

Re-producing familism? Approaches to Community-Based Social Care in East and Southeast Asian Countries

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Introduction

With rapidly ageing populations, provision of social care for older persons is of increasing concern, not least in East and Southeast Asian countries. In response, there is increasing interest in the adoption of community-based care throughout this region, i.e. services and support to help people with care needs to live as independently as possible in their communities, postponing the need for more expensive and less available nursing home care.

When labelling the Asian welfare states regarding welfare provisions in general, a number of descriptions can be found, varying from 'Confucian welfare states' (Jones 1993) to 'authoritarian welfare states', (Johnson 1982) and 'productivist welfare states' (Gough 2001). These labels reflect the different dimensions of strong state, social policy development as being subordinate to economic development and the special ethos of altruism, close family ties and placement of societal values before individual.

This paper provides an analysis of the development of community based care the developed economies of Singapore and South Korea, rapidly emerging middle-income countries such as China, Thailand, Indonesia, Vietnam, and the Philippines, as well as two countries with less developed economies: Cambodia and Myanmar. The paper will look into what is common across the countries in terms of policy responses and practical applications to the need for community based care and how the responses are reproducing – or not - the characteristics of the Confucian welfare state, with regard to in particular the welfare mix, and thus the involvement of state, market, civil society, religious organizations and institutions, and finally family. And also whether the development suggests convergence or divergence between countries and with prevalent approaches to community based care in Europe.

It is in particular the emphasis on the role of the family that appears to be unique to the Asian social care model – as well as Southern Europe - with social care traditionally being the responsibility of the immediate family. While Confucianism and its core values of familism are especially applicable in China, Korea, Singapore and Vietnam but less so in the other countries in this study, the family is deeply involved in providing care for its older members in all of

these countries. In practice, familial care responsibilities fall in particular on women. Consequently, one of the focus points of this paper is the gender issues arising from this particular manner of structuring and developing community-based care in policies as well as local practices. As pointed out by Peng (2012), however, development away from what Peng sees as a familialistic male breadwinner welfare regime has taken place in e.g. South Korea, where social policy reforms have gradually modulated and transformed this model into something resembling a gender equal policy regime. The gendered impact of national policy development and of the actual organisation of community-based care approaches is thus also one of the focal points for the paper. The paper is based on a study of community-based care financed by HelpAge International 2013-2014.

Methodology and conceptual definitions

The paper is based on desk studies and a number of country reports conducted as part of a project commissioned by Helpaged International, Asian Office, in 2013-2014. National experts have compiled a review study based on a standardized research design. The national experts consists of the following persons: Cambodia, (Ms Dalin Meng), China (Professor Dr. Du Peng), Indonesia (Dr Tri Budi Rahardjo), the Philippines (Ms Aura Sevilla) and Thailand (Assistant Professor Siriphan Sasat and Ms Viennarat Chuangwiwat).

The definition of *community-based care* applied in the paper is based on the WHO definition, where community-based care includes 'services and support to help people with care needs to live as independently as possible in their communities.' More specifically, in this study we mean helping and assisting targeted older people with social care related to (1) activities of daily living (ADL) and/or (2) instrumental activities of daily living (IADL), which are also complemented by (3) social support to foster greater social interaction and emotional well-being, taking place in their home or the local community, and involving a third party.

The target groups of *older people* (age 60+) are defined to include those who are partially or fully dependent on others with respect to either ADL or IADL tasks—the frail and bedridden as well as those who are largely independent but require occasional assistance with such tasks due to physical impairments and/or cognitive, mental or psychological disabilities.

Theoretical approach: Care diamond

The paper takes as a starting point the departure in the particular social care models applied in the various countries, which can be understood as a particular constellation of social, political and economic arrangements for meeting social care needs, which influences and structures the division of care responsibilities in the welfare mix between formal and informal care providers, between government, family, civil society and market, as well as between men and women. The welfare literature on care regime theory reflects a 'cultural geography' of the role of the state and social policy. One often hears talk of a particular universal public service

model regarding social care, as found in the Scandinavian countries; a family care model in the Southern European countries; a state-supported subsidiary model, where the family takes on responsibility first, supported by public cash payments, in the Continental European countries; and a minimalist, publicly-funded help model in the Anglo-Saxon European countries (Anttonen & Sipilä 1996; Bettio & Plantenga 2004; Rostgaard 2011).

When labelling the Asian welfare states regarding welfare provisions in general, a number of descriptions can be found, varying from 'Confucian welfare states' (Jones 1993) to 'authoritarian welfare states', 'developmental welfare states' (Johnson 1982) and 'productivist welfare states' (Gough 2001; Holliday 2000). These labels reflect the different dimensions of strong state, social policy development as being subordinate to economic development and the special ethos of altruism, close family ties and placement of societal values before individual.

However, as the stages of social care development are very diverse in the East and Southeast Asian region, and at present most developed in South Korea, China and Singapore, it is difficult to summarize the characteristics of the social care approaches in the nine countries in the study within one model, also given the geographical spread. Instead the analytical approach is theoretically based on the concept of the care diamond (See e.g. Evers, * Razavi, 2007).

The diamond model has advantages compared to other models of welfare in focusing on the various societal sectors involved in organizing, financing and providing care, including market, family, state, voluntary organisations and religious organisations. As noted by Orchai (2009), applying the care diamond approach in Asian societies clearly illustrate the inadequacy of reducing the welfare regimes in this region to simple categories like the 'Asian model' or 'familism'. Instead, the patterns of the care diamond vary across societies, by type of care and over time. The care diamond thus acknowledged that e.g. family care holds different characteristics than voluntary care, as most voluntary care is performed outside the family and often within a formal frame of statutory funding and policy formulation. In order to understand the importance of the family, it must therefore be looked upon on its own but it should not be understood in a vacuum either, as it exists in an interrelationship with other spheres also providing care and services. Applying the theoretical concept of the care diamond, the paper thus differentiates between the involvement of central and local governments, family, civil society, religious organizations and market, and how these are supported by national policy and local practice.

Drivers of change

The provision of care for ageing populations is of increasing concern, worldwide as well as among the nine East and Southeast Asian countries studied in this paper. However, as well as having different ageing profiles, the countries covered are at different stages of economic development. The paper includes the developed economies of Singapore and South Korea,

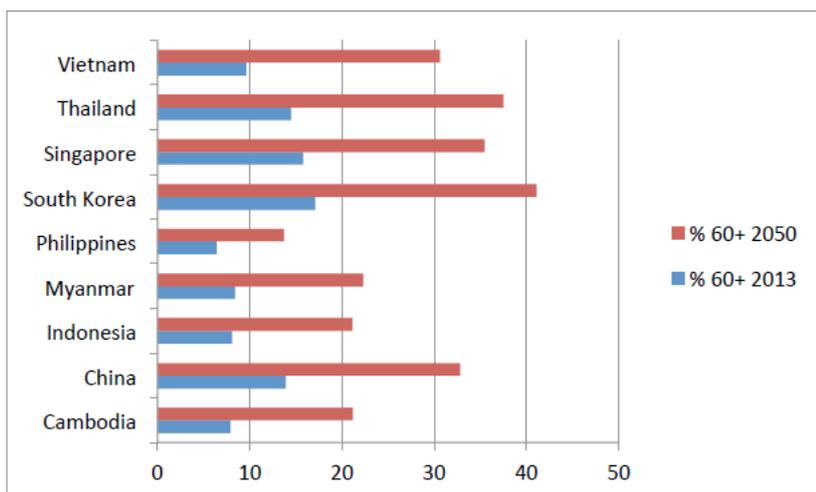
rapidly emerging middle-income countries such as China, Thailand, Indonesia, Vietnam, and the Philippines, as well as two countries with less developed economies: Cambodia and Myanmar.

In keeping with the worldwide trend, these countries also find themselves in the midst of a demographic transition caused by the confluence of reduced mortality and fertility together with life expectancy increases. In fact, some of the most rapidly ageing populations in the world are found in Asia. While most developed nations have had decades to adjust to shifting age structures, the ageing of the respective populations in these countries is taking place very rapidly, often within a single generation.

In Indonesia, for example, the average life expectancy increased from 38.3 years in 1950 to 68.6 years in 2005 (United Nations 2013a; 2013b). In a period of less than 25 years, the percentage of Indonesia's population aged 60 and above is expected to increase from less than 7% to more than 15%. In comparison, this same transition took 114 years in France (Mirkin & Weinburger 2001).

At varying rates, apart from the Philippines—as becomes evident in Figure 1—these countries will all become 'aged' nations over the next 40 years, with 15% or more of the population being 60+ by that time. The increase in the number of the 60+ population between 2013 and 2050 is expected to be around 136% in these nine countries, representing a total increase from 252 million to 595 million older people (United Nations n.d). The proportion of 60+ will increase the most in this period in Thailand, from 14.5% to 37.5%, and the least in the Philippines, from 6.4% to 13.7% (see Figure 1).

Figure 1. Proportion of population 60+, %, 2013 and 2050.



Source: United Nations 2013.

Among the Southeast Asian countries belonging to the Association of Southeast Asian Nations (ASEAN), Singapore in particular will experience this rapid ageing of society. Singapore has not yet made it into the list of the top-ten countries with the oldest populations in the world,

nor will it have by 2050, when 35.5% of the population will be aged 60+ (and 11.2% aged 80+). By 2100, however, Singapore is expected to top this list, with a median age of 56.4 years and an average life expectancy of 94 years. By then, 46.0% of the population is expected to be aged 60+ (and 20.7% aged 80+). But considerable variation is found among the ASEAN countries. The development is somewhat slower in Cambodia, where the current 60+ population is at 7.9%, and expected to rise to 21.2% by 2050 (United Nations 2013a). Myanmar is also undergoing less accelerated ageing than the other Asian countries, although this will change in the near future (HelpAge International 2013). Outside the ASEAN countries, mainland China is the only country in the world with more than 100 million citizens aged 60+. By 2050, the number of 60+ Chinese will have increased from the present 192 million to 450 million, or from 13.9% to 32.8% of the population. Furthermore, the 80+ are expected to increase in China from the present 1.6% to 6.5% by 2050 (United Nations 2013a).

Also outside the ASEAN countries, South Korea will experience the ageing of society and is expected to join China by 2050 as the only two countries in this study on the list of top-ten countries with the oldest populations, with a median age of 52.6 years. By 2100, South Korea is expected to have the highest life expectancy at birth in the world: 95.5 years, even exceeding Japan, which is predicted to be in third place (United Nations 2013a).

Of equal significance for the development of community-based care is that while the ageing of societies is a national trend, some local geographical areas are affected more than others. With economies relying less on agrarian production, there is an increase in rural to urban and also international migration. The increase in labour migration has affected the ageing profile of the rural population drastically. For example, more than 100 million rural Chinese are estimated to have moved to cities in search of work. On the other hand, bigger cities like Shanghai and Beijing are experiencing extremely low fertility rates, which will eventually affect the prospects of filial care provision (Xiong 2009).

In all of these countries, then, ageing will not only bring about a general shift in the composition of populations, it will also take place at a rapid speed and include more people in the group of the oldest-old (80+). The ageing of societies will have implications for the old-age dependency ratio, with fewer working age people to finance, support and care for the ageing population and an expected increase in the number of older persons requiring support and care.

National ageing and social care policies

How have countries then responded to the increasing need for social care provisions? And in particular, which community-based approaches to care are supported by national ageing and social care policies prevalent? This part of the paper provides an introduction to the national policies and legal frameworks in place, which structure the role and involvement of the central and local governments, family, third sector and for-profit sector in the organisation, financing and provision of social care.

National policies on ageing are a relatively new phenomenon in the nine countries, at least in comparison to Western societies. Before the 1980s, there were no national policies on ageing in these countries and only within the last decades have specific policies on long-term care or even community-based care been developed. Thailand and Singapore were among the first nations in the 1980s to formulate national policies to address the needs of ageing populations. In Thailand this was with the '1st National Policy for Older Persons' and in Singapore by forming the 'Committee on the Problems of the Aged'. They were soon followed by other countries, which also began recognising the increasing need to protect older persons, influenced by a number of international conferences, such as the 1st 'World Assembly on Ageing', held in Vienna in 1982, and the 2nd 'World Assembly on Ageing—International Plan of Action', held in 2002 (e.g. Do-Le & Raharjo 2002). An exception to this is Myanmar, where an understanding of population ageing and care issues remains at an early stage. While Myanmar currently has no national policy on ageing, the Parliament requested the development of national policies on ageing in 2013, so rapid changes are expected in the years to come (Myanmar country report).

As for the other countries in the study, the new focus on the needs of older people has resulted in the inclusion of older people in health care coverage, such as in the Law on the Elderly (2010) in Vietnam, which stipulates that health care should be developed for older persons in a given community (Hoi et al. 2012). On the other hand, the issue of social care, either institutional or community-based, has received less political attention. When addressed, policies often emphasized the importance of the family for caring for older people. In Thailand, for example, the first *National Long-term Plan of Action for the Elderly (1986-2001)* emphasized the importance of seniors co-residing with their families together with values of respect for those taking care of elderly relatives (Schmitt & Wirth 2013). Such filial obligations may be enshrined in legislation. E.g. the Cambodian Constitution states that Cambodian tradition dictates that children are obligated to care for their parents. In Vietnam, the marriage and family law highlights that adult children are responsible for respecting, taking care of and nurturing their parents; moreover, adult grandchildren are responsible for nurturing grandparents whose sons and daughters have all passed away. The civil law also emphasizes that the responsibility of children/grandchildren to take care of parents and grandparents is a moral tradition. In Singapore, for example, the 1995 *Maintenance of Parents Act (MPA)* allows destitute older parents to sue their adult children for financial maintenance should they not do so voluntarily (Rozario & Rosetti 2012).

Although the assumption in all countries continues to be that the primary responsibility for providing long-term care remains in the family, a growing sense of urgency has however prompted governments in all countries in the recent decade to consider the development of care outside the family realm, and most countries have addressed this issue in new policies, with Myanmar the only exception (Myanmar country report). The interest in long-term care for the elderly has been sparked by demographic shifts and the realisation that the family

cannot constitute the sole source of care. In China, for example, the so-called 4:2:1 phenomenon is where, on average and according to the widespread norm of filial piety, every adult today has two parents and four grandparents to care for. Accompanied by increasing rural to urban migration and increasing female participation in the formal economy, honouring of traditional kinship values poses a problem, and China is not alone in this regard.

New policy making has included the promotion of and support to the development of civil society initiatives, the state acting primarily to assume the role of facilitator. Governments generally promote the continued provision of care by families but now also encourage the establishment of community-based care through NGOs and social organisations, with the actual care and support provided by local volunteers.

In 1989, the Indonesian government issued *Law No. 13/1998 on Welfare for Elderly People*, stating that the 'community has the right and opportunity to play a role in improving the welfare of the older people' (Do-Le & Raharjo 2002). Through the work of a coalition of government agencies, NGOs and academia—and with support from international government and private organisations such as HelpAge International and HelpAge Korea together with active support from older people constituencies themselves—Indonesia has developed a number of community-based care programs managed by the Department of Social Affairs. These to a high degree cater to the traditional forms of support to frail and poor older people provided in and by the community (Do-Le & Raharjo 2002), but which were heavily reduced in the aftermath of the 1998 economic crisis. Likewise, in *The Second National Plan for Older Persons (2002-2012)*, the Thai government emphasises community-based services that enable 'ageing in-place'. This encompasses the 'Lam Sonthi model of community-based care' project, with care provided by paid care assistants (see Part II for more details). Likewise, Vietnam has set an ambitious target in the *National Action Plan on Older Persons 2012–2020* to provide long-term care for 25% of all older people who are without family members to care for them. The goal is to provide community-based care for 20% of this group of older people (HelpAge International 2013).

As part of their new ageing policies, all of the countries in the study promote the individual's responsibility to maintain health and prevent frailty under the slogan of active ageing and not least self-care. At present, Singapore most likely has the most advanced and ambitious national policies regarding active ageing: the *Eldercare Masterplan 2006–2010* encouraged enhanced employability and financial security for older people; providing holistic and affordable healthcare and eldercare; enabling 'ageing in-place'; and promoting active ageing. This has been followed by the *Enabling Masterplan (2012–2016)*, which takes a social investment and life-course approach to care, focusing on childhood to later life. The new master plan encourages an integrated approach, including the resources of people, community, public and private sectors. Moreover, the idea about an inclusive environment is promoted, such as making the city age-friendly and promoting active ageing, and good care in terms of accessibility, affordability and quality (HelpAge International 2013).

Experience, however, shows that policies may not always be enacted or result in the actual development and implementation of programs. One problem may be the lack of coordination between responsible ministries or between programs, or a lack of priority at the central level. A recent assessment of public services for senior citizens in Cambodia found that the needs of the ageing population have not previously been a priority for the government, resulting in a lack of public health or care services for older persons (HelpAge International 2013). Other problems may be related to the lack of local capacity to build and manage programs, which possibly have limited funds and resources. The evidence from both the Philippines and Indonesia also suggests that the devolution of powers to the regional and local levels possibly poses some obstacles to the development of community-based care programs in that population ageing may be a priority at the national level but varies greatly at the provincial and local levels, not least in the recent times of economic crisis and recovery, but also due to the wide range of ageing populations among provinces (Do-Le & Raharjo 2012; Philippines country report).

Other countries have taken a more centralised approach to the socialisation of care by acknowledging the collective responsibility of the state in co-financing social care. In South Korea, the 2008 establishment of the Long-Term Care Insurance (LTCI) has created a new constituency of beneficiaries as all older people 65+ are now entitled, but actual entitlement depends on a needs assessment. This does not change that the family is still acknowledged as the primary informal caregiver in South Korea (Baek, Sung and Lee 2011) but seems to have changed how non-family care is organised and delivered, from mainly institutionally based care to more community-based care, such as home care and home helper services, public health nurses, day care services, and short-term stay. Consequently, the focus of elder care has also shifted from the medical to the social care model (Peng 2009).

While Thailand, for instance, maintains that providing for the frail elderly remains a family responsibility and hence has no expansion plans for government-sponsored institutional residential homes beyond the present limited number of local government and ministry-provided homes (Knodel 2012), China originally supported 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 has resulted in a rapid increase in the share of institutional care in China. In the city of Tianjin, for example, there were only two government-run nursing homes in the period 1950–1988; by 2001, the number had increased to 300 private and community-based homes. Overall, however, institutional care currently only accommodates less than 1% of all older people, while 12% of China's older population has reported to prefer to live in an old age home (Xu & Chow 2011).

With institutional care being costly for the older people and their caregivers, however, and with concerns regarding the quality of care and relatives' guilt and/or shame over placing their elderly family members in care outside of the family, community-based care is also now recognised in China as a feasible policy option. Since the 1990s, the Chinese state has accordingly launched initiatives, such as the Starlight project, hosting a variety of community based service programs. Most of these initiatives have been health-related, such as house calls, emergency aid, day care programs, health and wellness clinics and recreational activities (Xu & Chow 2011). The ideal elder care model in China is now seen to be family care as the main part, supported by community-based services and complemented by institutional care (Shang & Wu 2011).

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. These include the 2006 *Opinions about Accelerating the Development of the Service Sector for Older Persons* and the 2008 *Opinions of Comprehensively Promoting Home-based Services for Older Persons*, which both in 2011, the *Plan of Constructing Social Service System for Older Persons (2011–2015)* emphasised that the policy is to increase community daycare centres and to assist family caregivers including the construction of barrier-free facilities at home. The plan also emphasises the responsibility of local governments to subsidise home-based care and confirm the role of central government in co-funding community daycare centres and nursing homes (Xu & Chow 2011). Most recently, the Chinese government adopted amendments to the *Law on the Protection of the Rights and Interests of the Older Persons* in 2013 that mean that the ageing population is now incorporated into economic and social development plans and local and national government budgets. The government has announced measures to encourage organisations and individuals to offer elder care services (HelpAge International 2013).

The Chinese state has also encouraged the establishment of 'grass-roots' community groups, volunteerism and community participation projects, a phenomenon also observed in other countries. The establishment of community organisations known as *Shequ* (meaning community) is the most prominent example of this phenomenon in the Chinese context.

Traditionally, China has been cautious about allowing NGOs to operate on a large scale, for which reason this sector initially was relatively inactive in the provision of community-based care (Shang & Wu 2011). Changes can also be observed in this regard, however, with a growth rate of 7% in the number of NGOs since 2008, now numbering 230,000 in total (Xiong 2009). These often operate as quasi-government organisations, with the state acting as the coordinator, facilitator and regulator of social service provision through a network of religious and nonreligious welfare organisations (Rozario & Rosetti 2012). As regards the implementation of new policies, the evidence also points out the need for focusing on coordination between different responsible national and local public agencies as well as

considering the national—and in particular regional and local—lack of capacities and interest in promoting the development of community-based care.

In contrast to the other countries in the study, China has also emphasised the role of the market as stated in the publication ‘Speeding up the development of the service industry for older people’ to increase service provision for older people. Assigning the responsibility of regulation to the state, the publication encourages market-provided services, stating that the development of eldercare “should be guided by state policies, supported by the government, run by the society, and driven by the market” (Shang & Wu 2011). 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 (Peng 2009); but for-profit organisations are prohibited from providing care services to seniors (Shang & Wu 2011).

Community-based care approaches

As the overview of national ageing and social care policies has underlined, there is increasing interest in the development of community-based care. In the following section, a number of different approaches to community-based care will be presented, with the emphasis on community-based care involving a third party—a person outside of the family—either in the direct provision of care or in the form of financial or practical support for a family member’s provision of care. Following the care diamond approach, distinction will be drawn between the involvement in community-based care by 1) the family, 2) civil society, 3) religious institutions and organisations, 4) the for-profit market sector and 5) the government sector.

a. Supporting family involvement in community-based care

Traditional forms of informal care provided by families may be supported by third party involvement, such as NGOs or local authorities, supporting the family practically or financially. There is widespread support in all of the countries under investigation for continued family involvement in elder care as a central component in community-based care. This is evident in the development of overall national policies as described above, and also in the actual policy means supporting the involvement of the family in community-based care implemented in each country, which will be the focal point for this section along with considerations of (changes) in attitudes to family obligations as well as critical issues related to family care.

Although shifting economic and social structures, including declining family size and increased urban migration contributing to the dispersion of adult children, make it increasingly difficult for families to undertake the support and care for frail elderly relatives at home, this still constitutes the main provision of care in all nine countries, especially outside the urban areas. In Vietnam, for example, children and grandchildren are the main caregivers of elderly needing help with one or more ADL tasks, who account for almost one-third of the rural elderly (Hoi et al. 2012).

However, there are different norms and expectations in the different countries concerning the responsibility assigned to specific family members, which in effect structures the involvement of family members in the provision of community-based care and how to support such family members. In Thailand, for example, the traditional bilateral kinship system places the caring responsibility on a specific child, although the matrilineal residential rules will prevail, assigning this responsibility mainly to the adult daughter. In Thailand, 38.6% of the older people who live with an adult child live with a daughter, and 29.1% are co-residing with a son (Knodel 2012). South Korea has a traditional stem-family system, thus placing the responsibility on no child in particular, while the Chinese patrilineal system places more responsibility on sons (Ochiai 2009). Consequently, Chinese elderly with sons are more likely to be in a co-resident situation (Knodel & Ofstedal 2003). In all of the countries, older people with no offspring, or those whose children have possibly migrated to the city, may be cared for by nieces and nephews (Ochiai 2009). Support for continued family involvement in community-based care should thus take into account norms and expectations regarding filial obligations while also acknowledging how they maintain a traditional gendered division of care responsibilities.

Despite different norms concerning the liable family member, the expectation that adult children should provide care and support to their elderly parents continues to be widespread, not least in the traditionally family-oriented Myanmar, where an almost equal proportion of older people in urban and rural residencies agree with this: Among the 60+, 84% of those in urban areas and 81% in rural areas support filial responsibility for care and support of older parents (Myanmar country report). In Thailand, many elders also indicate that at least one child should be present in order to provide personal care rather than leaving this to someone outside the family (Knodel & Ofstedal 2003), but there is evidence of declining support over time among older people themselves for filial care. On the other hand, the proportion of older people nominating their spouse as the preferred caregiver has increased (Knodel 2012).

Preferences for filial support also seem to be changing with respect to co-residence. A survey in the Philippines thus found that the vast majority of older people preferred living independently, albeit in the near vicinity of their adult children (HelpAge International 2013). Nevertheless, co-residence appears to remain the most common living arrangement in a number of countries for those elderly requiring the greatest amount of support, with e.g. 59.3% of older people co-residing with an adult child in Thailand and 56.5% of older persons in Beijing in China (Knodel 2012; Zimmer et al. 2004).

Despite the prevalence of family care and importance of families in the provision of community-based care, families are assisted in their main role in financing and providing care to varying degrees, whether this consists of support for their use of time and forfeited labour market income, their costs for purchasing supplementary care or in the provision of training

and respite care. Despite government co-funding of the long-term care insurance in South Korea, for example, the families' share of payment remains critical, reflecting the persistence of the traditional sense of familial responsibility (Chan, Soma & Yamashita 2011). Co-payment consists of 20% (institutional care) or 15% (home-based care), with a government subsidy covering 20% and an insurance contribution of 60–65% (Kwon 2011) (see later section on the LTCI).

Older adults in Singapore applying for subsidies for the costs of their long-term and healthcare needs are referred to a means assessment under the *Maintenance of Parents Act* that takes their adult children's financial situation into account. If able but unwilling to pay, adult children can be sued in court. There is no information on the results of such cases. Moreover, the fact that most families do not question their responsibility to support their elderly relatives financially and that most older people living alone in Singapore report that their children are also financially insecure makes it questionable whether such financial support can be sustained (Rozario & Rosetti 2012).

And while the National Council of Social Services (NCSS) in Singapore states that its goal is to ensure that 'frail seniors and their caregivers had access to services which promote independence and security' (HelpAge International 2013), a survey among those providing informal care to older persons in Singapore revealed that every second informal caregiver reports an unmet need for assistance with or information on how to help their frail elderly relatives remain in their own home as long as possible (Rozario & Rosetti, 2012). A national grant is available to caregivers who want to undertake training (HelpAge International 2013). In the Philippines, under the 'Carers of caregivers' project, older people and their informal caregivers are visited by local care workers, informing them about the proper and most practical way of providing care and about local health care services

As the survey among informal caregivers in Singapore reveals, informal caregivers often require assistance when providing care. Informal caregivers can gain from respite care, which can relieve them of some of their care tasks on weekends and holidays. While the *National Plan on Long-Term Care* implemented in 2011 by the Thai government aimed at extending the support to caregivers, including the provision of respite care (HelpAge International 2013), this seems to be little developed in other countries, despite the importance in sustaining the family as a caregiver.

A few countries practice the support of informal caregivers by reimbursing some of their costs and lost earnings. In Singapore, adult children acting as informal caregivers receive an annual tax relief contingent on their dependent parents' living arrangements and activities for daily living (ADL) functioning. Tax relief is available to one adult child only, amounting to SGD \$11,000 in 2011 for each co-resident parent with ADL needs, SGD \$4,500 for a non-co-resident and physically independent parent (Rozario & Rosetti 2012). Thailand now also

offers a tax rebate to adult children for taking care of an older parent (max. 30,000 Baht per year per one parent, and only one child can benefit from this law) or paying for health insurance (max. 15,000 Baht per year per one parent)(Schmitt & Wirth 2013).

Another means of alleviating the economic burden for informal caregivers is to provide cash-for-care benefits. Such benefits are relatively uncommon in the countries under investigation. This also applies to the South Korean 'Long-Term Care Insurance' (LTCI), although based on the German model, where cash payments are normal. In South Korea, a cash benefit option was not adopted due to initial concerns over potential abuse and criticism from the women's movement about the potential pressure on women to provide informal care. Interestingly, another concern was the risk of informal caregivers providing inferior care. In order to provide high quality care, South Korea thus adopted a solution favouring the marketbased sector and the continued increase in female labour force participation (Kwon 2011). While cash for care is available, it is mainly provided to those in remote areas or nearby islands where no regular service support is available (Schmitt & Wirth 2013). Indonesia has paid a cash benefit since 2006, now referred to as the 'Social Assistance for Older Persons' (ASLUT). This benefit is paid to neglected older people. This is paid to the older person him/herself, however, as it presumes the absence of an informal caregiver. By 2012, there were 26,500 beneficiaries, representing a mere 0.34% of the 60+ population. This is an increase from 2006, when there were 2,500 beneficiaries in six provinces, but still low considering the estimated number of 1.8 million poor and neglected elderly (HelpAge International 2013; Priebe & Howell 2014).

Giving informal caregivers time off from work can be a way to help maintain their labour market relation, especially if accompanied by a cash benefit to supplement their earned income. None of the countries provide such leave, although it is being advocated for in Singapore and being provided as part of CSR policies by multi-national companies, such as the Alpine telecommunications company in Thailand.

A final policy measure intended to sustain filial responsibility is the joint-living initiative in Singapore, one of several government initiatives aimed at alleviating the housing shortage. Although adult children may not question their responsibility to cofinance the care for their older parents, they may be less willing to reside with the parent. This may provide evidence of an emerging preference for nuclear family units among Singaporeans (Göransson, quoted in Rosario & Rosetti 2012). Consequently, the Housing and Development Board (HDB) has built larger apartments to encourage intergenerational co-residence and granted priority to adult children who want to live closer to their older parents in their tenancy policy with respect to rental properties. HDB has also changed its tenancy rules in order to exclude new older tenants whose children are able to accommodate them in their own homes or have the financial means to provide alternative accommodations (Rosario & Rosetti 2012). Another policy example that can promote co-residency—or generally prolong the time older persons

can remain in own homes—is the Thai plan to offer a benefit to older people to modify their homes of up to 15,000 Baht (approx. USD500).

b. Civil society involvement in community-based care

Realising its limitations and recognising the role of civil society, governments in all of the countries in the study are also encouraged the involvement of civil society in elder care. However, civil society involvement in elder care has for instance in Indonesia also been sparked by a growing sense of urgency among civil society actors, both from the demographic changes as well as the realisation of the limitations of government initiatives. In Indonesia, many government-initiated programs for older people were shut down or severely reduced in the aftermath of the 1997 economic crisis. There are lengthy traditions for civil society involvement in Indonesia, and social organisations have flourished in number since then, with more than 400 registered organisations focusing on older people in the early 2000s (Do-Le & Raharjo 2002).

Some community-based care approaches are initiated by national governments but run by civil society. And as noted in the Philippines' country report, the involvement of national government can have importance for resources, organisational and operational skills, motivation and transferability. In this manner, they may have a direct effect on the sustainability and quality of an organisation's programs. As an example of a government initiative supporting civil society programs from the Philippines, the Federation of Senior Citizens Associations in the Philippines (FSCAP) sprouted from a national government initiative. Most FSCAP provisions consist of regular socialisation and physical fitness, both fostering social support among members. The programme covers persons aged 60 and older through a number of sites around the country.

Another example is the aforementioned *Shequ* community organisations in China, established since 2000 at the initiative of the government. The establishment of the *Shequ* is a national government attempt at reconstituting institutions capable of replacing the workplace as the primary social institution. The *Shequ* are directed by government agencies, run by local community groups and have officially recognised functions. Part of the activities possibly includes the operation of residential homes and nursing homes facilities, apartments, care centres and daycare centres for older persons. By 2000, one in three *Shequ* provided one or more such activities (Ochiai 2009).

Yet another Chinese national government initiative to encourage civil society involvement is The Golden SunshineAction, a Chinese national project, under the Starlight programme. This project targets a specific resource group: young people. Under the project, various volunteer organisations have been encouraged to take part in the provision of care for older people. One of the ambitions has been to involve teenagers. Activities include caretaking and the provision of medical and health care as well as legal aid in the nursing homes as well as in the homes of

the older people living in the community. According to the Chinese government, an estimated 630 million hours of volunteer service have been provided in 13 million cases, reaching over 2.8 million older people (State Council Information Office 2006).

Other national programs specifically target older people as caregivers for other older people, also reflecting active ageing policies that recommend continued engagement and involvement in old age. Consequently, some volunteer programs encourage seniors to partake in voluntary, community-based care activities. This is the case with the 'Friends Help Friends' programme, which Thailand established in 2004, providing financial support for programs promoting volunteer work by the older people themselves. The programme was partly established to co-finance the costs of establishing voluntary services and community networks. It is implemented by local Old People's Associations (OPAs) (HelpAge International 2013). Likewise, the Philippine 'Home Care Assistance Project', co-funded by the Older People's Association in the Philippines and local governments, has succeeded in involving older people as partners rather than mere recipients. Older people receive training on care for the frail elderly and the ill.

The Thai government initiated in 2003 the national programme 'Project of Older Persons Home Care Volunteer', which aimed to provide care and support to the older people in communities and focused on the development of caring skills. The programme offers a 3-day course for volunteers who want to act as caregivers, teaching them about theory and practice with respect to health and social service delivery. In 2011, an estimated 40,000 volunteer caregivers provided care to older people as part of the programme. The volunteers visit the elderly on regular bases, offering a variety of services, including companionship; assistance with personal care, domestic chores, health checks and transport; home renovations; and check-ups on health and physical exercise (Schmitt & Wirth 2013).

As is the case with a number of programs found in the countries in this study, this programme is also intended to assist in the conservation of traditions and culture of unity, respect and gratitude towards older people. With respect to community-based care, such approaches may underscore and support the continuation of traditional Asian values emphasising respect for elders as well as the continued filial and community responsibility for care.

Some programs, such as the local initiative in Singapore, 'Neighbouring Links', specifically target neighbours as a source of help. Neighbours are rarely identified in the literature as specific care providers but may nevertheless often provide care informally and be an important means for enabling frail older people to remain in their home, not least in countries with little formal care provision and in rural areas with labour force migration. In contrast to community-based voluntary care provision, this represents a care relationship established on the basis of living physically close to one another and on a feeling of non-filial responsibility,

which may nevertheless be based on a long shared history and having provided assistance to one another in the past.

The Neighbourhood Links programme thus emphasises the neighbour relation. It addresses the social and relational needs of older adults in specific neighbourhood precincts. The programme is designed as a focal point whereby neighbours can volunteer their services for those in need. Neighbourhood Links activities are usually informally self-managed by local residents under the auspices of family service centres (Rozario & Rosetti 2012).

Older People's Associations (OPAs) are often involved in locally initiated activities. Although OPAs are not designed to organise and provide community-based care, this often becomes part of their activities, whether aimed at personal care or activities involving socialisation, exercise etc. For example, around 10% of the beneficiaries reached in the local OPA projects in Myanmar in 2013 received home-based support and assistance with ADL/IADL functions (Myanmar country report). OPAs are present in all nine countries and go under different names, such as Integrated Community Posts for Older Persons in Indonesia or Intergenerational Self Help Clubs in Vietnam. Here, the generic term 'OPA' will be applied. OPAs are rapidly increasing in number; e.g. there were 317,000 OPAs in urban and rural China by 2005 (HelpAge International 2012a, 2012b; Xiangdong & Deng 2011) and 23,367 OPAs in Thailand in 2012 organised under the Senior Citizen Council of Thailand (SCCT) with roughly 1,640,000 individual members. The number of OPAs in Vietnam has increased from 60 in 2006 to 628 by 2012 and expected to grow to 5,000 by 2020. OPAs comprise of self-managed, community-led, and often multi-functional organisations. They typically have a strong local foundation, as in China, where they have a strong link with village committees (Klien 2013). Members usually pay a monthly fee, and the associations also receive income from interest on loans, donations and from the surplus from social enterprise activities. The association typically uses the income for micro-credit loans, activities for members, fund raising and running cost (Klien 2013).

Many OPAs organise activities aimed at improving health care, participation in community life, supporting disaster responses and building livelihood and food security. This support often consists of the promotion of self-care knowledge, such as awareness of appropriate nutrition and a healthy lifestyle, as well as providing information on the prevention of non-communicable diseases and simple self-care skills. This may include the promotion of physical exercise through group exercise or posters (see Box 1 for an example of an exercise poster).

OPA membership may not be restricted to older people and are not set up specifically to be involved in the organisation and provision of community-based care, but they constitute an important platform for many of the activities which directly or more indirectly are helping older people to be able to continue living in their community, and OPAs play an increasing role in the organisation and provision of such support and care for frail older people. Most

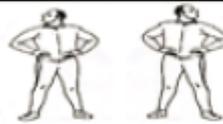
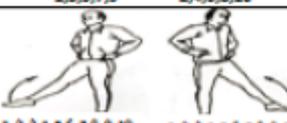
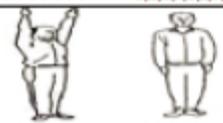
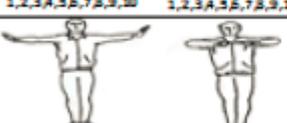
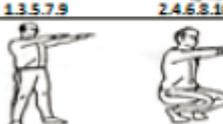
importantly, OPAs are now involved in most countries in the provision of social care through the ROK-ASEAN home care programme.

The Republic of Korea-ASEAN Cooperation Fund (ROK-ASEAN) Home Care Programme, seems to be the most prevalent community-based care approach in the countries under investigation. It is based on the same founding principles but adapted to the local context. Initially established by HelpAge South Korea in collaboration with HelpAge International, it was intended as a way to support community-based care based on a successful South Korean project. As of 2013, it has been established in Indonesia, Cambodia, Laos, Myanmar, Vietnam, Brunei Darussalam, Malaysia, the Philippines and Thailand.

The programme is intended to assist older people who have lost the ability to care for themselves fully, in order to enable them to remain in their own home and community as long as possible, independently or with their families. It specifically targets the poor elderly, often living alone, who struggle with their daily living activities and require support to supplement the care they receive from family members. Most of the beneficiaries of this project are women.

The ROK-ASEAN caregivers are volunteers, often living nearby, which enables them to reach the older people easily and quickly in cases of acute need. In some cases, community-based Older People's Associations help to coordinate the local work. The main services provided are emotional support, befriending and companionship, but may also involve personal care services (lifting, assistance with walking, personal hygiene), domestic chores (cleaning, cooking, laundry), and escorting (to shops, doctors, social events, worship). In some cases, the volunteer may also provide health information and/or a referral to local agencies for additional services. As most service provision is typically for 1–2 hours of care a week, the ROK-ASEAN is to be regarded as an assistive service, not intended for intensive needs.

Box 1. Exercise poster

| Bài tập thể dục dưỡng sinh 14 động tác | | | |
|--|---|----|---|
| 1 |  1,3,5,7,9 2,4,6,8,10 | 8 |  1,3,5,7,9 2,4,6,8,10 |
| 2 |  1,3,5,7,9 2,4,6,8,10 | 9 |  1,3,5,7,9 2,4,6,8,10 |
| 3 |  1,2,3,4,5,6,7,8,9,10 1,2,3,4,5,6,7,8,9,10 | 10 |  1,2,3,4,5,6,7,8,9,10 1,2,3,4,5,6,7,8,9,10 |
| 4 |  1,3,5,7,9 2,4,6,8,10 | 11 |  1,3,5,7,9 2,4,6,8,10 |
| 5 |  1,2,3,4,5,6,7,8,9,10 1,2,3,4,5,6,7,8,9,10 | 12 |  1,3,5,7,9 2,4,6,8,10 |
| 6 |  1,3,5,7,9 2,4,6,8,10 | 13 |  1,3,5,7,9 2,4,6,8,10 |
| 7 |  1,3,5,7,9 2,4,6,8,10 | 14 |  1,3,5,7,9 2,4,6,8,10 |

Mỗi động tác làm 10 lần

The activities of the national ROK-ASEAN approaches differ according to the national context of existing services, need and what is culturally acceptable. In countries with relatively strong and developed health care services, the activities typically concentrate on social care tasks, such as home help and befriending. In countries with less developed health care services, tasks may also include basic health services. This is the case in Myanmar and the Philippines (HelpAge Korea 2014).

c. Involvement of religious organisations and institutions in community based care

Religious institutions may also be involved in community based care, such as is the case e.g. in the pagodas in Cambodia. Cambodia is a predominantly Buddhist country, and some older people choose to spend their last days at a pagoda, helping to clean the pagoda, do grounds work, prepare food for the monks, helping organise pagoda festivals and partaking in meditation. There are 4,237 pagodas in Cambodia, and around 10,000 older people stay at the

pagodas. Instead of using family-based care, some older people choose to remain in the pagodas, where their basic needs are met. Pagodas, however, rarely take care of any ADL or IADL needs that such persons might have (Cambodia country report).

Care and support for older people provided by religious organisations can also be found in Indonesia, such as the *Cita Sehat* in Yogyakarta, *Yayasan Akutsar* in Central Sulawesi and *Vina Dulcido* in East Nusa Tenggara. These organisations are supported by the Ministry of Social Affairs, which provides caregivers and some food, while the Ministry of Health provides health services (Indonesia country report).

In Thailand, the Buddhist temples play an active role in community-based care by providing emotional support via spiritual care, rehabilitation and home visits and by offering a meeting place for social and religious activities.

In China, a few religiously based organisations, mainly Christian, now provide services for older persons, but mainly institutional care.

d. Involvement of the market in community-based care

With the increasing care need and lack of formal care provision, market-based solutions are a potential option to help narrow the care gap. Apart from China and Singapore, however, the market provision of community-based care is not supported nor particularly encouraged in the national policies addressing community-based care.

In China, government support for market-based care solutions includes service vouchers. In Taicang city in the Jiangsu province, for example, the government provides the elderly with a voucher for services purchased by the government. Clients receive a monthly card of a value of 720 Yuan (approx. US\$118) from the government. All community-based care service suppliers are equipped with mobile card machines which accept the card. In Beijing as well, older people are supplied with a service voucher as a means to purchase care services. As of 2010, Beijing provides those over the age of 80 with a monthly 100 Yuan (approx. US\$16) service voucher, to be used to pay for household care, rehabilitation assistance and other home-based care services (China country report).

Alternatively, the Singapore government assists the purchase of market-based care by offering to reduce the employer's contribution, representing a value of SGD\$95 (US\$75) monthly (Rozario & Rosetti 2012), also offering a SGD\$120 (US\$95) grant for families, in both cases in order to assist families hiring a foreign domestic care worker (Schmitt & Wirth 2013). This is a common care solution. Nearly half of all respondents aged 75+ in a nationally representative study in Singapore reported having received help from a foreign domestic worker on a daily basis in the performance of at least one ADL activity (Rozario & Rosetti 2012). Domestic care workers usually live with the family and work 24/7. While the use of

domestic care workers is an increasing trend in the urban cities (Ochiai 2009), domestic workers in China typically come from rural areas.

The foreign domestic workers are usually from other Asian countries, such as the Philippines, Indonesia, and Vietnam, and usually female, with the Philippines being the global leader in foreign domestic workers (Philippines country report). The domestic care workers thus constitute an important care resource in the receiving countries while at the same time undermining the continuation of the traditional kinship support system at home. According to the 2007 Philippine Longitudinal Study on Aging, about a fourth of those aged 60+ in the Philippines have at least one child living or working abroad, more elderly females (34%) than males (22%) relying on overseas remittances for their subsistence. As a consequence of the new care chains, new patterns of care relations have also emerged, particularly with the role of older Filipinos in the family, who now serve as surrogate parents to the children of Filipinos working overseas (Philippines country report).

e. Government involvement in community-based care

In comparison to the provision of healthcare services, governments—whether central or local—are generally less involved in the provision of community-based care to older persons. Governments are mainly involved as the initial facilitator of volunteer programs or as the regulator of service premises.

One exception to the otherwise limited involvement of local government in community-based care is China, where the government has traditionally played a relatively larger role than in the other countries under study. While national policies are drawn up at the ministerial level as elsewhere, local level government departments, such as sub-district office and village committees, play a larger role in terms of being responsible for the organisation, implementation and integration of services.

Also in Thailand, the policy on the responsible party of social care including long-term care (LTC) for older persons (for non-health care) has been geared towards the local administration organisations, which are the local governments, in accordance with the decentralisation policy. The Thai *Lam Sonthi* model in Lopburi Province providing ADL and IADL services is an example of such local government involvement. Here, the aim is to prevent the frequent revisit of chronically ill health and dependent older persons and a shortfall of the family caregivers due to the emigration of adult children or their unavailability due to work requirements. In addition to health care, services include personal care such as assistance with bathing, dressing, mobility and household chores such as cleaning and assisting in finding accommodation. Originally provided by local volunteers, services are now provided by paid care assistants, paid by the local government. Care assistants have received training in basic care for older persons, receive on-the-job Training and work under the supervision of health professionals from the local hospital. This

model provides a good example of the collaboration between the health (hospitals) and social sectors (Local Administration Organisations, communities). While there is a regular monitoring and supervision system in place, there is a lack of documentation due to the information system not being developed to keep track of the patient receiving social care

The Chinese authorities have also played an important role in developing formal caregiver certification, recognising this as an occupational category. Training centres are providing different training programs, however, and a coherent training standard has yet to be established. In Thailand, a 420-hour (3-month) training course for the paid care assistant position mentioned above has been available for the last 15 years. The national qualification exam was introduced some 5 years ago and is currently under revision (Sasat 2013).

Another example of government involvement is found in the development of the 'Long-Term Care Insurance' (LTCI) in South Korea. Implemented in 2008 by the Ministry of Health and Welfare and executed by the National Health Insurance Corporation (NHIC), it is a universal scheme for persons 65+ who have difficulty taking care of themselves for at least six months due to typical geriatric diseases. Needs are assessed by local NHIC agencies and a medically based assessment committee. The care plan can recommend nursing home care or community-based care. In-home services covered by the insurance include support for daily activities, home nursing, functional therapy and medical treatments. Care is provided as a service benefit, except when service agencies are not available, typically in rural areas. On a national basis, approx. 600 users receive cash instead of services.

The LTCI system assumes a certain quality of care, and care workers must complete a 240-hour training course and pass a national exam. Provider agencies must also hire care workers according to the minimum required staff-user ratio (Schmitt & Wirth 2013).

The cost of care is shared between the user, insurance company and the government. The user pays 15% of the home care costs, with a government subsidy covering 20%, and insurance contributing 60–65% (Kwon 2011).

Conclusion

The countries in the study are all in the midst of a pronounced demographic shift, experiencing combined trends concerning reduced mortality and fertility together with increased life expectancy. This will affect the demographic composition of the populations and will take place within a relatively short time span, albeit more in some countries than others. In combination with changing family structures, labour force migration and most likely also an increase in the morbidity prevalence, there is an increasing interest in addressing the need for long-term care for the ageing population; and as is the focus for this study, the need for developing community-based care. In recent decades, all countries have acknowledged the social risks of old age and developed national policies to address these risks, including self-care and active ageing policies as preventive measures in the most advanced countries.

Generally, older people's access and entitlement to health care and to some degree also to income support has been addressed in recent policy measures, while there is still urgent need to develop long-term care policies.

Community-based care is recognised for providing a cost-effective and sustainable care solution. Given the preference for family care and given that institutional care is often viewed as the last resort, the development of community-based care seems to be the most viable policy solution, and one which is pursued in all countries. This is also the case for China, where government investments in long-term care otherwise initially took shape mainly in the form of financial support to nursing homes.

National policies on long-term care have generally emphasised the continued importance of family involvement in the provision of care, taking into account the tradition for family responsibility as a fundamental and traditional value in Asia. Modern law making has emphasised this filial obligation in civil law (e.g. Cambodia and Vietnam) or, as is the case in Singapore, laws that specifically enable destitute older parents to sue their adult children if they are not willing to finance nursing home care. Filial obligation may also be stimulated through policy making, as in Thailand, where there are incentives for children to support their parents by providing income tax reduction benefits. In all of the countries under study, policy continues to encourage the family's main responsibility for care provision, and specific policies have been developed to support continued family care. The continued reliance on the family has certain gendered effects, as informal care provision is traditionally carried out mainly by women. A social care model which builds on the care provision by families in this way also sustains a traditional division of unpaid labour. It also has some implications for older people, who are without near relatives or whose relatives do not live close by, for instance because they have migrated to other areas of the country.

Recognising the limitations of family-based care systems, the policy in all of the countries is marked by the realisation that government action is necessary in order to sustain and support the family in care giving as well as the need for providing care outside the family realm. Myanmar is perhaps the only exception to this, apart from the support to establish the ROK-ASEAN approach. New policies have sought to involve civil society in the organisation and provision of care, with the state mainly acting as a facilitator. Government action has generally consisted of the support for local community and NGO involvement in care provision. China is perhaps an exception in the sense of traditionally being less favourable toward NGO involvement, but also here changes have taken place and numerous social organisations now operate in China.

The Chinese state has continued to play a major role in financing long-term care and is also active in terms of operating government-run nursing homes. Collective responsibility for long-term care as expressed in government action is otherwise mainly seen in the development of the Long-Term Care Insurance in South Korea.

The for-profit market sector remains underdeveloped in most countries. At present, China seems to be in the lead in the promotion of market-based care solutions, while South Korea has instead promoted the establishment of independent but regulated entities of legal corporations.

Overall, this suggests that the social care models being developed in these countries continue to rely on the family as the main caregiver, but allowing more room for civil society initiatives, whether based on local community action or part of larger NGO activities; and in the Chinese case, also to the market. On the other hand, central government plays a role in the development of new policy making; beyond that, however, it is mainly a facilitator of social care provision.

However, it is in particular the emphasis on the role of the family that appears to be unique to the Asian social care model with social care traditionally being the responsibility of the immediate family. Development away from what Peng (2012) sees as a familialistic male breadwinner welfare regime may have taken place in e.g. South Korea, where social policy reforms have gradually modulated and transformed this model into something resembling a gender equal policy regime. The family is nevertheless deeply involved in providing care for its older members in all of the 9 countries. In some countries this is underscored by Confucianism and its core values of familism, being especially applicable in China, Korea, Singapore and Vietnam but less so in the other countries in this study.

In practice, familial care responsibilities fall in particular on women. Consequently, one of the focal points for national policy development should be the gender issues arising from this particular manner of structuring and developing community-based care in policies as well as local practices.

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