Care in Old Age in Southeast Asia and China

SITUATIONAL ANALYSIS

Contents

1. Key messages

- **Demographic changes are likely to exert unprecedented demand on care and health services for older people.Changing family structures, labour force migration and increased female participation in the workforce are contributing to a decline in the availability of family-based care.**

- **Poverty is the most significant issue for older people in the region; without access to pensions or free health care, many cannot afford the services they need.**

- **There are gaps in care for older people in the region. Lack of adequate social support is more prevalent than care gaps.**

- **While the greatest relative care need is among the oldest old, the greatest absolute care need is in the 70 to 79 age group.**

- **The care gap in China is more than three times the size of that in all the other countries put together.**

- **The mental health and emotional issues that can be experienced by older people are stigmatised and poorly understood.**

- **Carers receive little support in material or emotional terms; the lack of support and knowledge, as well as poverty, can lead to elder abuse.**

- **Community-based care models could provide not only care and health services to the rural and isolated older population, but could also provide the social networks they and their carers need.**

- **Volunteerism in older people could increase their own wellbeing and contribute to the expansion of services.**

- **Further development of community-based care models should make good use of existing structures and institutions, including older people's groups and religious centres.**

- **Cascade models could be used to foster social networks and engagement in carers and older people by providing training and education.**

- **Training for volunteers and carers would be a good investment for local and national government, and would ensure consistent quality of care.**

- **A cost-benefit analysis of community-based care models could help to make the case for further public investment.**

- **Governments need to share knowledge from replicable practice and policy, and to develop comparable data collection mechanisms, to ensure that the region as a whole benefits.**

2. Executive summary

2.1 Project overview

The objectives of this project are twofold: to develop a typology of care in South East Asia and China based on the use and currency of available terms; and to evaluate the current state of care provision in the region. The 14 countries under consideration are Brunei, Cambodia, China, East Timor, Indonesia, Japan, Korea, Laos, Malaysia, Myanmar, the Philippines, Singapore, Thailand and Vietnam.

This report is intended to provide stakeholders in the care sector with information and recommendations regarding the provision of care; these stakeholders may include NGOs, care providers and policy makers. The conclusions reached in this report are evidence-based; it should be noted, however, that the diversity of countries in the region and the breadth of care provision mean that any research conducted on the topic will not be wholly conclusive.

2.2 Recommended terminology

The recommended terms with most currency and most widespread (and appropriate usage) include:

Category	Recommended terminology
Care in old age	"Eldercare" or "senior care"
Older people	"Older people" or "seniors"
Family or home-based care	"Family care" or "home care"
Community-based care	"Community care" or "community-based care", with specific applications (for example "community-based home care") made clear
Institution-based care	Terms relevant to the specific institution or "residential care"

2.3 Situational analysis

The two most significant issues that will have an impact on the provision of care in the future are demographic changes and financial access. Between now and 2050, the dramatically ageing population will place unprecedented demand on care and health services; countries are unlikely to be in a position to meet these needs without early and significant investment in infrastructure and services. The lack of universal pension provision in most countries in the region, and the lack of free universal health care for older people, is likely to create a situation in which older people simply cannot afford to access the services they require. Labour force migration to urban centres, of which many younger people are a part, will also create a further financial impact on older parents and relatives with the removal of family-based care as an option.

Older people are not being consulted as to the care they need and want, which is partly contributing to significant gaps in care provision. The biggest care-related gap for older people is not care per se, but a lack of social support. The group for whom this is the biggest issue is older people aged 70 to 79, possibly because they are larger in number than the 80 plus age group but less mobile and connected than the 60 to 69 age group. Many carers fail to understand the basic needs of their older relatives and many lack the support structures and training they need. The development of community-based care is potentially a solution to several issues. As a communication centre for health and care information, community centres will provide significant benefits; community groups and networks can provide support for older people and carers; and community care facilities can ensure that services are received by the most isolated and rural of older people.

There are more older women than there are older men, and they face a particular set of challenges. Less frequent workforce participation means that financial stability is less certain in later life and access to pensions is limited. The biggest health risk for older women is poverty. Loneliness is also a key factor due to a high rate of widowhood in later life. While there are predominantly more older women in later life with longer life expectancies, care must be taken that research around older people's needs is relevant to both genders.

The increased longevity of older people, and their longer working lives, may prove to be beneficial to governments in financial and resource terms, however. By providing more flexible working opportunities in later life, as well as by encouraging volunteering activity in older people, policy makers may create a situation where older people are more active in the community, more valued, and build stronger support networks. In return, governments can fill significant resource gaps in community-based care.

2.4 Recommendations for the development of community-based care models

Community holistic care

- The model of providing care within and by the community is likely to increase the wellbeing of older people, who can stay at home, and also relieve the pressure on institutional services.

- Close cooperation is needed between community groups, policymakers and service users to ensure that the provision meets requirements across the continuum of care.

- Investment in community infrastructure, such as village centres, may be needed to ensure that services are delivered safely.

Working with and supporting existing family carers

- Carer support is vital and their needs are a significant unmet gap; training and support for caregivers should be prioritised. HelpAge could consider building in the support of carers to its volunteering models. This could be through training volunteers in carer support or through providing training sessions directly to family carers.

- Establishing carer support groups based at local community centres or religious institutions is also recommended.

Social support and mental health services

- This research has demonstrated that the biggest care-related need of older people in the region is in social support. This should be a key focus of any new community-based models of care.

- Strategies for social support might include basing care services at a local community or religious centre (see below under working with existing structures) in order to encourage interaction, with home-based services only provided in exceptional circumstances; and providing transport assistance to older people who might otherwise struggle to get there.

- Also worth considering in the development of any model is the provision of (a) awareness raising activities around mental health and (b) training in mental health support. It was apparent during the research that there is stigma attached to mental health problems, both for older people and for their caregivers. Better understanding of the issues may reduce stigma and thereby increase the quality of care and support available.

Target groups and communities

- While the greatest relative need is in the 80 and above age range, the greatest absolute care need is in the 70 to 79 age range; this group should be prioritised.

- Other priority groups include older people living in poorer communities and older carers.

- The country with the largest combined absolute and relative care gap is China. When deciding where to base any initial follow-ons to ROK-ASEAN, HelpAge should consider this, and balance it against the need to pilot any revised models in areas in which its networks and local links are strongest, and where there are good levels of existing structures such as older people's groups.

Information services and positioning

- Older people need to remain fully apprised of key risks to their health. Updated information will also require communication to, and training of, health workers in community care.

- Community-based care schemes may need to be presented clearly as being complementary to family-based care, and not as something which in any way suggests that family care is inadequate or insufficient, in order to prevent possible stigma.

- HelpAge could also consider disseminating preventative information and advice, aimed at younger age groups, through existing local structures.

Planning

- Planning should incorporate how to access the hard to reach – people who may not wish to ask for help, or those who live with family who are unable or unwilling to care for them.

- Care support needs to be tailored according to local circumstances; for example greater levels of support should be factored into care plans for poorer areas. Equally, other services should be planned according to local context: for example, a much greater focus on social support in the Philippines than in Laos. The complexities of both gender and family dynamics also need to be taken into account when planning local projects and services.

Working with existing structures

- There is a strong and growing network of older people's groups in the region. One of the limitations of ROK-ASEAN is its reach; local projects have been relatively small scale. Working with existing structures such as older people's groups and self-help clubs could help to extend the reach of community-based care services.

- As with volunteer training, this could be approached using a cascade model – training national NGOs with local or regional offices to work with older people's groups to deliver the model.

- The high rate of religious adherence in the region may prove valuable in terms of disseminating health and care information. Religious venues may also serve as venues of care.

Increased use of technology

- Care and health providers can use technology to provide care, support and diagnostic services efficiently and cheaply. This is likely to be a growing trend as regional coverage grows; services could be piloted in countries in which technological uptake is already considerable, such as Korea or Japan.

Training

- Using "train the trainer" courses, NGOs can be equipped to deliver training to carers and families, sharing best practice and providing information on care techniques and support.

- NGOs can also foster social networks and engagement in older people by providing training and education.

- Health education courses and material, delivered through community centres, may help to raise awareness of health issues.

Finances

- Delivery costs could be met in part by income-generating activities through self-help groups, for example through sale of crafts, thereby promoting activity (and reducing future costs of care) among older people.

- A detailed cost-benefit analysis of community-based care models would provide a case for investment and can be presented to governments.

3. Method

A search strategy was developed at the project's inception, which:

- Defined the search terms.

- Set search strings.

- Set the sources, including academic reports, university publications, government reports, other grey literature, news reports and project/programme websites.

- Defined the criteria on which information would be included or excluded, including quality, language, date and level of source (e.g. international agency sources for statistics).

A literature review on terms relating to care and ageing was delivered first. This was used to develop the typology of care, and also to help inform the rest of the project. The literature review was also informed by a number of regional experts on care and ageing, who advised on use and local interpretation of relevant terms.

The next stage encompassed a mapping exercise of relevant policies, programmes and services relating to care and ageing. There were two parts to the maps:

- A map of public policies and care services in the region.

- A map of community-based age care services and projects delivered by civil society organisations in the region.

The literature review and the maps, together with a data review and a further extensive search, were used to inform the situational analysis. The situational analysis covered demographic, epidemiological, social and economic trends, which combined a qualitative analysis with an analysis of international data and forecasts to 2050.

Original data came from a number of sources, including the United Nations, World Health Organization and World Bank. They were linked as part of the analysis; for example, the proportion of older people experiencing a care gap (source: WHO World Health Survey) was applied to the total number of older people (source: UN Population Prospects). The 14 countries were grouped into three income bands for the purposes of missing data; where data was missing for individual countries on certain indicators, an average of data for that country's income group was used.

Care gaps were forecast by applying the current estimated proportion of older people experiencing a care gap to UN projections for numbers of older people in 2050 in each of the countries in question. These were increased by 20 per cent and 40 per cent respectively for medium and high change scenarios, on the basis that the proportion needing care is likely to increase due to external pressures (older people living longer, fewer adult children to care for them, migration, and so on).

The situational analysis was used to draw out policy implications, together with recommendations for policy and practice. Recommendations focused on aspects such as long-term policy approaches, provision (approaches and focus) and financing. Recommendations were developed at a country level and a regional level; recommendations for HelpAge included practical steps about how to use the report's findings most effectively, together with suggested areas for future research.

Limitations of the research include its scope and scale; the volume of information available to feed into the project, set against its scope, mean that some key information will inevitably have been missed. Calculations and projections provide a best estimate only; limitations include the use of proxies and the use of averages to account for missing data.

4. Overview and typology of care within Southeast Asia and China

Different perspectives on, and understanding of, terms and services can create conflict between service users, carers, policy makers and other interested parties[1]. The terms outlined are intended to inform the development of a conceptual framework to assist people working in care for older people in the Southeast Asia and China region.

4.1 Typology of care

Figure 1: Dimensions of care
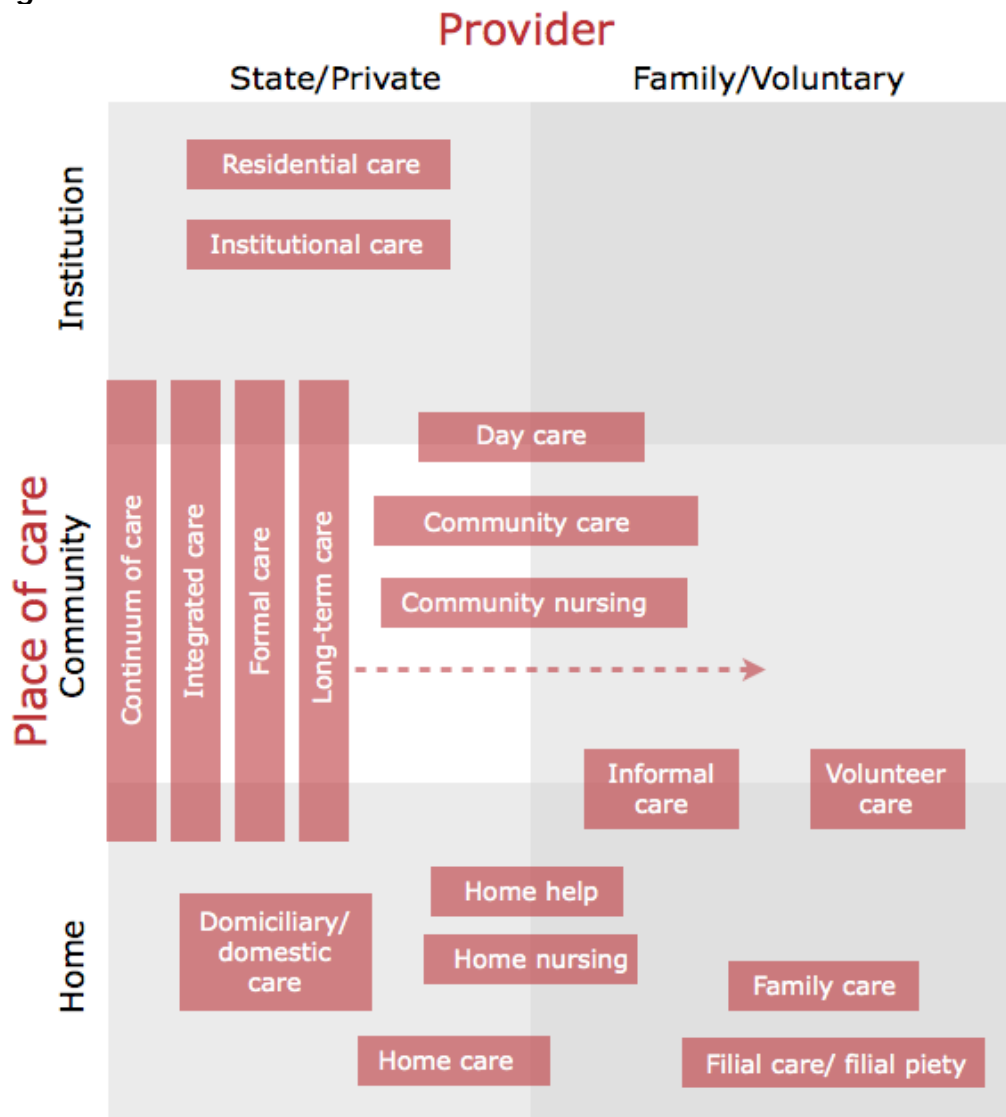
The typology has a particular focus on social care from the perspective of care in old age.[2] Such a typology could potentially encompass hundreds of terms, from the general (for

---

[1] See, for example, Waine B et al, *Developing social care: values and principles,* Social Care Institute for Excellence, 2005, p.1

[2] Successful ageing assumes minimising the risk of disease and disability (as enabled through health care), continuing engagement with life (as enabled through social care) and income security or economic care; it also implies maintaining physical and mental function, which are supported by both health care and social care (source: Rowe and Kahn, cited in Kahn R, Successful aging: myth or reality? *The 2004 Leon and Josephine Winkelman Lecture*, Michigan, University of Michigan School of Social Work, 2004, p.2; and expert input from Dr GiangThanh Long, 28 May 2013).

example, informal care) to the highly specific (for example, ambulatory care). Given the nature of the project and the need to keep the eventual typology at a relatively high level, this review focuses on general terms; the typology also excludes terms, which are too broad for useful conceptual distinction, such as "care" and "social care". It also focuses on social care rather than medical care. Due to the breadth and complexities of terminology related to care, it is worth noting that this typology, unlike most typologies, is two-dimensional.

Place of care: institution | provider: state/private
Residential care | Institutional care

"Residential care" and "institutional care" both refer to care provided within an institutional setting, usually a nursing home or care home and, less commonly, a hospital. The implication is that care is long-term. Residential care is more common throughout Southeast Asia and China.

In literature focused on Asia, there is also a trend towards describing the kind of institution providing long-term care, for example, "nursing home" or "care home", in contrast to the type of care provided. This may be a result of the fragmented nature of institutional care provision.

Integrated care

According to the World Health Organization, "integrated care" is "a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve the services in relation to access, quality, user satisfaction and efficiency".[3] This term has shifting meanings according to national and regional contexts.

Formal care

"Formal care" is care and assistanceas delivered by trained professionals and institutions. Usage of this term in the region is infrequent.

Long-term care

The definition of "long-term care" is not concerned with the type of provision or the provider of care; rather, it is concerned with the fact that the care requirement is indefinite in terms of time, and can cover a range of different types of care and support. According to the United Nations, "long-term care" is "material, instrumental and emotional support provided formally or informally over an extended period to people in need, regardless of age".

Provision of long-term care in Asia is increasingly in demand, but supply is limited. In Thailand, the comprehensive long-term care (LTC) model includes both institutional (day care, respite care, day hospital, residential home, nursing home, long-stay facility) and non-institutional (home services, home modification, home nursing, home and community health services) services. At present, however, while there is free universal health care for older people, LTC and rehabilitation services are not included.

While HelpAge's experience is that this term is increasingly popular in policy circles, Google books *Ngram* viewer shows the term being used consistently throughout the 1990s, and declining very slightly in usage throughout the 2000s. A 2003 book looking at culture change in long-term care found that the term "carries with it considerable baggage and immediately focuses on services, often those provided in a nursing home, rather than on needs" (Weiner et al, 2003). In a policy context, the term may be popular due to its use by organisations such as the World Bank and United Nations. It has also entered the popular vernacular through being part of the name for Japan's social insurance programme for older people; this programme is cited often in policy discussions of financial mechanisms for supporting care.

Continuum of care

The "continuum of care" refers to people's overarching care needs, which may change depending on circumstance. The continuum can run not only between different care levels, but between different caregivers (see Figure 1: Dimensions of care and Figure 4: Continuum of care.

---

[3]WHO European Office for Integrated Health Care Services. Integrated Care Working Definition, 2001

Place of care: institution | provider: family/voluntary

Day care

See below under "locus of care: community | provider: state/private".

Place of care: community | provider: state/private

Day care

"Day care" implies short-term care, usually offered to enable older people to remain in their homes while still receiving external care support. Occasionally day care may be offered as respite care, or to give family carers time off from caring duties; this is still relatively rare in an Asian context, however.

Community care

"Community care" is defined by the WHO as "services and support to help people with care needs to live as independently as possible in their communities".[4] The definition of "community" varies and understanding of it varies. It may refer to recipients' immediate locality, but as the effects of distance are minimised through increasing use of technology and ease of travel, traditional conceptions are starting to change. "Community-based care" is also used frequently.

Community nursing

"Community nursing" implies greater professionalisation than "home nursing"; it suggests carewhich is given by a group of suitably qualified practitioners. It includes nurses who work in industry, public health, schools and other community-based organisations such as community clinics.

Place of care: community | provider: family/voluntary

Informal care

"Informal care" is care and assistance provided by family, friends and neighbours. Usage of this term in the region is infrequent. Key conceptual issues include the difficulty of defining, measuring and assessing the value of informal care, and the risk that measuring its value in comparison to formal care leads to the two being treated as substitutable.

Volunteer care

"Voluntary" or "volunteer care" has minimal use in Southeast Asia and China. Where used, it tends to refer to care given by voluntary sector organisations rather than by individual volunteers.

Day care | Community care | Community nursing

See above under "locus of care: community | provider: state/private".

Place of care: home | provider: state/private

Domiciliary/domestic care

"Domiciliary"and "domestic care" tend to imply non-professional care which is paid for by the individuals concerned. "Domestic care" can also refer to other home-based care activities such as paid-for childcare. Neither term is used frequently in the region with regards to care in old age.

Home care

"Home care" generally refers to professional or formal services that assist older people in the tasks of daily life, allowing them to remain in their homes. The discussion of home care service focuses on formal home care provision; occasionally, however, this provision can be informal.

---

[4] WHO Centre for Health Development, *A glossary of terms for community health care and services for older persons: ageing and health technical report volume 5,* World Health Organization, 2004, p.16

Home help

Despite its regional prevalence in every day usage, the term "home help" largely seems to have been replaced with "home care" in academic literature. "Home help", however, tends to imply less formal training than "home care". "Home-based care" is also used frequently.

Home nursing

As with "home help", "home nursing" implies care delivered without any formal nursing or care training, although occasionally regional sources imply a professional status. Greater medicalisation is implied by the terms "home health nursing" and "home health care nursing", which are understood as the delivery of professional nursing care services in the home.

Place of care: home | provider: family/voluntary
Family care

"Family care" refers to the informal care of older people by close relatives, usually a spouse or adult child. It may include personal, social, health and financial support and usually occurs over a prolonged period of time.The term "family care" is widely used in policy documents and other literature relating to the region.

Filial care/filial piety

"Family care", "filial care" and "filial piety"are often used interchangeably in reports relatingto China and Southeast Asia. It should be noted, however, that "filial piety" in particular carries connotations of a specific moral obligation absent from the more descriptive term "family care".

Informal care | Volunteer care

See above under "locus of care: community | provider: family/voluntary".

Home care | Home nursing | Home help

See above under "locus of care: home | provider: state/private".

4.2 Ageing terminology

Category	Terms Considered
Terms relating to older people	Old age; Older people; Older persons; Older adults; the Elderly; Elders; Seniors; Senior citizens; Ageing in place
Terms relating to older people's care	Eldercare/Elder care; Elderly care; Care of/for older people; Senior care; Old age care

Terms referring to older people

Figure 2: Regional usage[5]
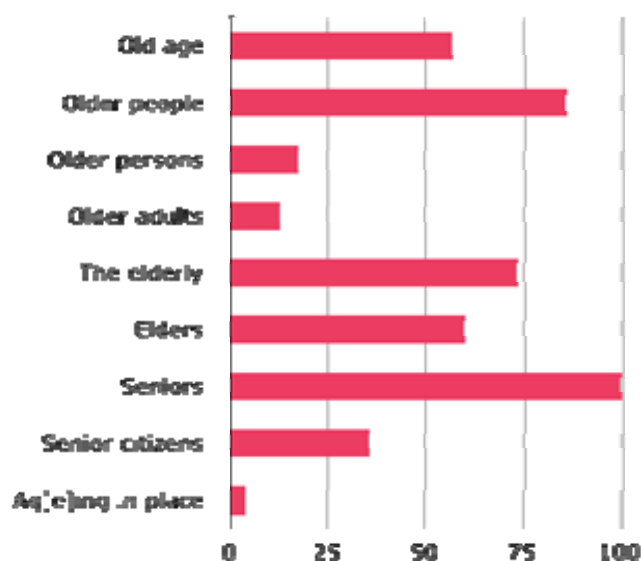
Old age

Current usage of this term tends to be in conjunction with other terms to refer to specific services, for example "old-age support" and "old-age security".

Older people

Academics tend to prefer the term "older people" to most alternatives. It is also popular in Asia, although its frequency of use at a regional level is influenced heavily by its popularity in China. In Cambodia, the term "older people" might be contentious if it is confused with the Khmer Rouge's designation of "new people" and "old people".

Older persons

The term "older persons" was adopted in 1995 by the United Nations Committee on Economic Social and Cultural Rights. It has become a preferred term by many medical academics. It is used infrequently in Southeast Asia and China.

Older adults

"Older adults" is sometimes used interchangeably with "older people"; again, it is used infrequently in the region.

The elderly

This term is used frequently in Southeast Asia and China, considerably more so than its less controversial counterpart "older people". Fears have been expressed – generally not in the region itself – that the word implies frailty and presents a negative stereotype of old age.

Elders

The term "elders" is associated with respect and a positive attitude towards older people; its use in religion and in relation to specific ethnic groups can be confusing, however.
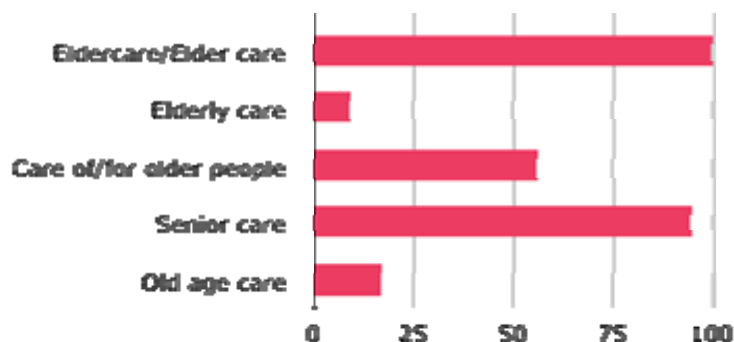
Seniors | Senior citizens

Use of both terms is common across the region. They imply both status and respect.

Terms relating to older people's care
### Figure 3: Regional usage[6]

There are multiple terms available to describe the care of older people. The terms in the graph above have been selected for inclusion based upon popular regional terms relating to ageing. "Eldercare"/"elder care" and "senior care" are the most popular regional terms.

4.3 Discussion of concepts

Culture is an important determinant of the types of care received by older people. Older people tend to receive more care from their children in cultures that place greater emphasis on family. Family care is lower in countries with stronger welfare states, but in these countries, older people receive more help with household and paperwork tasks. Societal determinants tend to have a greater influence on the use of formal care than on informal care.[7]The application of the concept of "primary responsibility" varies across countries; responsibility may lie with the individual, the nuclear family or the extended family. In Europe, this has been defined as the Scandinavian model (individual responsibility), the Continental model (responsibility of the nuclear family) and the Mediterranean model (responsibility of the extended family).[8]

Figure 4: Care services and placement on continuum of care/long-term care[9]
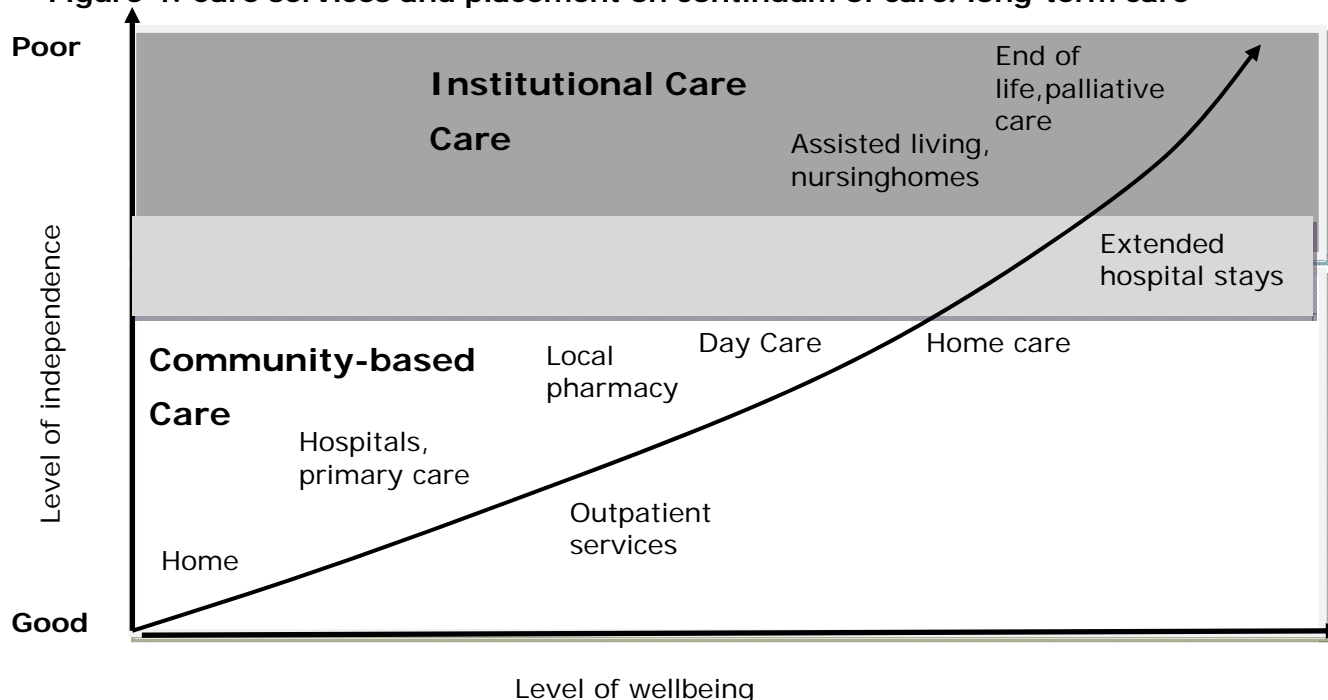
[6] See footnote 4.
[7]Suanet B et al, "Informal and formal home-case use among older adults in Europe: can cross-national differences be explained by societal context and composition?", *Ageing & Society*, 2011, pp.1-25
[8]Jehoel-Gijsbers G et al, *Social exclusion of the elderly: a comparative study of EU member states,* Brussels, CEPS, 2008, p.12
[9] Framework developed by Nancy Johnston, HelpAge International

The continuum of carecan be used as a way of viewing the path between different care settings. This is shown in the diagram above. The "care diamond" is another conceptual way of viewing the provision of care, involving the family or household, markets, the public sector and the not-for-profit sector.[10] In the case of Japan, a UN paper has examined the influence of the policy context on the care diamond, finding that underlying government motivations for cutting the fiscal outlay for the care of older people has led to an emphasis on home-based solutions.[11]

An alternative way of conceptualising care is through the Kaiser Triangle (see below), which depicts three levels of care ranging from requiring a high proportion of self care (most people with long-term conditions) through to requiring a high proportion of professional care (high risk cases).

Figure 5: Kaiser triangle
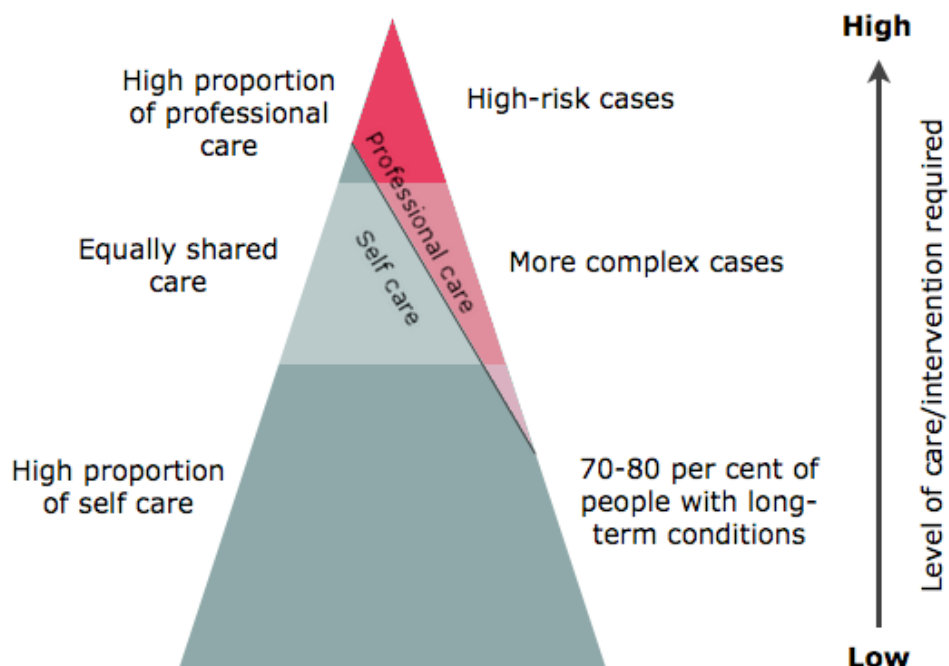
Models of collaboration between social care and health care professionals are in their infancy; the evidence base in this area is weak.[12] The medical model of disability is based on the premise that illness or disability is the result of an individual's physical condition. The social model, created by disabled people, holds that disability is the result of societal failure to take into consideration individual differences. The WHO adheres to the medical model, and states that disability is "any restriction or lack, resulting from an impairment, of ability to perform any activity in the manner or within the range considered normal for a human being".[13] The Scottish Accessible Information Forum describes the social model of disability as follows: "people with impairments are disabled by the fact that they are excluded from participation within the mainstream of society as a result of physical, organisational and attitudinal barriers".[14]

---

[10]Razavi S, "The political and social economy of care in a development context: conceptual issues, research questions and policy options", Gender and Development Programme Paper Number 3, United Nations Research Institute for Social Development, 2007

[11] Abe A, "The changing shape of the care diamond: the case of child and elderly care in Japan", Gender and Development Programme Paper Number 9,United Nations Research Institute for Social Development, 2010

[12] Meads G et al,*The case for interprofessional collaboration in health and social care,* Oxford, Blackwell Publishing, 2005, p.5

[13] World Health Organization, *International classification of impairments, disabilities, and handicaps: a manual relating to the consequences of disease*, Geneva, World Health Organization, 1980

[14] Carson G, "The social model of disability", The Scottish Accessible Information Forum, 2009, http://www.ukdpc.net/site/images/library/Social%20Model%20of%20Disability2.pdf p.11 (1 May 2013)

The World Health Organization developed a glossary of terms for community health care and services for older persons, as part of which it identified a number of key concepts and principles, including the rights of older people; a life-course perspective viewing health in old age in the context of previous access to resources; and healthy ageing.[15] "Independence" and "participation" are both enshrined in the United Nations Principles for Older Persons; the latter states that "older persons should remain integrated into community life and participate actively in the formulation of policies affecting their well-being".[16]

4.4 Recommended terminology

This section makes recommendations as to the most appropriate terms and concepts for HelpAge to use in its work in the region. The selection has been based on accuracy, relevance to and resonance with partners and target audiences, and alignment with HelpAge's goals and values.

Conceptual framework

It is recommended that terms are viewed within the framework developed for the typology; that is, along the following dimensions:

- Locus of care: institution, community or home

- Provider of care: state/private or voluntary/family

Splitting the provider of care down further into four categories (state, private, voluntary, family) leads to a high degree of overlap and makes it more difficult to view terms in light of how they link to other concepts.

Terminology

The following section includes the top two terms per category that have the most resonance, accuracy and relevance to the work of HelpAge, apart from cases in which only one term is felt to be appropriate. Within each category, the terms are ranked in order, with the first term as the preferred recommended term and the second as an alternate, valid option; the pros and cons of each term are also considered.

Care in old age

"Eldercare" is the preferred recommended term to denote care in old age; the benefits of the term are the implications of respect and tradition, and its clarity of meaning. The term may prove challenging in search terms, however, until it is more firmly established in usage.

Exclusions include "care of older people" and "old age care", partly due to lesser use and partly because they are less simple in their construction.

Term	Pros of usage	Cons of usage

---

[15] WHO Centre for Health Development, pp.3-5

[16] United Nations Economic and Social Commission for Asia and the Pacific, The United Nations Principles for Older Persons, http://www.unescap.org/ageing/res/principl.htm (18 April 2013)

1. Eldercare	• Popular and recognised throughout the region. • It incorporates the positive connotations attached to the term "elder" without risking confusion with religion or ethnicity, as it has "care" attached. • The term is simple and clear in meaning.	• Terms relating to older people (for example "elder", "older people", "elderly") are not independent of the word, meaning that people searching for relevant documents/projects may not find them if they are not familiar with the term. • The term is used infrequently in China and Cambodia.
2. Senior care	• Also popular throughout the region. • The term "senior" is independent of "care", meaning that it should come up in more searches of people looking for relevant documents or projects.	• It is recognised, but used less frequently, in Malaysia, Myanmar and the Philippines.

Older people

"Older people" is the most logical and apt term for usage in this category; it is already used by HelpAge and has strong currency. While it may have less frequent usage than "seniors" in the region, its strong resonance outside the region, and similarity to UN terminology, is a mitigating factor.

"Elderly" as a term is recognised widely throughout the region. It has been excluded from the recommended terms above due to wider concerns outside the region about its association with frailty. It may nevertheless be a useful term for informal conversations with local partners about care in old age, due to its popularity and recognition.

Term	Pros of usage	Cons of usage
1. Older people	• It is already used by HelpAge and therefore has currency among its staff and partners. • The term is relatively popular in the region (second after "seniors"). • It would fit well with HelpAge's work outside the region; it also has similarity to the UN's agreed term of "older adults".	• Its popularity within the region is weighted heavily by the frequency with which it is used in China; all countries use it, but – other than China and Brunei – it is considerably less used than the alternative "seniors".
2. Seniors	• It is the most popular term to describe older people in the region, and is also the most popular term in all countries other than China and Vietnam. • Its use denotes respect.	• It may lack currency outside Southeast Asia, China and North America, limiting its use as an international term. • Its popularity may not entirely be down to its use to denote older people (for example, seniors as an educational term).

Terms to denote family- and home-based care

"Family care" is the most appropriate term to denote care received at home and by the family; it has less moral implication and greater country coverage than "filial piety", yet still conveys the familial context. It is recommended that it is used alongside "home care".

In discussions of formal home-based care, we recommend the term "home care".

Term	Pros of usage	Cons of usage
1. Family care	• The term is widely used and its meaning is clear. • The family as an institution is of critical importance in most Southeast Asian and Chinese communities. This term is therefore central to discussions of home-based care.	• It does not have wider application in terms of including non-family home care providers. We therefore suggest that it is used alongside, rather than instead of, home care.
2. Filial piety	• Filial piety is the key value informing family-based care in several countries within the region. It is used in preference to filial care. • It is widely used and understood.	• Filial piety is not a value central to all countries across the region. • It implies a moral obligation which is not always present in family-based care.

Terms to denote community-based care

Possible terms are limited to "community care" and "community-based care", both of which are popular and which can be used interchangeably. There is a risk that their broad usage has turned them into general terms, however, which may lack meaning; it is recommended that more specific terms are incorporated into the general term in order to pinpoint meaning, for example "community long-term care".

Terms used to denote institution-based care

Institution-specific terms such as "nursing home" are recommended above the more general usage of "residential care"; the latter term, when used generally, can lack the specificity of institution and the type of care provided.

Term	Pros of usage	Cons of usage
1. Terms relevant to the specific institution, e.g. nursing home	• The fragmentary nature of institution-based care in the region means that it is often more effective to refer to particular types of institution, rather than care in general.	• It prevents discussion of institution-based care in general terms.
2. Residential care	• It is used more frequently than institutional care and is the most accurate general term to reflect institution-based care.	• Residential care is unusual, and therefore has not developed fully as a recognised concept within the region.

Notes on general care terms

We recommend avoiding the terms "formal care" and "informal care". They are not widely used or recognised.

5. Situational analysis

Analysis of the current situation and the implications for the provision of care in the region has been developed by outlining the current context in terms of trends and demographics; by considering different approaches to care; and determining the areas requiring consideration and development.

5.1 The context

While this section provides an overview of the most recent prominent contextual trends influencing care and ageing in the region, it must be noted that there is a high level of diversity both between and within countries. This analysis is intended to be indicative, not fully representative.

Influences on increasing demand for care
Figure 6: Life expectancy at birth, current and projected[17]

2010-2015	
2045-2050	

Between now and 2050 across Asia, it is likely that:[18]

• More older people will be in the oldest age groups;

• Most older people will be women;

• Proportionately fewer older people will be widowed within each age cohort as life expectancies rise;

• They will have fewer adult children to care for them.

Although populations are ageing across the region, some are making the transition more quickly than others, meaning that they are likely to have to deal with the challenges of old age while remaining at low income levels. Other challenges include the changing structure of family and the possibility of unhealthy aging.[19]

Fluctuating birth and death rates are largely behind the demographic changes that countries in Southeast Asia and China are due to experience between now and 2050. According to one study, "with fertility and mortality rates stabilizing at low levels, the changes in the age

---

[17] UN Population Prospects, 2010 Revision, Medium Variant
[18] Asia's Aging Population, http://sites.asiasociety.org/asia21summit/wp-content/uploads/2010/11/Asias-Aging-Population-East-West-Center1.pdf (7 May 2013)
[19] Menon J et al, *Aging in Asia: Trends, Impacts and Responses*, Manila, Asian Development Bank, 2009, p.2 and pp.4-5

structure over the next forty-five years will largely reflect dynamic evolution of past birth and death rates, and the age structure will move toward stability".[20]

Figure 7: Old age dependency ratio: number aged 60+ per 100 aged 15-

59[21]

2013	
2050	
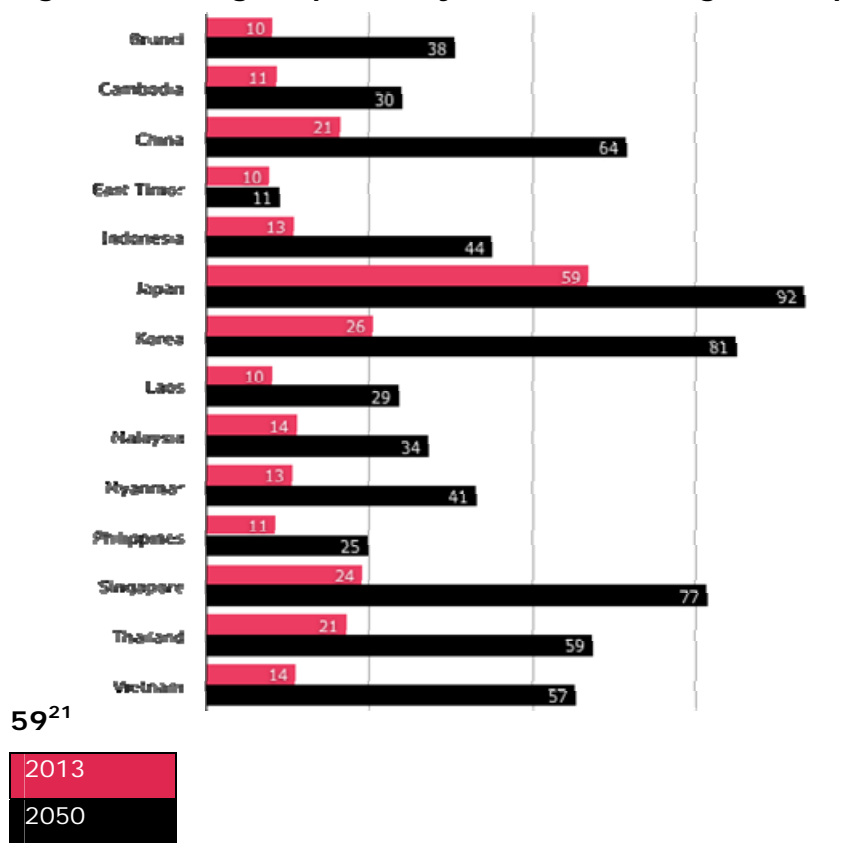
The number of older people for every 100 people of working age is forecast to rise dramatically, as shown by the figure above. This has implications both for financing of care, the care burden on families and for the proportion of the working age population who will need to be trained as care professionals: if the proportion of the working age population working as care professionals remains static, there will be a drastic shortfall in the numbers needed to care for the growing numbers of older people.

Changing female labour market participation has had a significant impact upon the traditional family-based care model; women who would once have looked after their parents or parents-in-law are now working.[22] Conversely, increasing longevity and health may mean that older people are able to offer increasing amounts of childcare for grandchildren, enabling greater female workforce participation.[23] Increasing workforce participation by women in well-paid professions may lead to the employment of carers to look after older relatives. This is likely to be the case only for a minority, however, as employment opportunities for many women are limited and low-paid.[24]

A complicating factor in the analysis of the impact of female workforce participation on care is that female employment is not a recent trend; rather, it is waged and formal female employment that is a relatively new trend (women historically worked in crafts and agricultural work that was often unrecorded).[25] It may therefore be the case that the care gap is not

---

[20] Bloom et al, "Population aging and economic growth in Asia", in T Ito et al (eds), *The economic consequences of demographic change in East Asia,* Chicago, University of Chicago Press, pp.70-71
[21] Calculated from UN Population Prospects, Medium Variant, 2010 Revision
[22]Wahyuni, p.75
[23] Preparing for the Challenges of Population Aging in Asia: Strengthening the Scientific Basis of Policy Development, https://download.nap.edu/catalog.php?record_id=12977, p.16 (9 May 2013)
[24] Lloyd-Sherlock P, *Population ageing and international development,* Bristol, Policy Press, 2010, p.125
[25]Quah S, *Major trends affecting families in East and Southeast Asia,* New York, United Nations, p.18

changing in this regard as significantly as might otherwise be expected from the data; women caregivers have often had to balance work with caring responsibilities in the past, and many continue to do so now.

In many Asian societies, people often return to their home villages or towns when they retire. This is related to cultural ties and the cost of living.[26] Across the region, the rural population is older than the urban population, reflecting migration patterns – young adults moving to towns and cities for employment, and older people returning to rural areas when they retire. The ageing of rural populations may even be underreported.[27]

Migration of adult children for work has had a significant impact on the care available to older people. Rural-urban migration means that there is less space available for older parents to live with their children, and that the physical distance between them is greater. The impacts of migration are not always negative, however; better jobs may enable people to offer greater financial support to older relatives.[28]

Observations

- The implications of ageing populations on the provision of care have been widely documented; these include the increase in demand and the necessary expansion of care services. Less commonly discussed likely impacts of ageing populations include younger family caregivers, who are usually women, having to care for older relatives for significantly longer periods of time than previously – and increasingly into their own retirement.[29] Additional support may also be required for family caregivers, who are likely to be working themselves, and are likely to have fewer siblings to share the responsibility.

- Women's changing workforce participation may mean that the traditional provision of care in the home is affected; this may be offset, however, by increased care activities and capacity in the community. A coexisting trend of older people having increased longevity and economic activity could also provide a solution; encouragement of older people to undertake volunteering roles or flexible work within the community or care sector may help to fill resource gaps, and benefit volunteers at the same time.

The "demographic window"

One challenge that is particular to many Southeast Asian nations is the likelihood that they will grow old before they grow rich. In the case of China, economic security may come first, but the risk of ageing without being able to pay for the necessary infrastructure remains.[30] Some countries have only one generation in which to prepare for a rapidly ageing population.[31]

There is a general assumption in the literature that changes in family structure will have negative consequences for the care of older people and for society more generally. Widespread awareness of population ageing, however, creates opportunities for behavioural change. Individuals may be able to work more as they have fewer children to care for, and (retired) parents available to help; savings may increase due to higher incomes and lower expenditures; and expenditure on education may increase. The potential negative effects of ageing may therefore be countered.[32] The Asian Development Bank describes this potential behavioural change, together with the bulge in the working age population in many countries across the region, as a "demographic window".[33] From the perspective of care, personal savings and tax receipts may help to contribute to meeting the growing care burden.

---

[26]Ananta, p.41
[27] Papers in Population Ageing No.1, http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2006/papers%20in%20pop%20ageing%20no.%201%20(2006).pdf, p.28 (12 May 2013)
[28] Preparing for the Challenges of Population Aging in Asia: Strengthening the Scientific Basis of Policy Development, https://download.nap.edu/catalog.php?record_id=12977, p.15 (9 May 2013)
[29] Preparing for the Challenges of Population Aging in Asia, p.15
[30]Howse K, "Long-term care policy: the difficulties of taking a global view", *Ageing Horizons 6*, 2007, pp.1-11
[31] Active Healthy Ageing: The Global Perspective, http://www.searo.who.int/mediacentre/newsletters/hisea/whd-12_hisea.pdf (10 May 2012)
[32] Bloom et al, p.64
[33]Menon et al, p.3

Economic interactions between countries in the region that are ageing at different rates may help to reduce possible negative impacts.[34] The Asian Development Bank expects savings rates to fall, for example, but suggests that countries will be able to borrow from each other to help mitigate any negative effects, due to their populations ageing at different rates.[35]

Observations

- Countries may experience significant increases in demand for care, and need for expanded infrastructure, without having experienced the level of economic development needed to pay for the necessary level of public care services.

- Regional dialogue about the preparation for ageing populations and mitigation strategies for the impact should be frequent and transparent; the possibility of inter-regional loans should also be considered.

5.2 Approaches to care

Cultural and traditional approaches to care

According to the World Health Organization, "traditional values and practices still occupy a key position where long-term care of the very old is concerned".[36]Philosophical and religious influences in the region include Confucianism, Buddhism, Islam and Christianity.[37] Religious values, together with norms and traditions, influence the extent to which older people are cared for by their families and communities.[38] The United Nations Population Fund states that "the tacit intergenerational agreement is that parents raise children and when the children attain adulthood they in turn 'repay' the parents by providing care and support in old age".[39]

In traditional Southeast Asian societies, relationships between generations and issues of caring and managing illness are usually considered private matters and are generally kept within the family.[40] The role of formal institutions is considered limited.[41] Long-term care is most often home-based[42] and placing parents in long-term institutional care is often considered shameful.[43] There are no nursing homes or care facilities in Cambodia and Laos as families are generally expected to, and want to, care for older people.[44]

Filial piety, the virtue and duty of respect and care for parents and older family members, is "the core idea of Confucian ethics for ordinary people", according to one scholar.[45] Confucian ethics are not only central to Chinese culture, but have heavily influenced culture in certain other Asian countries, including Japan, Korea, Thailand and Malaysia.[46] According to a study on filial piety and its impact on long-term care policies in Asian Chinese communities, filial piety

---

[34]Menon et al, p.5

[35]Menon et al, pp.5-6

[36] WHO Health in South East Asia Newsletter, March 2012, http://www.searo.who.int/mediacentre/newsletters/hisea/whd-12_hisea.pdf(17 April 2013)

[37] Phillips D (ed), *Ageing in the Asia-Pacific region: issues, policies and future trends*, London, Routledge, 2002, p.2

[38]Ananta A et al, "Older persons in Southeast Asia: from liability to asset", in Arifin E et al, *Older Persons in Southeast Asia: an emerging Asset*, Singapore, Institute of Southeast Asian Studies, 2009, pp.3-46

[39] Papers in Population Ageing No.1, http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2006/papers%20in%20pop%20agening%20no.%201%20(2006).pdf, p.32 (12 May 2013)

[40] WHO Health in South East Asia Newsletter, March 2012, http://www.searo.who.int/mediacentre/newsletters/hisea/whd-12_hisea.pdf(17 April 2013)

[41]International Council on Social Welfare, Strengthening Family Institution: Caring for the Elderly http://www.icsw.org/doc/Strengthening-Family-ICSW-on-Care-of-Elderly-5thGO-NGO-Nov10.pdf p.9 (25 April 2013)

[42] WHO Health in South East Asia Newsletter, March 2012, http://www.searo.who.int/mediacentre/newsletters/hisea/whd-12_hisea.pdf(17 April 2013)

[43]Kang Y et al, "Korean nurses' attitudes towards older people with dementia in acute care settings", *International Journal of Older People Nursing 6(2),* 2011, pp.143-152

[44]Anhaouy C et al, "People of Cambodian and Laotian descent", in N Waxler-Morrison (ed), *Cross-cultural caring: a handbook for health professionals*, Vancouver, UBC Press, 2005, pp.95-126

[45] Hwang K, "Filial piety and loyalty: two types of social identification in Confucianism", *Asian Journal of Social Psychology 2*, 1999, pp.163-183

[46] Wang J et al, "Confucian values and the implications for international HRD", *Human Resource Development International 8(3)*, 2005, pp.311-326

"remains the most important value regulating the behaviour of children towards their elderly parents and relatives".[47] Adult children in China were traditionally expected to care for and serve their parents; at the same time, however, older people were expected to maintain their parental duties into old age, and to care for and educate their grandchildren.[48]

It is not just Confucianism that has influenced the development of filial piety in Southeast Asia; some scholars have argued that filial piety was a central concept in early Buddhism.[49] In Thailand, spouses and children are expected to provide care for older people who require it.[50] In Myanmar, familial care is traditionally considered to be a noble practice. According to the World Health Organization, "younger family members serve the needs of the elderly with great pride".[51]

Observations

- While filial piety has a positive effect on informal care structures, it has led some governments in the region to assert the importance of family responsibility and to avoid the development of significant pension and formal care arrangements for older people.[52] Gaps exist in the traditional model of filial piety; this is often related to severe poverty.[53] This means that under the traditional model, some older people risk being overlooked.

- The traditional model of family-based care will also be affected by the tendencies of families to have fewer children and for parents to have increasing longevity; alternative solutions and means of support will need to be considered to prevent situations where older people, themselves requiring care, are still carers for their own parents.

Co-residence

There is a difference, linked but not limited to a country's development status within the region, as to the extent to which older people live with their children and wider families. Between 1960 and 2005, the percentage of Japanese older people aged 65 and above living with their children fell by almost half; over the same timeframe, the percentage living alone increased from four per cent to 15 per cent.[54] In Cambodia, on the other hand, over three quarters of all people over the age of 60 live with one of their children; five per cent of older women and only one per cent of older men live alone.[55] Figures are similar in Myanmar.[56]

Assessment of the impact of living arrangements on informal care structures needs to take into account the proximity of family; where family lives close by, older people's care needs can be met.[57] 97 per cent of older people in Myanmar, for example, have a child living in the same township.[58] Similarly, crude assessment of data based on proximity of older people's children may miss the complexities of family dynamics. In many Javanese communities, for example, a sister's children are equivalent to a woman's own, and alternative arrangements for the support of older people may include adoption.[59] An analysis by the United Nations Economic

[47] Chow N, "The practice of filial piety and its impact on long-term care policies for elderly people in Asian Chinese communities", *Asian Journal of Gerontology & Geriatrics 1(1)*, 2006, pp.31-35

[48] Yue K, "People of Chinese descent", in Waxler-Morrison et al (eds), *Cross-cultural caring*, Vancouver, UBC Press, 2005, p.70

[49] See, for example, Xing G, "Filial piety in early Buddhism", *Journal of Buddhist Ethics 12,* 2005, pp.82-106

[50] Intergenerational Care for and by Older People in Thailand. http://www.psc.isr.umich.edu/pubs/pdf/rr11-732.pdf (17 April 2013)

[51] Key message from Regional Director on World Health Day 2012 and for Health in South-East Asia http://www.searo.who.int/myanmar/mediacentre/WHD2012factsheet.pdf (17 April 2013)

[52] Mi Oh K et al, "Care services for frail older people in South Korea", *Ageing and Society 21*, 2001, p.702

[53] Knodel J, *The situation of older persons in Myanmar*, Chiang Mai, HelpAge International, p.VIII

[54] NIH & WHO, *Global health and aging*, Bethesda, National Institute on Aging & World Health Organization, 2002, p.23

[55] Knodel J et al, "Gender and well-being of older persons in Cambodia", *Population Studies Center Research Report 09-665*, 2009, p.18

[56] Knodel, *The situation of older persons in Myanmar*, p.VII

[57] Knodel, *The situation of older persons in Myanmar*, p.54

[58] Knodel, *The situation of older persons in Myanmar*, p.60

[59] Kreager P et al, "Ageing and gender preferences in rural Indonesia", *Centre for Research on Ageing Discussion Paper no. 0905*, 2009, p.17

and Social Commission for Asia and the Pacific has identified "different realities of support relationships among family members".[60]

Observations

- The complexities of co-residence are not fully understood; nor are the myriad different relationships and living arrangements of families in different countries. Improved research into understanding these structures may help to ensure that the care provision in these areas is appropriate and tailored towards individual circumstance.

- There is a research gap on the effects on older people and their families of co-residence. According to Knodel, co-residence can have a positive effect on both generations, but this changes over time until older people are largely dependent on their younger relatives for care and support.[61]Further research is required into the impact of co-residence on older people and their families, so that decisions made by families can be informed.

Changing family and care structures
Family structures

Traditional family care models are coming under increasing pressure due to demographic shifts, labour migration[62] and greater female workforce participation.[63] There has also been a significant shift from the traditional extended family structure to the nuclear family structure over the last 20 years.[64]Financial support from children is expected to decline gradually as family sizes shrink.[65]

In Indonesia, a move from extended to more nuclear family models has been suggested by increases in the number of households and decreases in the average household size (the number of households grew from 40 million in 1990 to57 million in 2003; and between 1990 and 2000, the average household size decreased from 4.5 to 3.9).[66] Other Asian countries showing falls in the numbers of older people living with their families include Korea and Thailand, both of which went through rapid economic development and are now experiencing rapid population ageing. In Thailand, the percentage of people aged 60 and over who were living with a child decreased from 77 per cent in 1986 to 59 per cent in 2007.[67]

In 2007, news magazine the Beijing Review noted that the model of family-based care was likely to be extinct within 20 years.[68] The United Nations Population Fund reports that the concept of filial piety is diminishing: "the tradition for family to provide older persons with basic life assurance is being continuously weakened, and the proportion of older parents receiving economic support from their children is declining".[69] Other sources suggest that we should not underestimate the level and impact of falls in co-residence; according to one study on Thailand, "the much smaller family sizes of the persons entering older age in the future and the increased migration of their adult children to find employment have serious implications for filial elder care".[70]

---

[60] UN ESCAP, "In the care of the state and the family", p.52

[61]Knodel, "Gender and ageing", p.16

[62]Knodel J et al, "Intergenerational family care for and by older people in Thailand", *Population Studies Centre Report 11-732*, 2011, p.3

[63] World Health Organization, *Health of the elderly in South-East Asia: a profile*, New Delhi, WHO Regional Office for South-East Asia, 2004, p.9

[64]International Council on Social Welfare (2010), Strengthening Family Institution: Caring for the Elderly http://www.icsw.org/doc/Strengthening-Family-ICSW-on-Care-of-Elderly-5thGO-NGO-Nov10.pdf p.5 (25 April 2013)

[65] UN ESCAP, "In the care of the state and the family", p.16

[66]International Council on Social Welfare (2010), Strengthening Family Institution: Caring for the Elderly http://www.icsw.org/doc/Strengthening-Family-ICSW-on-Care-of-Elderly-5thGO-NGO-Nov10.pdf p.5 (25 April 2013)

[67]United Nations, *Current status of the social situation, wellbeing, participation in development and rights of older persons worldwide*, New York, United Nations, 2010, p.8

[68] Milligan C, *There's no place like home: place and care in the 21st century*, Farnham, Ashgate Publishing, 2009, p.51

[69] Demographic Change in China: Ageing of the World's Largest Population http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2007/papers%20in%20pop%20agening%20no.%204%20(2007).pdf (18 April 2013)

[70]Knodel, "Intergenerational family care", p.2

A draft of a report submitted to the UN General Assembly, however, refers to survey research contradicting the notion that development has led to adult children abandoning their caring responsibilities.[71] Regional patterns also vary by country. In Brunei Darussalam, for example, caring for older people is considered to be the responsibility of the family; living arrangements are still often traditional in the sense of older people living with their children and grandchildren.[72] There is little evidence to suggest that traditional Thai respect for older people has changed in recent years.[73] According to a recent HelpAge study on Myanmar, "even for a region such as Southeast Asia, [the] cohesion of the traditional family structure in Myanmar is exceptional… This family support is crucial, usually efficient, and reflective of Myanmar's strong cultural traditions of respect towards parents and elders".[74] The United Nations Population Fund argues that, with the exception of Japan, only "modest" falls in co-residence across the region suggest that the policy focus should be on supporting families to care for their older relatives.[75]

Observations

- Whether or not filial piety is being eroded, increasing pressures on family-based care are inevitable.As with co-residence, ensuring that care provision meets requirements is challenging with myriad different family arrangements for support and residence, and significant changes occurring due to labour and financial trends. Further research into understanding family structures may help to design and provide appropriate provision, and to ensure that incorrect generalisations, such as the "one-way dependency" of older people, are not used to formulate policies and initiatives.

- The location of care is particularly significant in situations where older people are isolated geographically or due to seasonal occurrences such as monsoons. Situating care services either in community centres, or ensuring that emergency services are available in cases of isolation, should be key policy priorities.

Policy approachesto care
Regional priorities

The main regional priorities in age-related policies and programmes are (a) access to pension benefits, (b) opportunities for economic participation and (c) advancement of health and wellbeing into old age.[76] The ageing of Asia's populations has two major implications for policy: firstly, how to provide economic and social security for the growing numbers of older people, and secondly, how to maintain economic growth with a lower proportion of people in the workforce.[77]

Of the 14 countries considered in this research, the majority have dedicated national plans or policies on ageing; there are questions, however, over the wider currency of the plans and policies in Laos and Korea in particular. While there appears to be widespread awareness of the likely impact of ageing populations, corresponding policy activity is not uniformly apparent. Access to health care differs throughout the region, with some countries preferring enforced employee contributions, others favouring health insurance and others offering free health care for all older people.

---

[71]United Nations, *Current status*, p.34
[72] Brunei Darussalam Country Report
http://www.mhlw.go.jp/bunya/kokusaigyomu/asean/asean/kokusai/siryou/dl/h19_brunei.pdf(23 April 2013)
[73]Knodel et al, "Gender and ageing", pp.1-34
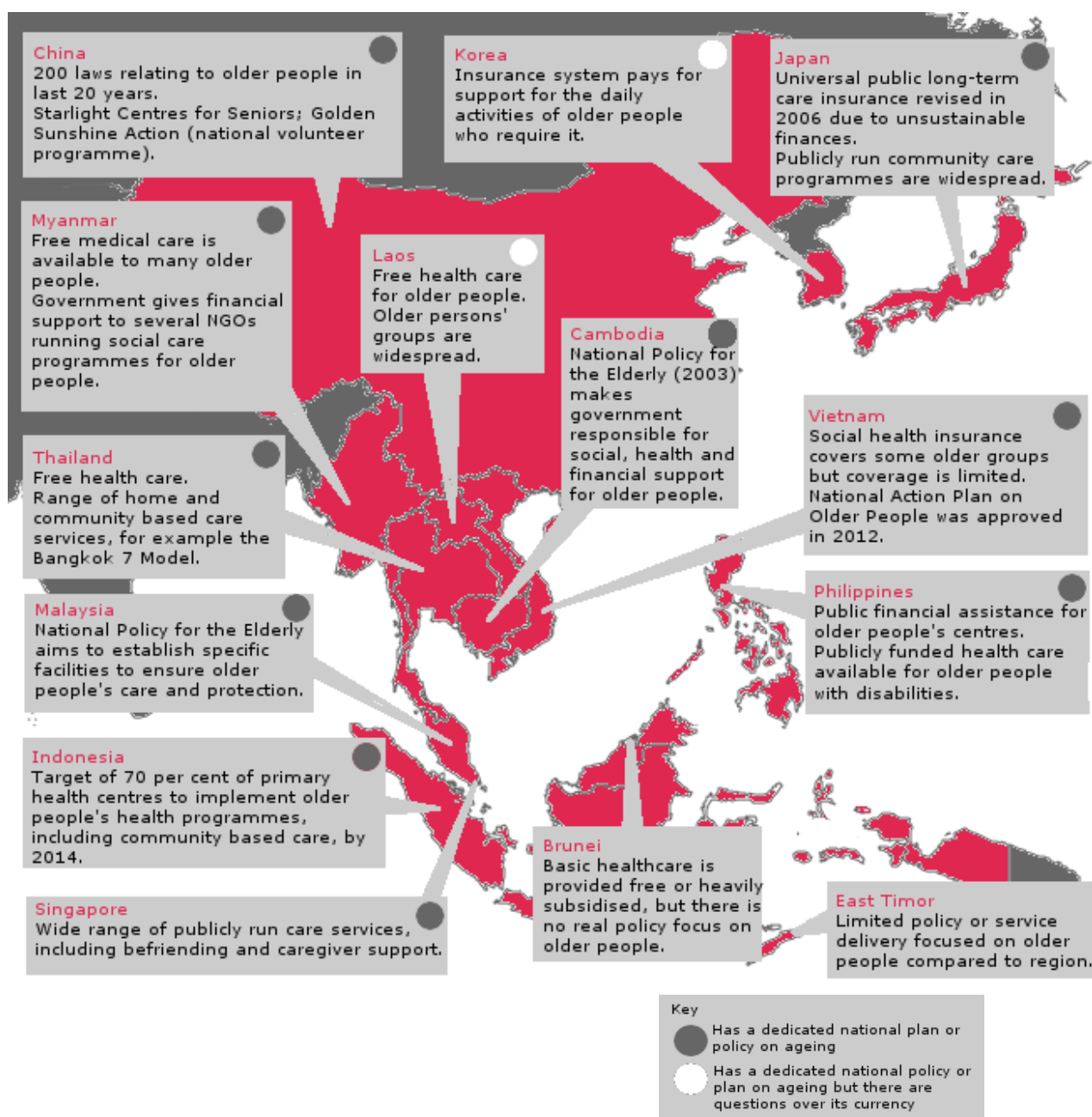[74]Knodel, *The situation of older persons in Myanmar*, p.110
[75] Papers in Population Ageing No.1,
http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2006/papers%20in%20pop%20agening%20no.%201%20(2006).pdf, p.33 (12 May 2013)
[76] UN ESCAP, "In the care of the state and the family", p.53
[77] Mason et al, pp.1-8

Figure 8: Public policy map

China
200 laws relating to older people in last 20 years.
Starlight Centres for Seniors; Golden Sunshine Action (national volunteer programme).

Korea
Insurance system pays for support for the daily activities of older people who require it.

Japan
Universal public long-term care insurance revised in 2006 due to unsustainable finances.
Publicly run community care programmes are widespread.

Myanmar
Free medical care is available to many older people.
Government gives financial support to several NGOs running social care programmes for older people.

Laos
Free health care for older people.
Older persons' groups are widespread.

Cambodia
National Policy for the Elderly (2003) makes government responsible for social, health and financial support for older people.

Vietnam
Social health insurance covers some older groups but coverage is limited.
National Action Plan on Older People was approved in 2012.

Thailand
Free health care.
Range of home and community based care services, for example the Bangkok 7 Model.

Malaysia
National Policy for the Elderly aims to establish specific facilities to ensure older people's care and protection.

Philippines
Public financial assistance for older people's centres.
Publicly funded health care available for older people with disabilities.

Indonesia
Target of 70 per cent of primary health centres to implement older people's health programmes, including community based care, by 2014.

Brunei
Basic healthcare is provided free or heavily subsidised, but there is no real policy focus on older people.

East Timor
Limited policy or service delivery focused on older people compared to region.

Singapore
Wide range of publicly run care services, including befriending and caregiver support.

Key
● Has a dedicated national plan or policy on ageing
○ Has a dedicated national policy or plan on ageing but there are questions over its currency

The future uptake and costs of care will depend on the health of future cohorts of older people, which is uncertain.[78] Costs may be manageable if governments take preventative action to limit chronic diseases; this needs to be balanced against factors which may drive up the costs of care, including higher pharmaceutical prices, new technologies, rising wage costs and patient demands.[79]According to a global study on health and ageing by academics at the UK's University College London, "while health care costs may increase through increased absolute numbers of people with chronic conditions, levels of disability associated with ageing may not be as great a burden on the costs of social and health services as has often been assumed".[80]

Social security in most countries is limited both in terms of coverage and amount.[81] The tax base is likely to shrink as the proportion of the population who are of working age decreases,

---

[78] Hyde M et al, "The health profile of ageing populations", in S Newman et al (eds), *Chronic physical illness: self-management and behavioural interventions*, Maidenhead, Open University Press, 2009, pp.3-27
[79] UN ESCAP, "In the care of the state and the family", p.10
[80] Hyde et al, p.21
[81] Papers in Population Ageing No.1, p.58

reducing the ability of governments to pay for growing care bills;[82] although economic growth may go some way to countering this effect.[83]Health systems in most Asian economies have tended to focus on communicable diseases, together with maternal and child health; these will have to be reoriented as populations age towards non-communicable diseases, and functional and cognitive disabilities.[84] There is little awareness of dementia in developing countries, leading to a stigma and a lack of individuals or organisations to lobby government to improve dementia care services.[85]Governments globally have been attempting to diversify social care provision, for example by allowing commissioning authorities to purchase care services from private and not-for-profit organisations. They have also been attempting to give service users greater choice and control.[86]

Delivery of care

Challenges for governments include how to define and manage care in old age, and how to deliver coherent policies and services. There is a tension, for example, between the concept of integrated care and the specific health care needs of older people. Thailand and Indonesia have focused on the latter, and have identified geriatric medicine as a key component of their health systems.[87]Viewing the spectrum of care services as a coherent continuum (the "care continuum") also requires considerable cohesion between care providers, both social and health, and governments. Policies relating to ageing are often covered by more than one government ministry, leading UNESCAP to suggest that "there is overlap and lack of clarity in the division of labor and responsibility among the relevant ministries in implementing the national policy on ageing".[88]

Governments throughout the region are promoting individual responsibility and family-based care, which has the effect of reducing potential public financial impacts of growing old age care needs. One clear gap among current public policies is how to care for people who fall through the cracks in the family-based care model. The United Nations Population Fund has recommended that more countries throughout the region follow the example of Thailand and Singapore in using tax incentives to promote care and support of older people by their adult children. It also recommends the education of volunteers and adult children in home-based care.[89]Many organisations are arguing for "active ageing" policies to be taken up by governments across the region, in which healthy lifestyles and preventative policies are prioritised.[90]

Many Southeast and East Asian countries have much in common, such as institutions based on the value of filial piety.[91] Regional cooperation which sees late agers[92] learning from early agers may be one means of maximising any commonality; initiatives such as ASEAN+3 may also help to support economic integration in the context of population ageing.[93] Institutional contexts vary significantly,[94] however, and therefore common policy responses to the impact of ageing societies are unlikely, if not impossible. Despite this, there are many projects exemplifying good practice which can be used as starting points for governments and CSOs to adapt to local institutional, economic and cultural contexts.

---

[82] Papers in Population Ageing No.1, p.58

[83] Dr KanwaljitSoin, *Ageing: From peril to Promise- Asean societies are ageing, but this should be welcomed rather than feared*, The Straits Times (7 June 2013)

[84] (2006 data) Preparing for the Challenges of Population Aging in Asia: Strengthening the Scientific Basis of Policy Development, https://download.nap.edu/catalog.php?record_id=12977, p.21 (9 May 2013)

[85] Giles J et al, "Elder parent health and the migration decision of adult children: evidence from rural China", *IZA Discussion Paper No.2333*, 2006, pp.1-18

[86]Malley J et al, "Measuring quality in social care services: theory and practice", *Annals of Public and Cooperative Economics 81(4),* 2010, pp559-582.

[87] State of Geriatrics and Long-Term Care for Elderly Persons in Countries of the WHO South-East Asia Region, http://www.searo.who.int/mediacentre/newsletters/hisea/whd-12_hisea.pdf (10 May 2013)

[88] UN ESCAP, "In the care of the state and the family", p.14

[89]Mujahid G et al, *The impact of social pensions: perceptions of Asian older persons*, Bangkok, United Nations Population Fund, 2008, p.25
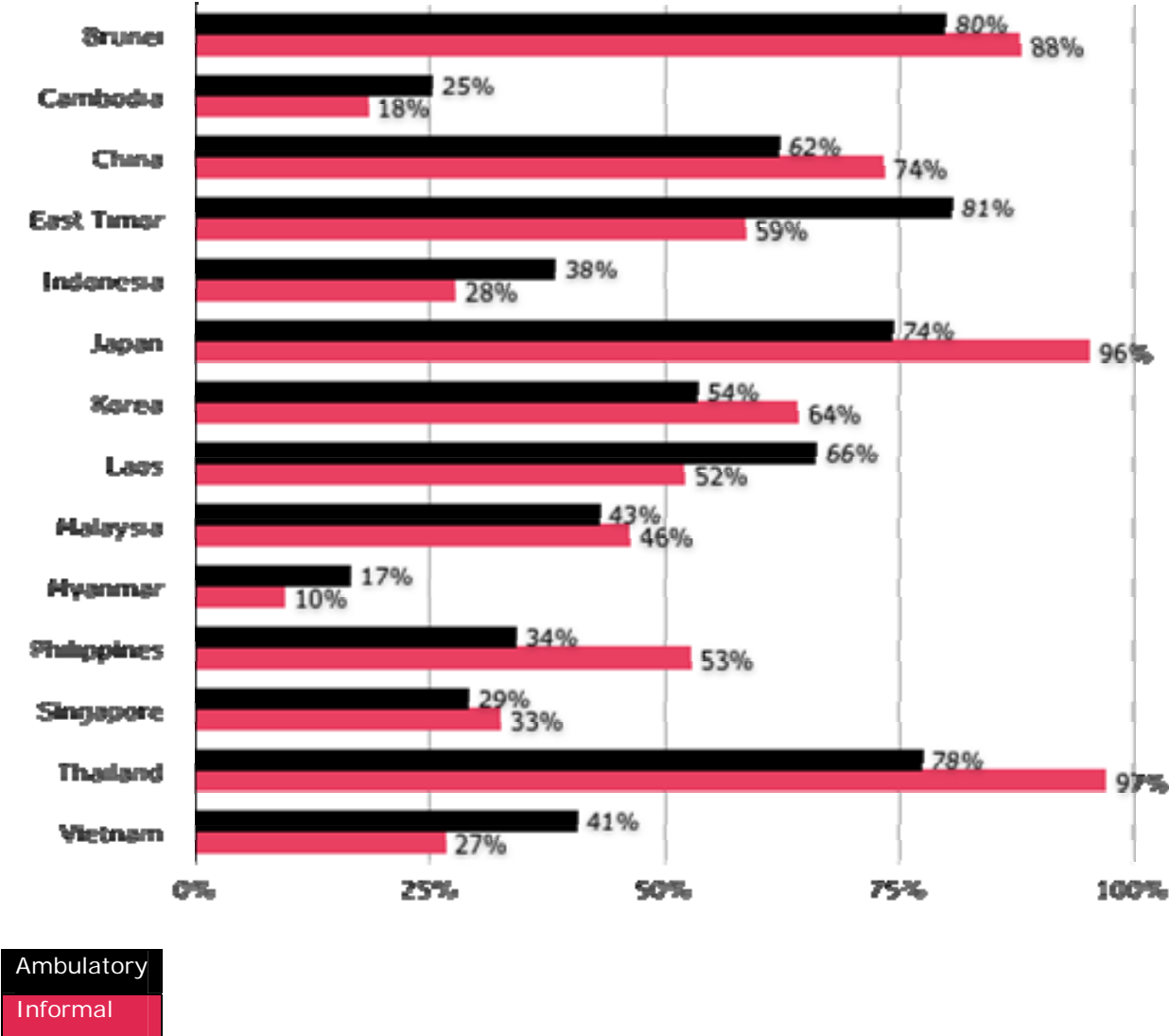
[90]Ananta, p.40

[91]Howse, pp.1-11

[92] Countries which are seeing a significant increase in the numbers of older people sooner than others

[93]Menon et al, p.6

[94] See, for example, Howse, pp.1-11

Figure 9: Estimated state provision of care services to older people[95]

Legend:
- Ambulatory (black)
- Informal (pink/red)

Data shown in the chart:

Country	Ambulatory	Informal
Brunei	80%	88%
Cambodia	25%	18%
China	62%	74%
East Timor	81%	59%
Indonesia	38%	28%
Japan	74%	96%
Korea	54%	64%
Laos	66%	52%
Malaysia	43%	46%
Myanmar	17%	10%
Philippines	34%	53%
Singapore	29%	33%
Thailand	78%	97%
Vietnam	41%	27%

Estimated numbers of older people receiving state care services[96]

	Brunei	Cambodia	China	E.Timor	Indonesia	Japan	Korea
Ambulatory	10,620	47,921	49,917,688	9,254	1,591,717	14,129,442	2,096,608
Informal	48	7,795	1,812,705	1,505	259,524	52,302	8,490

[95] These were estimated using the following data sources: WHO World Health Survey country reports for China, Laos, Malaysia, Myanmar, the Philippines and Vietnam (data on ambulatory health service use by age, informal health service use by age, proportional ownership of ambulatory health services and proportional ownership of informal health services); UN Population Prospects, Medium Variant, 2010 revision (data on numbers of 60-69 year olds and those aged 70 and above); and WHO World Health Observatory data (general government expenditure on health as a proportion of total health expenditure). Where individual country data was unavailable (World Health Surveys), an average of each country's income group for the region was used (see footnote 123 for method). Numbers were estimated by calculating the number of older people using each service; then applying the government health spend as a proportion of total health spend as a proxy for the proportion of services delivered by government; and then applying a weight according to the proportion of government expenditure allocated to each type of health care service.

[96] See above.

	Laos	Malaysia	Myanmar	Philippines	Sing.	Thailand	Vietnam
Ambulatory	11,497	504,675	143,117	409,245	115,546	3,442,636	1,156,008
Informal	2,778	2,307	31,710	17,101	509	72,331	177,926

Observations

- The most significant impact of policy making on older people and the care they receive is the financial structures giving them access to care and health services. In almost all countries in the region pensions are limited to those in the formal sector or ex-services personnel; this means that all those in rural or agriculturally-focused areas, or in informal employment, are likely not to have the financial means to access care. Some poorer developing countries elsewhere have introduced universal pension schemes, while others have achieved excellent healthcare systems.[97] While the long-term development of universal pension coverage and supportive healthcare systems for older people might be challenging in the current economic environment and in the poorest countries in the region, it is therefore not impossible. In the meantime, means-tested subsidised care and health services may allow those without financial means to access the care they need.

- Gender is an important consideration. Most age-related policies in Asia-Pacific countries are gender neutral, meaning that the specific needs of older women are not being addressed.[98] Equally, research highlighting the needs of older women tends to ignore the needs of older men; research and policy development therefore needs to be nuanced and differentiated by the needs of different groups.

- Public policies need to be designed to cover existing gaps in family-based care structures, for example where older people have no adult children, or where those adult children are unable or unwilling to provide care.

- There are opportunities for NGOs such as HelpAge to work closely with governments in the region to identify and share good practice, to broker regional cooperation and to mainstream ageing into policy.

Care in practice
Caregivers

As evidenced elsewhere in this report, care of older people in the region is generally delivered informally and by family members. The majority of informal caregivers, both within and outside the household, are women; pressure on them is compounded by their tendency to be employed within the informal economy.[99] Many informal caregivers are themselves older people, and this trend is likely to increase further with population ageing.[100]

Caregivers are more likely to suffer from mental and physical illness.[101] They have needs themselves which vary by culture, income, living circumstances and the extent of external support. Caregivers also need detailed information about conditions, symptoms, medications and lifestyle adaptations; and training in home health skills and partnership working. According to the World Health Organization, "equally important are skills to help them identify available resources, navigate the system and become effective advocates… Caregivers also need a forum to express their experiences and recommendations for system change and for sensitizing service providers. Most importantly, caregivers need 'respite' – time off from their caregiving role."[102]

---

[97] Input from HelpAge International's Global Strategic Advisor, 20 June 2013 (citing universal pension schemes in Bolivia, Lesotho and Nepal, and Costa Rica's healthcare system)
[98] UN ESCAP, "In the care of the state and the family", p.13
[99] Vlachantoni A et al, "Exploring gender and pensions in Japan, Malaysia and Vietnam", *Centre for Research on Ageing Discussion Paper no. 1101,* 2011, pp.1-43
[100] UNFPA and HelpAge, *Ageing in the twenty-first century: a celebration and a challenge*, New York/London, UNFPA &HelpAge International, p.91
[101] UNFPA and HelpAge, *Ageing in the twenty-first century,* p.91
[102] WHO, *Women, ageing and heath*, p.20

One of the challenges of continuing with the family-based care model is that families often do not have the skills or experience required to look after older people with significant care needs.[103] It is not only family caregivers who lack appropriate skills, however; other challenges include a lack of trained professionals.[104] The increased care requirements of an ageing population, both in social and health terms, are likely to create a significant number of employment opportunities.

Community-based care

Holistic community care is a model in which care is provided comprehensively, incorporating physical, social and psychological services, in both institutional and home-based settings.[105] It is akin to the "care continuum" concept, in which all services for older people are viewed coherently, with differential levels according to the health needs of the older person.[106] Key parts of the system include short-stay houses and clinics for those needing medical care; community-run centres for older people; community buses which stop at regular points and which enable older people to travel to the shops, to see friends and attend care or activity centres; and training in dementia for local volunteers. According to the Economic and Social Commission for Asia and the Pacific, "such an environment provides a choice of care and services for older persons that can meet their changing needs as they age and cater to their diverse abilities, needs and lifestyles". Examples of successful adoption of holistic community care include Japan's Musashino City.[107]

In modern Thailand, holistic community care has developed into a modern conception of care involving both the community and volunteers.[108] One Thai academic suggests a model where religion, education and care services co-exist and are provided through NGOs at a local level. By using volunteers of all ages, community engagement may be fostered; an added advantage could be the early identification of younger people with an interest in social, care and health work. Older people can benefit from the social aspects of their involvement, as well as the health benefits of activity and the potential for lifelong education.[109]

Different models of community-based care exist throughout the region. Integrated care is provided in East Timor, where volunteers and community leaders provide health services and social services in community facilities.[110] SPICE centres in Singapore also operate integrated services, but also operate in a home setting where required.[111] Thailand has piloted a scheme through 26 local hospitals known as "home health care". This scheme is targeted at older people living at home and services include health promotion, treatment and rehabilitation. Thailand has also piloted service models which integrate health and social care – the "Bangkok 7 Model" and the "Community-Based Integrated Services of Health Care and Social Welfare" for Thai Older Persons; they involve collaboration between local authorities, volunteers and older people.[112] On the whole, however, models of collaboration between social care and health care professionals are not prevalent; further research in this area is required[113].

The most prevalent community-based care programme throughout the region is the ROK-ASEAN Home Care Programme, supported by HelpAge International. This programme builds on

---

[103] Kespichayawattana J et al, "Health and health care system for older persons", *Ageing International 33*, 2009, pp.28-49
[104] See, for example, The State of Professional Social Work and Social Services in Indonesia, http://www.bpsw.org/More%20on%20Indonesia-Dec10-1.pdf (29 April 2013) or Ambigga et al
[105] Holistic Care for Elders in Hong Kong, http://www.cpu.gov.hk/doc/en/events_conferences_seminars/20081215%20Nelson%20Chow.pps (14 May 2013)
[106] Effectiveness of the Continuum of Care to Promote Older People's Quality of Life in Hong Kong, http://ajgg.org/AJGG/v1n2/84-T8.pdf (06 June 2013)
[107] UNFPA &HelpAge International, *Ageing in the twenty-firstcentury*, pp.126-127
[108] Bhikkhu M, "A Buddhist Model for Healthcare Reform", Journal of the Medical Assocation of Thailand 90(10), 2007, p.9
[109] Bhikkhu, p.10
[110] Strengthen Communities in the Area of Health through SISCa, http://www.basics.org/documents/13-SISCa-Guidelines.pdf, p.9 (19 May 2013)
[111] Singapore Programme for Integrated Care for the Elderly (SPICE), http://www.aic.sg/page.aspx?id=782 (30 April 2013)
[112] Kespichayawattana, pp.28-49
[113] Meads G et al, *The case for interprofessional collaboration in health and social care,* Oxford, Blackwell Publishing, 2005, p.5

the success of a home care model involving volunteers in Korea; it has been implemented in all ASEAN countries with adaptations according to local context.[114]Community groups and networks, and older people's groups, are also ways of providing community-based support. Older people's groups (or "senior citizens' clubs") operate or are planned in Brunei[115], Japan[116] and Thailand[117]; they can offer support networks, health information dissemination and fitness activities.

Elder abuse

Studies on elder abuse, defined by the Encyclopedia of Primary Prevention and Health Promotion as being characterised by "physical abuse, psychological or verbal abuse, financial abuse or exploitation, and neglect",[118] have exposed a dark side of family-based care.

A study of 1,000 caregivers in Korea found evidence of psychological abuse and neglect of older relatives, leading to a call for psychosocial support services and programmes for caregivers in order to reduce the prevalence of abuse.[119] In Myanmar, elder abuse tends to be verbal rather than physical.[120] A Japanese study found the three key predictors of elder abuse to be older people who wander due to senility; caregivers' health problems; and caregivers' misunderstanding of the care receivers' conditions. It also found the most common perpetrators to be daughters-in-law.[121] Elder abuse tends to be ignored in most developing countries.[122]Increasing numbers of cases are being reported in which older people are mistreated and violated.[123]

Observations

- Despite the popular conception of female caregiving, significant variation exists regarding the gender dimensions of care.[124] The complexities of gender dynamics need to be taken into account in community based approaches to care. Nevertheless, caregivers do tend to be women, many of whom are themselves older.

- In addition to considering how to recruit and activate volunteers, it is critical that HelpAge consider how to support existing family carers. Supporting caregivers is vital for two reasons: it is likely to increase the quality of care given to older people, and it supports caregivers' own wellbeing (which is especially important if they themselves are older carers). The need for information sharing and training is key in working with family caregivers. The issue of elder abuse stems, in the most part, from a lack of information about the care needs of older people and the stigma of seeking help when caring for older relatives. By informing carers of their options and ensuring that they have the support, both material and emotional, to cope with their responsibilities, it is likely that the quality of care will improve, as well as the wellbeing of both the carer and the older person.

- The expansion of community-based care would serve a dual purpose of being a means of sharing information and support about health and care services, and a way for older people and carers to share support.

---

[114] Community-Based Home Care for Older People in South East Asia, http://www.helpage.org/download/4daefd047e0c2/(26 April 2013)
[115] Making Ageing Population lead Active, Healthy Life, http://www.bt.com.bn/news-national/2011/12/20/making-ageing-population-lead-active-healthy-life (19 May 2013)
[116]UNFPA and HelpAge International, *Overview of available policies and legislation,* New York, UNFPA, 2011, p.21
[117]UNFPA and HelpAge International, *Overview of available policies and legislation,* p.41
[118] Fisher J et al, "Elder abuse", *Encyclopedia of Primary Prevention and Health Promotion,* Springer (online), 2003, pp.449-454
[119] Lee M, "Caregiver stress and elder abuse among Korean family caregivers of older adults with disabilities", *Journal of Family Violence 23(8)*, 2008, pp.707-712
[120]Knodel, *The situation of older persons in Myanmar*, p.107
[121]Anme T, "A study of elder abuse and risk factors in Japanese families: focused on the social affiliation model", *Geriatrics & Gerontology International 4(1)*, 2004, pp.262-263
[122] Lloyd-Sherlock, *Population ageing,* p.124
[123] Demographic Change in China: Ageing of the World's Largest Population, http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2007/papers%20in%20pop%20ageing%20no.%204%20(2007).pdf (18 April 2013)
[124] See, for example, Kreager, pp.1-28

- Training of volunteers and carers is vital to ensure the sustainability of care and also to ensure the quality of care. Cascade models of training could be considered, in which NGOs are trained to provide training to volunteers and to family members; this would be similar to a "train the trainer" course. Training needs to be a long-term commitment on the part of local and national government and CSOs; the knowledge and skills required will change over time, as will the carers.

5.3 Needs analysis

This section focuses on analysis of key aspects of care provision and issues that are likely to have an impact on care provision in the future.

Estimated care needs and gaps[125]

According to a United Nations Population Fund report, "when older persons become ill, their greatest anxieties are around how they would be taken care of and treated".[126]Most older people express a personal preference for home care over residential care where possible.[127]Care needs are not limited to individuals' own needs; they include a requirement for support to help care for disabled or ill partners.[128] Older people are also taking on increasing childcare responsibilities.[129]

Care preferences change not only with age, but also with time; this is possibly linked to cultural changes or to globalisation. In Thailand, the proportion of older people whose child was their desired carer when ill fell from 76 per cent in 1986 to 57 per cent in 2002; over the same time period, the proportion who selected their spouse as their desired carer when ill tripled from 12 per cent to 36 per cent. The most recent data indicates that the importance of children as carers rises as people age, and as more are widowed.[130] For those who are unmarried and without children, preferred carers are siblings. Men are considerably more likely to choose their spouse as their preferred carer than women are,[131] reflecting both levels of widowhood and patterns of care.

---

[125] Data used in this section came from the following sources: UN Population Prospects, 2010 Revision, Medium Variant; UN Human Development Report; World Bank World Development Indicators; annex tables from UN-DESA/Population Division's *Living Arrangements of Older Persons around the World*; WHO World Health Survey (country reports for China, Laos, Malaysia, Myanmar, Philippines and Vietnam; the other countries had not been surveyed). Countries were grouped into three by income: lower income (GDP per capita in USD: $0-3,999: Cambodia, East Timor, Indonesia, Laos, Myanmar, Philippines and Vietnam), middle income ($4,000 to $9,999: China, Malaysia and Thailand) and higher income ($10,000 [effectively $22,000] and above: Brunei, Japan, Korea and Singapore). Where data was missing for individual countries on certain indicators, an average of data for each of that country's income group was used, apart from in the case of the WHO data where Malaysia (as the highest income country available) was used as a proxy for the richer countries. The proxy for "care needs" was "some difficulty with self care in the last 30 days", the proxy for "social care needs" was feeling "sad, low or depressed in the last 30 days", and the proxy for "care gaps" was "unmet care need". Gender, rural/urban and poverty measures were weighted according to information given separately for all age groups. This section provides a best estimate only and limitations include the following:
- Lack of WHO data for Brunei, Cambodia, East Timor, Indonesia, Japan, Korea, Singapore and Thailand;
- Two different dimensions of poverty were used, one at a country level to estimate overall poverty levels (proportion of the population in multidimensional poverty) and one from the WHO data as a very rough proxy to estimate the differences in care needs/gaps between people in poverty and the general population; this was quintile 3 (to estimate average population not in poverty) compared to quintile 5 (the 20% most in poverty).
- Estimates of the population living rurally and in poverty were only available at a whole population level; proportions were applied to the total number of older people to get the numbers estimated here. As older people tend to be more likely to live in poverty and rurally than the wider population, it is likely that each of these categories has been underestimated.

[126]Mujahid p.26
[127] OECD, *Recipients of long-term care*, Paris, OECD, 2011, p.168
[128]The Impact of Social Pensions: Perceptions of Asian Older Persons
http://www.globalaging.org/pension/world/social/impact.pdf, p.27 (25 April 2013)
[129]Population Reference Bureau, Today's Research on Aging, No. 6, August 2007
http://www.prb.org/pdf07/TodaysResearchAging6.pdf, p.1 (25 April 2013)
[130]Knodel et al, "Intergenerational family care", p.11
[131]Knodel et al, "Intergenerational family care", p.13

There has been little research into any possible gaps between perceived and actual needs in terms of practical assistance in Southeast Asia and China. Evidence from the UK (included due to a lack of studies in the Southeast Asia and China region on support with tasks) shows a gap between tasks with which many older people would like assistance, which in turn can minimise risk – such as securing carpets to reduce the risk of falls or pruning trees to give more light; it also shows the inability of public bodies to "make the same linkages between risks and possible responses".[132]

Observations

- Older people in the region tend to prefer to remain in their own homes and to live close to adult children.[133] There is an assumption among many studies that older people wish to live with their children, and it is younger people who are challenging this model. This is not always the case, however: a survey in the Philippines found, for example, that many more older people preferred to live apart from their children than those who actually did so.[134] Older people living in poverty are more likely to live with their children unwillingly, because they cannot afford to live separately; this is also more likely for families living in towns and cities due to higher accommodation costs.[135] According to one assessment, views about older people's preferences in terms of living arrangements are based on "past norms".[136]

- Consideration of how to access the hard to reach – people who may not wish to ask for help, or those who live with family who are unable or unwilling to care for them – needs to be incorporated into project and service design.

Underlyingregionaldata[137]

Indicator	Number	Per cent
Older people (60+)	294,005,000	N/A
Oldest old (80+)	37,721,000	12.8
Older women	155,191,000	52.8
Older people in multidimensional poverty	32,076,749	10.9
Older people living in a rural location	129,778,464	44.1
Older people living alone	26,995,458	9.2
Older women living alone	16,446,417	10.6
Older people needing care	72,238,029	24.6
Older people needing social support	101,359,511	34.5
Older people with unmet care needs (care gap)	3,788,310	1.3

---

[132] Clough et al, *The support older people want and the services they need*, York, Joseph Rowntree Foundation, 2007, p.6
[133] Strengthening Family Institution: Caring for the Elderly http://www.icsw.org/doc/Strengthening-Family-ICSW-on-Care-of-Elderly-5thGO-NGO-Nov10.pdf, p.10 (25 April 2013)
[134] Current status of the social situation, well-being, participation in development and rights of older persons worldwide, http://www.un.org/esa/socdev/ageing/whatsnew%20PDF/Ageing%20Comprehensive%20report%202010%202%20September.pdf, pp.8-9 (25 April 2013)
[135] Lloyd-Sherlock, *Population ageing,* p.125
[136] Living arrangements and well-being of the older population: future research directions, http://www.un.org/esa/population/publications/bulletin42_43/velkoff.pdf (6 May 2013)
[137] Data for this section is available in Appendix 1.

Figure 10: Care needs[138] and social support needs[139] of older people

Legend:
- Care needs (black)
- Social support needs (pink/red)
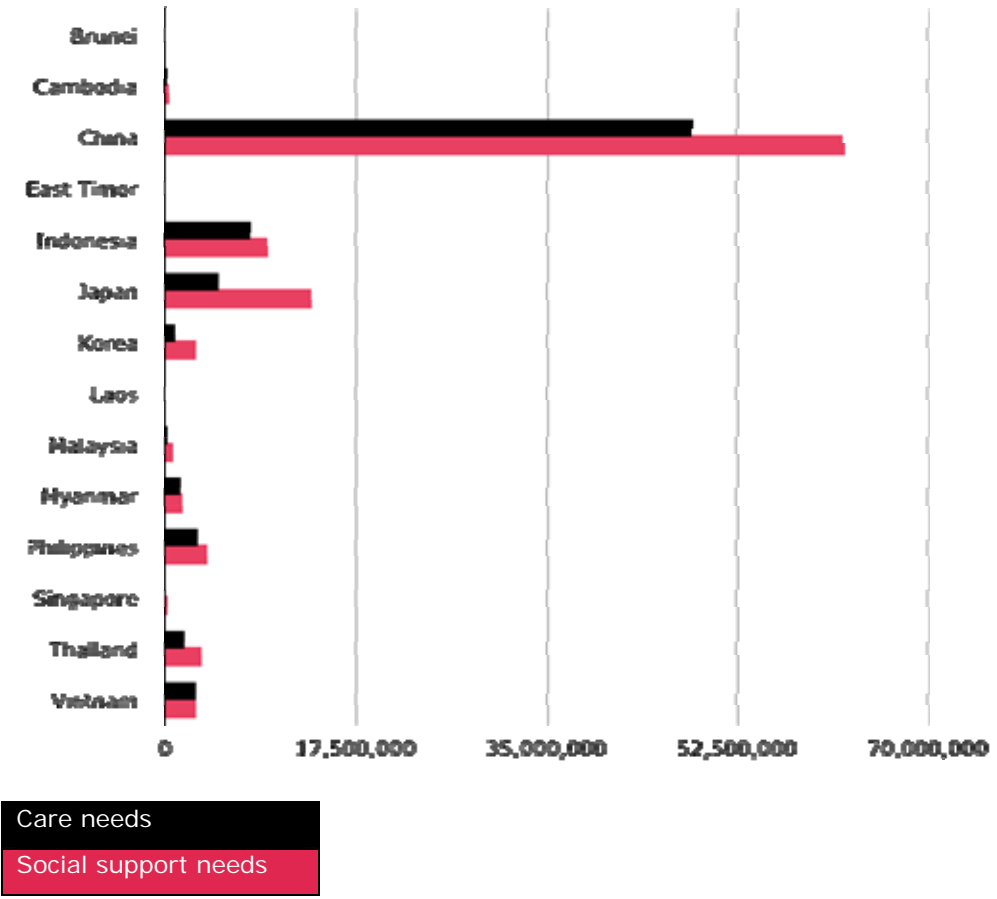
Figures under 200,000 (for Brunei, Laos and care needs in Singapore) are too small to show on this graph.

Social support needs, as measured by the proportion of older people who have felt sad, low or depressed in the last month, outstrip care needs in almost all countries. The most significant differences between social support needs and care needs are in Japan and China. The combined care and social support needs in Indonesia are also significant in relation to the population size of older people; the Philippines also has a large number of older people in need of care and social support compared to population size.

---

[138] Estimated number that had some level of difficulty with self care in the last 30 days
[139] Estimated number that reported feeling sad, low or depressed in the last 30 days

Figure 11: Care gaps[140]
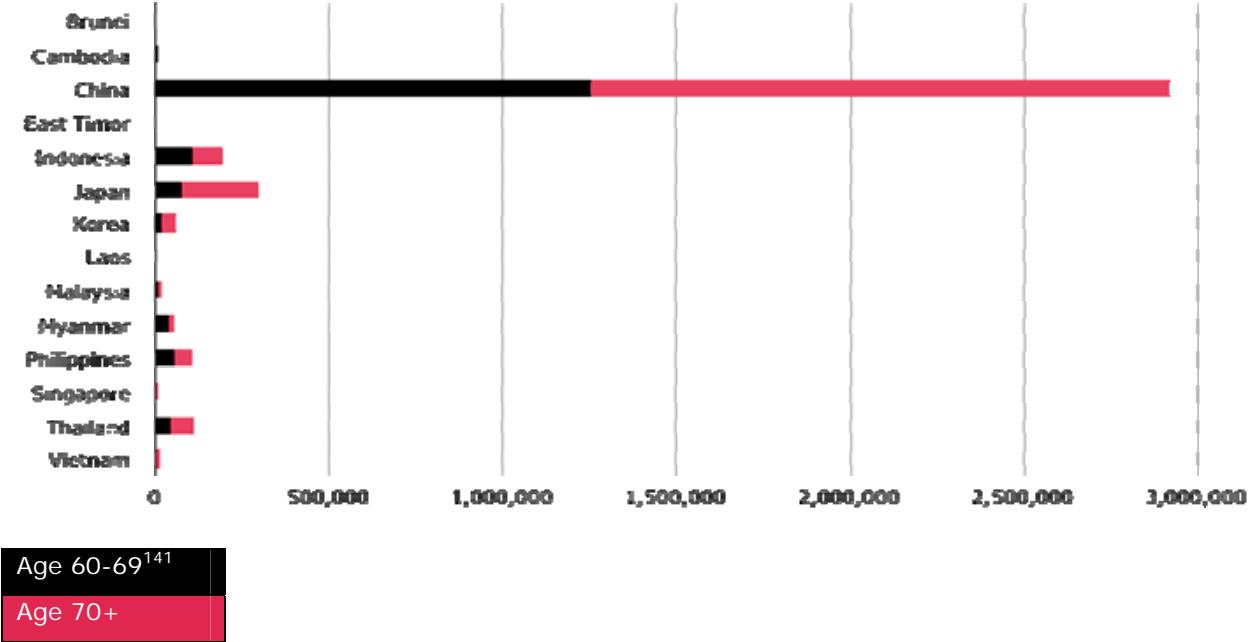
The prevalence of family-based care can, of course, lead to older people with care needs being missed, where they have no family nearby (or their family is unable or unwilling to help); where there are no statutory or voluntary services which can fill the gap; or where older people themselves cannot or choose not to ask for help. Despite Myanmar's strong tradition of respect and resulting care for older family members, for example, gaps in care can develop where families struggle to meet their own needs or where older people wish to avoid becoming a burden on their children and do not therefore ask for their help.[142] Older people may not know about their options; in Vietnam, 60 per cent of older people do not know about care services available to them or how to access them.[143] Institutional care in the region can be patchy, unaffordable and considered to be shameful in that people are not being cared for by family. Further, it should not be assumed that co-residence necessarily leads to suitable care for older people; adult children who are unemployed, disabled or substance abusers may be more likely to live with their parents.[144]

---

[140] Estimated number who had unmet care needs
[141] Data was not available with a breakdown of 60-79 and 80+
[142] Knodel, *The situation of older persons in Myanmar*, p.110
[143] UNFPA, *The aging population in Viet Nam: current status, prognosis, and possible policy responses*, Hanoi, United Nations Population Fund, 2011, pp.1-68
[144] Lloyd-Sherlock, *Population ageing*, p.124

Figure 12: Care gap by gender
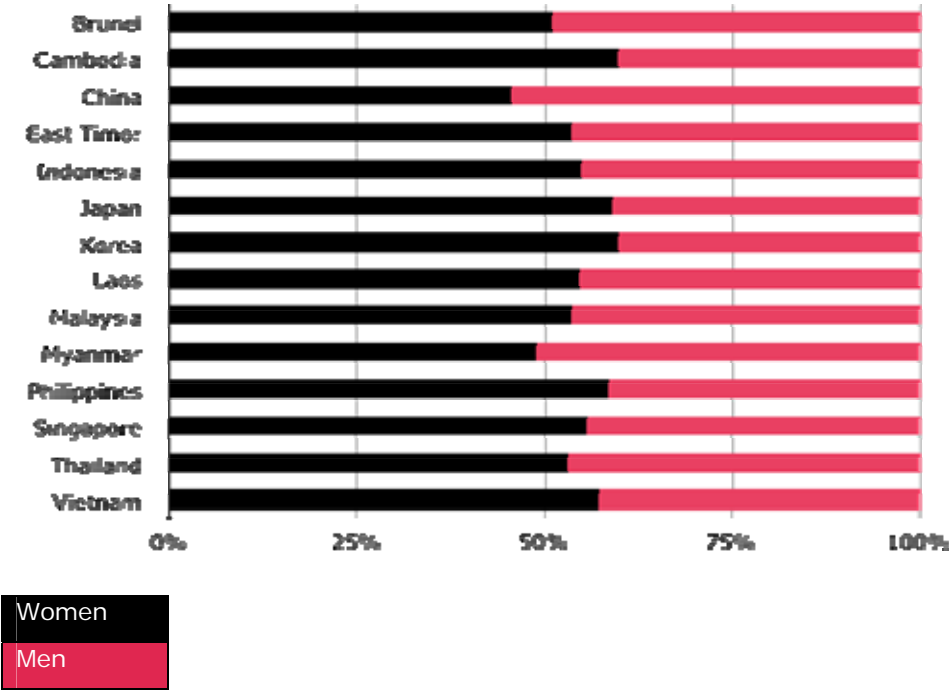
Women
Men

Care gaps are experienced differently according to gender and country; in the Philippines and Malaysia, proportionately more women than men perceive an unmet care need, whereas in China and Myanmar, this is the case for men more than women. In Laos and Vietnam, the proportions are the same. The proportion of care gaps experienced by each gender moves fractionally towards women when applied to the overall population of older people, as there are more women than men. As shown by figure 12 above, care gaps are experienced by both genders. While there are more older women, and their needs have been neglected in the past, older men also need attention. The differentiated implications of gender on old age care are not sufficiently understood at present; this is an area where further research is required.

Figure 13: Care gap by location (urban/rural)
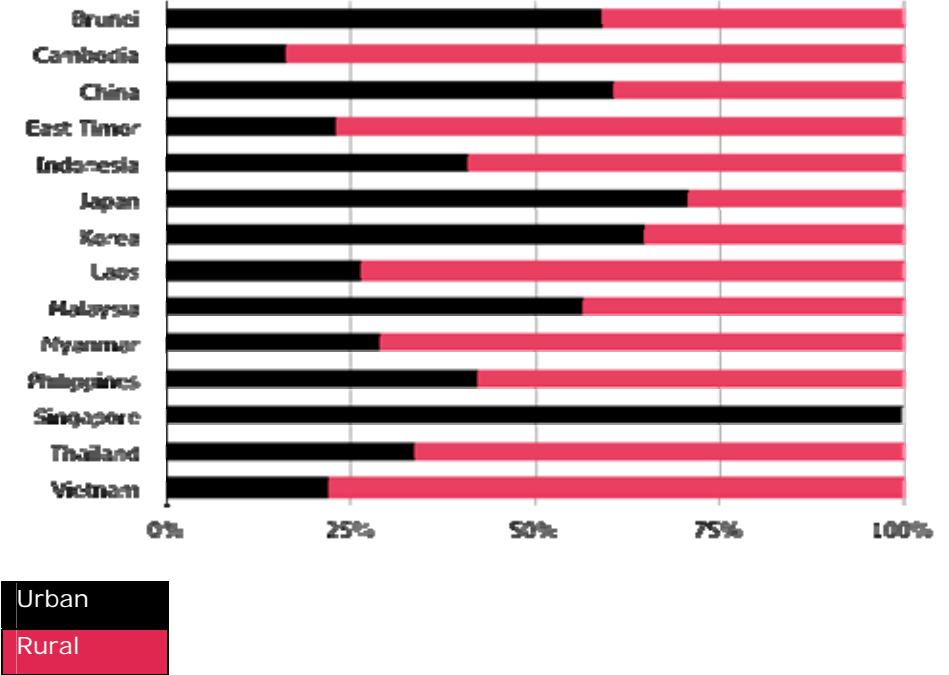

Urban
Rural

Figure 13 above shows older people experiencing care gaps broken down by whether they live in an urban or rural location. The underlying data shows that a greater proportion of people

living rurally experience care gaps than those living in towns and cities, apart from China,[145] where care gaps are experienced by a greater proportion of people living in urban locations.

Figure 14: Care gap by poverty level
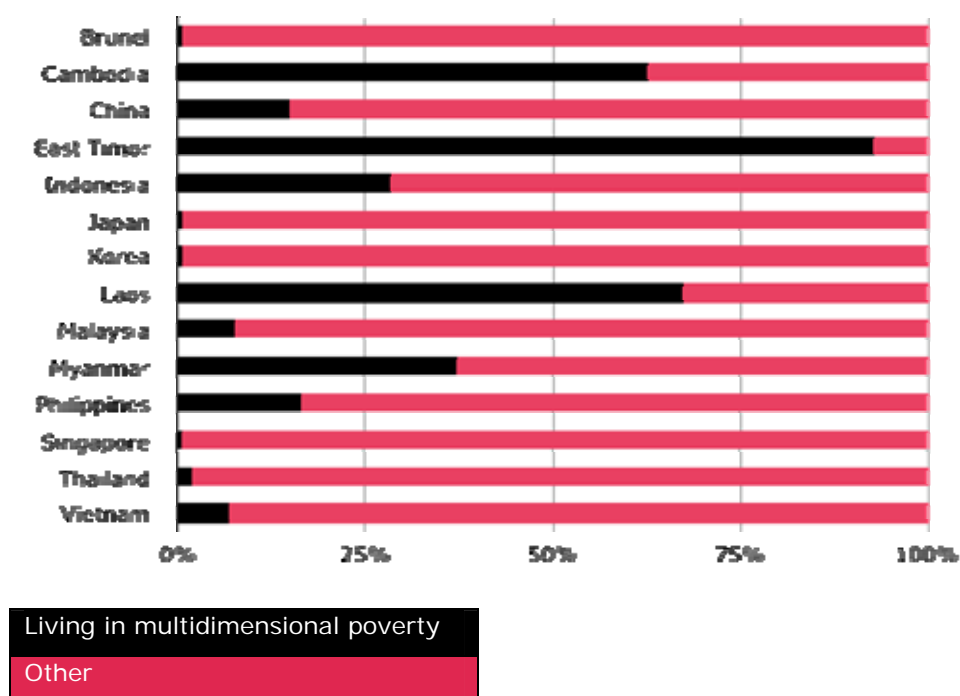

Living in multidimensional poverty
Other

Figure 14 above shows the proportion of care gaps experienced by older people living in multidimensional poverty. This measure of poverty covers three dimensions: health, education and living standards, consisting of 10 indicators.[146] It is therefore a relatively strict level of poverty, and there will be many older people experiencing aspects of poverty who are not represented by this graph. There are two key implications of this data. First is the overwhelming link between multidimensional poverty and care gaps in East Timor, Laos and Cambodia. The second is the link between poverty and care gaps across all countries: the underlying data shows that the poorest fifth are 1.2 times more likely than the middle income fifth to experience poverty gaps in Malaysia; 1.3 times more likely in Myanmar; 1.5 times more likely in China; 1.6 times more likely in the Philippines; 2.5 times more likely in Laos; and 5 times more likely in Vietnam.

Observations

- The key implication of this data is that social support needs are far more prevalent than care needs, yet very little provision exists for it at the present time. There is little consideration of the social support needs of older people in policy making and research, in comparison to the consideration of more general care and health needs. It is critical for policy makers to consider ways in which social support can be provided to older people, even those without more general care needs.

- There is a stark link between care gaps and poverty in East Timor, Laos and Cambodia, and people living in poverty are more likely to experience care gaps in all countries. Community-based care programmes should have a particular focus on targeting poorer communities; and also on older people's groups which can support income generating activities to help meet the costs of care.

[145] And in Singapore, which is a city state; this is not included in the original data, however
[146] Multidimensional Poverty Index, http://hdr.undp.org/en/statistics/mpi/ (14 June 2013)

- While the greatest relative care need[147] is among the oldest old, the greatest absolute care need[148] – and the age group at which HelpAge should consider focusing much of its effort – is therefore in the 70 to 79 age group. This could be because they are larger in number than the 80 plus age group, but less mobile and connected than the 60 to 69 age group.

- If HelpAge is to select one country in the region on which to focus its efforts, China outstrips the others not only in terms of scale, but also – with the exception of the Philippines - in terms of proportional need. The care gap in China is more than three times the size of that in all the other countries put together.

- Despite there being more older women than men in China and Myanmar, more men experience care gaps in both of these countries; the reasons for this need to be explored further so that they can be addressed in local programmes.

Projected care gaps

The following graphs give projections of gaps in care to 2050, based on the proportion of older people experiencing care gaps from the projected population in each country.[149] The baseline scenario assumes that the same proportion as currently will experience gaps in care; the second two scenarios assume that the proportion experiencing gaps in care will increase by 20 per cent and 40 per cent respectively, on the basis of demographic changes and external influences highlighted elsewhere in this report (for example, fewer adult children available to care for parents who are living longer).[150]

Figure 15: Projected care gaps, current and 2050, baseline scenario

2013
2050

---
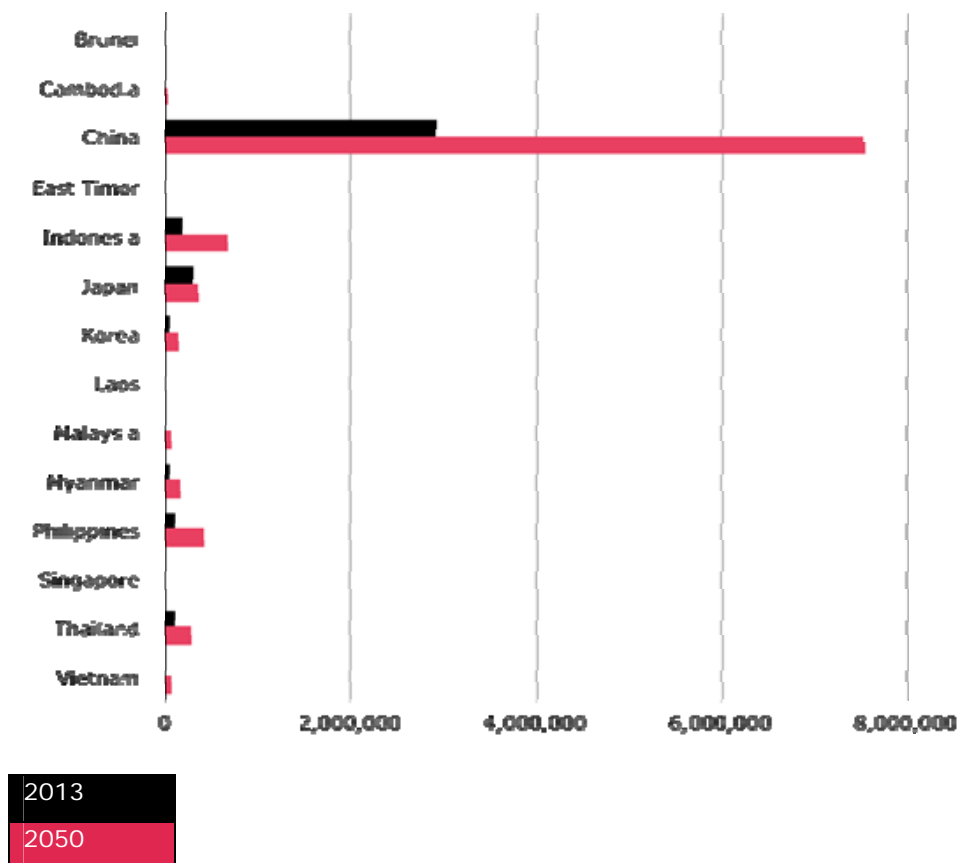
[147] We define "relative care need" as the level of care needed compared to those who need no assistance with the activities of daily living.
[148] We define "absolute care need" as the number of people needing care.
[149] UN Population Prospects 2010, Medium Variant
[150] There is no concrete data from which to base the proportional change for the medium and high change scenarios; these figures are intended to be illustrative only.

Figure 16: Projected care gaps, current and 2050, medium change scenario (plus 20 per cent)
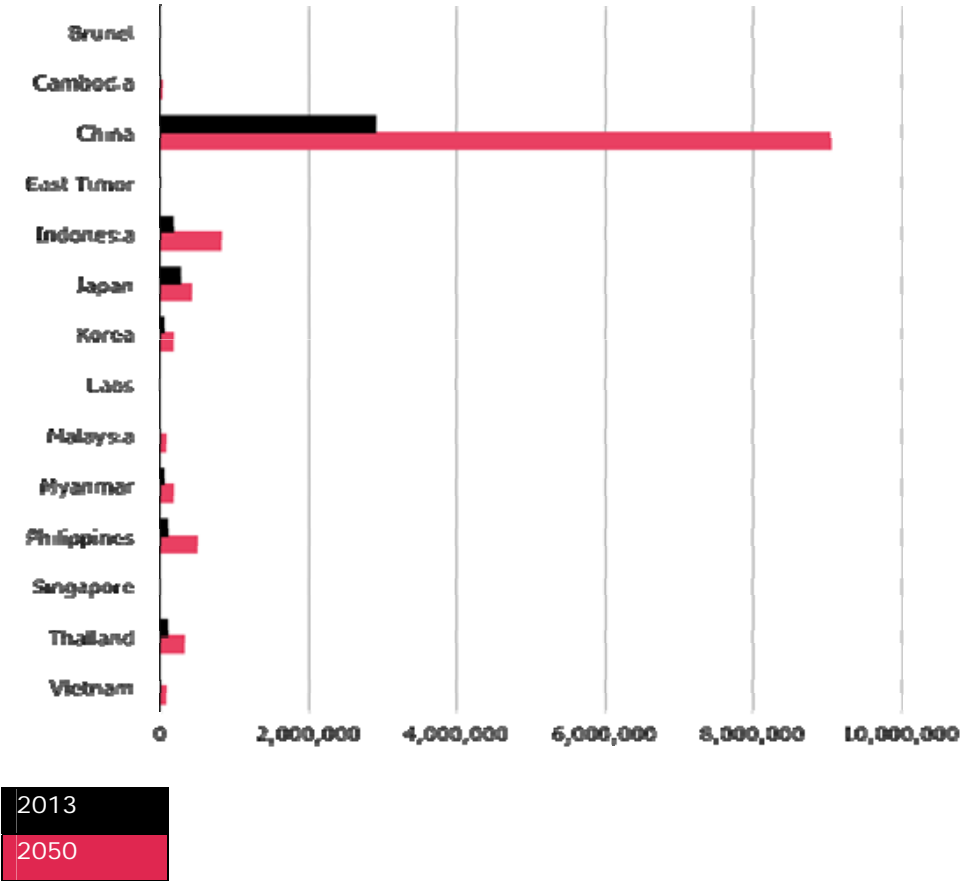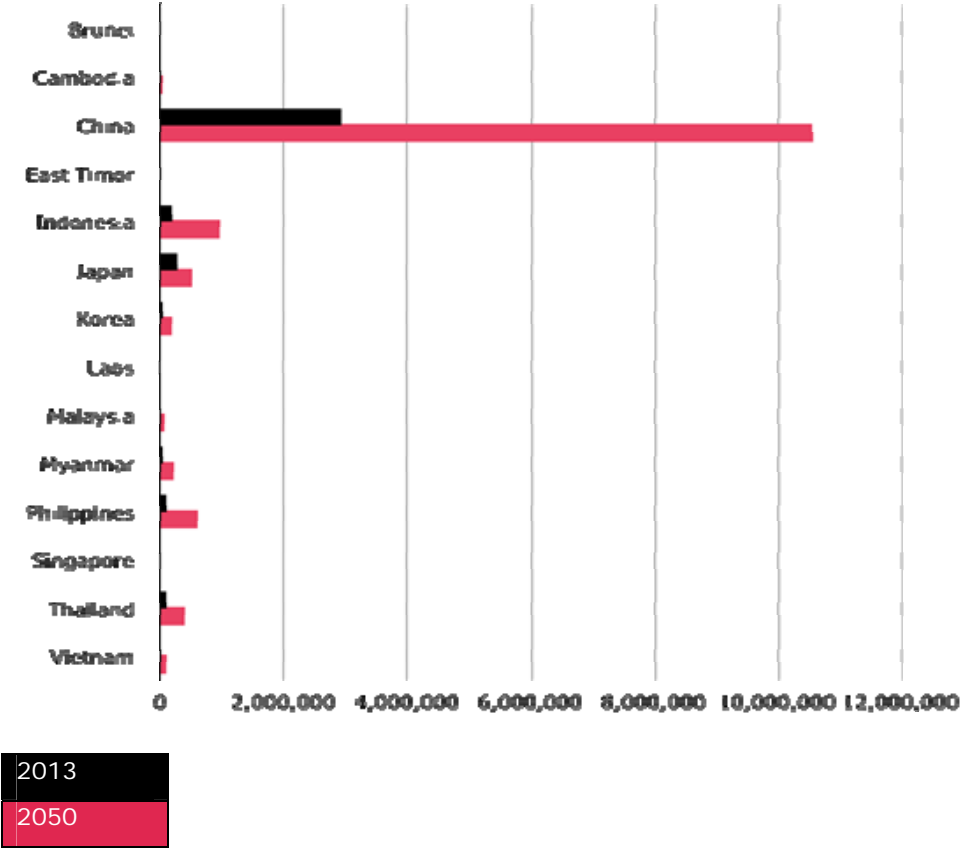

2013	
2050	

Figure 17: Projected care gaps, current and 2050, high change scenario (plus 40 per cent)

2013	
2050	

	Brunei	Cambodia	China	E.Timor	Indonesia	Japan	Korea
2013	182	8,830	2,919,752	535	194,360	296,000	57,982
2050 baseline	1,018	32,296	7,530,952	1,886	684,008	369,188	146,022
% change	559	366	258	353	352	125	252
2050 medium	1,222	38,755	9,037,142	2,263	820,810	443,026	175,226
2050 high	1,425	45,214	10,543,333	2,640	957,612	516,863	204,431

	Laos	Malaysia	Myanmar	Philippines	Sing.	Thailand	Vietnam
2013	1,926	15,770	52,383	107,102	5,520	112,564	15,404
2050 baseline	7,506	62,222	157,584	429,880	18,484	281,944	67,280
% change	390	395	301	401	335	250	437
2050 medium	9,007	74,666	189,101	515,856	22,181	338,332	80,736
2050 high	10,508	87,111	220,618	601,832	25,878	394,721	994,192

Health

The social determinants of adult health and health in later life are complex; they include stress, early life, social exclusion, work, unemployment, social support, addiction, food and transport.[151]Noncommunicable diseases are influenced by a variety of factors which include diet and malnutrition, smoking and alcohol use, exercise and exposure to toxins; these in turn are linked to income, housing conditions, working conditions, transport, agriculture and education.[152]

Health inequalities are evident from the differences in life expectancy rates across the region. Health inequalities are also prevalent within countries; some groups of older people are more susceptible to disease and illness than others, and much of this is determined by both levels of income and public policy.[153] Scores for activities of daily living (ADLs) and quality of life can vary according to location; this may be related to the level of an area's economic development[154] or to the availability of care systems for older people,[155] but further investigation is needed.

The increased lifespan linked to ageing populations brings with it a number of health challenges. The five most prevalent diseases and conditions for older people in Southeast Asia are cardiovascular diseases (33 per cent of all disability adjusted life years: 76,038,788), cancer (14 per cent: 33,298,876), sense organ diseases (12 per cent: 26,686,055), respiratory diseases (9 per cent: 21,286,144) and neuropsychiatric conditions (8 per cent: 18,050,340). The main increases in prevalence between now and 2030 are likely to be in:[156]

- Respiratory infections and respiratory diseases
- Sense organ diseases
- Genitourinary diseases

---

[151] Marmot M, "Social determinants of health inequalities", *The Lancet 365*, 2005, pp.1099-1104
[152]Health in the post-2015 development agenda: need for a social determinants of health approach, http://www.worldwewant2015.org/file/300184/download/325641(12 May 2013)
[153] Marmot M, pp.1099-1104
[154] See, for example, Okumiya K et al, "Comprehensive geriatric assessment for community-dwelling elderly in Asia compared with those in Japan: IV. Savannakhet in Laos", *Geriatrics & Gerontology International 5(3)*, 2005, pp.159-167
[155] Wada T et al, "Comprehensive geriatric assessment for community-dwelling elderly in Asia compared with those in Japan: V. West Java in Indonesia", *Geriatrics & Gerontology International 5(3)*, 2005, pp.168-175
[156] Calculated from WHO's projections of mortality and burden of disease, 2004-2030, Standard DALYs – Baseline Scenario, http://www.who.int/healthinfo/global_burden_disease/projections/en/index.html (7 May 2013)

- Oral conditions

- Unintentional injuries

- **Epidemiology projections for those aged 60 and above (proportion of disability adjusted life years)[157]**

Cause	2008	2030	Rise/Fall
Communicable diseases & nutritional conditions	**7.5%**	**6.3%**	⇓
Infectious and parasitic diseases	3.6%	2.2%	⇓
Respiratory infections	3.3%	3.7%	⇑
Nutritional deficiencies	0.5%	0.4%	⇓
Noncommunicable diseases	**88.7%**	**88.4%**	⇓
Cardiovascular diseases	32.8%	31.4%	⇓
Malignant neoplasms (cancer)	14.4%	11.7%	⇓
Sense organ diseases	11.5%	16.2%	⇑
Respiratory diseases	9.2%	11.9%	⇑
Neuropsychiatric conditions	7.8%	6.5%	⇓
Diabetes mellitus	3.3%	3.0%	⇓
Digestive diseases	3.2%	1.9%	⇓
Musculoskeletal diseases	2.9%	2.1%	⇓
Genitourinary diseases	1.7%	1.9%	⇑
Oral conditions	0.8%	1.3%	⇑
Endocrine disorders	0.7%	0.2%	⇓
Skin diseases	0.3%	0.2%	⇓
Other neoplasms	0.2%	0.1%	⇓
Congenital anomalies	0.0%	0.0%	⇓
Injuries	**3.7%**	**5.4%**	⇑
Unintentional injuries	2.9%	4.7%	⇑
Intentional injuries	0.8%	0.7%	⇓

Mental health is a key area of unmet need. It tends to be influenced by external factors. Older people are particularly at risk of isolation and alienation due to rapid change, modernisation and economic crisis, which in turn increase rates of depression and anxiety.[158]Dementia rates are expected to increase by over 300 per cent between 2001 and 2040 in China and South Asia, compared to 100 per cent in developed countries.[159]Poor mental health can be an under-reported issue among older people in the region; stoicism is valued and mental illness is often stigmatised. According to one study, among Khmer and Lao cultures, "being labelled as mentally ill is devastating to the individual and to his or her family. As a consequence, mental illness tends to be feared or denied." This can lead to people reporting physical symptoms rather than seeking help for mental health issues.[160]

Observations

- Significant proportions of the older population are likely to have long-term illness; this will have a large impact not only on the level of health and social care required, but also the type of care provided. In order to provide the correct care for older people, it will be necessary for social and health care providers to collaborate closely, and for the appropriate supporting policies to be developed.

---

[157] Calculated from WHO's projections of mortality and burden of disease, 2004-2030, Standard DALYs – Baseline Scenario, http://www.who.int/healthinfo/global_burden_disease/projections/en/index.html (7 May 2013)
[158] Lloyd-Sherlock P, "Epidemiological change and health policy for older people in developing countries: some preliminary thoughts", *Ageing Horizons 2*, p.22
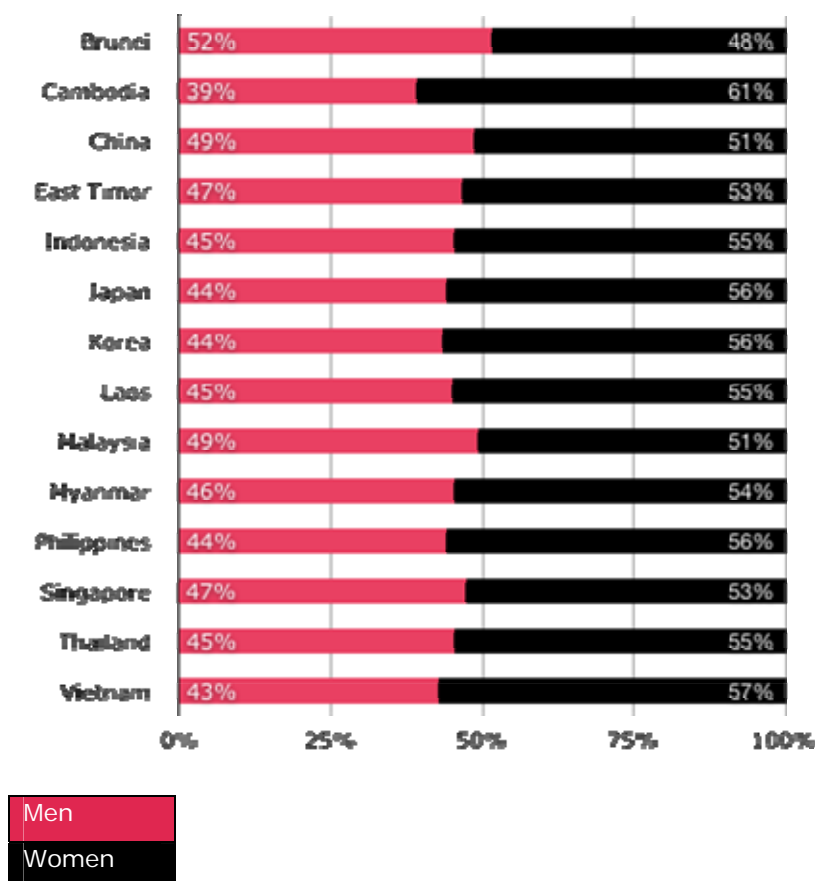[159] Prince M et al, "Mental health care for the elderly in low-income countries: a health systems approach", *World Psychiatry 6(1)*, pp.5-13
[160]Anhaouy C et al, "People of Cambodian and Laotian descent", in Waxler-Morrison et al (eds), *Cross-cultural caring*, Vancouver, UBC Press, 2005, pp.116-117

- Health care needs to be tailored according to local circumstances. There may be different prevalence of types of conditions; equally, health may be more of an issue generally in poorer areas.

- A "life course" perspective is important here; HelpAge might consider building public education programmes into their work with older people's groups in order to reduce the prevalence of debilitating conditions in future generations.

- With changes in epidemiology over time, it will be necessary to ensure that older people remain fully apprised of the key risks to their health. Updated information will also require communication to, and training of, health staff in community care scenarios. The most prevalent conditions are cardiovascular diseases and cancer; key areas of changeare in respiratory infections and respiratory diseases, sense organ diseases, genitourinary diseases, oral conditions and unintentional injuries.

- Home- or institution-based palliative end-of-life care is likely to become increasingly needed as populations age.[161] It is not yet known how scientific and technological advances may affect longevity; it is possible that life expectancy will increase beyond current projections. It is also possible that illness and disability could be reduced significantly through such advances, making societies better able to deal with demographic change.[162]

- Further research would be useful on factors which influence the differences in ADLs and quality of life between locations.

Gender
Figure 18: Proportion of older people aged 60+ by gender, 2013[163]

	Men	Women
Brunei	52%	48%
Cambodia	39%	61%
China	49%	51%
East Timor	47%	53%
Indonesia	45%	55%
Japan	44%	56%
Korea	44%	56%
Laos	45%	55%
Malaysia	49%	51%
Myanmar	46%	54%
Philippines	44%	56%
Singapore	47%	53%
Thailand	45%	55%
Vietnam	43%	57%

Men

Women

---

[161] WHO, *Women, ageing and heath*, p.19
[162] (2006 data) Preparing for the Challenges of Population Aging in Asia: Strengthening the Scientific Basis of Policy Development, https://download.nap.edu/catalog.php?record_id=12977, p.22 (9 May 2013)
[163] Calculated from UN Population Prospects, 2010 edition, Medium Variant

The gender ratio varies significantly by country. In Cambodia, for example, there are proportionately more older women than in other countries in the region due to the high number of men who died during the time of the Khmer Rouge.[164] The impacts of gender on ageing and care are also context-dependent; according to one set of authors who have conducted several country-level analyses of gender and ageing across the region, "assessments of the interaction of gender and ageing need to move beyond assumptions of universal disadvantage among older women and explore the experiences of both older men and women in specific social and temporal contexts".[165]

Women in many parts of Asia are encouraged to marry men who are older than them, which makes widowhood in later life more likely.[166] In Myanmar, for example, over half of older women are widowed, compared to just one fifth of men.[167] Women are often discouraged from remarrying, and may be stigmatised if they do so. Men, by contrast, are often encouraged to remarry.[168] In Indonesia, for example, older men are more likely than women to remarry if their spouse dies, and to marry somebody younger who can help to care for them.[169]

In many Asian societies, older women are likely to live with the family of one of their children after the death of a spouse.[170] The prevalence of migration, however, means that instead of receiving care, they often have to look after their own grandchildren. According to one assessment, "this means that the role of family caregiver is still carried to the end by elderly women in many traditional societies".[171]

There is a strong link between poverty and poor health in older women; the greatest risk factor for poor health in older women is poverty.[172] Women's health in later life is defined by greater longevity than men, but poorer health. A number of factors leave women particularly vulnerable to ill health in old age. These include reduced access to food and care in childhood due to gender discrimination; lower levels of education and income; domestic violence; widowhood, which can lead to loss of income and social isolation; and limited access to health care due to cultural traditions and attitudes.[173]

This vulnerability to poor health is reflected by research across the region. Older women in Cambodia report their health to be worse than older men do; they have more functional limitations, and they are also more likely to feel unhappy.[174] Gender differences in mental health and wellbeing are also apparent in Thailand, where older women are "more likely to feel stressed, moody, hopeless, useless, unhappy, or lonely".[175]

Some diseases, including Alzheimer's disease, are more prevalent among women because they live longer; others, such as cervical cancer and breast cancer, tend to be female-specific. Women are more likely to suffer from osteoarthritis and osteoporosis. They are at greater risk from blindness than men in part because of their longevity, but also because they have less access to treatment. Access to treatment is a key contributory factor for many health conditions in older women. According to the WHO, women with heart disease "are less likely to

---

[164]Knodel J et al, "Gender and well-being of older persons in Cambodia", *Population Studies Center Research Report 09-665*, 2009, p.8
[165]Knodel J et al, "Gender and ageing in Thailand: a situation analysis of older women and men", *Population Studies Center Research Report 08-664*, 2008, p.2
[166]UNESCAP, "In the care of the state and the family", p.7
[167]Knodel, *The situation of older persons in Myanmar*, p.13
[168]UNESCAP, "In the care of the state and the family", p.7
[169] Do-Le K et al, "Community-based support for the elderly in Indonesia: the case of PUSAKA", paper presented at the 2002 IUSSP Regional Population Conference on *Southeast Asia's Population in a Changing Asian Context,* Jakarta, Research Centre for Population, 2002,pp.1-23
[170]Wahyuni E, "Gender issues in elderly care in Malaysia and Japan", in The Nippon Foundation (ed), 2008, *Are we up to the challenge? Current crises and the Asian intellectual community*, Bangkok, The Nippon Foundation, pp.67-76
[171]Wahyuni, pp.67-76
[172]WHO, *Women, ageing and heath*, p.32
[173]WHO, *Women, ageing and health*, p.5
[174]Knodel, "Gender and well-being of older persons in Cambodia", pp.1-34
[175]Knodel, "Gender and ageing in Thailand", p.11

seek or be provided with medical help and to be properly diagnosed until late in the disease process".[176]

Observations

- Community health providers and community leaders may wish to consider ways in which older women (particularly widows or those without family) can be helped to access health services and community support. This may include the provision of transport or money.

- The health risks to older women are significantly higher than for older men; targeted health initiatives and increased awareness of the issues involved, and the risks, may help to ameliorate some of the impact. The use of community care providers or religious authorities to disseminate health information specifically for older women may help to overcome some of the barriers of isolation; specific awareness of issues such as depression and loneliness may be particularly needed.

- Following evidence that older women are neglected in research into, and provision of, care services, there is a risk that the needs and preferences of older men may be neglected. Research into care services and the provision of appropriate policy needs to ensure that both genders are considered and consulted equally.

Social networks

Family-based social support is important for older people throughout the region. The social networks available to older people are dependent on both culture and context; the Khmer Rouge, for example, eroded traditional strong family ties in Cambodia.[177] The importance of family networks can leave older people vulnerable if their children migrate. This can be for a range of reasons, including a lack of available physical care, lack of anticipated remittances if children do not earn what they expected, having to look after grandchildren or having to sell assets to raise capital for their children.[178] Increasing female labour force participation is leading in some cases to the employment of carers to look after the needs of older parents, but an absence of care by close relatives may have a negative impact on the psychological and social support available to these older people.[179]

Social capital can have an effect on health; strong networks and support are associated with preventing the onset of functional disability,[180] lower levels of depression[181] and reducing the link between physical impairment and depression.[182] There is a paucity of research looking at the relationship between social capital and health in developing countries, however, and still less linking it to age. One of the key areas of academic research and debate in this area examines whether the health boosting aspects of social capital are limited to countries that have achieved sufficient wealth to enable them to make the "epidemiological transition".[183]

While older people in developed countries tend to be more involved in volunteering and community organisations than other age groups, evidence for this in developing countries is fragmentary. The limited available evidence from developing countries suggests where there is involvement in such groups, it is only available to older people who are highly educated or otherwise privileged.[184] This suggests that more work needs to be done to build volunteering

---

[176] World Health Organization, *Women, ageing and heath*, pp.11-14

[177] Anhaouy C et al, "People of Cambodian and Laotian descent", in Waxler-Morrison et al (eds), *Cross-cultural caring*, Vancouver, UBC Press, 2005, p.104

[178] Krieger P, "Gaps in the family networks of older people in three Indonesian communities", *Oxford Institute of Aging Working Paper Number 305*, p.5

[179] Lloyd-Sherlock, *Population ageing,* p.125

[180] Aida et al, "Does social capital affect the incidence of functional disability in older Japanese? A prospective population-based cohort study", *Journal of Epidemiology and Community Health 67*, 2013, pp.42-47

[181] Chan A et al, "Living arrangements, social networks and depressive symptoms among older men and women in Singapore", *International Journal of Geriatric Psychiatry 26(6)*, 2011, pp.630-639

[182] Suttajit S et al, "Impairment, disability, social support and depression among older parents in rural Thailand", *Psychological Medicine 40(10)*, 2010, pp.1711-1721

[183] Campbell C, "Social capital and health: contextualising health promotion within local community networks", in Baron S et al (eds), *Social capital: critical perspectives*, Oxford, Oxford University Press, 2001, pp.182-196

[184] Lloyd-Sherlock, *Population ageing,* p.127

and community involvement opportunities for broad groups of people in some of the poorer countries in the region.

Good practice identified through the mapping of services throughout the region in terms of building social support networks for older people includes the following:

- Provision of transport services, such as a community bus scheme which runs regularly and which stops often, to enable mobility-impaired older people to attend health centres, activity centres, shops and other places which can keep them mobile, active and plugged in to social networks.
- Focusing care services in local community centres to encourage older people to remain active and to reduce the risk of social isolation. Where people cannot or will not leave their homes, home-based care is offered, but only where essential.
- Activities in day centres or community centres. These might include art, sports and other leisure activities. While these are not directly related to care, they can keep people active and engaged and thereby act preventatively.
- Provision of regular meals at a community level in order to encourage mobility and interaction, and offered at home as a last resort.
- Development of a model which can be set up and run by small local groups, with national support and eventual accreditation to encourage groups to meet certain quality standards.
- Training older people in ways to plan and implement their own services and group activities.

Observations

- As demonstrated under "Care gaps" above, social support is the key area of need identified for older people in the region.

- The relationship between social capital and health is little understood; it is thought, however, that improved social capital contributes to greater wellbeing. Conducting research into this area may outline new ways in which to engage older people and improve their wellbeing.

- Older people in many countries are suffering from isolation and loneliness; an unrelated, but still important issue, is the lack of resources in many community care centres and organisations. By encouraging older people to volunteer their time and become involved in initiatives and organisations, both issues may be addressed.

- Potential mechanisms to build social networks and greater community involvement include older people's groups, which are a popular and growing institution in many countries, including Vietnam and Thailand. HelpAge may be able to support this model, perhaps by providing training to organisers within these groups in areas such as mental health and working with those affected by dementia.

Paying for care

The level of economic assistance given by children to their parents varies between and within countries. In Myanmar, adult children living in one of the main cities or abroad give more to their parents than those living closer. In general, two thirds of adult children give money or goods to their older parents, and over 40 per cent help their parents with economic activities. These flows of economic assistance are two-way. More than half of older people living with their children in Myanmar contribute to their households financially; support can also be non-financial in the form of childcare, housework and house maintenance.[185] According to one book looking at the relationship between population ageing and international development, the two-way nature of flows of support mean that "it is more helpful to view household relations in terms of interdependency, rather than who supports whom".[186]

Formal safety nets for older people are rare in Asian countries. Mandatory pension scheme coverage varies significantly; coverage is 95 per cent of the labour force in Japan but only 16

---

[185] Knodel, *The situation of older persons in Myanmar*, p.VII
[186] Lloyd-Sherlock P, *Population ageing and international development,* Bristol, Policy Press, 2010, p.124

per cent in Indonesia. The fact that a high proportion of people are employed in the informal economy complicates the lack of social support systems in many countries, as these individuals are unlikely to have formal pension provision.[187]

Access to formal care services, particularly in some of the poorer countries in the region, are tempered by people's ability to pay for them. There is evidence to suggest that many older people are living in poverty. Challenges for the care of old people also tend to be more serious and enduring when poverty is a factor.[188]Some older people decide not to get treatment rather than sell family assets.[189]

Paying for care is less of a challenge in some of the more developed countries in the region and those which have social security or insurance schemes for older people, such as Japan, Singapore and Thailand. Even in these countries, however, paying for care can be problematic. Many Singaporeans depend exclusively on a mandatory retirement savings fund in Singapore. In reality, however, few elderly people have the decreed amounts in their Central Provident Fund accounts.[190] There is an assumption among policy makers that the family will supplement individual savings.[191] Many older people throughout the region continue to work, particularly in less developed areas.

Observations

- While many countries have pension provisions for some of their citizens, in most circumstances it is not universal; as a result, some older people will have no financial means of accessing care, and no family to provide support. In these situations, means-tested subsidies for care may be a solution in countries where free universal health care for older people is not an option.

- The impact of older people's income level on their care choices is little understood and would benefit from further research.

Technology and environment

The application of telecarehas thus far been limited in many developing countries due to a lack of suitable infrastructure; this may change with the rapid uptake of mobile technology. It has been used successfully in certain countries in the region, mainly in relation to medical care rather than social care. In China, for example, a hospital established a pharmaceutical care programme by text message for discharged patients; messages included medication reminders.[192] Videoconferencing has been used in China and Korea as an assessment tool to diagnose dementia and other mental health problems.[193] A study looking at solutions to ageing in Japan set various technological benchmarks for ageing and care, including smart homes, bed sensors, telecare, robot care and call centre support.[194] Again, it seems unlikely that many of the less developed countries in the region will be able to make use of these technologies – at least not beyond a wealthy elite – in the near future.

Building design is an important consideration for many older people. In Singapore, stairs are an issue in many blocks, and older estates can lack easy-access doors or taps which are easy

[187] (2006 data) Preparing for the Challenges of Population Aging in Asia: Strengthening the Scientific Basis of Policy Development, https://download.nap.edu/catalog.php?record_id=12977, pp.17-18 (9 May 2013)
[188]Krieger P, (August 2005) Gaps in the family networks of older people in three Indonesian communities, Working Paper Number 305, Oxford Institute of Ageing http://www.ageing.ox.ac.uk/files/workingpaper_305.pdf, p.32 (26 April 2013)
[189] Kato E, "Ageing in Cambodia: tradition, change and challenges", in Phillips D (ed), *Ageing in the Asia-Pacific region: issues, policies and future trends*, London, Routledge, 2005
[190]Choon C, "The Central Provident Fund and Financing Retirement Needs of Elderly Singaporeans", in H Lee (ed), Ageing in Southeast and East Asia http://books.google.co.uk/books?id=N0iQ0rFfsokCp.31 (26 April 2013)
[191]Chan A, Singapore's Changing Structure and the Policy Implications for Financial Security, Employment, Living Arrangements and Health Care, http://www.populationasia.org/Publications/RP/AMCRP3.pdf, Asian MetaCentre for Population and Sustainable Development Analysis, National University of Singapore, p.9
[192] Mao Y et al, "Mobile phone text messaging for pharmaceutical care in a hospital in China", *Journal of Telemedicine and Telecare 14*, 2008, pp.410-414
[193]Botsis T et al, "Current status and future perspectives in telecare for elderly people suffering from chronic diseases", *Journal of Telemedicine and Telecare 14*, 2008, pp.195-203
[194] Solutions for Japan's Ageing Population, http://www.oecd.org/internet/ieconomy/46977818.pdf (15 May 2013)

to turn on[195]. As a result, ageing in place policies are supported by various housing schemes initiated by the Housing and Development Board (HDB). The HDB has also improved building accessibility for elderly and disabled people through the Barrier-Free Accessibility programme and put in place measures to create more user-friendly environments in new HDB homes.[196]In the Philippines, improved accessibility to public buildings and facilities for older and disabled people have been enshrined in law since 1982.[197]

Observations

- The use of technology to aid the diagnosis and delivery of care needs is minimally established in the region; the major challenge to its wider usage is the lack of technological infrastructure generally, and specifically in rural areas. In the wealthier countries in the region and in urban hubs, however, the use of technology may also enable the delivery of support mechanisms, such as online phone/video contact between families and older people, and also online training for carers or volunteers. It is also an area which may rapidly increase its potential due to the uptake of mobile technology.

- While physical accessibility is recognised as a vital part of older people obtaining care and support, it is not enforced in many countries in the region. This is, partially, due to poverty and lack of dedicated resources for infrastructure projects of this nature. The creation of new community care facilities, or the use of existing centres, needs to be viewed in light of accessibility for all older people.

6. Analysis and recommendations

6.1 Challenges and opportunities

Challenges

The key challenges facing care provision in the region include, but are not limited to:

- Lack of evidence/data
- Demographic changes
- Changing family structures
- Stigmas and perceptions
- Quality of care
- Accessibility and financing care
- Infrastructure

Lack of evidence/data

There are a number of gaps in the available research and literature that make analysis of the care provision and needs of older people in the region challenging. One of the biggest areas in which information is lacking concerns the preferences and needs of older people as regards the care they receive; there is also a lack of information on carers themselves and the support they require. English language information is thin in some cases, particularly relating to summaries of relevant CSO projects; this may prevent the identification of replicable good practice. Mental health, both of older people and of their carers, is also an area of research to which insufficient attention has been paid.

While it is likely to be challenging to achieve in practice, the standardised collection of data on older people throughout the region would be highly beneficial in terms of ensuring consistent

[195]Voices of Older People (VOP) Programme,http://www.tsaofoundation.org/pdf/Voices_of_Older_People_Housing_for%20website.pdf, p.4 (26 April 2013)
[196]State of the Elderly in Singapore 2008/2009, http://app.msf.gov.sg/Portals/0/Summary/research/State%20of%20the%20Elderly_Release%203.pdf (30 April 2013)
[197]Philippine Country Report, http://www.jicwels.or.jp/about_jicwels/ASEAN&JapanHighLevelOfficialsMeeting/5th%20Mtg.%20Country%20Report%202007%20-Community%20Services%20for%20the%20Elderly-/Philippines.pdf (1 May 2013)

information on the situation; it would also allow comparative analysis. For countries such as East Timor, where very little information on older people is available, it would also create an evidence base.

Demographic changes

Much of the literature concerning older people in the region focuses on the implications of demographic changes - specifically, the ageing population and the declining birth rate. These changes pose immense challenges to the provision of care in the region, particularly in cases where families are responsible. With fewer adult children to care for their longer-living parents, and the relocation of many workers away from their rural homes, the physical provision of care will become even more difficult in the future. Increased longevity also means that the length of time for which an older person may require care is likely to be longer. In some instances, it may mean that younger family members need to care for their relatives into their own retirement age, possibly creating a compound situation of carers requiring care.

Female longevity is a key challenge as far as care provision is concerned; older women are less likely to have independent finances, basic education or a history of formal employment which might have created a pension fund. The nature of the care provided, and the needs of older women, also provide challenges. Women are more likely to be susceptible to mental health issues and other conditions, and to rely on their families for comparatively longer than their male counterparts. The differentiated implications of gender on old age care are not sufficiently understood at present, however; this is an area where further research is required.

Changes in demographics also present challenges in terms of publicly provided care and the balancing of supply of care with demand. The collection of data, particularly related to the care needs of older people, is vital for policy makers to anticipate the future care requirements. The implications for older people in situations such as that of Japan, where there are two to three year waiting lists for places in aged care facilities, also needs to be considered.

Changing family structures

As with changing demographics, the changes in family structures are also cited prominently as one of the key factors influencing the provision of aged care. Specifically, this refers to the shift from an extended family model to a nuclear family model, the trend of labour force migration to urban centres and the growing participation of women in the workforce. In terms of the challenges that these changes present to older people, the primary impact is in situations where the family is responsible for the provision of care, or where the older person is not able to access care or support from other sources. In these situations, the options available to the older person include living alone or relocating to urban centres to live with family; there are implications for themental and physical wellbeing of the older person in both scenarios.

The expectation that families will bear responsibility for older people is also challenging in situations where younger family members are not able to provide care; for example, in cases where younger family members are unemployed, disabled or experiencing health issues, or experiencing poverty. In these situations there is a higher likelihood of elder abuse, where carerseither do not understand the care requirements of the older person, experience frustration with the older person or have their own health issues that require care.

While the model of institutional care is suggested as a solution to situations where families cannot or will not provide care, it can also bring its own challenges. In instances where older people require specialist care, have specific health issues or where the family cannot access the support it requires to care for the older person, institutionalisation can separate families.

Stigmas and perceptions

A lack of understanding and prevalent stigmas relating to care and mental health issues are significant challenges. The lack of understanding of the care older people want and need is of particular concern. The emphasis on familial care to the exclusion of the provision of public care in some countries is not always beneficial to the older person; in situations where the carers experience poverty, illness or disability, the older person is more likely to receive a reduced standard of care. The social stigma in some cultures of placing older people in institutional care, particularly where the family is unable to provide care due to poverty or illness, is also a significant challenge that needs to be overcome.

Care preferences of older people are little understood. There is an assumption, for example, that older people wish to live with their children, when in fact many older people in the region tend to prefer to stay in their own homes and live close to their adult children. The impact on the carer of providing care is also insufficiently understood and is likely to result in a lack of support being provided to the carer. Carers are more likely to experience depression and anxiety; the stigma of mental health issues requires a shift in perception, particularly where it affects carers and older people.

Quality of care

The challenge for all countries operating dual public/private models of care provision is to ensure the consistency of quality in both models. In developing countries, and particularly those where additional community-based models of care are encouraged, this is particularly important. Quality assurance can be provided through the training and qualification of care professionals; making this training accessible in poorer countries and in rural areas may be challenging, however. In instances where trained care providers are not available in rural areas, inducing them to relocate may also prove challenging.

The quality of care older people receive from families is also extremely variable. A lack of support for family carers and lack of education about the requirements of the older person may contribute to a situation where both the carers and the care recipient are neglected. The stigma surrounding institutional care, where families are unable to discharge their obligation due to poverty or other pressures, can also contribute to situations where care is not adequately provided. Support mechanisms such as care networks, local carers' groups and respite care may ease the burden on families. The provision of mental health support, both for carers and older people, would also be beneficial.

Accessibility and financing care

Making care accessible in geographic and financial terms is a significant challenge for older people and governments in the region. In some rural areas, poor roads and infrastructure mean that older people are not able to access care facilities; in countries experiencing monsoon seasons once or twice per year, even more isolation is possible.

Financial barriers to accessing care and health services are also prevalent in countries without universal health care or state pension provision. Older people that previously worked in the informal sector are likely not to have pensions; older women, in particular, have less access to finances generally. Financial support that older people receive from their children is also likely to decrease in future as family sizes become smaller. There is an overwhelming association between poverty levels and care gaps across all countries. Financing care is a critical policy challenge facing the region.

Data on care gaps indicates that support needs are overlooked far more than care needs are; this reflects the lack of awareness of the support needs of older people and the lack of corresponding activity. Older people aged 70 to 79 are experiencing the greatest need of social support and care.

Infrastructure

Technological and physical infrastructure is a key challenge to the delivery of care; in many less developed countries, lack of transport infrastructure limits access to care and lack of telecommunications infrastructure limits the potential of telecare. Infrastructure in terms of the collaboration between care and health providers, and the lack of cohesion across the care continuum, is also a key barrier.

Opportunities

The key opportunities facing care provision in the region include, but are not limited to:

- The "demographic window"
- Potential for economic activity
- Community and holistic care
- Volunteerism
- Training and employment
- Technological advances

- Religion

"Demographic window"

The impact of ageing populations is likely to be felt by the next generation, who will then be of working age; countries, therefore, have a unique window of opportunity to make an impact upon the current generation, who will then be at the stage of requiring care. By raising awareness of the impacts of population ageing, policy makers may be able to mitigate some of the more negative possible outcomes. The potential to change behaviour in terms of encouraging greater savings during working life, and the ability to earn more as a result of having fewer children, is significant. Additionally, people with fewer children and more savings are likely to spend more on education, which creates a virtuous circle for the work and earning potential of future generations.

Community and holistic care; and integrated delivery models

There is unexplored potential in the area of community holistic care; in this model, care is provided by people locally who are not necessarily family. Community holistic care also utilises community centres, community buses to enable shopping and visits, short stay houses and clinics, and training for local volunteers in dementia care. This model would enable older people to access the peer support and services they need in a centralised, local way.

Integrated care models could also enable better provision, centralised services and cost savings for governments; it would require, however, that care services are viewed as a cohesive continuum rather than disparate services. In Singapore, the Integrated Care Centres for the Elderly (SPICE) centres offer health, social care and rehabilitation services in the home and in dedicated centres. By providing these services in a centralised manner with core specialist staff, as opposed to separate provision in multiple facilities (hospitals, care centres, social care offices) significant cost savings should be possible.

Volunteerism

The untapped market of volunteers could yield a large source of support for older people at a local and community level. The Golden Sunshine Action scheme in China recruits teenage and adult volunteers to work with older people, providing company and support. In conjunction with community-based care models, training volunteers to work with older people could significantly increase the wellbeing of not only the older people, but the volunteers themselves.

It is worth noting that in some countries, involvement in volunteering or community organisations may be limited to those who are highly educated or privileged; while many people may interact with and help older people, they may not realise that their actions constitute volunteering. Increased knowledge of the benefits of volunteering, not only for the volunteers but also for the recipients, may help with recruitment.

Training and employment

Support mechanisms for carers, volunteers and older people themselves are limited; using training as a way of engaging these groups may be beneficial. For carers, a "cascade model" of training may prove cost effective and self-implementing; in these models, training is provided to NGOs, who then provide training for carers and family members. Training for older people themselves in ways of planning and implementing their own networks and social needs may prove valuable for empowerment and forging social connections; training carers will also provide networks and a source of support. In terms of quality, developing and delivering regionally-recognised training courses will provide a benchmark for quality and also provide the carer or trainee with recognition.

The increased care requirements of an ageing population, both in social and health terms, is likely to create a significant number of employment opportunities. Policies supporting the education and training of individuals in the care sector, and remunerative rewards or incentives for increasing employment in the sector, are likely to mitigate any shortfall in the resources required.

Technological advances

Telecare has great potential to support home-based care, certainly in the more developed countries in the region; as infrastructure develops elsewhere, telecare will become more useful at a regional level.

Religion

The prevalence of religious practice in the region could provide an opportunity to share knowledge and encourage community involvement. While not all localities or villages have access to a community centre for older people, most areas have access to a place of worship relevant to the local faith/s. The central role that these places of worship will play in the community could be a powerful way to raise awareness of the issues of older people and the likely impact of demographic and familial changes. It may also be possible for local religious leaders to encourage community members to volunteer their time to assist local older people and to monitor their wellbeing and health.

Gaps in care

The key implication of this data is that social support needs are far more prevalent than care needs, yet very little provision exists for it at the present time. There is also little consideration of the social support needs of older people in policy making and research, in comparison to the consideration of more general care and health needs. It is critical for policy makers to consider ways in which social support can be provided to older people, even those without more general care needs.

There is a stark link between care gaps and poverty in all countries, and poorer communities experience the majority of care gaps in East Timor, Laos and Cambodia. Community-based care programmes should have a particular focus on targeting poorer communities; and also on older people's groups which can support income generating activities to help meet the costs of care.Older people over the age of 70 are suffering more care gaps than those aged 60 to 69; breaking down the figures on care needs (see Appendix 1), the greatest need in terms of absolute numbers is in the 70 to 79 age bracket.

6.2 Recommendations

Policy

Increasing family care

- Policies that reinforce the value of familial care may help encourage more care at home.

- Incentives for home-based carers, particularly financial incentives, may help more people care for relatives at home.

- It is important to ensure that the push for increased family care is not a means of replacing government financial support for older people.

Changing perceptions of older people

- Valuing older people, and their knowledge and skills, may increase their social capital and inclusion.

- Lifelong learning and flexible employment will not only increase older people's health and esteem, but also benefit the economy.

- A gendered approach to ageing needs to be built into policy mechanisms.

- Policies promoting the particular needs of older women, with regards to care, financial assistance, and health are required.

- Ensuring that all policies relating to older people, and data that is collected, includes women as equally as men is essential.

Matching supply and demand of care

- Policy and planning needs to focus on ensuring the right number of care services for older people are available in the future.

- The increased use of data forecasting services and research will help policymakers to develop strategies to combat increased demand.

- Advantage should be taken of "the demographic window" by publicising policies on the ageing population and raising awareness of the situation.

Addressing care gaps

- More information is needed on the gaps in care that are occurring, particularly related to social support needs and older people aged 70 to 79.

- Tailored policies and activities designed to engage these people, and the use of existing community networks, may help to ensure that care needs are being met.

- Where care is not delivered at a community level, emergency planning is needed to ensure that there is a strategy for meeting older people's care needs in emergency or disaster situations.

Quality management

- Promoting the training and qualifications of care workers, and raising the esteem of the care profession, will increase take-up.

- Ensuring that training centres are adhering to set quality standards and frameworks will raise the overall quality of provision of care.

- Financial or career incentives may be used to encourage qualified workers to provide care in rural areas.

Streamlining bureaucracy

- Ensuring inter-departmental and inter-agency cooperation around issues of ageing and care is essential.

- Multi-agency and multi-departmental policies need to be developed that clearly define the responsibilities and outputs.

- Within the region, sharing knowledge and information about ageing population strategies may ensure greater success as a whole.

Financing care

- Identification of who pays for care in old age is one of the most important policy challenges facing the region.

- Developing options for those requiring care, particularly financial options in the form of means-tested subsidies, may mean that those requiring care most can access it.

- Co-funding models, where families/individuals and the state jointly fund care requirements, may relieve some of the financial pressure.

Valuing carers

- The role of carers is insufficiently understood and acknowledged; this should be addressed.

- Education and support for carers, in the form of community groups and networks, is essential.

Replicable practice

Interesting or useful elements of projects, which may be replicable in other community-based care projects include the following:

- Getting older people involved at early stages of any new project in order to help design and manage it.

- Provision of transport services, such as a community bus scheme which runs regularly and which stops often, to enable mobility-impaired older people to attend health centres, activity centres, shops and other places which can keep them mobile, active and plugged in to social networks.

- Focusing care services in local community centres to encourage older people to remain active and to reduce the risk of social isolation. Where people cannot or will not leave their homes, home-based care is offered, but only where essential.

- Activities in day centres or community centres might include art, sports and other leisure activities. While these are not directly related to care, they can keep people active and engaged and thereby act preventatively.

- Provision of regular meals; again, these can be offered at a community level in order to encourage mobility and interaction, and offered at home as a last resort.

- Training in mental health support given to organisations working with older people.

- Provision of training in care to family members and other caregivers.

- Ensuring that care services are appropriately advertised and communicated so that older people, and their carers, are aware of them.

- Development of a model which can be set up and run by small local groups, with national support and eventual accreditation to encourage groups to meet certain quality standards.

Recommendations for further development of community-based care models

Community holistic care

- The model of providing care within and by the community is likely to increase the wellbeing of older people, who can stay at home, and also relieve the pressure on institutional services.

- Close cooperation is needed between community groups, policymakers and service users to ensure that the provision meets requirements across the continuum of care.

- Investment in community infrastructure, such as village centres, may be needed to ensure that services are delivered safely.

Working with and supporting existing family carers

- Carer support is vital and their needs are a significant unmet gap; models which prioritise caregivers in terms of giving training and support may be more successful in the long term. HelpAge could consider building in the support of carers to its volunteering models. This could be by training volunteers in carer support or providing training sessions directly to family carers.

- Establishing carer support groups based at local community centres or religious institutions is also recommended.

Social support and mental health services

- This research has demonstrated that the biggest care-related need of older people in the region is in social support. This should be a key focus of any new community-based models of care.

- Strategies for social support might include basing care services at a local community or religious centre (see below under working with existing structures) in order to encourage interaction, with home-based services only provided in exceptional circumstances; and providing transport assistance to older people who might otherwise struggle to get there.

- Encouraging volunteering by older people themselves could be considered; and ensuring that volunteers come from a broad social background (as volunteering opportunities in developing countries have been shown to focus often on those with privileged backgrounds).

- Also worth considering in the development of any model is the provision of (a) awareness raising activities and (b) training in mental health. It was apparent during the research that there is stigma attached to mental health problems, both for older people and for their caregivers. Better understanding of the issues may reduce stigma and thereby increase the quality of care and support available.

Target groups and communities

- While the greatest relative need is in the 80 and above age range, the greatest absolute care need is in the 70 to 79 age range; this group should be prioritised.

- Other priority groups include poorer communities, as older people living in poverty are less likely to be able to pay for care and have proportionately greater unmet care needs; and older carers.

- The country with the largest combined absolute and relative care gap is China. When deciding where to base any initial follow-ons to ROK-ASEAN, HelpAge should consider this, and balance it against the need to pilot any revised models in areas in which its networks and local links are strongest, and where there are good levels of existing structures such as older people's groups.

Information services and positioning

- Older people need to remain fully apprised of key risks to their health. Updated information will also require communication to, and training of, health staff in community care scenarios.

- One point not raised in the research, but which might be worth consideration, is how community-based care services are positioned. There is often a stigma attached to residential care, as it is felt that care should be delivered by the family; community-based care schemes may need to be presented clearly as being complementary to family-based care, and not as something which in any way suggests that family care is inadequate or insufficient. Equally, it is important to ensure that there is no stigma attached to such services for the older people themselves, for example through intimations that services are for people who can no longer cope alone.

- HelpAge could also consider disseminating preventative information and advice, aimed at younger age groups, through local structures.

Planning

- Planning needs to identify how to access the hard to reach – people who may not wish to ask for help, or those who live with family who are unable or unwilling to care for them.

- Care support needs to be tailored according to local circumstances; for example greater levels of support should be factored into care plans for poorer areas. Equally, other services should be planned according to local context: for example, a much greater focus on social support in the Philippines than in Laos. The complexities of both gender and family dynamics also need to be taken into account when planning local projects and services.

Working with existing structures

- There is a strong and growing network of older people's groups in the region. One of the limitations of ROK-ASEAN is its reach; local projects have been relatively small scale. Working with existing structures such as older people's groups and self-help clubs could help to extend the reach of community-based care services.

- As with volunteer training, this could be approached using a cascade model – training national NGOs with local or regional offices to work with older people's groups to deliver the model.

- The high rate of religious adherence in the region may prove valuable in terms of disseminating health and care information. Religious venues may also serve as venues of care.

Increased use of technology

- Care and health providers can use technology to provide care, support and diagnostic services efficiently and cheaply. This is likely to be a growing trend as regional coverage grows; services could be piloted in countries in which technological uptake is already considerable, such as Korea or Japan.

Training

- Using 'train the trainer' courses, NGOs can be equipped to deliver training to carers and families about best practice in care techniques and support.

- NGOs can also foster social networks and engagement in older people by providing training and education.
- Health education courses and material, delivered through community centres, may help to raise awareness of health issues.

Finances

- Delivery costs could be met in part by income-generating activities through self-help groups, for example through sale of crafts, thereby promoting activity (and reducing future costs of care) among older people.
- A detailed cost-benefit analysis of community-based care models would provide a case for investment and can be presented to governments.

Research and dissemination

Research gaps

Further research into the following topics, related to the provision of care in the region, is recommended.

- The link between care gaps and poverty.
- Mental health of older people in the region, together with perceptions of mental health.
- Preferences and needs of older people requiring care.
- Relevant CSO projects through local language research.
- Research from outside the region on models which could inform the development of community-based care projects.
- Research on carers, their support needs and the impact upon them of their caring duties.
- Ways in which gender differences influence health in older age.
- Care provision and trends in East Timor.
- The ways in which gender dynamics affect community-based approaches to care.
- The relationships between social capital, health and age.
- The effects of co-residence on older people and their families.
- The relationship between the needs of older people, their income levels and their age.
- Relevant research on the less developed countries in the region in which research is sparse.
- Evidence of collaborative models between social care and health care professionals.

Dissemination

- Research findings and messages need to be made applicable to, and in suitable language for, local and community audiences, so that good practice may be replicated.
- Knowledge about key health issues and care options needs to be disseminated more effectively through local community channels.