Community-based social care in East and Southeast Asia

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HelpAge International
age helps

Contents

The challenge: rising care needs and gaps

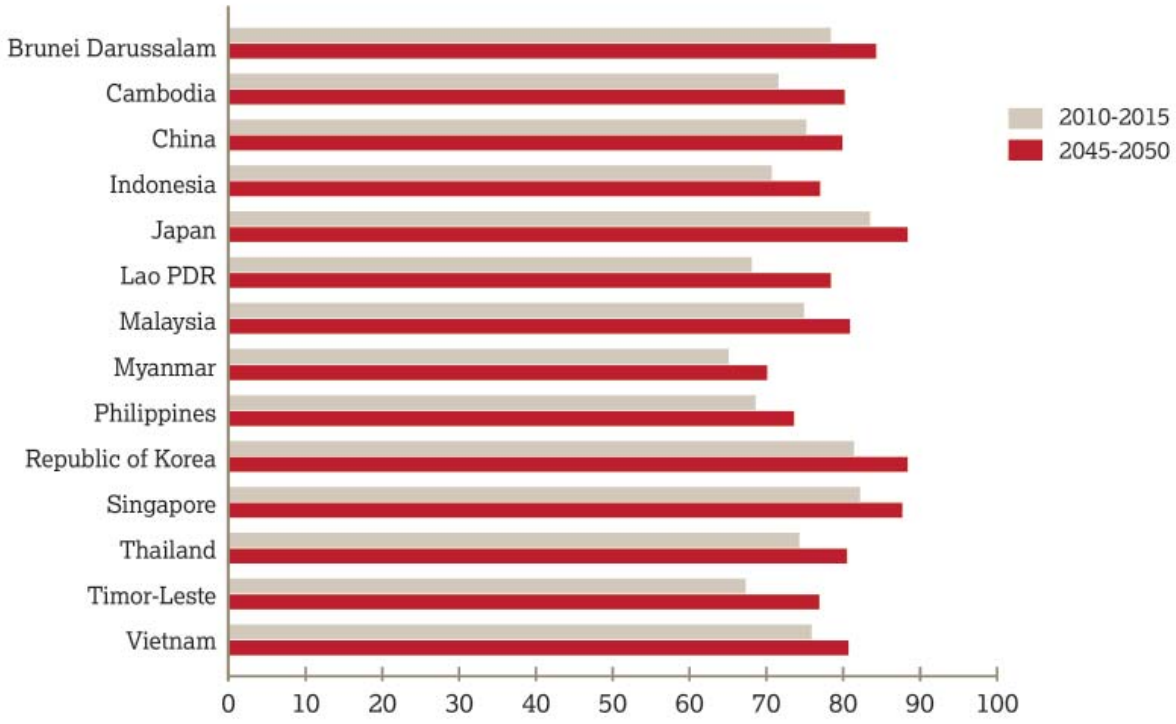
Despite the strong tradition of family care in East and Southeast Asia, dramatic demographic, economic and social trends are creating significant gaps in care for older people (aged 60 and older). Meeting the care needs of a rapidly ageing population is therefore an increasingly serious policy concern for governments in the region.

Population ageing is increasing demand for care

Demographic changes across the region are being driven by lower birth rates and an increase in life expectancy. Some of the most rapidly ageing populations in the world are found in East and Southeast Asia. While most developed nations have had decades to adjust to shifting age structures, the ageing of the respective populations in many Asian countries is taking place very rapidly, often within a single generation. Over the next 40 years, the proportion of older people in the population will increase most rapidly in Thailand, from 14.5% to 37.5%, and the least in the Philippines, from 6.4% to 13.7%.[1] The absolute number of older people will also increase dramatically. The number of Chinese people aged 60 and over, for example, is expected to increase from 192 million in 2014 to 450 million in 2050. Life expectancy is also projected to rise to over 70 years in all countries in the region, and to 80 years or older in several countries, by 2050.

1. United Nations, *Profiles of Ageing 2013*, CD-ROM version, New York, UN Department of Economic and Social Affairs: Population Division, 2013, Available online: http://www.un.org/en/development/desa/population/publications/dataset/urban/profilesOfAgeing2013.shtml

Figure 1: Life expectancy continues to climb



Life expectancy at birth, current and projected[2]

In all of these countries, ageing will not only bring about a general shift in the composition of populations, it will also bring many more people in the group of the oldest-old (aged 80 and older). By 2050, for example, the oldest-old are expected to comprise 11.2% of the total population in Singapore and 6.5% of the total population in China.[3] At these older ages, people are more likely to experience challenges with disability and chronic illness and require care from others.

Demographic and labour patterns are limiting the supply of family caregivers

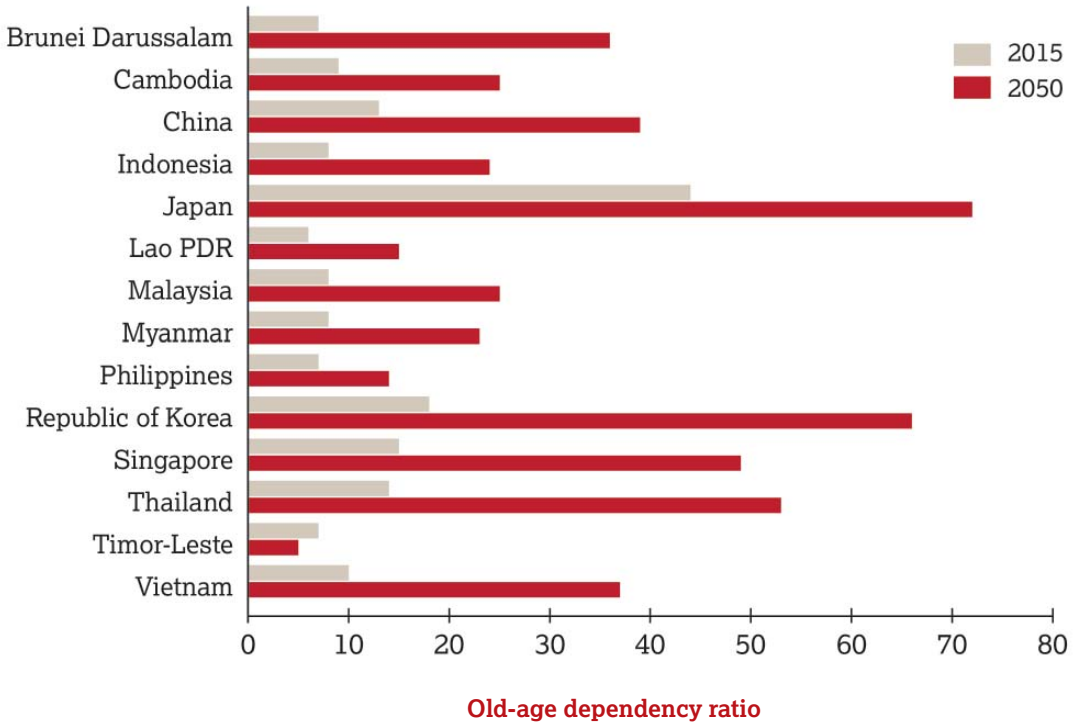
The rapidly ageing population means that the ratio between the number of older people and those statistically of working age (age 15-64) will rise dramatically (see Figure 2 below).[4] In short, there will not only be more people in need of care but also fewer people of working age able to contribute practically or financially towards that care. This has implications for the financing of care, the care burden on families and the proportion of the working age population who will need to be trained as care professionals. A drastic shortfall in the numbers of caregivers needed for the expanding population of older people is anticipated. At the household level, lower fertility rates mean shrinking family sizes over time, thus reducing the number of potential family caregivers per older person.

2. United Nations, *World Population Prospects: The 2010 Revision, Volume I: Comprehensive Tables, ST/ESA/SER.A/313*, New York, UN Department of Economic and Social Affairs, Population Division, 2011, Available online: http://esa.un.org/unpd/wpp/documentation/pdf/wpp2010_volume-i_comprehensive-tables.pdf

3. United Nations, *World Population Prospects: The 2012 Revision, Key Findings and Advance Tables*, Working Paper No. ESA/P/WP.227, New York, UN Department of Economic and Social Affairs, Population Division, 2013, Available online: http://esa.un.org/wpp/documentation/pdf/WPP2012_%20KEY%20FINDINGS.pdf

4. Calculated from United Nations, *World Population Prospects: The 2010 Revision*, 2011.

Figure 2: A rising old-age dependency ratio implies fewer family members to care for older persons[5]



Aside from shifts in the population structure, economic and societal changes have also limited the supply of caregivers. These changes include increased labour market participation by females and escalating migration. Responsibility for the care of older relatives has traditionally fallen on women. However, an increasing number of women who would once have looked after their parents or parents-in-law now have jobs in the formal economy, with less flexible working conditions compared to informal sector work. Increased rural-to-urban and international migration has also strained the traditional family-based care model. For example, more than 100 million rural Chinese are estimated to have moved to cities in search of work since economic reform began in 1979.[6] Migration means that older parents are less likely than in the past to live with their children, and the physical distance between them is greater.

However, today's dramatic trends in society are not purely negative. Increased life expectancy, longer working lives and migration clearly bring economic and personal benefits. While some older people need care from the family, many others provide various forms of assistance to their households. For example, older people often continue to work, and many watch over their grandchildren at home, thereby freeing up the mothers and fathers of those children to earn income locally or as migrant workers. Active younger-olds are increasingly caring for older-old members of the family, and older people for their spouses. At various times of their lives, from birth to end of life, all family members need support from, and provide support to, other members of the family. Care in old age is just one example of reciprocity within the household.

5. The old-age dependency ratio is the ratio of the population aged 65 years or over to the population aged 15-64. It is presented as the number of dependants per 100 persons of working age (15-64). Calculated from United Nations, *World Population Prospects: The 2012 Revision, Volume I: Comprehensive Tables*, ST/ESA/SER.A/336, New York, UN Department of Economic and Social Affairs, Population Division, 2013, Available online: http://esa.un.org/wpp/documentation/pdf/WPP2012_Volume-I_Comprehensive-Tables.pdf

6. Xiong Y, "Social Change and Social Policy in China: National Adaptation to Global Challenge", *International Journal of Japanese Sociology*, 18: 33–44, 2009.

Social care needs are neglected

Caring for illness and physical or mental disability involves multi-dimensional needs: addressing not only medical conditions but also practical complications in daily life arising from illness or disability. Whether or not foreseen, it also includes the risks of social isolation and emotional vulnerability, especially if the older person becomes housebound. Both health care and social care are critical. In this briefing, *social care* is defined as assistance in the three main areas described in the table below:

Three components of social care		
1. activities of daily living (ADL)	basic self-care tasks	walking and moving around, getting up from a chair, bathing, dressing, toileting, brushing teeth and eating
2. instrumental activities of daily living (IADL)	activities necessary for an independent life style	help with cleaning the house, cooking, shopping, getting around, referral to a doctor, communications, finances and managing medication
3. social support	assistance to foster greater social interaction and emotional well-being, provided when delivering ADL and IADL assistance	reassurance, personal advice, companionship (e.g. chatting or reading, escorting to social/ religious activities)

Because older people's needs are interrelated, there are clear benefits to the close collaboration of social care and health care providers and the development of integrated services and policies.[7] Globally, some countries are seeing distortions arise when the two spheres are distinct and are aiming to better integrate the provision of health and social care, such as the United Kingdom through its *Health and Social Care Act 2012*. This briefing focuses on social care needs, not in isolation but integrated with other care services.

Health care is often the most urgent need of older people. Yet health care providers generally do not provide long-term assistance with daily living activities except as part of medical care, so other parties need to fill the gap when family care is insufficient. And although health services in the region are often weak, there are structures in place for health service delivery in every country and strong voices advocating to improve them. In contrast, social care is relatively neglected and community mechanisms to deliver it are limited. This is partly because social care has historically been considered almost entirely a private function of the family, reflecting both culture and societal necessity. But as noted above, dramatic changes in society means that wide gaps in social care are emerging quickly, and countries of the region need to anticipate them.

Aside from assistance with practical daily activities (ADL/IADL), the third component of social care described above is also important: social support. In many countries across the region, older people report even greater challenges associated with social interaction than with their physical self-care needs, as the following figure shows for five countries of the region, which are at various stages of economic development. The definition of 'self-care needs' used in the graph is "some difficulty with self care in the last 30 days" and relates principally to performing the daily living activities described in the table above, based on the World Health Organization (WHO) World Health Survey.

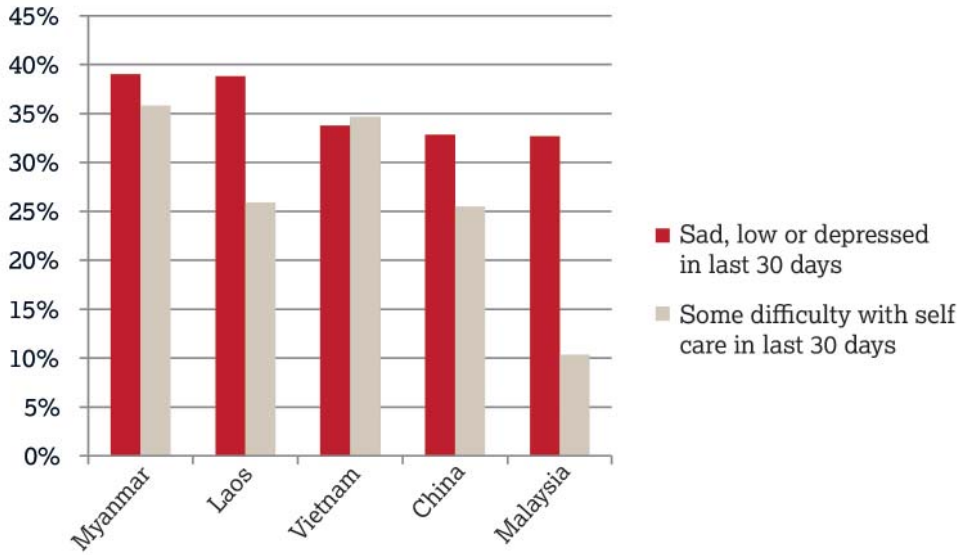
In most of the countries below, the percentage of people experiencing difficulty with self-care was surpassed by that of people feeling "sad, low or depressed in the last 30 days".[8] Older people in the most affluent country of this group, Malaysia, are much less likely to report difficulties with self-care compared to those in the other countries. This is possibly because they are more likely to

7. Meads G et al, *The case for interprofessional collaboration: In health and social care*, Oxford, Blackwell Publishing, 2005, p.5

8. The Research Base, *Care in Old Age in Southeast Asia and China: Situational Analysis*, Chiang Mai, HelpAge International, 2013, p.31; using data from WHO World Health Survey 2003 reports, available online: http://apps.who.int/healthinfo/systems/surveydata/index.php/catalog/whs

have greater resources to meet their care needs such as assistive devices, more convenient home environments and better healthcare services. However, reports of being sad, low or depressed are not so different across the five countries, possibly because psychological challenges are more difficult to alleviate with financial resources only.

Figure 3: Social support needs may be even more common than self-care needs[8]



Percentage of older people reporting social or practical care challenges, by country

Providing further social support to older people – such as companionship, community interaction and emotional reassurance – should thus be seen as an essential part of meeting overall care needs and can positively affect physical health. Family-based social support networks are particularly important for older people throughout the region, and older people can be left vulnerable if their children migrate. This vulnerability can arise from a number of reasons including a lack of available physical care; loneliness or isolation; a lack of financial assistance if migrating children do not earn much or send sufficient remittances home; or feelings of pressure on older people to look after their grandchildren when the parents migrate. In many cases of migration, technological changes in communications and transport are enabling stronger social connections with distant relatives than were possible in the past.[9] However, social care as defined here implies not only social support and companionship but also assistance with ADL and IADL, which cannot be provided from a distance.

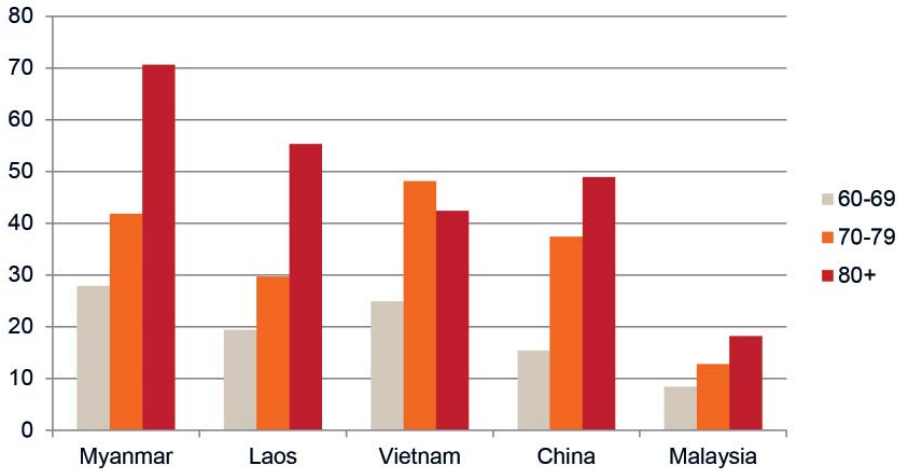
Factors affecting care needs and gaps

It is important to recognise that the majority of older people, particularly most younger-olds in their 60s, are relatively independent and do not need significant amounts of care. This means that older people in the population are often net contributors to their families, communities and countries. As noted above, many continue to work, provide local leadership or care for grandchildren and other members of the household. In this briefing, the target group for social care is therefore not all older people but those who are partially or fully dependent on others with respect to either ADL or IADL tasks. This includes the frail and bedridden as well as those who are largely independent but require occasional assistance with such tasks due to physical or mental impairments. These care needs and gaps in care provision vary by age, gender, place of residence and economic status.

9. See, for example, Knodel J et al, "The Future of Family Support for Thai Elderly: Views of the Populace", *Journal of Population and Social Studies*, Volume 21 Number 2, January 2013: 110-132.

By age: Generally the need for care increases with age, as Figure 4 below suggests, but this does not mean that absolute gaps in care provision rise with age in a straight line. The largest cohort of older people is the younger-olds, those in their 60s. Although most of them are active, the absolute number who need some assistance is large. The oldest-old cohort (those aged 80 or over) has the greatest proportion of people requiring care. However, by this age, many older people live with their families, and most of their care needs can be met in the home. The group in their 70s is larger in number than the 80-plus age group, but typically less mobile, active and independent than the 60–69 age group. Many older people and their families experience the 70s as a period of transition from relative independence to relative dependence, and the transition may create risks and unanticipated gaps in care.

Figure 4: Self-care needs generally rise with age[10]



Percentage of older people reporting "some difficulty with self care in the last 30 days", by country and age cohort

By gender: There are proportionally more older women than older men in nearly all countries of the region and women also generally tend to report greater care needs. A number of factors lead to unmet care needs for older women. Women generally report poorer health than men in old age, despite having greater life expectancy. Partly because of their longevity and tendency to marry at younger ages than men, women are also much more likely than men to be widowed and thus without a spouse as caregiver in later life. In Myanmar, for example, over half of older women are widowed, compared to just one fifth of men.[11] On the other hand, older women are often more likely than men to live with the family of one of their children after the death of their spouse, so older men often find themselves relatively isolated in widowhood.

By place: The relationship between rural/urban location and unmet care needs varies according to country. Countries such as Japan and South Korea, with a large urban population, have greater unmet care needs in urban centres rather than rural areas. Overall, however, the rural population across the region is older than the urban population, which is partially a reflection of migration patterns, and the greatest care challenge is in rural areas. By country, as illustrated in Figures 3 and 4 above, the percentage of older people with social care needs varies greatly, based on WHO figures. The absolute number of older people needing some support with social care, now and in the future, is tied to the size of the countries' older populations and the rate at which those populations will age, as well as other factors such as the country's development path including changes in its disease profile. Despite gaps in data on care

10. World Health Organization, World Health Survey 2003 reports, available online: http://apps.who.int/healthinfo/systems/surveydata/index.php/catalog/whs

11. Knodel J, *The situation of older persons in Myanmar*, Chiang Mai, HelpAge International, rev. 2014.

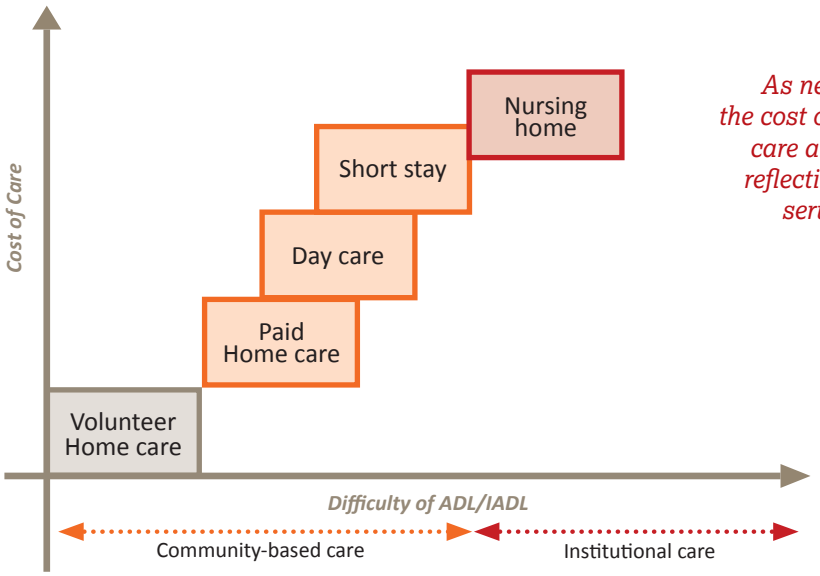
needs, one country stands out clearly: China. Based on WHO's survey, China today may have 50 million older people who need help with self-care, and more than 60 million who need social and emotional support. China and other countries are ageing rapidly, so the numbers will escalate sharply across the region over the coming decades.

By economic status: Where formal healthcare and social care services are available, poor older people who need care beyond the household are unlikely to have the ability to pay for these services. Assistance with daily activities and mobility, in the absence of an urgent medical condition, is rarely provided free by government, if at all. Formal safety nets and pensions for older people, especially women, are limited in East and Southeast Asian countries. Older parents and their children living in one household are often financially interdependent, with older parents contributing some income or unpaid grandchild care and household chores, and adult children ensuring their parents' basic needs in old age. Without social safety nets and pensions, paying for additional care is beyond the resources of many poor and even middle class households, and older people may resist paid care services to avoid burdening their families.

The response: how care is provided

It is clear that although most older people are relatively independent, many need extra help as a result of physical or mental limitations. The health and social care services they receive are delivered in various locations and by various providers. As illustrated in Figure 5 below, each society needs a continuum of care options appropriate to its context. Care should be provided along that continuum, depending on intensity of care needs, the preference of the older person and the means to address the needs. The means to address them includes the ability of the family and older people themselves to meet care needs, as well as the resources of the community and state to support them.

Figure 5: Continuum of care[12]



As need increases, the cost of appropriate care also increases, reflecting the type of services required

12. HelpAge Korea, *Home care for older people: The experience of ASEAN countries.* Seoul, HelpAge Korea, 2014.

The nature of care provision ranges from informal home-based care to formal institutional care, and costs rise correspondingly as Figure 5 illustrates. While institutional care is sometimes necessary – though not yet common in most countries of the region – *community-based care* is considered the first line response along the continuum of care. That is because most older people prefer to remain in their own communities and because care delivered in the community is more affordable for governments and families. This briefing therefore highlights community-based care, while acknowledging the importance of other types of age care services.

Care terminology in this publication

Care terms are used in somewhat different ways by various parties. In this document, the term **community-based care** refers in the first instance to *location*. It is discussed further below. As seen here, community-based care encompasses the three components of self-care, family care and third party care, all taking place within the community. According to WHO, community-based care includes 'services and support to help people with care needs to live as independently as possible in their communities.'[13]

By contrast, **long-term care** refers fundamentally to *time/duration*. 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'.[14] It is provided through a continuum of care, in the community or beyond the community, and through formal or informal means. Both community-based care and long-term care include elements of health care and social care and are not limited to care for older people but also, for example, people of any age with disabilities. While many older people require long-term care, it is important to remember that functional disability is often episodic and relatively independent persons may require short periods of assistance.

Social care is understood here as having three components: assistance with ADL and IADL and accompanied by social support. See above.

What is community-based care?

Community-based care is care delivered in the community, including the home. As illustrated in Figure 6, this document presents three critically important components of community-based care corresponding to the provider of care:

- *Self-care* refers to activities that older people can handle by themselves and includes tasks to manage illness or disability.
- *Family care* refers to care that family members provide directly to the older person, and it remains the foundation of care services in Asian societies.
- *Third party care* is supplementary assistance from others in the community besides the family.

13. World Health Organization, *A glossary of terms for community health care and services for older persons*, Ageing and Health Technical Report, Volume 5, WHO/WKC/Tech.Ser./04.2, Geneva, WHO Centre for Health Development, 2004, p.16.

14. United Nations, *Guide to the National Implementation of the Madrid International Plan of Action on Ageing*, New York, UN Department of Economic and Social Affairs, 2008.

Figure 6: Components of community-based care

Self-care

Self-care is important because it can delay or mitigate conditions that can force a person to seek assistance from the family or another party. Here, self-care is grouped into two main categories: disease and disability prevention and disease and disability management. *Disease and disability prevention* is typically addressed through complementary strategies on health, including activities promoting healthy and active ageing. Disease and disability prevention is important not only for today's older population but can reduce future demands on care services by introducing a life-course approach to health among younger generations as they age. *Disease and disability management* supports the other components of community-based care. For example, it allows older people to manage their chronic health conditions fairly independently. It also enables greater personal autonomy and mobility through assistive devices (such as walking, visual or hearing aids) or a more accessible physical environment.

Significant barriers can prevent an individual from practising self-care. These barriers can be grouped as physical (poor sight, weakness), psychological (depression or distress), cognitive (an individual's understanding of their own condition and its implications), economic (ability to keep accessing appropriate services) or social/cultural (support from family and friends).[15] For example, women are usually more integrated into extended family networks and are more likely to be living with members of other generations, while men often rely on spouses for support.

Family care

In East and Southeast Asia, caring for older people and managing illness has traditionally been considered a private matter to be kept within the home. Family care is provided informally within the household, typically by adult children or children-in-law, the spouse or grandchildren. Care within a multigenerational household is a common expectation. In family-oriented Myanmar, for example, 84% of older people surveyed in urban areas and 81% in rural areas agree that adult children should be responsible for the care and support of elderly parents.[16] In some countries, certain family members are expected to take up the role of primary family carer. In Thailand, for example, the traditional kinship system places the caring responsibility on a specific child, usually an adult daughter. In contrast, the Chinese system places more responsibility on sons, and by extension on daughters-in-law also. In practice, familial care responsibilities fall predominantly on women across the region.

15. Jaarsma T et al, "A Middle-Range Theory of Self-Care of Chronic Illness", *Advances in Nursing Science*, Volume 35, Number 3, September 2012, pp. 194-204.

16. "Myanmar Country Report", cited in Rostgaard T, *Approaches to Community-based Social Care in East and Southeast Asian Countries: Regional report*, Chiang Mai, HelpAge International, 2014 (unpublished).

This traditional family approach remains fundamental, but as explained above it is coming under pressure because of demographic and societal changes. Care preferences within the family also change, not only with age but also with time. In Thailand, for example, the proportion of older people who want to be cared for by their children when they become ill has declined sharply since 1986, while the proportion who name their spouse as their desired carer when ill has risen steeply. Men are considerably more likely to choose their spouse as their preferred carer than women are, reflecting both levels of widowhood and traditional patterns of care.[17]

Many older people in the region prefer to remain in their own homes but close to their families rather than living in the same home as them. A survey in the Philippines, for example, showed that many more older people wanted to live apart from their children than actually do.[18] The growing preference for independent living, especially as rising household incomes make separate housing an option, may challenge traditional assumptions. For now, co-residence with children remains the most common living arrangement across the region, though declining. Among older people in Thailand, for example, co-residence with children fell from 77% to 57% between 1986 and 2011.[19] When older people do live with their children, it is often the result of external factors such as poverty or the higher accommodation costs they would face if moving to towns and cities to be closer to their children.

Assistance with family care may mean helping families to provide better care, or to continue providing that care with less stress. Family care is closely related to third party care (see below) because often what family caregivers need most is respite and assistance from others to fulfill their care responsibilities. Government or non-government bodies in some countries also provide direct support to families in the form of financial assistance, housing support or tax relief. 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. Families may neglect to consult with older family members about the care they need and want, widening the gap in appropriate care provision. In the Philippines, 'Carers of Caregivers' is an example of a project providing training for family carers by local care professionals.

Third party care in the community

In addition to informal care by neighbours, the providers of third party social care in communities can be summarised as civil society organisations, the public sector and the private sector, who in turn often work with para-professionals or community volunteers. Third party care includes practical and financial support to older people and their family members as well as care services delivered directly by a third party within the community. The approaches may encompass both formal and informal care, but with greater emphasis on reinforcing and complementing traditional forms of informal care.

As noted above, respite care provided by third parties is closely associated with family care. Family caregivers may suffer from the heavy demands of care provision, leading to mental and physical fatigue or even elder abuse. Respite care during weekends and holidays helps alleviate some of the pressures on family caregivers.

Much of the social care provided by third parties in the region depends upon **community-based volunteers** for its delivery. These volunteers may be trained and supported by local NGOs, community groups, religious organisations or local authorities. Such schemes provide support to primary caregivers and help enable older people who have lost the ability to fully care for themselves to continue living as long as possible in their own home and community, whether independently or with their families. For example:

- The most widespread programme for volunteer-based care across the ASEAN region is a home care programme initiated by HelpAge Korea,

17. Knodel J and Chayovan N, *Intergenerational Family Care for and by Older People in Thailand*, PSC Research Report No. 11-732, 2011.

18. Velkoff VA, "Living arrangements and well-being of the older population: future research directions" in United Nations, *Ageing and Living Arrangements of Older Persons: Critical Issues and Policy Responses*, Population Bulletin of the United Nations, Special Issue Nos. 42/43, ST/ESA/SER.N.42-43, New York, UN Department of Economic and Social Affairs, 2001.

19. Knodel J et al, *The Changing Well-being of Thai Elderly: An update from the 2011 Survey of Older Persons in Thailand,* Chiang Mai, HelpAge International, 2013.

mostly in poor rural settings.[20] Typically, a locally operating NGO trains and manages the volunteers and matches them with older people in the community. The government makes guidelines, sets policies, monitors and may provide funding to civil society bodies for replication.

- China's government-led 'The Golden Sunshine Action' programme enlists the voluntary services of young people to care for older people.
- Through Thailand's 'Friends Help Friends' initiative, older people's groups receive funding from the government to train volunteers to provide support for frail, dependent older people who have no family to meet their needs. Volunteers are mostly recruited from older people's groups. They provide health information, basic health care, rehabilitation and social support.
- Singapore's 'Neighbouring Links' promotes voluntary care provision by neighbours in the local community. Activities are usually informally managed by local residents under the supervision of family service centres.
- The Indonesian Pusaka was established in Jakarta in the 1970s. In addition to basic health care services, volunteers at a community centre provide assistance with food, clothing, housing improvements and physical exercise.

Volunteer schemes are often managed by NGOs, but strong community-based groups can also manage volunteers in their own local area. **Older people's associations (OPAs)**, also known by other names, are organisations usually led by older people which aim to improve the well-being of older people and their communities through collective activities. Some OPAs now arrange social care assistance for their members, mainly playing the facilitating role for a volunteer-based system like those described above. There were 410,000 government-established OPAs in China by 2012 according to the China National Committee on Ageing, and more than 23,000 OPAs in Thailand in 2012 organised under the Senior Citizens Council of Thailand. Other OPAs are set up by NGOs to be multi-functional, organising frequent social, health or livelihoods related activities in the community.

Community centres can function as a communication hub to provide health and care information. In addition, day care delivered in community centres can provide help for older people and carers. Other services delivered by community-based care models include providing regular meals and transport services that enable older people to attend health centres, activity centres, shops and other places which can keep them mobile, active and connected to social networks. The Chinese *Shequ* system, which aims to reconstitute community institutions which can replace the workplace as the main social institution, now operates day care centres in many communities.

Religious institutions may have potential to play a greater role in the provision of social care in some countries, but in general they currently provide only occasional accommodation and emotional and spiritual care. In Cambodia, for instance, some older people choose to spend their last days at a Buddhist pagoda, helping to clean the pagoda grounds, prepare food for monks, organise festivals and practice meditation. There are more than 4,000 pagodas in Cambodia, and around 10,000 older people stay in them. However, they rarely take care of specific health and social care needs, implying a level of independence for those who stay there. Care for older people is also provided by some civil society organisations with a religious mission.

In reality, social care provided by the **private sector** remains limited in communities of developing countries, particularly in rural areas where most older people live. Many families cannot afford the costs. However, the increased care requirements of an ageing population are likely to significantly expand employment opportunities for caregivers, not least women. While volunteers can and do provide many vital care services, paid caregiving will become increasingly needed. These caregivers may be managed by the private sector or by NGOs and the public sector. Recruitment of a sufficient number of

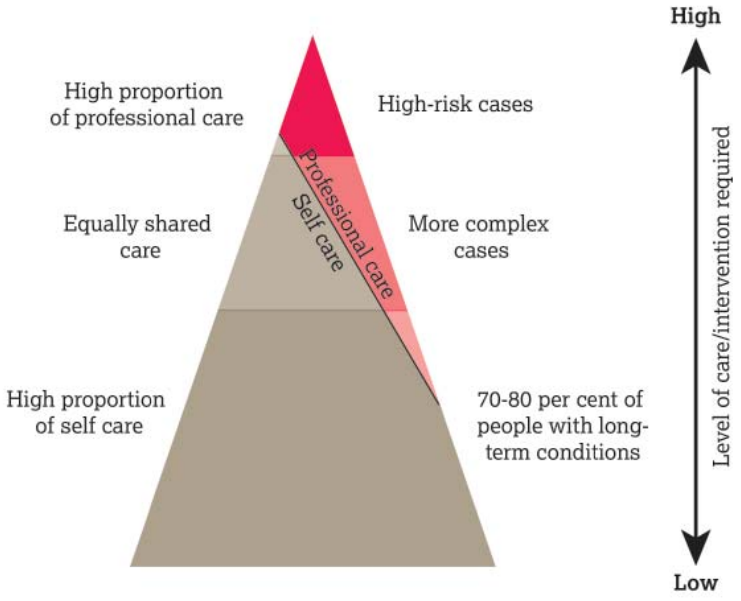
20. Republic of Korea-ASEAN Cooperation Fund (ROK-ASEAN)

community-based caregivers may be more feasible if they receive a salary, and it may be easier to require them to undertake training if their services are paid. Education and training for the care sector may thus help to mitigate a shortfall in human resources in the long term.

Care beyond the community

Although community-based care should be considered the priority, some types of care beyond the community will always be needed. This includes institutional care, which is often delivered in hospitals (for health care) or in residential centres such as nursing homes (for social care). As the Kaiser Triangle in Figure 7 below illustrates, high-risk and more complex cases may ideally require more intensive intervention by skilled professionals who are often not available in communities, particularly rural villages of developing countries.[21]

Figure 7: More complex care requires skilled help



The emphasis on care by the family has so far resulted in a limited role for formal providers beyond the community, as demonstrated by the lack of nursing homes and other residential care facilities across the region. Social care is most often home based and families are generally expected to, and want to, care for parents and other older household members. Placing parents in long-term institutional care can be considered shameful, although perceptions will no doubt change over time, and the social stigma will need to be addressed.[22] Most low and middle income countries of the region recognise that widespread institutional care is not an economically feasible or socially acceptable strategy to address the rise in social care needs in the near term. However, it must remain an option when needed and will certainly expand with the rise in dementia and other conditions which require more intensive and skilled care.

Thailand, for instance, maintains that providing for frail elders remains a family responsibility and hence has no expansion plans for government-sponsored institutional residential homes beyond the present limited number.[23] China originally focused on the creation of institutional care as a means to fill the gap for care, mainly by means of private investment capital into this sector. This resulted in a rapid increase in the share of caregiving provided through institutions in China. With the ageing population, however, the need has vastly exceeded the capacity of these centres, and several policies have since been issued in China to encourage the further establishment of community-based care.[24]

21. Diagram from Bury M and Taylor D, "Towards a Theory of Care Transition: From Medical Dominance to Managed Consumerism", *Social Theory & Health 6*, 201–219, 2008. Diagram available online: http://www.palgrave-journals.com/sth/journal/v6/n3/fig_tab/sth20089f1.html

22. Ping B, "Nursing homes losing stigma as society ages," *China Daily*, 30 March 2013. Available online: http://www.chinadaily.com.cn/opinion/2013-03/30/content_16360102.htm, accessed 15 October 2014.

23. Knodel J and Chayovan N, "Intergenerational Family Care for and by Older People in Thailand," *International Journal of Sociology and Social Policy* 32(11):682–694, 2012.

24. Rostgaard T, *Approaches to Community-based Social Care in East and Southeast Asian Countries: Regional report*, Chiang Mai, HelpAge International, 2014 (unpublished).

The role of governments in community-based care

Some countries have developed ambitious national approaches to social care (South Korea and Singapore in particular) or encouraged local government to be more involved in community-based care (as is the case in China and Thailand). Other countries rely heavily on civil society, yet even civil society providers require organisational, practical or financial support from national or local governments.

Government **laws and policies** in the region begin with the assumption that care in old age is fundamentally the responsibility of the family. In China, for example, the ideal elder care model is seen to be principally family care, supported by community-based services and complemented by institutional care only when necessary.[25] In Vietnam and Cambodia, the legal framework specifies that the care of older people by their children or grandchildren is a moral obligation. And, in parallel with some other countries, Singapore allows destitute older parents to sue their adult children for financial maintenance should they not provide it voluntarily.[26] The ASEAN Strategic Framework for Social Welfare and Development (2011–2015) promotes community-based care systems for older people 'to supplement the role of the family as primary caregiver'.

One study suggests that 'neglecting care has political advantages, allowing governments to pass on its costs to families and communities, rather than financing care as a public good.'[27] Despite the pressures of fiscal space and strong precedents of tradition, however, there is growing awareness among Asian governments that social care needs cannot be met solely by the family. They see widening gaps in access resulting from demographic and social change. And governments increasingly view community-based care approaches as offering the most viable solution to providing care for older people whilst taking social norms and economic means into account. Community-based care is seen as cost-effective and reinforcing social networks in the community, and it is generally favoured by older people and their caregivers over institutional care.

A critical challenge is getting the commitment not only of central governments but also of local governments. Nearly all countries in the region now have national policies on ageing, but the policies do not always translate into local action: funding is often limited and coordination between government departments is weak. For instance, evidence from the Philippines and Indonesia suggests that devolution of powers to the regional and local levels can be challenging for the development of community-based care programmes. Whilst population ageing may be prioritised at national level, at provincial and local levels where both funds and human resources may be limited, priorities may be different.[28] Local government departments, such as sub-district offices and village committees, are usually responsible for the organisation, implementation and integration of care services.

Some governments **directly support social care services**, delivered either by government or indirectly through third party providers, although such support is still fairly limited given the scale of the need. As noted above, social care provided by third parties in the community typically comes through civil society organisations and local volunteers. However, there is a trend of public initiatives to promote and assist these civil society schemes, with the state acting primarily as facilitator, funder or regulator.[29]

South Korea has taken the most comprehensive government approach to service provision. The family is still acknowledged as the primary informal caregiver, but the 2008 Long-Term Care Insurance system created a new constituency of beneficiaries as all people aged 65 and over were technically entitled to enroll, depending on a needs assessment. The delivery of non-family care in South Korea has now shifted from mainly institutional care to more community-based care, such as home care and home helper services, public health nurses, day care services and short-term stay centres.[30]

25. Shang X and Wu X, "The care regime in China: elder and child care", *Journal of Comparative Social Welfare*, 27(2), 2011.

26. *The Maintenance of Parents Act 1995*, described in Rozario PA and Rosetti AL, "Many helping hands: A review and analysis of long-term care policies, programs, and practices in Singapore," *Journal of Gerontological Social Work*, 55(7): 641–658, 2012.

27. Eyben R and Fontana M, *Caring for Wellbeing*, The Bellagio Initiative, 2011. Available online: http://www.bellagioinitiative.org/wp-content/uploads/2011/10/Bellagio-Eyben-and-Fontana.pdf

28. Do-Le KD and Raharjo Y, *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", Bangkok, 2002. Available at http://archive.iussp.org/Bangkok2002/S23Dole.pdf, accessed 23 May 2014; and "Philippines Country Report", cited in Rostgaard, *Approaches to Community-based Social Care in East and Southeast Asian Countries: Regional report*, 2014.

29. Rostgaard, *Approaches to Community-based Social Care in East and Southeast Asian Countries: Regional report*, 2014.

30. Baek S-H et al, "The current coordinates of the Korean care regime," *Journal of Comparative Social Welfare*, 27(2), 143–154, 2011.

Cash or in-kind contributions for care are not common in the region, though cash transfers through social protection schemes such as social pensions are expanding and may provide indirect help. China and Singapore support community-based care by financing service vouchers. In Beijing and Taicang city in Jiangsu Province, for example, the government provides older people with a voucher for services purchased by the government. Beijing provides those over the age of 80 with a monthly service voucher, to be used to pay for household care, rehabilitation assistance and other home-based care services. But such cases are rare. Even in South Korea, a cash benefit option was not adopted due to concerns over potential abuse and quality of services, and criticism from the women's movement about the potential pressure on women to provide informal care.[31] While cash for care is available, it is mainly provided to those in remote areas or nearby islands where no regular services are available.

Tax relief for family caregivers is offered by both Thailand and Singapore, although such examples are uncommon in the region. Through housing policy, Singapore has also promoted co-residency with older family members and tried to improve physical accessibility in building design. Accessibility can reduce barriers to daily activities, enhance independence and reduce the need for care assistance.

Governments have an important role to play in **quality assurance, training and regulation**. Government action may involve the development of quality assurance standards, training and regulation to be carried out by local government agencies. Some governments also promote training for care workers. For example, the Chinese authorities have developed a formal caregiver certification provided through training programmes, and Thailand has a three-month training course for those taking roles as paid care assistants.

In contrast, there is relatively little national policy **promoting market-provided services**. China provides a notable exception, where the market is considered to have a central role to play in the delivery of care services, albeit regulated by the state.[32] The South Korean government sees the investment in the social care market as a way to create a virtuous cycle leading to job creation, the development of a new service sector market and eventually also to positive economic growth;[33] but for-profit organisations are prohibited from providing care services to seniors.[34]

Conclusion: choices and challenges in community-based social care

This briefing describes how demographic and societal transformations are increasing demand for care while constraining the supply of caregivers. Population ageing, migration, shrinking family size, declining co-residence and greater female workforce participation all threaten to widen gaps in the provision of social care for older people. Despite resource constraints, societies have some options in how they address those gaps. Their choices can minimise the burdens on families and older people and maximise the contribution that people in later life can make to their families, communities and societies. These conclusions suggest that considerable work is needed to address the rising challenges:

- **Social care is a neglected component of age care and needs to be better integrated into health care.** Social care is defined above as practical assistance for physically or mentally dependent older people in carrying out their daily living activities, complemented by social interaction. Health services generally do not deliver social care except in the context of medical treatment. Health care receives greater attention, but social care should be

31. Kwon S, "The introduction of long-term care insurance in South Korea," *Eurohealth* 15(1): 28–29, 2011.

32. Shang and Wu, "The care regime in China: elder and child care," 2011.

33. Peng I, *Paid Care Workers in the Republic of Korea*, UNRISD Research report 4, New York, UNRISD, 2009.

34. Shang and Wu, "The care regime in China: elder and child care," 2011, pp.123-131.

better integrated with health systems to address the long-term challenges that vulnerable older people and their families are facing.

- **Social protection policies and programmes can help address gaps in social care.** Social protection is increasingly recognised by governments in the region as important in meeting basic needs. Older people can better meet their own needs – reducing any burden on their families – through a range of social protection measures including cash allowances for older people and vulnerable households, as well as flexible labour laws and policies (for instance, entitlement to care leave or flexible work hours).
- **Dementia care is complex and requires specific knowledge and skills.** The risk of dementia increases with age and the number of people suffering from dementia will increase as populations age. Services to support older people with dementia are limited and family caregivers struggle to provide proper care. There is a great need to expand policies, programmes, facilities, knowledge and skills related to dementia care.
- **Community-based solutions are part of the mix of an appropriate, cost-effective response to the challenge of care.** Community-based care is defined here as having three important components: self-care, family care and third party care in the community. Community based-care relieves the pressure on public services. It is also culturally appropriate because it supports family caregivers and responds to older people's clear preference for receiving care within the home or local community rather than in an institutional setting. Most countries of the region now accept this principle but struggle to support its wider implementation. This approach needs to be reinforced through pilot schemes, research on effectiveness and costing, and sharing of best practice.
- **Promoting self-care among older people can reduce the need for care by others and foster greater autonomy and dignity.** A crucial response to the care crisis is to take steps that enable greater independence for older people by promoting healthy ageing and disease and disability self-management to the extent possible. More accessible physical environments help reduce barriers and complement self-care.
- **As the bedrock of age care, family caregivers need relief and support.** Much of this burden falls on females in the family, as the traditional main providers of care to parents, grandparents and husbands. Governments and other parties can respect and support the role of family in various ways, including providing respite care, training and generally promoting community-based solutions.
- **Civil society organisations and community volunteers are important vehicles for expanding community-based care.** Social care provided in the community underscores values of solidarity and reciprocity within the community and between generations. Older people themselves should be supported to become volunteers for their peers. Volunteer-based approaches managed by NGOs, local authorities, older people's associations and religious organisations have potential to expand, although the sustainability of recruiting and retaining volunteers remains challenging.
- **Paid care workers are increasingly needed to bridge care gaps.** Care assistance provided by families and volunteers increasingly needs to be complemented by paid care workers. Older people with complex needs require a higher level of care beyond the capacity and nature of volunteers' work. Paid care workers can be recruited within the community, and then trained, supervised and supported by existing structures such as local authorities and health and care professionals.

- **Care concerns the younger generations, not just today's older generation.** The issue of social care must be addressed not only with the current cohort of older people but also those in adulthood, so that those entering old age will be more healthy and the demand for care can be stemmed. Social care is a concern across the life-course.
- **Governments need to expand and clarify their role in filling gaps in social care, because families are increasingly stretched.** The government has an important role, for example, in establishing policy and regulatory frameworks and financing civil society service providers. Government needs to ensure financing as well as the quality of care and the availability and training of caregivers. Caregivers therefore include not only volunteers but also care professionals and paid caregivers, and they are also part of any strategy related to community-based care.

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HelpAge International helps older people claim their rights, challenge discrimination and overcome poverty, so that they can lead dignified, secure, active and healthy lives.

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