; Bell and Gibbons, 1989; Parker, 1992 cited by Sasat 2011; Sasat 2012), as follows (see Figure 1).

Figure 1: Classification of Care Workforce

Source: Sasat and Sakunphanit (2018).

Informal Carers/Caregivers

In general, care for older people in Thailand is mainly provided by informal caregivers. The 2011 National Survey of Older Person showed that the majority of older people received personal care from family members, including daughters (52%), grandchildren (37%), sons (36%), children-in-law (35%), spouses (25%), and siblings (19%) (Knodel, Prachuabmoh, & Chayovan, 2013).

In theory, informal caregivers refer to persons who have never been trained but provide assistance in ADL. Care may take 24 hours/day without pay. Their care and assistance may be due to their love and sense of responsibility or gratitude. Most of these persons who provide care are married and may even have family relationships. They can be classified according to the relationship with the

older patients and the amount of care. First, those classified by relationship with older people, including the primary family caregivers and the secondary carers and informal helpers who are their relatives, friends, or neighbors who provide assistance without pay (Sasat, 2012). Second, caregivers classified by duration of care whereby the one allocating the most number of hours would be the primary caregiver.

Much of the community-based care in Thailand focuses on family caregivers and volunteers. Capacity building has been adapted for the volunteers quite systematically and progressively while little has been done for the family caregiver despite the fact that they are essentially the main caregivers (Sasat and Chuangwiwat, 2013). Nonetheless, there has been an increasing trend

to hire non-family caregivers, paid caregiver, to provide care for older family member.

Formal Carers/Caregivers

The increasing demand for formal care providers is attributed to the declining household size. This phenomenon is related to an increase in the number of older people living alone or only with a spouse, the migration of adult children to the city, and the increasing female participation in work outside the home. In addition, older persons with fewer children are less likely to live with an adult child suggesting that the trend towards smaller families combined with greater dispersion of children will contribute to a continuing decline of co-residence with children (Knodel, Teerawichitchainan, Prachuabmoh, & Pothisiri, 2015). This situation has raised concern about the future availability of family caregivers.

Formal caregivers refer to a group of occupational care personnel from service organizations who have been trained and/or receive payment for providing care services. They could be medical doctors, nurses, and other health personnel including the care assistants from the service providers or volunteers who provide care at home. The formal caregivers could be classified according to their professions or organizations as follows:

Volunteers: Volunteers are a major human resource in caring for older people after the family. They have been officially trained in basic personal care for older persons. They work without pay, however, those who volunteer under the government project will receive a transport allowance. There are four

types of volunteers (Sasat and Chuangwiwat, 2013):

Village Health Volunteers (VHV): VHVs have been initiated by the MoPH in 1997. The VHVs play an important part in the public health system as change agents on the ground. Their work includes home visits to follow-up cases, data collection, health promotion, prevention supervision, basic health care and medication, rehabilitation, referrals, organization of activities for health development in the communities, and collaboration with the community leaders and the LAOs to develop the public health system in the communities. The VHVs work effectively in rural areas. The role of VHS is low in most of the urban areas. On average, one VHV is responsible for 8-15 households and there are about 10-12 VHVs per village. Since the VHVs cover all age groups and they work on voluntary basis, they can only provide care to older persons according to their capacity and availability (Sasat and Chuangwiwat, 2013).

Home Care Volunteers for Elderly (HCVE): the Bureau of Empowerment for Older Persons (Department of Older Persons), MSDHS, has developed as a pilot project on home care volunteers in 2003 that has been scaled nationwide in 2007 with the aim to support older persons in the communities. In general, volunteers can provide basic health services such as checking blood pressure and body weight. Each volunteer is responsible for supervising and monitoring of at least (1) five older persons who are dependent, have no carer, receive inappropriate care or treatment, are neglected, poor or living alone, and

(2) 15 older persons who are still active and independent. Later on, the HCVE has been transferred to the LAO, which would be the main responsible body for the implementation in collaboration with other government sector, the civil society network, the community-based organisation with technical support from the MSDHS.

Friends help Friends by the Senior Citizen Council of Thailand: the Senior Citizen Council of Thailand (SCCT) has initiated the Friends help Friends project with financial support from the Health Promotion Fund aimed to maximize the active old-age groups to support the dependent older persons in the community. The volunteers, most of whom are members of the Senior Citizen Clubs, the affiliate of the SCCT in the communities, are trained to provide basic health care, rehabilitation, and social support to dependent older persons who lack of family carers. The ratio of volunteers to older persons is 1:5, where the latter is to be visited twice a week. The project has been transferred to the responsibility of the LAOs in 2009. The effectiveness of the project varies depending on the interest and capacity of each LAO (Sasat and Chuangwiwat, 2013). Although there are many voluntary groups in the community, but they are more likely to be the same persons.

Volunteer Caregiver (VCG): in 2016, there was an initiative project on The Development of public health LTC system for dependent older people in LTC sub-district. The Volunteer caregiver training project aims to serve dependent older person in the community (Bureau of Elderly Health, 2016;

Wattanayingchroen, 2016). Although, VCG provides the same basic health care as VHV, their main responsibility is only dependent older persons who need LTC.

Capacity and quality of services provided by these volunteers for older people varies across communities. Upon evaluation, it was found that only one third of local authorities reported that services provided by the volunteers met the needs of older people in their communities (Suwanrada, Pothisiri, Siriboon, Bangkaew, & Milintangul, 2014). The VHV also provide care for older people and they share the same problems as HCVE. In addition, it was difficult for the existing volunteers to provide regular or routine care especially for severely dependent older persons because they have other roles in the community (Lakbenjakul, 2013).

Professional Care Personnel

This group within the care workforce operates under professional organizations that provide supervision and support to their members. Most members of this group are in the health and social sectors with multi-disciplinary professions such as, doctors, nurses, pharmacists, dentists, physiotherapists, occupational therapists, and other personnel who receive payment for providing care services.

Geriatrician: a medical doctor specialized in geriatric medicine. The pioneer geriatricians were trained in both the United Kingdom and the United States. At present, there are two institutes offering a two-year training program: Siriraj Hospital and the

Ramathibodi Faculty of Medicine of Mahidol University.

Gerontological Nurses: there are nurses who specialize in caring for older persons. They can obtain such qualification through various means: specializing in Gerontological Nursing which can be obtained in a four-month postgraduate training programs; completing a two-year Master's degree of Nursing Science (Gerontological Nursing); and obtaining a Doctoral Degree in Gerontological Nursing. Together with the initiative project of the DoH of the MoPH on *The Development of public health LTC system for dependent older people in LTC sub-district*, care managers who are nurses have been trained on care management to assess and plan for continuing care with VCG for dependent older persons who needs LTC in the community.

Physiotherapist and Occupational Therapist: the need for occupational therapist who help older people improve their functional ability to perform tasks in their activities of daily living and working environments will escalate due to the aging of society.

Social Workers: there is a need to produce social workers who have holistic points of view in caring for older people. They can also contribute to the development of policies including the improvement of both service delivery and the progression of a new social welfare system in the Thai context.

Other professionals There are many professions which can share their expertise in caring for older

persons. There has been an increasing awareness of the aging society in Thailand, so most professionals have added knowledge related to older persons in their curricula and training.

Non-Professional Care Personnel

This group comprises persons who are actually providing private care for older people especially at home or in the community. They have not been formally trained, but rather use past experience or their own knowledge and skill in caring for their own family members. This group can be called paid care-givers and can be classified into trained and un-trained caregivers:

Trained Paid-caregivers: these are non-professional caregivers who were trained to provide care to older persons and receive payment from providing such services. In general, the responsibility of this caregiver is to provide personal care such as bathing, transferring, walking exercise, management of medication, and home care services. Care assistants are trained paid-caregivers and play important roles in health care assistance to older persons or disabled persons. In Thailand, this particular care provider refers to persons who have been trained in elder care for three months or 420 hours and will receive a certificate from care assistant training institutes which is certified by the Ministry of Education. There is also a formal community-based care volunteer for dependent older persons who are part of a care team. This group of volunteers has been trained for 120 hours through lectures and on-the-job training.

Untrained Paid Caregivers: these are those who provide care in terms of activities of daily living and household chore services based on their own basic skills and experience without certificates from care assistant training institutes. The actual number of untrained paid caregivers is unknown and there is a lack of studies on this issue.

Financing in LTC

At present, there is no LTC program in Thailand; however, the Universal Coverage Scheme (UCS) has added LTC for the community for dependent older persons and funding comes from general taxation.

The LTC package has been introduced by the National Health Security Office (NHSO), but it only provides care related to health while social care is not included. The MoPH also tries to design a care package for individual who are in need in the community through the Family Medicine Program.

The Ministry of Finance through the Government Saving Bank (GSB) has introduced the reverse mortgage program to allow older persons aged 60-85 years old to convert their residence into cash. The fund will be paid in installments until the older person dies or the fund is fully exhausted. The maximum loan amount is 10 million Baht ("GSB to introduce," 2017).

Laws and Regulations

In most cases, government regulations or other standards set the minimum quality that providers

must meet to operate as well as receive government funding (Mor, Leone and Maresso, 2014).

Laws and Regulations that Deal with Care Provision

There have been a number of laws and regulations supporting the provision of care to older persons.

The 2nd National Plan on Older Persons (2002-2021)

It is the main strategic plan for the implementation of policies that address population aging issues, which began in 2002. In 2007, the MSDHS monitored and evaluated the implementation of the plan. The first revision was issued in 2009 in order to adapt the plan to the present social situation. Changes have been made with regards to the strategy for the social protection system for older persons.

The revised plan suggests establishing and developing health and social services for older persons, including community-based LTC systems that are easily accessible by older persons. In particular, this includes a system focusing on integrated health care, as well as social home-based care with services as LTC and support, palliative care system, major chronic disease care, community volunteers, and enhancement of knowledge and skills of the carers.

Resolutions of the National Health Assembly

Following evidence from the public health system and research reports on the provision of care for older persons with chronic illnesses and dependent older persons which are consistently supportive to

the recommendations on the significance of the development of LTC system in Thailand, the resolutions on LTC were adopted at the 2nd National Health Assembly in 2009. This led to one of the most concrete policy advocacy efforts that civil society meaningfully participated in. Although the National Health Assembly Resolution is not legally binding, it has proven to be a powerful tool for policy advocacy driven by a consensus from a civil society network and the relevant government agencies.

Establishment of the Sub-committee to Advocate and Push Forward the LTC Agenda

The National Committee on Older Persons, chaired by the Prime Minister, recognized the significance of LTC systems. Appointed by a sub-committee in 2006 to advocate the agenda of LTC for older persons, it is comprised of a representative of the MoPH, and a representative which serves as the Deputy Secretary to the National Committee on Older Persons. It has been assigned to establish the Task Force according to the Action Plan on LTC which will be chaired by the Permanent-Secretary of the MoPH as stated in the Ministerial Decree of MoPH 69/2011. This may be noted as the first step to push forward the implementation of LTC in Thailand.

The Twelveth National Economic and Social Development Plan (NESDP) (2017-2021)

This plan involves the advancement of human resources focusing on the social determinants of health and preparations for an aging society (Office of the Prime Minister, 2012). Through this plan and continued action, LTC and other aspects related to older persons will continue to develop.

Actions of the Current Government

The statement of the current government delivered by the prime minister at the National Legislative Assembly in 2014 includes the following plans and policies involving population aging (Bureau of Empowerment of Older Persons, 2015):

Preparations for an Aging Society: this preparation plan includes: enhancing the quality of life of older persons, initiating a home-based care system, and rehabilitation facilities with collaboration between the public and private sectors, communities and families. A system to finance care for older persons also has to be developed.

Setting up a Policy on "Family Doctor": the goal of this policy is that people and communities will become self-sustainable and will not neglect each other. From the beginning of the Fiscal Year 2015, three targeted groups, which are the bed-ridden, persons with disabilities who need care and palliative care patient, will be under the care of the family doctor team. This is a multi-disciplinary team from hospitals, communities, and civil society networks among others. One family doctor team is responsible for 1,250-2,500 persons (Bureau of Medical Services, 2014).

Financial Support from the Government for Long-term Care: in 2015, the Cabinet, approved 600 million Baht for the National Health Security Office (NHSO) to provide a LTC system for the dependent older population (over 100,000 persons in the first year). The implementation started on the 1st of October 2015 and would be extended to cover one million people within three years. The objective is

to support the health care facilities and the LAOs as per guideline and criteria set by the Sub-Committee on Long-term Care of the Dependent Older Persons (NHSO, 2016). For the second year of the project, 2017, the Central government increased the budget to 900 million Baht to extend the provision of care for 150,000 dependent older persons (NHSO, 2017).

Legislations and Programs Related to Long-term care of Older Persons

Currently, a law on LTC does not yet exist in Thailand. However, the 2007 Constitution, as well as the 2003 (revised 2010) Act on Older Persons, indicate the following on the rights of older persons:

The Constitution of the Kingdom of Thailand 2007

Section 53: “A person who is over 60 years of age and has insufficient income for a living shall have the right to enjoy the public welfare and facilities, with dignity, and shall receive the appropriate assistance from the State.”

Section 80: “The State shall act in compliance with the social, education, public health and culture policies as follows: Protecting and developing the children and youth,...including providing social assistance and welfare to the older persons, the indigents, people with disabilities, the handicaps and the destitute persons for their attainment of better quality of life and self-sustainable.”

Older Persons Act

The 2003 Act on Older Persons contains several

key issues, including the rights, the protection and the support of the older persons. This is done by stipulating that persons of Thai nationality, who are 60 years of age or over, are entitled to protection and support in terms of social, health and economic aspects, and they have the rights to receive public services and access to public facilities (The National Committee on Older Persons, MSDHS, 2009:22).

Registration Act for LTC Facilities

Although there is no particular law or regulation to regulate and oversee the LTC facilities, there are several other regulations from different bodies of authority that have been already applied.

Ministry of Commerce: for prospective entrepreneurs who wish to provide healthcare products, such as home care services or LTC facilities, they are required to apply for a business license from the Ministry of Commerce. However, since these products are health- or medical-related, this raises a concern on how the quality of the products is controlled.

Ministry of Public Health: in 2016, the Department of Health Service Support has issued the Health Business Act to regulate spa and massage therapy businesses (The Royal Government Gazette, 2016), under which other types of health businesses related to older people such as day care, health clubs, and senior residence could be registered. Besides the 2016 Health Business Act, the Ministry of Public Health has revised the 2009 Ministry's Notification on Businesses Harmful to Health (6th edition) by stating that all businesses offering home

healthcare for older persons must be categorized as a controlled business according to the Public Health Act, B.E. 2535. This notification aims partly to protect older persons from being abused by a paid-caregiver at home. However, due to lack of publicity to relevant governmental agencies before the enactment, thus, only a few local governments have so far set up the registration system for the home health care business.

Ministry of Interior: the Ministry of Interior by the Department of Public Works and Town and Country Planning has issued the Building Control Act 1979, under which the design of LTC facilities are controlled for safety reasons (The Royal Thai Government Gazette, 1979). The latest amendment to the Act in 2015 requires all buildings and facilities to have a universal design to facilitate the access of older people and people with disability.

Office of the Consumer Protection Board: the number of LTC facilities in the major cities of Thailand has been increasing, and with it the number of complaints made about abuse, malpractice, caregiver's inadequate skill, or overcharging fee, causing dissatisfaction among care recipients as well as their family. Currently, there is only one regulation that could be applied to protect the consumer's rights and to offer remedies. The Act is called the 1979 Consumer Protection Act under the Product and Service Section.

Further Government Initiatives

Based on recommendations from previous studies (Sasat, Choowattanapakorn, & Lertrat, 2009; Sasat, et al., 2013), together with social pressure

arising from constant complaints received by the Office of the Consumer Protection Board about quality of care, as well as the Government's will to promote the social enterprise to accommodate the increasing need of LTC facilities, the Department of Older Persons, a permanent secretariat for the National Committee on the Elderly, convened the first inter-sector meeting to draft the National Care Standard for Older Persons in order to improve the quality of care and quality of life of individuals. Recently, the Ministry of Finance and other related ministries have jointly designed incentive mechanisms to promote the involvement of private sector in aging society.

At this current stage, the Sub-committee on Integrated Care Standard for Older Persons made up of representatives from the MSDHS, MOPH, Ministry of Finance, Ministry of Interior, Ministry of Education, Ministry of Commerce, academia, Thai Red Cross, Bangkok local government, the Nurses Council, and the Association of Thai Elderly Promotion and Health Care Association have been set up. Then, three working groups on Standardized curriculum, Standards for older persons caregivers and Standardized facilities for older persons have been established to review the draft standards before presenting them to the Sub-committee on Integrated Care Standard for Older Persons.

The Standard for Facilities

This can be divided into five categories. The detail of the initiative drafting standards are:

Caring at Home: this standard governs the provision of care at the residence only. The

entrepreneurs are required to follow this standard, in addition to the Ministry's Notification on Businesses Harmful to Health.

Day services: day services include day care and day centers. At present, the Day Care Standard is being drafted by the MOPH while the Standard for Day Centers is drafted by the MSDHS.

Residential homes: in 2012, the MSDHS has released the Standard Guide to Elderly Homes to assist the LTC service providers, both private sector or government agencies. In order to have facility construction standards and safety for the welfare of older persons, six standard requirements were included regarding building, living room, environmental health, service provider, management, and services.

In 2008, the Working Group on Standardized Facilities for Older Persons and the Department of Health Service Support has jointly drafted the standards for private residential home, which provide care, promote health and rehabilitation, under the 2016 Health Business Act. These standards involve premise (e.g. building and environment), safety (e.g. first aid and fire alarm) and services, including needs assessment, practice guideline, referral protocol, and elder protection.

Elderly Establishment: an effort to draft the Standard for Nursing homes for dependent and high level of care need originated from research findings. However, since there has been no law or legal framework to support the nursing home service, the process to draft the standard was

suspended until the law is available, but the elderly establishment is being draft instead.

Geriatric hospital: it is a new initiative to draft a standard to accommodate older persons who need treatment from the hospital. This drafting of this type of standard is in progress.

Standard of Curriculum

The majority of education and training programs for healthcare professionals involving older person care in Thailand has been verified and approved not only by the Ministry of Education but also their respective professional councils. For non-professional group, there are various curricula and training programs for care workers. To draft the national curriculum, all existing relevant curricula need to be examined for their strengths and limitations. Thus, there was a call for all existing training course curricula for non-professional care workers from institutions or organizations. The working group on standardized curriculum has then classified all curricula into three levels and subsequently drafted the standard by choosing the relevant topics from each curriculum and adding recent knowledge as follow:

Basic Curriculum in Caring for Older People: this an 18-hour training course catering to family caregivers and volunteers.

Medium Curriculum in Caring for Older People: a 70-hour training course designed for volunteer caregivers for community LTC, as well as semi-paid-caregivers.

Advanced Curriculum in Caring for Older People: this curriculum is a 420-hour course for paid caregivers or care assistants.

Standard for Paid Caregivers

For health professionals, normally, there will be a compulsory process to go through the examination for obtaining a license after completing their courses of study and they will be supervised by their respective professional councils. Therefore, there is no need to draft a standard for professionals but there is a need for drafting a standard for paid caregivers who are not professionals. At the moment, there are two bodies who provide the examinations after a paid caregiver completed 420-hour training; the Department of Skill Development of the Ministry of Labor and the Institute of Professional Qualifications.

| Policy Recommendation

Human Resource Skill Development

Since there are different levels of care needs for individuals, the preparation of human resources to cover all levels of care are needed. New types of care workers need to be created for specific task and to be recognized in relation with career development.

There is a need for a policy to promote human resource development such as to encourage unemployed persons to receive training in caring for older persons, to provide soft loans, or to create a certification system for those who pass the training and examination. There remains a

shortage of care professionals including geriatricians, gerontological nurses, and occupational therapists. The strong recommendation, alongside additional funding, needs to be directed toward all universities and colleges to produce more related professionals.

Strengthening Volunteerism

Although there are two existing groups of volunteers as described earlier, there is still a need to recruit new volunteers who have genuine spirit of volunteerism and are not compensation-oriented (Suwanrada et al., 2014). Another issue is that some volunteers are highly dedicated to provide care to older persons but are unable to fully commit to the volunteer job because they have to work for a living (Suwanrada et al., 2014). The capacity of volunteers to enhance the quality of life of clients is therefore affected by availability of care services. Volunteer care networks should be complemented by other initiatives including training about health in later life for volunteers and investment in community LTC services (Lloyd-Sherlock, Margriet Pot, Sasat, and Morales-Martinez, 2017).

In general, older person needs are ranging from social care, health care, to medical care. According to VHV, they provide basic health care while HCVE provides basic social care. It would be better to equip volunteers with integrated knowledge and skills in both social and health aspects of care. With this, the MSDHS and the MoPH may need to work closely and create a joint curriculum and training

for local volunteers for better, more effective work within the community and to avoid duplication of intervention and funding.

Quality of Care Improvement

Thailand is in need for establishing regulatory mechanism together with care standards and service guidelines for dependent older persons in LTC Institutions (Sasat et al., 2015). There is also a severe shortage of manpower in providing health care for dependent older persons. The need for LTC workforce is an additional need for the health workforce in acute care setting. The estimated workforce required are 2,041 doctors, 58,841 nurses, 3,649 physiotherapists, 412 practical nurses, and 82,528 care assistants. The existing shortage of the health workforce in the field of the medical and public health service system is worsened by the increasing needs for the LTC workforce (Sasat, Pagaiya, Wisesrith, 2015).

Law and Regulation for LTC Facilities Development

A specific Act for high care in LTC facility needs to include nursing homes where nurses can perform professional practice with a medical doctor's consultation for treatment or transferring. The registration system, as well as the regulatory enforcement for LTC facilities, needs to be developed and tested before implementation throughout the country. Moreover, there is a need for the federal government to inform the local governments before the enactment of the regulation.

The Availability of LTC Facility for Those Who Are in Need

Access to LTC institutions is still limited only to those who can afford to pay for services provided by private nursing homes. To improve equality of care, accessibility, the assessment tools, the criteria to determine the persons who need care and a referral system need to be created.

Limiting Factors

There has been a long wait for a specific law on LTC institution provision. Although there are public residential homes available for a long period of time, little is known on the other types of LTC facilities such as assisted living, nursing homes, and LTC hospitals.

When the need for LTC is prevalent, the private sector has to respond to meet this demand but there is no regulation body responsible for registration. The existing law and regulation does not cover all types of facilities, so there is a gap. A new law has to be drafted.

To be able to response to the rapid change to the new circumstances of an aging society, the law needs to be more feasible and flexible. Actions have to be taken to urge policymakers to understand the new needs and new type of care provided and to react quicker to ensure that older persons are protected and cared for with quality.

For Further Studies

Human Resource Data Base

There is no database on human resources, particularly on care assistants who are paid caregivers, working in older persons' homes, and in the LTC facilities. Since the actual number of care workers is unavailable, this is an important gap in need of addressing because work and pay conditions influence respect and status. It may affect whether it will be possible to recruit the number of staff required in the future.

Financial Situation and Income of Family Caregiver

Most research findings state that caregivers often face financial hardship due to the change in their working pattern from working full-time to part-time, or even leaving their job completely to become a caregiver. However, there is no information available in terms of the financial situation and income of family caregivers. This gap needs to be addressed by future studies.

Abbreviations

ADB	Asian Development Bank
ADL	Activities of Daily Living
CTOP	The Community-based Integrated Health Care and Social Welfare Services Model for Thai Older Persons
DSD	Department of Skill Development, Ministry of Labour
HCA	Health Care Assistants
HCVE	Home Care Volunteer for the Elderly
IADL	Instrumental Activities of Daily Living
ILO	International Labour Organisation
ILTC	Institutional Long-term Care
JICA	The Japan International Cooperation Agency
LAOs	Local Administrative Organisations
LTC	Long-term Care
LTOP	The Project of Long-term Care Service Development for the Frail Elderly and Other Vulnerable People
MoE	Ministry of Education
MoPH	The Ministry of Public Health
MSDHS	Ministry of Social Development and Human Security
NESDB	The National Economic and Social Development Board
NHSO	The National Health Security Office
SCCT	The Senior Citizen Council of Thailand
ESCAP	Economics and Social Commission for Asia and the Pacific, United Nations
VHV	Village Health Volunteer

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Vietnam

Do Thi Thanh Huyen

Overview of Population Aging in Vietnam

According to the result of Population and Housing Census and other annual national and sample surveys, Vietnam's population is aging at an unprecedented speed. In 2011, the proportion of people aged 60 and over reached 10% and Vietnam started its population aging period. According to the General Statistic Office's population projection description until the year 2038, the proportion of people aged 60 years and over will be approximately 20% and start the period of aged population (General Statistics Office, 2015). Therefore, to adapt to population aging and prepare for the period of aged population, there are many challenges as well as opportunities for economic development in Vietnam. Taking care and promoting the roles of the older people is one of the special concerns. The policies and laws in Vietnam aim to ensure the healthy and happy lives of the older persons and promote their humanistic and positive values in society.

In this report, older persons refer to Vietnamese citizens aged 60 years and above. The

retirement age of the men is 60 and 55 for women.

"Aging, age": According to Cowgill and Holmes (1970), a population is classified as "aging" when the proportion of older persons (65 and over) accounts for 7 to 9.9% of the total population. Similarly, 10-19.9% of people 65 and over identifies a population which is "aged"; a population with 20-29.9% of people of 65 and over is "very aged" and more than 30% of aged people describes a population which is "hyper aged". This categorization is used by the United Nations and other international organizations.

This report summarizes and analyzes available data from the General Statistical Office and the General Office for Population Family Planning. It also considers documents relevant to older persons including reports and studies carried out by agencies or organizations of the government such as annual reports of Ministry of Labour, Invalids and Social Affairs (MOLISA) and the Institute of Labour, Science and Social Affairs. Also reports from other agencies/ organizations such as United Nations Population

Fund (UNFPA), World Bank (WB), World Health Organization (WHO), and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) have been consulted.

Aging Population Trends

Over the three decades prior to 2009, the older person ratio of Vietnam's total population did not grow quickly. The ratio of older persons increased from 7.1% in 1979 to 7.2% in 1989; and subsequently to 8.0% in 1999. It reached 8.7% in 2009. Since then, the increase of the older population accelerated and became 9.9% in 2011 showing an annual average increase of 6.7%. People aged 65 years and above

account for 7% of population in 2011 and nearly 10% in 2016 (General Statistics Office, 2016).

The duration of the demographic transition from an aging to an aged population is projected to be much shorter in Vietnam than many developed countries (United Nations Population Fund, 2011). The dependency ratio, which is measured as the ratio between the people aged 65 years and older and the population aged between 15 and 64 years, will rapidly increase especially from the year 2020 onwards.

Table 1: Dependency Ratio (65+ years/15-64 years)

Year	1979	1989	1999	2009	2019	2029	2039	2049
Ratio	8.4	8.4	9.4	9.3	9.9	15.9	21.9	27.9

Source: General Statistical Office (GSO) (2015).

Marital Status of Older Persons

The Vietnam National Aging Survey (VNAS) on the status of the Vietnamese older population which was released in May 2012, shows that the share of this age group who are married and living with their spouses decreases significantly with age, while the share of those

who are widowed increases. From ages 80 years and older, the share of older widowed is 62%. Women survive their husbands, which leads to a high share of widows among the older population (50.7%). The share of older widowed is higher in rural than in urban areas.

Table 2: Marital Status of Older People (%), 2011

	Age group			Gender		Location	
	60-68	70-79	80+	Male	Female	Rural	Urban
Widowed	19.4	41.2	62.0	14.0	50.7	32.5	37.7
Divorced/ separated	2.2	0.6	0.6	0.6	1.7	1.6	1.2
Married	72.7	54.9	37.1	84.3	42.1	61.1	68.0
Never married	5.6	3.3	0.4	1.2	5.4	4.8	3.2

Source: Vietnam National Ageing Survey (2012).

Health Status of Older Population

The VNAS reflects that more than half of the older population reported bad or very bad health conditions. There is no difference in terms of gender and location. The number of older persons who reported their health status to be good or very good accounts for less than 10% across all older age groups, sex, or location.

It is noteworthy that 95% of older population suffer from sickness which are mainly chronic and non-communicable diseases. These are namely arthritis (34.3%), high blood pressure (47%), heart diseases (16.5%), lung diseases (17.6%), and digestive problems (27.1%). More than 63% of the older population suffer from weak eyesight without supportive facilities. Those who are faced with at least one disadvantage in daily life is approximately 30% of the population (National Committee on the Elderly, 2012).

In 2015, 73% of all deaths in Vietnam were due to non-infectious diseases; nearly doubling compared to two decades ago. Of the total non-communicable disease-related deaths, those from the older population account for 77% and up to 40% of people died before the age of 70 years (World Health Organization, 2015). Due to the lack of regular medical check-ups and many other health-related habits that have had a negative effect on health since childhood. Such habits or characteristics are consuming less fruits and vegetables, performing less physical activity, and especially for men smoking or drinking alcohol. Non-infectious diseases are becoming much serious and treatment is very expensive because it is usually only diagnosed at later stages. As a result, non-infectious diseases are rapidly becoming the leading causes of disease and disability for the older population. It is noted that older women have a higher incidence of chronic disease than men.

Table 3: Self-reported Health Status

	Age group			Gender		Location	
	60-68	70-79	80+	Male	Female	Rural	Urban
Good, very good	6.3	3.7	3.7	10.1	5.7	8.1	7.2
Normal	35.3	27.9	21.5	41.5	32.5	43.5	2.7
Very weak, weak	58.4	68.4	74.8	48.3	61.8	48.4	60.1

Source: Vietnam National Ageing Survey (2012).

Education of Older People

For many reasons, including historical, many older persons have not received formal education. However, the percentage of literate people is comparatively high because many people are self-taught. According to data from the 2009 Census, nearly 80% of the older people are literate, while more than 60% completed second (2nd) to fifth (5th) grade levels of basic education. Of the total number of professors and associate professors, more than 50% are categorized as older. Among them, less than five-tenths of a percent attained a masters or a doctor's degree, and 2.16% hold a bachelor or comparable college degree and 3.33% acquired high school level or vocational training.

Income Sources of Older Population

The percentage of older people who live with adult children or grandchildren decreased from more than 80% in 1993 to 70% in 2008 (General Statistics Office, 2016). The proportion of older people living alone varies widely according to age, sex, and location. Within the older age group, a

higher percentage of women live alone compared with men. This reflects the longevity of women. A higher percentage of older population also live in rural than in urban areas.

The current older persons have experienced wartime. Most had to live under harsh conditions with a shortage of facilities for healthcare and protection. Among this population, 70% have no or very limited monetary savings. In recent years, in the context of the transition towards a market economy, they are among the group facing most disadvantages (Ministry of Labour, Invalids and Social Affairs, 2015).

Nearly 30% of the older population engage in income-earning work. In the age group of 80 years and above, however, only slightly more than 5% still earn income from work. More among the older people in rural areas than in urban areas are economically active. The main reason for not working is commonly weak health status. On average, about 60% of available income of the older population stems from two

sources: namely work income (29.4%) and from transfers from children (31.9%). Social assistance in the form of cash transfers or pensions constitutes under 10% of income of older people.

The share is highest in the age group of 80 and above, where it amounts to 16.6%. The income structure underlines the fact that many of the older persons work due to economic pressure.

Table 4: Income Sources of Older People

	Total	Age group			Gender		Location	
		60-69	70-79	80+	Male	Female	Urban	Rural
Work	29.4	46.9	26.3	5.3	35.3	29.4	23.4	32.2
Pension	16.1	20.4	17.9	7.3	20.7	16.1	26.5	11.2
Social allowances	9.4	5.2	9.1	16.6	9.4	9.4	3.8	12.2
Savings	1.3	1.8	1.1	0.8	1.8	1.3	1.1	1.4
Support from spouse	6.4	6.0	11.1	1.8	5.1	6.4	8.1	5.6
Support from children	31.9	13.8	27.5	65.5	24.9	31.9	32.9	31.4
Support from relatives/ friends	2.9	4.0	3.1	1.0	1.2	2.9	3.2	2.7
Other sources	2.6	1.9	4.2	1.7	1.6	2.6	1.0	3.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Vietnam National Ageing Survey (2012).

Poverty Among Older Population

The share of older persons living in poor households increases with age. Poor households are defined as households with per capita income below the poverty line, i.e. with less income than 700,000 VND/person/month in rural areas and 900,000 VND/person/month in urban areas

(poverty line period 2016-2020). In the age group of 80 years and above, the share exceeds one-fifth of all older people. The figure is identical with that of all older people in rural areas. Significantly more among older women live in poor households than older men.

Table 5: Older Persons Living in Poor Households

	Age group			Gender		Location	
	60-68	70-79	80+	Male	Female	Rural	Urban
Percentage	13.0	19.9	21.8	13.1	19.9	7.1	21.8

Source: Vietnam National Ageing Survey (2012).

The Vietnam National Ageing Survey captures the self-reported perception of the degree to which income covers the elderlies' daily needs (Table 6). Across age groups, less than 40% state that their income is enough or less than enough with regard to their daily needs. A majority states that

their income is not enough or sometimes not enough. The picture is worse in rural than in urban areas where in the former, nearly 70% state that their income does not or sometimes does not cover their daily needs.

Table 6: Self-reported Income Compared to Needs (%)

	Age			Gender		Area	
	60-69	70-79	80+	Male	Female	Urban	Rural
Not enough	23.6	29.1	27.2	23.4	28.1	17.9	30.0
Sometimes not enough	36.5	38.8	31.8	38.5	34.7	32.2	38.1
Enough	37.8	31.3	39.8	36.3	35.9	47.1	31.1
More than enough	2.0	0.8	1.3	1.8	1.3	2.8	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Vietnam National Ageing Survey (2012).

The number of older persons living alone, living with their spouse who is also an older person, or being abandoned by their families is also increasing because of the trend toward a reduced family size. It is expected that the number of older patients who will live alone will increase in the future, especially among those aged 80 years and over.

The older population are concerns of the state. The head of the national committee on older population is the deputy prime minister. The older people association is established from central to local level nationwide. It works actively with about 80% of total older people in the country.

Laws and Regulations Related to Older Persons

Population ageing has been included as one of the prioritized issues in the new national strategy on population and reproductive health for 2011-2020, as specified in a document labeled “Vietnamese following 10 years of implementation of the Madrid International Plan of Action on Aging (MIPAA, 2002-2012)” (Vietnam National Committee on Ageing, 2012). The Vietnamese Government has issued many national policies for the older people including the following:

The Constitution

Article 59 of the Constitution 2013 stipulated: *“The State creates equal opportunities for citizens to enjoy social welfare, develop social security systems and adopt social assistance policies for elderly people. Disability, the poor and other disadvantaged people”.*

The Elderly Law No. 16/2009-L-NCT

It is stipulated that the older Vietnam citizens from the full 60 years of age. The Elderly Law stipulated the rights and obligations of the older population; the responsibility of the family, state and society in supporting, caring and promoting the role of the older people in Vietnam.

Dated December 4, 2009 by the President Nguyen Minh Triet, it took effect from July 1, 2010. It included 6 chapters, 31 articles which were adopted at the 6th session by the National Assembly No. VII. It stipulated clearly on the rights and obligations of the older people; the responsibility of the family, state, and society in supporting, caring and, promoting the role of the older population. It has created the legal framework and social ethical standards in care and also promoting their role and potential. It has also shown great interest of the Vietnam State for the older people.

In order to implement the Elderly Law, the Government issued Decree No 06/2011/ND-CP dated January 14, 2011 on detailed regulations and guidelines for implementation of some articles of the Elderly Law.

The Health Insurance Law No. 25/2008/QH12

This law was adopted in 2008 and amended in 2014. According to this law, people who are 80 years old and older, are provided with health insurance free of charge and have complete coverage for medical services at the expense of the social security system (Law on Health Insurance, No.46/2014/QH13, 13 June 2014).

The National Action Program on the Elderly

The government approved the national action program for the older Vietnamese in the period of 2012-2020 with the aim of improving the quality of care, promoting socialization in caring, and promoting the role of the older population in accordance with the potential of economic and social development of the country.

The National Action Program on the Elderly with many activities and contents has been approved by the government and implemented. In provinces, many centers, cultural houses, entertainment centers for older persons appeared. The older people also participate in social activities and affirm their position and role in political, cultural, economic and social life. The older population actually confirmed that they are not *lão lai tài tận* but *lão lai tài bất tận*, which means that there was a shift from the previous view that this population no longer has much capacity toward the current view which considers the older people as still having capacity.

Action Month of the Elderly

In addition to activities celebrating the International Day of Older Persons, the Government of Vietnam also issued Decision No. 544 / QĐ-TTg dated 25 April, on Action Month for the Elderly in Vietnam and selected October each year is “Action Month for Older persons in Vietnam”.

Guiding Circular Sub-laws:

1. Circular No. 16/2002/TT-BLĐTBXH

In 2002, the Ministry of Labour, Invalids, and Social Affairs offers guiding principles on

implementation of some articles of Decree No. 30/2002/ND-CP of the Government

2. Circular No. 02/2004/TT-BYT

Dated 2004 and sourced from the Ministry of Health, this contains guiding principles for health care for older persons

3. Circular No. 21/2011/TT-BTC

In 2011 of Ministry of Finance stipulating on management and utilization of budget for initial health care for older persons in their residences

4. Circular No. 127/2011/TT-BTC

The Ministry of Finance issued the guidance providing the charge rates for visits to cultural or historical relics, museums, and scenery spots for the older people

5. Circular No. 35/2011/TT-BYT

From the Ministry of Health in 2011 provides the guiding notes on health care for older people

6. Circular No. 71/2011/TT-BGTVT

From the Ministry of Transport

7. Circular No. 17/2011/TT-BLĐTBXH

Issued on 2011 by the Ministry of Labour, Invalids, and Social Affairs

8. Circular No. 06/2011/TT-BVHTTDL

Dated 2012 from the Ministry of Culture, Sports, and Tourism.

9. Other relevant legal documents

Organizations and Agencies Related to Spiritual Life of the Older Population

The Vietnam Elderly Association

One of the most prominent non-government organizations representing the legitimate rights and interests of older Vietnamese is The Vietnam

Elderly Association. It is organized on the principle of voluntariness and acting on the basis of the Constitution, the laws, and the Charter. The funds of the Association are formed from the state budget, membership fees, and other sources. It was formally established in 1995. It has its own network at all levels and in all the cities and districts of the country.

Vietnam National Committee on Aging (VCNA)

This was established under the Decision No. 141/2004/QĐ-TTg dated on 5 August 2004. It is an interagency coordination organization to assist the Prime Minister to guide and enhance the coordination among Ministries, sectors, and localities in dealing with the issues relating to policies for the older population. There is a Committee on Aging at the provincial, city and municipal, and district levels to undertake the tasks of researching, proposing, and directing the related organizations to implement the work relating to older person care.

HelpAge International in Vietnam (HAIV)

This international organization supports older people in terms of rights, discrimination prevention, and poverty reduction. HAIV has been implementing some projects such as Project VIE051, “Enhancing the capacity of community organizations to improve the livelihoods of vulnerable groups in Thanh Hoa province”. There is also Project VIE049 which provides support for the poor and weak older persons in daily activities in order to help them to maintain their living at home as long as possible instead of being admitted to expensive

or inappropriate care institutions. Another one is Project VIE047 which is known as “Promoting the intergeneration self-help approach to improve the living of disadvantaged groups in Vietnam”.

Following the success of the project, the government issued Decision No. 1533/QĐ-TTg dated August 2, 2016 on the Master Plan of Replication of Intergeneration Self-help Clubs (ISHC) in the Period 2016-2020. The objectives of the Master Plan are to: a) replicating the ISHC model nationwide, using the intergenerational and community based self-help approach to contribute to the fulfillment of the targets set in the National Action Program on the Elderly and to the care for and promotion of the role of older people and pay attention to helping poor, near-poor and disadvantaged older people in the community, and b) promoting the participation of all levels and branches, social organizations, associations of the elderly (AEs) and the community in caring for and promoting the role of older people in the context of population aging. The Master Plan sets up the targeted indicators that a) in the 2016 – 2017 period: forming and managing around 1,200 ISHCs in at least 20 provinces/cities (with least 60,000 members, including 40,000 elderly participants, and b) in the 2018 – 2020 period: forming and managing about 2,000 ISHCs in at least 45 provinces/cities (with at least 100,000 members, including 65,000 older participants).

Overview of Actors Involved in Care Provision

Family and Community

Families in Vietnam have preserved the traditional value containing national cultural identity. The typical traditional values are: filial piety relating to filialness to grandparents and parents, love towards siblings, loyalty, and harmony within conjugal relationship. These values have always been emphasized in developing family principles and teaching morality for children to become the cultural norm in Vietnam. In developing and maintaining the family's traditional values, older persons are considered as the backbone of the family with a very important role.

In Vietnam, taking care of the older persons in the long term is mostly undertaken by family members. The Survey on the Elderly in 2011 showed that those who take care of older people the most when they need support in daily activities are spouses (of which, the proportion of men cared for by their spouse was 80% while the proportion of women cared for by their spouse was nearly 30% among all older people living with their spouse); children, and daughter-in-law. Meanwhile, hiring a caretaker or a healthcare staff is rare in the Vietnamese tradition.

Taking care of older persons by family members shows many advantages as well as challenges. The fact that 60% of the older population live with their spouse and nearly 70% of them live with their children are proper indications that the family members take care of the older person at home

which is in accordance with the law, economic condition, and Vietnam's cultural tradition.

Care for older people from their relatives is very important. Those who are not living with their spouse indicate that relatives assist them the most in terms of daily activities. However, similar to the family members, the relatives also face numerous challenges in caring for them.

Some of these challenges are related to the number of members taking care of the older person is getting less because the family has fewer members; their children are busy or working far away from them; and women, who are the main caregivers, also lack time as they are also working. Those taking care of the older persons are getting tired after a long duration with more and more complicated requirements due to the characteristics of the older persons' illnesses. There is also the lack of necessary knowledge and skills on care of family members which affects the quality of care. The alternative care services and supporting equipment are almost non-existent or very limited.

In conjunction with an increase in the number of older people and the needs of care, several home-based and community-based care models for the older people have been established in the past 10 years. These models provide services from a third party, including the models funded by international project, the models implemented by the Government agencies, the models organized by Associations, and the models undertaken by domestic private institutions including home-based care services provided by volunteers and lives support services.

There are also some clubs providing paid care-supporters.

State

Social Assistance

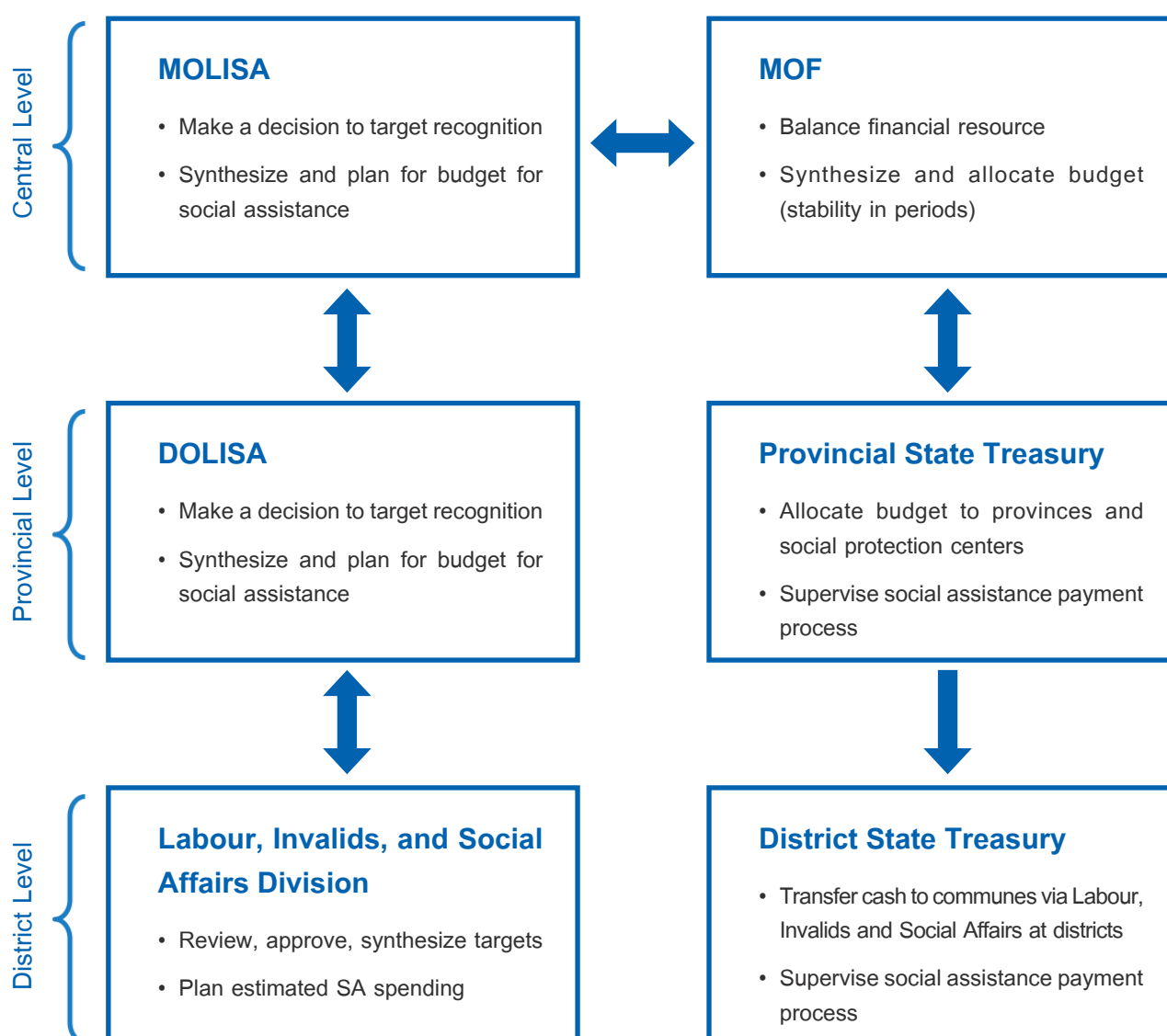
The implementing agency is The Ministry of Labour, Invalids, and Social Affairs. The Ministry is in charge of coordination with other ministries and provinces for the implementation.

Every year, the State budget ensures the payment to beneficiaries who are eligible to receive their monthly allowance under the social assistance

policy. Budget planning and allocation process are shown in the chart of decentralization (Figure 1). The State will adjust the allowance level in each period in accordance with the national socioeconomic development.

The central state budget assumes the role of ensuring financial resource to implement social assistance policy. Localities balance the state budget to pay social allowance in case of unbalanced budget on their own initiative; provided that allowance does not exceed the specified level. In case of inadequate state budget, a higher level shall compensate.

Figure 1: Chart of Decentralization and Budget Planning and Allocation



Cash Allowance to Those in Especially Difficult Circumstances

For the implementation of the Law on the Elderly, the government promulgated Decree 06/2011/ND-CP in 2011 providing detailed guidance for Article 6 of the decree 136/2013 on Social Relief Allowances and Decree stating:

1. People aged 80 years and older, who do not have a pension or social security, can claim monthly allowance and health insurance for life. Older people from poor families who do not have relatives and normal conditions of life can be accepted into nursing homes, where they must be provided with free care, monthly benefits from Social Security Fund, medicines, tools and means for rehabilitation, as well as provided with funeral in case of death.
2. The standard social monthly relief allowance for older persons is 270,000 VND (standard level).
3. Social relief allowance for older people who live in a community under the administration of the People's Committee of the commune or ward is 4050,000 VND/month per person (equal to 1.5 standard level) for those with ages of 60 and 80 years living in a poor household without anybody obliged to take care of them or with people taking care who may currently depend on monthly social relief allowances. A benefit level of 540.000 VND/month per person, which is equal to 2 standard level, applies for older people who have reached the age of 80 years and live in a poor household without support from people providing care, such as children or grandchildren, or with support from caretaking people who currently enjoy monthly social relief allowances. A benefit allowance level of 270.000 VND per person per month is granted for older persons who have reached the age of 80 years and do not benefit from pensions or other monthly social insurance allowances or monthly social relief allowances.
4. A benefit allowance level of 810,000 VND/month, which equals three-fold of the standard level, per person applies for older persons who live in public patronage establishments. It is also for those who are entitled to stay in public patronage establishments but are cared for by individuals from the community. The one-off payment of funeral costs amounts to 5.4 million VND. The Decree clearly states that depending on the condition of each locality, the People's Committee and concerned agencies can determine the relief allowance level but must not provide less than the lawful level promulgated by the state.

Table 7: Older Population Entitled to Monthly Social Assistance, 2007-2016

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of people (in thousands)	591.6	667	850	948	1,210.3	1,209.7	1,211	1,439.7	1,532.2	1,713
Benefit level (in 1,000 VND)	120	120	120	180	180	180	180	180	180	270
Change in eligible age	85	85	85	85	80	80	80	80	80	80

Source: Ministry of Labour, War Invalids, and Social Affairs (n.d.).

Social assistance for the older population are continuously developed. The Decree 67/2007/ND-CP specified that people aged 85 years and older who have no pension or social insurance benefits are entitled to monthly social assistance which has the basic norm of 120,000 VND/month. At the period of 2007-2009 the State subsidized annually for more than 600,000 older persons. Since 2010, the Decree No. 13/2010/ND-CP amending Decree 67/2007ND-CP has raised the standard allowance to 180,000 VND/month. Although not adjusting for age, the

total number of older people who are receiving it increased to 948,000 persons. Since the Elderly Law took effect in 2010 and the Decree No. 06/2011/ND-CP guiding the implementation of laws and regulations governing the age allowance reduced its recipients to 80-year-old persons (although not increase the standard of allowance), there are more than one million older persons who are entitled to monthly social assistance. And in 2013, Decree No. 136 also raised the standard allowance to 270,000 VND/month. (Table 7)

Table 8: Beneficiaries and Financial Support

Year	Old people without children caring person and living alone (60 – 80)		Old people over 80+ with pension		Total	
	# of beneficiaries	Cash support (USD)	# of beneficiaries	Cash support (USD)	# of beneficiaries	Cash support (USD)
2013	104,400	903,462	1,071,000	9,268,269	1,211,000	10,171,731
2014	99,700	862,788	1,340,000	11,596,154	1,439,700	12,458,942
2015	102,200	884,423	1,470,000	12,375,000	1,532,200	13,259,423
2016*	103,100	1,907,350	1,610,000	20,930,000	1,713,000	22,837,350

Source: Ministry of Labour, War Invalids, and Social Affairs (n.d.).

*2016: Monthly allowance increasing from 8.6 USD/month to 13 USD/month

Care at the Center

In order to care for the helpless people, a system of houses or centers of social protection was created. They operate at the expense of the social insurance fund or financial assistance from individuals and legal entities, whether national or foreign organizations. Such centers have different names depending on their specialization and include care centers, orphanages, centers of protection of disabled people, and the centers or homes of care for older persons among others. The centers of social protection have the opportunity for care for different categories of people, including the older people. The procedure for the establishment, operation, reorganization and liquidation are determined by the Government Regulation number 68/2008 / ND-CP by 30/05/2008. Older people from poor families who do not have relatives and normal conditions of life can be accepted into the homes of social protection (nursing home) where they must be provided with free care, monthly benefits from Social Security Fund, medicines, tools and means for rehabilitation, as well as provided with funeral in case of death amounting to 7 million VND (320 USD).

According to the Department of Social Protection under MOLISA, the number of centers of different types in the country is more than 400. Following that, there are 13 centers of social care and care for the older people with 443 staffs (34 staff/1 facility) and nursing care for 4,723 older persons (363 subjects/1 institution). There are eight public and five non-public facilities distributed in four regions: three (3) in Red River Delta; one (1) in

North Central, seven (7) in South East, and two (2) in Mekong Delta. In addition, with the rise of living standards of the population in cities in recent years, private care centers for the older patients or geriatric nursing homes have been established. These private organizations generally take care of the older people from modern nuclear families.

The president of the Socialist Republic of Vietnam is obliged to send greetings and give gifts to people who turned 100 years old. Also, the chairperson of the provincial People's Committee shall send a greeting to the presentation of gifts to people who are 90 years old; and heads of local authorities are obliged to organize a celebration for the older population, alone or with their families, on the occasion of their birthday, New Year's Day of Old People of Vietnam, the International Day of Old People at the ages of 70, 75, 80, 85, 90, 95 and 100 or more.

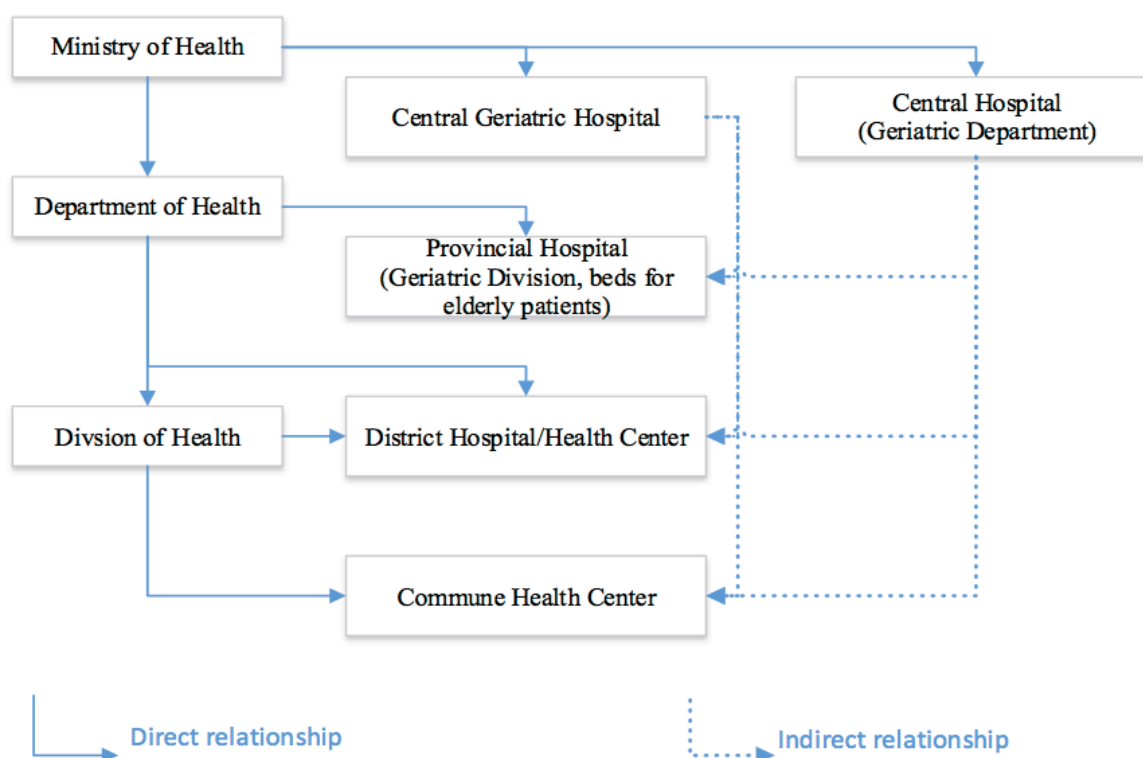
Health Care for Older Persons

The implementing agency is the Ministry of health in coordination with other ministries and provinces for the implementation. Regarding the policy stipulated in Article 29, rule 2 in the Law on the Elderly: "Ministry of Health shall: guide and organize the care for the elderly's health at medical facilities and in community...". The Law also promotes community-based care through the form of monthly social assistance policy which is equal to the cost level at social protection establishment. It provides health insurance and supports for funeral expenses for the older people who are eligible for living in social protection establishments but taken care by someone in the

community. Accordingly, the people aged 80 years and over without pension shall get free health insurance. The Law on the Elderly clearly indicates that hospitals, with the exception of pediatrics

hospitals, shall take responsibility for organizing geriatric departments or dedicate a number of beds for the treatment of older patients (Article 12. Medical examination and treatment).

Figure 2: Chart of Health Care Management for Older People



At the central level, the Central Geriatric Hospital, under the direct management of Ministry of Health, shall undertake the medical examination and treatment; guidance, training, and research. The hospitals at provincial level shall have geriatric departments or be in coordination with another department or provide beds for treatment of the older people under the management of the Department of Health. At the district level, the hospital and medical centers under the management of the Department of Health shall not have an exclusive geriatric department but

provide beds for the older persons. The health care stations at commune, ward, or town level shall take responsibility for taking care the older people at the community and these stations shall be managed by assigned staff members by the district medical centers. In the National Geriatric Hospital, there are 12 departments and six functional rooms, and one mentoring training center with 250 beds for in-patient treatment. The hospital has 329 officers, including 90 doctors, 131 nurses, 18 technicians, 13 pharmacists, and 87 other staffs (National Geriatric Hospital, 2016).

Table 9: Number of Turns of the Older Persons Receiving Medical Examination and Inpatient Treatment in 2015

	Total (number of turns)		Proportion	
	Medical examination for older persons	In-patient treatment for older persons	Medical examination for older persons	In-patient treatment for older persons
Hospitals at central level	2,143,071	317,318	8.0%	10.0%
Hospitals at provincial/cities under the Government level	10,019,986	1,395,837	40.0%	44.0%
Hospitals at district/municipal level	11,604,834	1,267,434	46.0%	40.0%
Other hospitals at Ministerial level	223,758	25,243	1.0%	1.0%
Non-public Hospitals	1,243,095	184,744	5.0%	6.0%
Total (whole country)	25,234,744	3,190,395	100.0%	100.0%

Source: Ministry of Health (2015).

Despite the fact that the hospitals at provincial level and district level have not yet ensured 100% out-patient examination department and in-patient treatment rooms exclusive for older persons, they have organized an area for reception, examination, and treatment. Besides, they are trying to set up more out-patient examination departments and in-patient treatments rooms for only the older patients with higher quality. Almost all the medical examination and treatment facilities have regulations on prioritizing the older people and have separate examination rooms for them (Ministry of Health, 2015). However, in many health care facilities at the district level, majority of patients are living in poverty, including many older people with chronic diseases that require

health counseling and health education. In relation to this, the implementation is deemed limited (Nguyen The Anh, 2016).

At the commune level, the health centers have yet to undertake the home-based treatment and care for the older people. The management and health care consultation for older people in remote and ethnic areas are facing numerous difficulties. There is a low number of care personnel in health centers at the communal level who are trained on the management of chronic diseases such as hypertension, diabetes, cancer, and chronic obstructive pulmonary diseases among others (Nguyen Thi Thi Tho et al., 2014).

The preventive health system, which is to control the non-communicable diseases that the older persons develop, has covered up to the village and hamlet levels. Some programs on non-communicable prevention have been effectively implemented. However, there is a lack of specialized units as well as surveillance system for non-communicable diseases. Until 2014, there were 81% of preventive medical centers participating in non-communicable prevention activities at different levels and scales. Majority of the provincial preventive medical centers participated in the activities to prevent diabetes (65%) and hypertension (55.6%). Of the said medical centers, the main activities were screening as means of early detection and counseling of patients. The preventive medical centers have not yet participated in activities to prevent cancer and chronic obstructive pulmonary diseases. There were only few centers that participated in activities to prevent the risk factors (Nguyen Thi Thi Tho et al., 2014).

Role of Social Organizations and Social Partners

The Vietnam Association of the Elderly is a social organization which is representative for the will, aspiration, legitimate rights, and interest of the older people in Vietnam. The Association is organized and operated on the principle of voluntariness, self-management, democracy, equality, and transparency; decisions are made by majority.

The Vietnam Association of the Elderly has its branches in 100% of all communes or wards in

the whole country. The Association has proactively participated in many social work such as: coordinating in developing policies, benefits for older persons, implementing social security policies on the older population, and developing clubs which are to improve older people's health and spiritual life. The Central Association of the Elderly have paid attention on developing the clubs. There are more than 58,000 clubs, attracting 2.6 million of the total 9.41 million older people (27.6%).

Private Sector and NGOs

Aside from the association recognized by the Government, many non-governmental organizations and private sector have participated in taking care for the older population. The special international organizations, particularly HelpAge, has cooperated to run the long-term care model for the older people through intergeneration self-help club model, which is an effective community-based care model that meet both requirements to take care and promote the roles of the older people. This model has been funded and implemented in 12 provinces and cities with 700 clubs, attracting 35,000 older participants. Some provinces, as Thanh Hoa and Ben Tre, have maintain and duplicated this model after receiving support.

The community-based care model for older people supported by the non-government organizations often relies on volunteers, which is not integrated into local programs. The activities of this model depend on the provided resources and focus on home-based care (mainly support for daily activities).

The private sector participated in providing care for the older people mostly by having care services in nursing centers and home-based care. The private care centers are usually concentrated in big cities. This model provides more service options for the older people and their families such as day-care, home-based care, and in-patient care. In the home-based care model, the family will hire someone to take care of them.

Conclusion and Recommendations

Conclusion

Traditional care of the family to the older persons is decreasing. Due to the trend of smaller family size and the fact that children are working far away from home, the time to take care of the them has been reduced. Women, who used to have the main role in taking care of older people at home, are now participating more in gainful employment. The number of the older persons who are living alone, living with their spouse or living in a skip-generation family has been increasing.

The living standard of the older population is low in general. Some of them have to live in temporary houses. Some have to work hard and they encounter many difficulties, especially the older persons in the difficult regions as well as the older members of ethnic minorities. Their income is unstable whereby the average pension is low and does not meet the basic needs leading to their insecure living condition after retirement. The low social allowance could not ensure the minimum

living standard of the older people. The Government care establishments could only support a small number of older people who are social protection recipients.

There is a lack of legal framework and policy on developing social care services in Vietnam. Until 2015, there has been a lack of a list of social care services, as well as standards of social care services. Therefore, it is difficult to adequately implement the mechanism where social care services are paid by the State for the existing non-public social protection establishments and future social work centers. It is considered as a huge limitation which needs to be addressed soon.

Despite the fact that the health care system in Vietnam has garnered some achievements, it has not adequately adapted the requirements of population aging. The family remains to be the main actor in long-term care for the older people whilst the long-term care at the care establishments provide services for a few number of lonely and the poor older persons without caregivers.

There are participations of organizations, partners, and private sectors in providing care services for the older population however, it is not the nationwide model.

Recommendations

It is necessary to implement all the policies and law on the older people and to create favorable conditions for them to enjoy and contribute to society by enhancing the implementation of old-age social security policy and adjusting the

benefit level in association with economic development. At the same time, reforming the way of providing public services for older people in order to facilitate the accessibility of services through: (1) prioritizing the strengthening and development of hospital system, human resources, and medical technology in taking care of the older people; (2) developing various types of services to meet the needs of daily life, culture, and entertainment of the older population; and (3) considering the strong and effective promotion of the role of the older persons as an effective solutions for old-age care.

The healthcare sectors should enhance the investment, improve the primary health care, integrate the medical care with social care; heed close attention on health care and nutrition for the older persons: “How to make the patients, especially the older persons, feel the care and feel comfortable as they are at home in hospitals” (Deputy Prime Minister Vu Duc Dam); develop the friendly living environment; and promote the role of the older people and care for them based on family and community.

It is necessary to develop more nursing home models which are suitable with traditional culture of the Vietnamese. Allow older people to interact more with people of different ages and give them advise to practice some sports, check their health periodically, care for their spiritual life, and create favorable conditions for them to access information on their interests to adapt with the changes in the way of life. Doing these, the older person will feel comfortable living with their children and grandchildren.

The older people are very sensitive. They need love and care from their children and people around them. Therefore, it is necessary to make the older people happy; make them feel close when taking care of them. This is one of the important things in taking care of the older persons.

It is necessary to develop a long-term care policy system and integrate it with other policies. There should be a policy to encourage the private sector to invest in the long-term care facilities including the community-based long-term care facilities such as land support and tax exemption.

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Conclusion

**Elke Loichinger
Wiraporn Pothisiri**

Introduction

In the previous 13 chapters, the role that each actor – the family, the state, local communities, NGOs and the private sector – plays in the organization and provision of care has been described in detail. As expected, the family is still the main provider of care in each of the ASEAN+3 countries. What differs is the degree to which families are supported in their care tasks, and who of the other actors is organizing and/or providing this support. This support can be financial, in kind or in terms of services that are provided so families can take care of their older members who have care needs. In cases where older persons cannot rely on support from their immediate families, other support mechanisms are often in place through which basic support and care is provided.

In this chapter, we present a brief summary of the care situation in each country, followed by a section where the main similarities and differences between countries are pointed out. Due to the important role of the government, this actor is dealt with in an individual section

before selected insights from countries' experiences are shared. The recommendations that follow are deliberately kept broad to do justice to countries' very diverse demographic and socio-economic settings. The chapter concludes with a presentation of the challenges that country experts faced in their endeavor to collect the information for their respective country reports and an overview of data sources that contain information on the older population in general and on care needs in particular.

Summary of Individual Country Situations

In this section, the focus is on the role of each of the five actors. We extracted the most relevant information from each report. For more detailed accounts of the situation in each country, please refer to each country report directly.

Brunei Darussalam

In Brunei Darussalam, the family, communities, the government and NGOs are the main actors when it comes to care of older persons, whereas

the private sector does not (yet) play a significant role. While the family is still the main care provider, the government has the role of initiating and partly also running care programs that are implemented through one of the other actors. The main actors provide care either individually or collaborate to form networks that support families and their older members. For example, the Home Care for Older People in ASEAN Countries Project had a lasting effect in Brunei Darussalam, where it was continued after the official project by HelpAge Korea and HelpAge International ended. Volunteers are still receiving training in giving social and care assistance and are crucial care providers within the community. While the number of older persons that are receiving support through this program is still small, it is expected to increase in the next decades. The government does not only provide training for volunteers but also specific training e.g. on dementia for professional care providers such as doctors, medical personnel, and community development officers. Family members that are in need of training to take care of older family members receive support through government programs as well. Active aging has been identified as a crucial factor in the preparation for an increasing number of older adults, and communities as well as NGOs are receiving government support to promote active and healthy aging at the local level. Within the community, the fact that the village head personally distributes monthly payments of old-age pensions, allowances as well as welfare assistance to older persons presents an ideal opportunity to monitor the situation of older persons and to suggest supportive measures, if necessary.

Cambodia

The current older population in Cambodia has lived through the reign of Pol Pot and still suffers from the negative effects of this period on their physical and mental health. Another consequence of the war is a skewed sex-ratio among older age-groups, meaning a noticeable share of women is not married and lives by themselves, lacking potential support from co-resident adults. Old-age care in Cambodia is dealt with by mostly three actors: the family, the government and Older People Associations (OPA). Since there is hardly any information available on care needs and provision to older persons in Cambodia, the report focused on aspects of health care. Health care services are to a large extent subsidized by the government, and the nominal user fee has been waived for those living under the national poverty line. Yet, universal healthcare is not a reality yet and the quality of health care also requires improvement. The community-based OPAs play an important role when it comes to the promotion of active aging and aging in place, and the provision of knowledge on a range of issues related to the lives of older adults. NGOs, volunteers and government personnel occasionally support the OPAs in these endeavors. The government, local pagodas and monasteries provide shelter for homeless older adults. The private sector presently plays a negligible role in the context of older person care.

China

As in other ASEAN+3 countries, the situation when it comes to care needs and provision differs between urban and rural areas. Long-term care

services are in general provided but their provisions are concentrated in urban areas, leaving fewer options for residents in rural areas. These residential care facilities – initially provided only by the government – are now also being provided through private organizations. This comes at a price though, and affordable options are limited for families who need outside support in care provision for their older member(s). Then again, the quality of institutions, and hence the costs, vary across institutions, and local as well as international companies cater towards this market. National/local NGOs exist in the form of charitable organizations and community organizations run by volunteers. Their tasks cover a wide range of actions: from the provision of geriatric training programs for primary care practitioners as well as informal family caregivers to the implementation of community networks for care provision that can adopt to a large range of local contexts. International NGOs, like HelpAge International, have projects in poorer rural areas that aim at supporting community networks of older persons. These community networks have the purpose to help with issues related to income security and health care, also by establishing links to relevant authorities.

Indonesia

When it comes to services to improve the social welfare for older Indonesians, the role of the government is above all to guarantee coverage of costs, to secure public facilities, infrastructure and legal aid, and to ensure the provision of health insurance. The majority of older adults live within their family household. If this is not possible or

not desired, publicly-run shelters/institutional residences exist within the community that provide services that go beyond the provision of basic physical needs. In addition, privately operated shelters/nursing homes exist. Shelters can also operate in a day-care set-up, where users still reside within the family and only make use of services and activities during the day-time. There are also home-care services, though they are not very plentiful. There are examples of initiatives by regional governments that explicitly focus on the situation of the elderly, including conducting tests to find out whether home-care is required. If necessary, the government also supports households that include older adults through supplemental food, health services, and social guidance.

Japan

Traditionally, wives, daughters and daughters-in-law have been the main care providers for older persons in Japan. While it is still a predominantly female task, this has gradually started to change and men have begun to engage in care provision as well. When it comes to older person care, the main actor after the family is the government. What started with public investment and provision of social welfare services and health care for the elderly eventually led to the enactment of the Long-Term Care Insurance (LTCI) Act, marking the start of mandatory long-term care insurance. Long-term care can be institutional as well as home-based, and while private providers exist as well, providers are predominantly public. Community-based programs provide services for older adults, offer opportunities to engage in various activities and

play an important role in health promotion. Maintaining and even improving physical as well as mental abilities of older adults as well as providing training for voluntary care givers are crucial aspects of the LTCI scheme that were added later on. NGOs also provide support of older persons at the local level, for example through local volunteers. A nation-wide time bank (*Fureai Kippu*) scheme where people volunteer their time for others and will receive time themselves in return in the future has been in existence for over two decades and has been very successful.

Lao PDR

In 2004, the Laotian government issued the first National Policy for Older Persons. However, the translation of this policy into action is very limited. So far there has been no law, strategy or action plan directly targeting the older population. Since there are no social or health protection programs to support older persons, care provision relies heavily on the family. Given fertility decline and changing social values, the role of family in providing care for older persons is likely to change. A few actions proposed to be taken by the government include the initiation of regulations directly for older persons, establishment of a non-contributory minimum social pension for older people who are not covered by the formal social security system, and provision of non-cash benefits for the older population, such as free health care, housing and transportation.

Malaysia

The government, through its various ministries and departments, is a major provider of services

and regulates the provision of social welfare and health services for the older population. This includes residential care as well as non-institutional services, and also covers support with housing itself through affordable housing schemes. Social welfare programs for older adult include for example financial assistance, help with transportation as well as the provision of publicly-funded shelters for those who have neither family nor any financial means themselves. Having said that, the family is still seen at the main actor when it comes to support and care for older adults; it is secondary whether family members provide this care themselves or engages paid formal services. An official care scheme that deals with long-term care needs has not been set up yet, but the government has recognized the need to distribute the increasing care burden and cost between all actors. This includes a review of existing care-related regulations and adjustments where necessary, for example of regulations for the emerging care industry. State governments are also active providers of residential facilities and care institutions, often in the Islamic tradition. Malaysia also has a wide range of civil society organizations that have purposes related to population aging and provide community-based services such as residential and day-care facilities, home visits, and care training to varying degrees. The private sector plays an increasing role in care provision in both residential nursing homes and care centers.

Myanmar

In Myanmar, international and national NGOs and community-based organizations play a crucial role

for older person care provision, next to the family who is still the by far most important provider of support for older persons, including care. The majority of older adults lives in traditional households with more than one generation where needed care is provided by family members. Those older adults who are in need of care, but either their family cannot provide it or they don't have a family, can find shelter in government-financed Homes for the Aged. The government also provides Day Care Centers for the Aged. Health-promoting activities are offered in clinics that specialized on older persons (geriatric clinics) in order to improve the health of older Burmese, and a health care program that targets older adults is being implemented. The ROK-ASEAN Home-care Model was implemented in collaboration with local NGOs; under this model, trained volunteers from within the community take care of those who require it. Another program that was introduced from an international NGO, namely HelpAge International, are Older Person Self-Help Groups (OPSHG). While this program has a broader scope of services and also includes economic support, long-term care provided by volunteers is also one of them. In addition, a range of national NGOs offer care or care support at the local level. The private sector has not yet entered the care market.

Philippines

The distribution of responsibilities towards older persons is reflected in the 1987 Philippine Constitution (Article XV, Section IV): "it is the duty of the family to take care of its senior citizen members while the State may design program of social security for them." The government runs permanent or temporary residential care services

for those older persons who don't have a family or were abandoned. A contributory social insurance scheme that has a provision in case of disability is also provided by the government and covers a range of workers in formal employment situations and self-employed workers with a monthly income above a certain threshold. Older adults are also covered under the national health insurance program. Local governments are responsible for welfare programs such as Senior Citizens Centers that provide a wide range of services and activities for older persons and for strengthening Senior Citizens' Organizations. On the community level, the Office for Senior Citizens Affairs assists older persons in a range of tasks related to services they are entitled to. In addition, several NGO's are involved in one way or the other in care-related activities throughout the Philippines. Several legislative endeavors that aim at improving the care situation of older Filipinos and Filipinas are under way, one of them specifically aiming at implementing a national long-term care program framework.

Republic of Korea

In the Republic of Korea, as in Japan, Malaysia and Singapore, the private care market is already quite established, much more so than in any of the other countries. The Republic of Korea is also one of the few countries in the world that has a long-term care insurance (LTCI) system. The declining role in older person care provision of the family was compensated by an increasing involvement of the government and the private sector. The government's role is mostly that of the creator, regulator and manager of the LTCI system. Several adjustments were made, and still will need to be made, to remedy

issues that emerged in the course of the existence of the insurance. The services that are provided under the umbrella of the LTCI scheme are almost exclusively provided through for-profit providers, and only a small share is provided by public or not-for-profit providers. The benefits from the LTC insurance cover services provided at home as well as in institutions (i.e. nursing homes). However, the majority of services are home-visits, not institutionalized care services. The involvement of community in care is larger in rural than in urban areas, due to both a larger sense of community in rural areas and the fact that LTCI services are not available everywhere outside urban areas.

Singapore

Singapore promotes a model where care responsibilities are foremost the responsibility of the individual, followed by the family, the

community and finally the government. In terms of actors, this means the family, the community, Voluntary Welfare Organizations (VWO), the private sector and the government play a role. What varies across actors is the degree to which they are involved in funding, regulating, and actually providing care. These distributions of tasks have been changing over time; for example, the government is increasingly also taking the role of being a care provider (cf. Table 1). Older persons themselves and their families predominantly have the task to provide financial resources and to provide home care (except medical services). Communities, VWOs and the private sector provide intermediate as well as long-term care, and this care can be institutional, center-based as well as home-based.

Table 1: Overview of Actors and Their Roles in Care Provision in Singapore (2017)

	Roles in care provision							
	Framework and Regulation	Financing	Types of Services					
			Acute Care	Intermediate and Long-term care				
				Residential/ institutional Care	Non-residential/Community-based care			
					Centre-based	Home Care		
						Medical	Nursing	Personal/ Emotional
Self, Family		+					+	+/+
Community and VWO		+		+	+	+	+	+/-
Government	+	+	+	+	+	+	+	
Private Sector			+	+	+	+	+	+/-

Source: Table 3 copied from Wong et al. (2018).

Note: + the actor has a role in the type of care provision in older adults; - the actor does not have a role in the type of care provision in older adults.

The formal branches of care are accompanied by extensive informal care provision through informal and family caregivers, which receive substantial financial and training support from the government (for example caregiver training grant, foreign domestic worker grant). The overall goal is to allow older adults to age in place and to support them through a range of initiatives and services that go well beyond the sheer provision of care, for example the financial support of home modification and assistive devices. The data situation is very favorable in Singapore when it comes to older adults' socio-economic situation and their health and care needs, which is essential to be able to perform policy-driven research and design evidence-based interventions.

Thailand

In Thailand, the family is still the by far most important provider for older persons – not only when it comes to social care but for any kind of support. Having said that, after the family, the government is the next important provider of social care and health care services. The support an older person can receive depends on the degree of dependency, i.e. on the need for support. On the community level, Village Health Volunteers (VHV) help with issues related to public health in general, not specifically for older persons. Volunteer caregivers (VCG) received training to provide care for older members within the community. Several national as well as international NGOs have been involved in various kind of voluntary care and support schemes. The number of LTC providers in the private sector has been

increasing; they represent an option to obtain care for those elderly who require skilled care that surpasses what untrained family members can provide, or who do not have family who can provide care.

Vietnam

The family is still the main care provider for older family members, and it is quite rare to hire a caregiver to fulfill this task. Still, under the pressure to react to increasing care needs, home- as well as community-based care models have been initiated. All actors are involved and play their part in older person care: the government, International NGOs, national associations, the community, and private providers. Various kinds of centers where older persons without family and very limited financial means can receive services and assistance and, if necessary, care, exist. The community-based Home-Care Model, initially introduced by HelpAge Korea and HelpAge International, has been continued in several provinces and is an example of a successful community-based scheme. Private organizations that offer care services are concentrated in urban settings and provide all three, residential care, home-based care as well as day care.

Noticeable Similarities and Differences

Given the different stages of economic development and population aging that ASEAN+3 countries find themselves in (see the introductory chapter for details), it is not surprising that the set-up of older person care and the distribution of

responsibilities of the involved actors differs vastly across countries. While the family is still the most important provider of care in each of the thirteen countries, the ability as well as the sense of obligation (keyword: filial duty) to do so seem to be declining. With family sizes declining due to past and/or ongoing reductions in fertility, there are fewer younger family members that are potentially able to provide care. Also, with adult children often migrating to urban areas or even other countries for economic reasons, the number of potential care givers is reduced further, and formal and informal (non-family) care givers are in demand to provide necessary care to those in need. In those instances where older persons do not have any family or have been abandoned, shelters that provide for basic needs exist in several countries. Old-age poverty – in particular of those who are without family – is an issue in several settings and various mechanisms to provide financial, in kind and emotional support for those in need have been introduced or are being discussed.

A development that seems to be uniform across countries is that investments and developments in the health care system happen at an earlier stage and consideration and implementation of a care system for older persons follows. This sequence is rational, since developments in the health care system are more basic and usually happen when the share of the older population is still relatively low. What differs is in how far the inclusion of the older population is of an explicit concern in the set-up of the health care system. Expenses for health care are mentioned as a

crucial issue for older adults in several countries, and the situation is more favorable in those countries where older persons have access to health insurance/free health care and where co-payments are low.

Care needs differ by severity of care support that is necessary. Several countries define long-term care needs as care needs that require support with activities of daily living. This support is often provided informally by family members; when it is institutionalized, it can be in day-care centers or in institutions where older persons reside permanently. These institutional provisions can be predominantly publicly run – as in e.g. Japan and Thailand – or run by private companies – as in e.g. the Republic of Korea and Singapore. In Malaysia, for-profit and not-for-profit long-term care providers both play an important role when it comes to providing care that goes beyond what family members can provide.

Japan and the Republic of Korea are the only countries among the 13 countries that are part of this report that have introduced long-term care insurance (LTCI); Japan in 2000 and Korea in 2008. Their experiences differ, not least due to the fact that LTC is mostly provided by the private sector in Korea, while there is a mix between public and private providers of LTC in Japan.

In countries with a shortage of local care-givers – for example in Singapore, Japan and Thailand – foreign domestic workers that work as care-givers are playing an increasingly important role. What varies is the degree of previous experience

and/or formal training of these foreign care-givers, and whether those with low levels of skills are receiving training in the destination country. In the case of Japan, extensive language and skill training is required and provided, whereas the overall situation is less supportive in Thailand. Needless to say, whether hiring foreign domestic workers is a possibility depends on the financial background of families and is not a universal option.

Most countries are facing the challenge that care needs and care provision differ between urban and rural areas. In some instances, care provisions by the state or the private sector are concentrated in a few urban centers, while the community as care provider is more active in rural areas. Since the socio-economic situation of older adults varies between urban and rural settlements, the solutions to provide care for an increasing number of older persons in both contexts will likely not be the same. One central aspect of this urban/rural discrepancy is the fact that adult children often leave rural areas in order to attend education and/or find employment in cities, meaning that older adults might be left with only one or no adult child that lives in the same household or close-by.

It is expected that dementia will become a disease that will play an important role for care provision in each country; however, as it stands, it was only explicitly mentioned in seven of the thirteen reports (Brunei Darussalam, Indonesia, Japan, the Republic of Korea, Malaysia, Singapore, Thailand). Older persons with advanced developments of

dementia often require a high intensity of care, which can surpass what families are able to provide by themselves. Support from other actors – be it directly with the provision of care or indirectly through e.g. specific trainings for family care-givers – is crucial.

| The Role of the Government

Due to its influential role and its ability to participate in all aspects – regulation, financing and provision - of older person care in a country, the government as an actor receives special attention. A basic observation is that while the ASEAN+3 governments share similar roles in policy making, regulating/directing, financing/funding, and providing care services to older persons, the degree of involvement in each role varies considerably across countries. While the summary provided in this section is mainly based on the information provided by the country experts in the country reports, two other review documents produced by the Economic and Social Commission for Asia and the Pacific (ESCAP) (2017) and Williamson (2015) are also consulted to comprehensively capture initiatives, legislation, and policies put in place by the government.

National Legislations, Policies and Plans of Action Focused on Older Persons

In terms of policy making, ten countries have overarching national legislation (e.g. law, ordinance, or act) to provide a legal framework for national policies, action plans and programs related to older persons (cf. Table 2). Three

countries, namely Cambodia, Lao PDR and Malaysia, have national policy focused on older persons. Cambodia is the most recent country to launch the national policy on aging (called National Aging Policy (2017-2030)). Ten countries have action plans addressing only older persons. All ASEAN+3 countries, except Brunei Darussalam, have both legal frameworks and implementation plans. For Japan, the Outline of Ageing Society Measures (latest revision in 2012), which was drafted based on the 1995 Aged Society Basic Law, serves as a mid- and long- term guideline to the government. In line with Williamson's study, we found that having a legal document is not associated with the level of economic development, but the current speed of aging population (Williamson, 2015). Myanmar and Cambodia in contrast to Brunei can be taken as examples for this.

Care for older parents is explicitly addressed as legal responsibility of children or/and the family in seven countries: China, Indonesia, Cambodia, Myanmar, the Philippines, Singapore and Vietnam. In China, the Law of the People's Republic of China on Protection of the Rights and Interests of the Elderly (2012 Revision) stipulates the provision of maintenance and support of the elderly by their families. This is similar to Singapore's Maintenance of Parent Act (1996). For Cambodia and the Philippines,

the duty of children to take care of older parents is addressed explicitly in the Constitution.

While health and well-being of older persons is covered by the national legislation/policy/plan of action on aging, eight governments have independent legislation/policy/plan of action specifically addressing older persons and various health related issues, including healthy aging, non-communicable diseases, care support, and financing and access to healthcare. These governments are China, Cambodia, Malaysia, Japan, Republic of Korea, Thailand and Vietnam. While Cambodia's 1999 National Policy on the Health Care for Elderly and Disabled People and Malaysia's 2008 National Health Policy for older persons focus on healthy aging, China's 12th Five Year Plan on Aging focuses on the physical access to health care by addressing the expansion of basic medical services to community-based clinics. This is similar to Malaysia's Action Plan on Health care for the Elderly (2001-2005) which aims to expand scopes of health care service by integrating geriatric care services and extend geriatric services to more hospitals. In the case of Vietnam, the policy covers free health insurance for all older persons, whereas the governments of Japan, Republic of Korea and Thailand have their own policies/plans to address long-term care specifically.

Table 2: National Legislations, Policies and Plans of Action Focused on Older Persons and Health Care Provision to Older Persons; Legal Care Responsibilities of Children.

	Legal document focused on older persons			Legal responsibility of children to care for older parents	Legal document focused on health care provision to older persons		
	Legislation	Policy	Plan of action		Legislation	Policy	Plan of action
BRN			•				
CHN	•		•	•			•
IDN	•		•	•			
JPN	•		•		•		
KHM	•	•		•		•	
KOR	•		•		•		
LAO		•					
MMR	•		•	•			
MYS		•	•			•	•
PHL	•		•	•			
SGP	•		•	•			
THA	•		•				•
VNM	•		•	•	•		

Social and Health Assistances and Services Provided by the Government

Table 3 shows that all 13 countries have different mixtures of old-age financial support schemes arranged by their governments. A public pension scheme is available in all ASEAN+3 countries, whereas financial assistance programs such as cash transfers are provided in nine countries. For Myanmar, the conditional cash transfer to older person scheme implemented in 2015 is just one-

off program, so far handed out to older persons only twice. The first cash transfer of about USD200 was given to all centenarians (100+ years old), while the second transfer was made to all older people age 90 years and above.

Just over half of the 13 countries have implemented a minimum old-age income scheme for older persons. The breadth of schemes varies widely across countries. While Brunei's and Thailand's

schemes are the universal kind, Japan's and the Republic of Korea's are means-tested. For China, the universal old-age allowance is not available nationwide, but in some provinces such as Shaanxi persons age 70+ years and older are eligible for old-age pension.

Community-based support programs are reported to be implemented by the governments of ten countries. The programs are reported to exist only

in some areas in Indonesia. Eight countries report to have a home visit program. Singapore's 2016 Action Plan for Successful Aging addresses explicitly the expansion of home visit programs to minimize social isolation of vulnerable older adults. Publicly owned homes for the aged or shelters do exist in all countries, except Lao PDR and Vietnam. In Vietnam, most of the old-age shelters are run by the private sector or NGOs. There are a few that are managed jointly by the government and NGOs.

Table 3: Types of Assistances and Health Care Services Provided by Governments

	Basic minimum income	Financial assistance schemes	Pension		Community-based support programs	Home visitation program	Home for the Aged
			Public sector	Private sector			
BRN	•	•	•	•	•	•	•
CHN	•*	•	•	•	•		•
IDN	•	•	•	•	•*		•
JPN	•	•	•	•	•	•	•
KHM			•	• •	•		•
KOR	•		•	•	•	•	•
LAO			•	•			
MMR	•	•	•	•		•	•
MYS		•	•	•	•	•	•
PHL		•	•	•	•	•	•
SGP		•	•	•	•	•	•
THA	•	•	•	•	•	•	• •
VNM	•	•	•	•	•		

Note: • denotes information taken from the country reports.

• • denotes information taken from Williamson (2015), * not implemented nationwide.

Insights from Individual Countries that Can Be Useful for Others

Japan and the Republic of Korea have a lot of experience in the implementation of a LTCI system where care is mostly provided through the private sector, and they gained a lot of experience over the years about what works and what does not work well. In the Republic of Korea, for example, the rapid expansion of care infrastructure after the introduction of the LTCI scheme has created an adverse impact on the delivery system and the working conditions of care workers, reflected in low wages and long working hours. This is not, however, reported in the case of Japan because its long-term care insurance system was implemented when care infrastructure was well established at the local level (Lee and Kim, 2013). This can be very useful insight for countries that are contemplating the introduction and implementation of such insurance. Not only the experiences with LTCI in general, but the experiences with leaving the provision of LTC to the private sector can be immensely useful for other countries. Granted, the specific situation is different in every country, but overall lessons learned will be applicable to other contexts as well (keyword: market failure issues).

Thailand is currently experiencing a situation where private LTC providers enter the scene before regulation for institutionalized LTC has been introduced by the respective administrative actors yet. This does not only pose a risk when

it comes to the quality of care provision, but also can cause issues related to financing of LTC by individuals and families. As in any policy area, the introduction of regulations will not be sufficient if the adherence of private care providers is not monitored and no sanctions are applied in cases where regulations are violated.

The clear distinction between health care needs and social care needs becomes particularly crucial once the need for LTC increases markedly due to older adults living longer and longer and with the number of older persons increasing. Singapore is trying to move away from the use of health care institutions in cases where it would be more appropriate to use LTC in the community. Otherwise, health resources are not used appropriately and also inefficiently, meaning that older person care becomes more costly than necessary. This is an issue that other countries are or will be facing as well. In many reports, it becomes clear that health care is still the dominant way of dealing with care needs, since care systems specifically catering to the needs of older adults have not (yet) been set up. The case of Singapore provides a lot of useful insights in how the transition from using predominantly the health system towards providing other means to provide LTC can be accomplished. The bottom line is that if there is no support for LTC needs/ongoing chronic care needs/social care needs, people turn towards and use the health care system in cases that are not acute hospital care situations. This means that acute hospital beds are used in cases where care would better be provided in the community. So, health care and

social care are strongly related and need to be considered jointly when establishing care systems for older persons.

If social care needs are supported at home and/or within the community, “aging in place” is possible and people won’t need institutional care or will require it only at a later stage. This is what for example Singapore is actively trying to support, through measures that explicitly target the older population, but also initiatives and programs that are in line with a life-course approach towards healthy and active aging. The longer that people can maintain their independence and lead a healthy and active life, the shorter will be the period of time that they require more or less intensive care support. Brunei Darussalam has as well a strong investment in health care screening, health promotion and prevention of illness through the state with support from NGOs, also aiming at maintaining older adults’ independence for as long as possible.

Volunteers are an important actor on the community level in many countries. In more instances than not, they receive some kind of care training, be it only initially or also repeatedly while they are volunteering. The concept of volunteer time banks in Japan (*Fureai Kippu* scheme) has been introduced already three decades ago, and experiences have been quite positive. The idea that people provide their time and manpower for social care services when they are younger and receive an equivalent amount of support when they are in need of it is something that could work well also in other contexts.

Policy Recommendations

The recommendations that follow in this section are deliberately kept broad to do justice to countries’ very diverse demographic and socio-economic settings. Individual country recommendations are included by the country experts in each individual country chapter. In order to estimate future care needs (LTC demand) and related expenses, it is more fruitful to categorize people as dependent based on individual characteristics (e.g. ADLs, chronic diseases, a combination of several indicators) instead of using a certain chronological age above which persons are assumed to become independent. Research has shown that individual characteristics are important determinants of health status, and that older persons of the same age can be quite heterogeneous in their care requirements because of this. Estimates of older persons’ care needs will also help in the discussion of which mix of actors might be best suited to provide LTC in the future, what the responsibilities of each actor are, and what kind of support actors can provide to each other. For example, if family caregivers received support from NGOs or the government – be it in the form of care training, in kind or financially – their ability to care for older family members could be crucially enhanced.

An aspect that was mentioned in several countries is the importance of having regulation of the long-term care sector in place in order to ensure quality of care. Such regulation can touch on a range of areas and might vary for

institutionally provided care and home-based care services, as well as between different administrative levels; states might impose specific rules that go beyond national legislation and the other way round. In addition, rules of quality assurance might differ depending on who is the care provider, i.e. whether volunteers or for-profit workers are involved. Besides having regulations and standards, monitoring of compliance and in cases of non-compliance the enforcement of these regulations need to be guaranteed.

The earlier systems like LTC insurance are put into place, i.e. the lower the number of beneficiaries, the lower are the initial costs. This means that also countries with still relatively young populations should consider implementing such systems rather sooner than later in order to not have to shoulder a large burden later on. At the same time, it requires a certain administrative infrastructure to implement such a complex system of contributors and recipients, a prerequisite which might not (yet) be given in every country.

As the subsequent section will show, there were some challenges in preparing the reports for each country due to limited data availability on the topic. The availability differs between countries, and particularly in those countries where no recent data on the living circumstances of older persons in general and care needs and care provision in particular are available, it would be recommended to include questions on such aspects in ongoing or new data collections.

National policy and action plans with respect to health care provision for older persons have become increasingly more complex in terms of technologies, fiscal implication and ethics. The complexity will likely be even higher in the future when younger cohorts with different demographic, economic, social and health characteristics are surviving to older ages and demand for health care services increases. Health service in the future will likely not only come with the potential for living longer and healthier but also high costs of care. For a country to formulate an appropriate health care policy specifically for older persons, it requires not only quantitative data on issues related to health status and health care needs, but also research and reports that document national and international experiences in policy and plans with respect to health service provision to older persons that have been implemented elsewhere. Such documents can help a country in drafting its own policy in the future, and other countries by providing evidence and early indications of emerging health trends to be aware of.

Data Challenges in Performing Research on Older Populations in ASEAN+3

It became clear in the course of this project that the data situation varies greatly between countries when it comes to statistics and information on care needs and care provision. While it is rather thin in some of them, others have a solid statistical base for information on care. Part of the reason for this discrepancy is that those with fewer data are also the ones with the relatively younger

population. Yet, in order to prepare for what's ahead in terms of expected shifts in the population structure also of the currently relatively younger countries, starting to build up a solid data base that includes information on, for example, older person's health status, living arrangements, financial situation, care needs, and the situation of care givers will be to the benefit of those in charge of care planning as well as those who will receive care. One way of achieving this is to have regular surveys that focus explicitly on the older population (50+ or 60+), as Thailand does already. Another or additional approach can be to include questions that address the situation of older persons in general and care needs in particular in other regular surveys, for example socio-economic surveys or even the census.

Table 4 presents different types of surveys that have been conducted in each country since 2000. Censuses were conducted in every country, while Demographic and Health Surveys (DHS) are available for five countries, namely Indonesia, Cambodia, Lao PDR, Philippines and Vietnam. These are countries with relatively low percentages of older persons. Both censuses and DHS collect data on household composition (e.g. the number of household members and their ages), educational attainment of each household member, housing characteristics and ownership of various assets; therefore information on the basic socio-demographic characteristics of older persons and of the households in which they live can be drawn (Teerawichitchainan & Knodel, 2015).

Table 4: Summary of Sources for Data Related to Older Persons, ASEAN+3 Countries, 2000-present

	Year																	
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
BRN		C										C						
CHN	C, LS1		LS1			LS1		CS	CS, LS1, LS2	LS1	C	LS1, LS2	LS1	LS2	CS			CS
IDN	C, LS		D	D			CS	D, CS, LS	LS		C		D		LS	LS		
JPN	C, CS	LS1	LS2	LS1		C	LS1, LS2	LS3		LS1, LS3	C	LS3, LS4	LS2		LS4	C		
KHM	D				CS	D				C	D				D			
KOR	C					C	LS		CS, LS		C, LS	CS	LS		CS, LS	C	C	
LAO						C						D	D			C		
MMR													CS		C			
MYS	C										C							
PHL	C			D				CS	D		C			D				
SGP	C				LS1			LS1	LS1	LS2	C, LS1, LS2	LS1, LS3	LS2					
THA	C		CS1				CS2, CS3	CS1		LS	C	CS1		LS	CS1, LS		CS4	CS1
VNM			D			D	CS1	CS1		C		CS2						

Note: (1) C = Census, D = Demographic and Health Survey, CS = Cross-sectional older Persons Survey, LS = Longitudinal study of Older Persons. For countries with multiple surveys, the numbers attached to the abbreviations indicate different surveys. For the surveys' full title, please consult Table 5.

(2) the DHS presented in this Table include only those undertaken under the DHS program.

Nine out of thirteen countries have comprehensive cross-sectional surveys designed specifically to study their aging populations. Table 5 lists the titles of these existing aging surveys. From the year 2000 until now, Cambodia and Myanmar have had only one cross-sectional survey of this kind, while Indonesia and Vietnam have had two, and China and Thailand have had multiple aging surveys. The minimum age requirement also varies across these surveys. For example, the age requirement for the Cambodian and Myanmar

aging surveys is 60 years and above, while that for Thailand and Vietnam is 50 years and over. All of the cross-sectional aging surveys listed in Table 5 are nationally representative, except two surveys that were carried out by SAGE in collaboration with the INDEPTH Network (in Indonesia and Vietnam, 2006-2007). These two surveys cover only older populations in one demographic surveillance site in Indonesia (namely Purwojero Health and Demographic Surveillance System (HDSS)) and the other in

Vietnam (namely FilaBavi HDSS) (Kowal et al., 2010 cited in Teerawichitchainan & Knodel, 2015).

Out of thirteen countries, six countries (i.e., China, Indonesia, Japan, Republic of Korea, Singapore and Thailand) have had at least one longitudinal/panel survey focusing on older persons. With this type of survey, researchers are able to conduct investigations of the existence of causality between variables of interest. China Health and Retirement Longitudinal Study (CHARLS), Japanese Longitudinal Study of Aging (JSTAR), and Korean Longitudinal Study of Aging (KLoSA) are panel aging surveys conducted in conjunction with the US-based Health and Retirement Study (HRS).¹ Singapore has had two longitudinal surveys of aging covering different geographic sites. The first survey, namely Singaporean Longitudinal Study of Aging (SLAS1), interviewed older persons age 55 years and older who lived in the South-east region. The second survey called SLAS2 recruited the respondents from the South-west and South-central regions (Nyunt et al., 2018). For the Philippines, it is noted that while the ageing survey is referred to as a longitudinal study of ageing there has not yet been any follow-up survey conducted so far (Teerawichitchainan & Knodel, 2015).

While longitudinal/panel surveys of older populations have been increasingly common during the past decade, high costs in terms of time and money, attrition due to loss of participants between successive survey rounds, respondent's fatigue due to long hours of interviews (Comendador & López-Lambas, 2016) as well as complex data structure which makes data collection, manipulation and analysis even more difficult have been recognized. For the ASEAN+3 countries that wish to conduct a longitudinal/panel study of aging in the future, the existing data should be reviewed first in order to assess if additional surveys are really needed given the above constraints. Countries with existing longitudinal surveys that are not designed to study ageing can expand such existing surveys to cover issues related to population aging. Meanwhile, countries without any longitudinal survey but multiple cross-sectional aging surveys may explore some situational trends related to aging from these existing data (Teerawichitchainan & Knodel, 2015). Other surveys that are designed to cover either all or adult population from 15 years old over, for example health and welfare surveys, labor force surveys and socioeconomic surveys, can be useful sources of data on older persons, particularly on consumption, economic activities, income and retirement.

¹ For more information, visit Gateway to Global Aging Data at <https://g2aging.org/>

Table 5: Summary of Available Aging Surveys in ASEAN+3, 2000-present

Country	Symbol in Table 4	Aging surveys
Cambodia (KHM)	CS	Cambodia Elderly Survey, 2004
China (CHN)	CS	Study on Global Ageing and Adult Health (SAGE), 2007-8, 2014, 2017
	LS1	China Health and Retirement Longitudinal Study (CHARLS), 2008, 2011, 2013
	LS2	Chinese Longitudinal Healthy Longevity Survey (CLHLS), 2000, 2002, 2005, 2008-9, 2011-12
Indonesia (IDN)	CS	WHO-INDEPTH SAGE Purworejo HDSS, 2006-2007
	LS	Indonesia Family Life Survey, 2000-2015
Japan (JPN)	CS	Fact-finding Survey on Long-term Care for the Elderly, 2000
	LS1	Nihon University Japanese Longitudinal Study of Aging, 2001, 2003, 2006, 2009
	LS2	National Survey of the Japanese Elderly (NSJE), 2002, 2006, 2012
	LS3	Japanese Study of Aging and Retirement (JSTAR), 2007-2011
	LS4	Longitudinal Survey of Middle-aged and Elderly Persons, 2011-2014
Myanmar (MMR)	CS	Myanmar Aging Survey, 2012
Philippines (PHL)	CS	Philippines Longitudinal Study of Ageing, 2007
Republic of Korea (KOR)	CS	National Survey of Older Koreans (NSOK), 2008-2014
	LS	Korean Longitudinal Study of Aging, 2006-2014
Singapore (SGP)	LS1	Singaporean Longitudinal Study of Ageing (SLAS1), 2004-2015
	LS2	SLAS2, 2009-present
	LS3	Panel on Health and Aging of Singaporean Elderly (PHASE), 2011
Thailand (THA)	CS1	National Survey of Older Persons in Thailand, 2002, 2007, 2011, 2014, 2017
	CS2	Survey of Health Status in Four Regions of Thailand, 2006
	CS3	Survey of Risk Factors for Older Thais, 2006
	CS4	Survey of Population Change and Well-being in the Aging Context, 2016
	LS	Panel Survey and Study on Health, Ageing, and Retirement in Thailand, 2009, 2013-2014
Vietnam (VNM)	CS1	WHO-INDEPTH SAGE FilaBavi HDSS, 2006-2007
	CS2	Vietnam Ageing Survey (VNAS), 2011

Source: Based on Teerawichitchainan & Knodel (2015).

Besides the issue of data availability, another relevant issue raised by the Thai country expert is the fragmentation of aging research. Given the aging research has become more multi- and inter-disciplinary in recent years, there is a potential overlap in research topics as well as geographic areas where the research is conducted. Duplication of work and effort between agencies can also occur. To reduce fragmentation, overlap and duplication, some actions are recommended: (1) analyzing the existing aging research, (2) synthesizing what is known so far, (3) identifying new research areas, and (4) monitoring the progress in addressing those new areas.

Noticeable Similarities and Differences

Given the different stages of economic development and population aging that ASEAN+3 countries find themselves in (see the introductory chapter for details), it is not surprising that the set-up of older person care and the distribution of responsibilities of the involved actors differs vastly across countries. While the family is still the most important provider of care in each of the thirteen countries, the ability as well as the sense of obligation (keyword: filial duty) to do so seem to be declining. Female family members are still the predominant care providers within the family. While this is true in every country in this study, there are noticeable differences across countries. The share of male care-providers has been increasing significantly particularly in Japan and Singapore. In order to support family care givers in their care duties, a few countries suggested or already introduced measures to reduce the

physical and mental stress that can be associated with providing care.

With family sizes declining due to past and/or ongoing reductions in fertility, there are fewer younger family members that are potentially able to provide care. Also, with adult children often migrating to urban areas or even other countries for economic reasons, the number of potential care givers is reduced further, and formal and informal (non-family) care givers are in demand to provide necessary care to those in need. In those instances where older persons do not have any family or have been abandoned, shelters that provide for basic needs exist in several countries. Old-age poverty – in particular of those who are without family – is an issue in several settings and various mechanisms to provide financial, in kind and emotional support for those in need have been introduced or are being discussed.

The share and absolute number of older persons who live alone is increasing. This phenomenon of one-person-households that consist of an older person is already much more prominent in countries with an on average older population. This requires solutions from the community or the government to provide care, should the need arise, particularly in situations where no family members are living close by. It depends on the country-specific setting whether care needs for single-person households are easier to accommodate in the city or in rural areas.

A development that seems to be uniform across countries is that investments and developments

in the health care system happen at an earlier stage and consideration and implementation of a care system for older persons follows. This sequence is rational, since developments in the health care system are more basic and usually happen when the share of the older population is still relatively low. What differs is in how far the inclusion of the older population is of an explicit concern in the set-up of the health care system. Expenses for health care are mentioned as a crucial issue for older adults in several countries, and the situation is more favorable in those countries where older persons have access to health insurance/free health care and where copayments are low.

Care needs differ by severity of care support that is necessary. Several countries define long-term care needs as care needs that require support with activities of daily living. This support is often provided informally by family members; when it is institutionalized, it can be in day-care centers or in institutions where older persons reside permanently. These institutional provisions can be predominantly publicly run – as in e.g. Japan and Thailand – or run by private companies – as in e.g. the Republic of Korea and Singapore. In Malaysia, for-profit and not-for-profit long-term care providers both play an important role when it comes to providing care that goes beyond what family members can provide.

Japan and the Republic of Korea are the only countries among the 13 countries that are part of this report that have introduced long-term care insurance (LTCI); Japan in 2000 and Korea in

2008. Their experiences differ, not least due to the fact that LTC is mostly provided by the private sector in Korea, while there is a mix between public and private providers of LTC in Japan.

In countries with a shortage of local care-givers – for example in Singapore, Japan and Thailand – foreign domestic workers that work as caregivers are playing an increasingly important role. What varies is the degree of previous experience and/or formal training of these foreign care-givers, and whether those with low levels of skills are receiving training in the destination country. In the case of Japan, extensive language and skill training is required and provided, whereas the overall situation is less supportive in Thailand. Needless to say, whether hiring foreign domestic workers is a possibility depends on the financial background of families and is not a universal option.

Most countries are facing the challenge that care needs and care provision differ between urban and rural areas. In some instances, care provisions by the state or the private sector are concentrated in a few urban centers, while the community as care provider is more active in rural areas. Since the socio-economic situation of older adults varies between urban and rural settlements, the solutions to provide care for an increasing number of older persons in both contexts will likely not be the same. One central aspect of this urban/rural discrepancy is the fact that adult children often leave rural areas in order to attend education and/or find employment in cities, meaning that older adults might be left with only one or no adult child that lives in the same household or close-by.

It is expected that dementia will become a disease that will play an important role for care provision in each country; however, as it stands, it was only explicitly mentioned in seven of the thirteen reports (Brunei Darussalam, Indonesia, Japan, the Republic of Korea, Malaysia, Singapore, Thailand). Older persons with advanced developments of dementia often require a high intensity of care, which can surpass what families are able to provide by themselves. Support from other actors – be it directly with the provision of care or indirectly through e.g. specific trainings for family care-givers – is crucial.

Abuse of older persons in the context of care can have many forms and can happen at home as well as in various kinds of institutions. The topic of abuse through family members or other care

providers was mentioned in the reports for Cambodia, the Philippines, Singapore and Thailand. Issues that were raised were the existence or need for the introduction of regulations to prevent abuse, procedures how to deal with cases of abuse, how to raise awareness of elderly abuse itself, and the need to collect data on the topic.

Assistive devices were explicitly mentioned by the country experts of Malaysia, the Philippines, Singapore and Thailand. Such devices can contribute to the quality of life of older persons and increase their level of independence. Depending on country-specific regulations, there can be financial or in-kind support in the acquisition of such devices.



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