Review of Initiatives on Long-term Care for Older People in Member States of the South-East Asia Region
Review of initiatives on
LONG-TERM CARE FOR OLDER PEOPLE
in Member States of the WHO South-East Asia Region
Foreword

Changing demographics across the WHO South-East Asia Region have caused a shift in morbidity patterns, posing serious challenges to the care of older people. The elderly population in the Region is expected to increase from 9% in 2017 to 22% in 2050. As highlighted in the WHO Global Strategy and Action Plan on Ageing and Health (2016), and the Regional Framework on Healthy Ageing in South-East Asia Region (2018-2022), the development of long-term care (LTC) systems is vital to meeting the diverse needs of older people, who may require support for basic, instrumental and advanced Activities of Daily Living (ADL), in addition to existing health services for acute and chronic conditions.

Member States Region-wide recognize the importance of including LTC systems in their national policies and strategies on healthy ageing, which are key to delivering on the Decade of Healthy Ageing (2020-2030). While advances have been made, several challenges – including inadequate resources – have stymied progress. The LTC sector is still largely informal and continues to rely on family care. Several examples of good practice nevertheless stand out, and should be harnessed by Member States as they develop their sustainable LTC systems. This is particularly important as countries strive to achieve universal health coverage – one of the Region’s Flagship Priorities – and develop more people-centered and integrated health systems.

I am certain this “Review of Initiatives on Long-Term Care for Older People in Member States of South-East Asia Region”, which explores how to create an effective LTC system, will be of use to Member States in the Region and beyond. I am also convinced that it will reinforce the Region’s momentum on achieving universal health coverage and help make the Decade of Healthy Ageing the success it must be.

[Signature]

Dr Poonam Khetrapal Singh
Regional Director
Contents

Foreword........................................................................................................................................................................... v

Glossary............................................................................................................................................................................. viii

Executive Summary ............................................................................................................................................................... ix

Chapter 1  Introduction......................................................................................................................................................... 01

Chapter 2  Demographics................................................................................................................................................... 07

Chapter 3  Long-Term Care: General Issues ....................................................................................................................... 11

Chapter 4  Long-Term Care: Global Situation ..................................................................................................................... 25

Chapter 5  Long-Term Care Initiatives in the South-East Asia Region................................................................................. 31

Chapter 6  Long-Term Care in Member States of the South-East Asia Region................................................................. 37

Conclusion........................................................................................................................................................................ 68

References........................................................................................................................................................................ 70
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Long-term care</strong> [1]</td>
<td>WHO defines long-term care as &quot;the activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity&quot;.</td>
</tr>
<tr>
<td><strong>Long-term care systems</strong> [1]</td>
<td>Long-term care systems are national systems that ensure integrated long-term care which is appropriate, affordable, accessible and upholds the rights of older people and caregivers alike. Depending on the national context, funding and care may be provided by a combination of families, civil society, the private sector and/or the public sector. Governments do not need to do everything but should take overall responsibility for ensuring the system's functioning.</td>
</tr>
<tr>
<td><strong>Functional ability and intrinsic capacity</strong> [1]</td>
<td>Functional ability refers to the attributes that enable people to be, and to do, what they have reason to value. It is determined by individuals' intrinsic capacity (a combination of all their physical and mental – including psychosocial – capacities), the environments they inhabit and the interaction between them and these environments.</td>
</tr>
<tr>
<td><strong>Organized versus unorganized care</strong> [1]</td>
<td>Organized care is coordinated by agencies, institutions or governments. Unorganized care is provided by family or other unpaid caregivers and is not coordinated beyond the level of individuals or families.</td>
</tr>
<tr>
<td><strong>Paid versus unpaid care</strong> [1]</td>
<td>Caregivers can be grouped into two broad categories: those who are paid for their work and those who are not paid. Paid caregivers may include professionals and paraprofessionals or family members who receive compensation for the long-term care services they provide to relatives.</td>
</tr>
<tr>
<td><strong>Universal health coverage</strong> [2]</td>
<td>Universal health coverage means all people receiving the health services they need, including health initiatives designed to promote better health, prevent illness and provide treatment, rehabilitation and palliative care of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardships.</td>
</tr>
<tr>
<td><strong>Out-of-pocket (OOP) payment</strong> [2]</td>
<td>Direct payment made to health-care providers by individuals at the time of service use, i.e., excluding pre-payment for health services, for example, in the form of taxes or specific insurance premiums or contributions and, where possible, net of any reimbursements to the individuals who need the payment.</td>
</tr>
</tbody>
</table>
Executive Summary

Demographic and epidemiological transitions are resulting in a dramatic increase in the proportion of older people in the world, where longer life expectancies and chronic disabilities of old age impinge upon the health and social fabric of countries. With rising long-term care needs of older people, public policies are urgently required to address the consequences of increasing prevalence of chronic disabilities and morbidities of long duration among older people and dwindling capacities of the informal/family support mechanisms.

While the issue of long-term care was previously associated with high-income, developed countries, the rapid increase in the proportion of older people in most parts of the developing world has resulted in a situation where the need for long-term care of older people assumes a significant public health challenge [3]. Moreover, these developing countries are experiencing increases in long-term care needs at levels of income that are far lower than the levels that existed in the industrialized world when these needs emerged.

This report is an overview of the status of long-term care in the South-East Asia Region, the future of its development as a result of the increasing burden of chronic morbidities and disabilities, and the changing caregiver system. It finds that long-term care is in its infancy in this Region, despite the enormous expressed and unexpressed demand for it. This burden is least shared by the formal sector and is mainly dependent on the family members of the person requiring care. Such caregivers, with poor skills and without motivation, are suboptimally contributing to the goals of long-term care in this Region. A few countries have not yet formulated a national policy/plan/strategy for long-term care.

This report consists of six main chapters

Chapter 1 introduces the various initiatives taken by WHO for the development of a long-term care strategy. It gives an overview of how WHO Guidelines on ICOPE programme is associated with the norms of long-term care.

Chapter 2 briefly describes the demography of Member States of the SEA Region. It contains the projection of geriatric populations in Member States by the year 2050. It gives a comparative picture of the life expectancy at birth and at 60 years of age in this Region. It reports on the living arrangements and family-based caregiver patterns of older individuals.

Chapter 3 introduces the concept of long-term care. It summarizes the various factors that put an older individual at risk of requiring long-term care. It explores the various components as well as the modalities of long-term care. It discusses the role of family in long-term care and various challenges of the family caregiving system. It explores the various modalities of long-term care, such as palliative care. It also examines the financing modalities of long-term care.
Chapter 4 situates long-term care in the global context. It reviews the modalities of long-term care, the methods of coordination, the organizational structures, the financial model, and methods of necessity assessment for long-term care, etc., in select high-income countries.

Chapter 5 gives details of WHO initiatives for the conceptualization of long-term care in the South-East Asia Region. It discusses the guiding principles of the regional framework with regard to long-term care. It assesses the mid-term progress on the Global Strategy and Action Plan on Ageing and Health.

Chapter 6 gives details of the steps taken by Member States for the establishment and promotion of long-term care in their respective socioeconomic frameworks. The report presents brief case descriptions of each country’s experience, outlining progress to date, the major challenges faced and the gaps that still exist.

It is observed that the family shares a major burden of long-term care in most countries. Among the family members, women play a central role, but their efforts are neither acknowledged nor financially encouraged. They do not have adequate skills, which results in suboptimal care of older individuals with compromised intrinsic capacity and functional dependence.

Formal systems of care in the form of old-age homes, care centres and home-based nursing care are on the rise. As of now, they have a minimal, but promising, contribution to the share of the burden of long-term care. Countries such as Bangladesh, Democratic People’s Republic of Korea, India, Indonesia, Sri Lanka and Thailand have developed some form of policy/plan/strategy/framework for long-term care, while other countries are in the process of developing it.

All countries of the Region need a fully integrated, sustainable long-term care system. They should work collectively towards this. National health policies should address the huge burden of long-term care. The importance of long-term care cannot be ignored, as it has a societal, national as well as global impact. It needs to be acknowledged that acute care alone cannot be a solution for old-age care. Governments should either establish and govern, or facilitate, the establishment of long-term care systems. A range of partners can work together to decide what needs to be done and assign responsibilities accordingly.
01 Introduction
According to the 2019 revision of World Population Prospects, by 2050, one in six people (16%) in the world will be above the age of 65 years, up from one in 11 (9%) in 2019. By 2050, one in four people living in Europe and North America could be aged 65 years or above. In 2018, for the first time in history, people aged 65 years or above outnumbered children aged under 5 years on a global level. The number of people aged 80 years or above is projected to triple from 143 million in 2019 to 426 million in 2050 [4].

Although the proportion of older people in the SEA Region was rising at a slower rate in 1975 (around 6% compared to the world average of around 8%), it has now caught up with the world rate.

In the SEA Region, the proportion of older people, which increased by only two percentage points in 35 years (from around 6% in 1975 to around 8% in 2010), is likely to increase by twice as many percentage points in the next 15 years (from around 8% in 2010 to around 12% in 2025). This means that the total population of older people, which was 142 million in the SEA Region in 2010, is likely to witness a quantum jump in 15 years, to over 242 million by 2025 [5].

Population ageing is poised to become one of the most significant social transformations of the 21st century. It has implications for nearly all sectors of society, including health, labour and financial markets; the demand for goods and services, such as housing, transportation and social protection; as well as family structures and intergenerational ties. With the unimagined demographic transition, thorough preparedness for tackling the challenges of ageing with a sustainable policy was always a necessity. Therefore, various conventions of the United Nations and other international organizations have made population ageing one of their major priorities in recent decades.

The 2002 Madrid International Plan of Action on Ageing (MIPAA), adopted during the Second World Assembly on Ageing, recognized the many benefits of greater longevity to individuals, families and society. Families benefit from the contributions of older generations through financial support for assistance with household maintenance or participation in childcare. Societies benefit from the experience of older people and from their contributions to the labour force; as well as from their volunteerism, philanthropy, and civic engagement. The MIPAA emphasized that older people should be able to participate in and benefit equitably from the fruits of development to enhance their health and well-being, and that societies should provide enabling environments for them to do so [6].

The Sixty-ninth World Health Assembly (WHA) [7], adopted the Global Strategy and Action Plan on Ageing and Health, having considered the multisectoral action for a life course approach towards healthy ageing. Member States, partner agencies and the WHO Secretariat were urged to implement the proposed actions described in the Global Strategy through a multisectoral approach. These actions would include the establishment of national plans or mainstreaming those actions across government sectors as per national priorities and specific contexts, while strengthening the capacity of relevant government sectors to deal with components of healthy ageing through leadership, partnership, advocacy and coordination.

Among other issues, the WHA desired that health and long-term care systems be formulated to deliver good-quality integrated care to older people within age-friendly environments [7]. Appropriate technical support to Member States was required to:

- establish national plans for healthy ageing;
- develop health and long-term care systems that could deliver good-quality integrated care;
- implement evidence-based interventions; and
- strengthen data systems on healthy ageing [7].
The Seventieth Session of the United Nations General Assembly recognized the challenges faced by older people in relation to the enjoyment of their human rights, such as prevention of and protection against violence and abuse; social protection; food and nutrition; housing; employment; legal capacity; access to justice; access to health services including physical and mental health support; and long-term and palliative care services. The 2015 WHA resolution called upon all Member States to promote and ensure the full realization of all human rights and fundamental freedom of older people [8, 9].

Similarly, the Seventieth Session also decided on 17 new global Sustainable Development Goals (SDGs) that were considered comprehensive, far-reaching and people-centered universal transformative goals and targets, to be fully implemented by 2030 [9]. Several of the 17 goals are consistent with issues related to various aspects of healthy ageing and health care of older people, for example: SDG 1 (ending poverty in all its forms); SDG 2 (ending hunger, ensuring food security and improved nutrition, and promoting sustainable agriculture); SDG 3 (ensuring healthy lives and promoting well-being for all at all ages); SDG 5 (achieving gender equality and empowering all women and girls); SDG 10 (reducing inequality within and among countries); and SDG 11 (making cities and human settlements inclusive, safe, resilient and sustainable) [9].

In addition, the Sixty-ninth World Health Assembly requested preparations for: a mid-term progress report on the implementation of the Global Strategy; proposal for a Decade of Healthy Ageing (2020–2030); and a global status report on healthy ageing for submission to the Seventy-third World Health Assembly. The Global Strategy and Action Plan on Ageing and Health had proposed four years of work to prepare the world for a decade of concerted global action – the Decade of Healthy Ageing (2020–2030). These actions (labelled as priorities) have to commence immediately if the Decade of Healthy Ageing is to be a success. While each action proposes a body of work that would be led by WHO, this will be possible only through collaborations with many key partners. Policy coherence and equitable impact will be achieved only if there is coordination and integration among these multiple stakeholders and actions (Box 1) [10].

**Box 1. 10 priorities towards a decade of healthy ageing [10]**

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Establishing a platform for innovation and change</td>
</tr>
<tr>
<td>2.</td>
<td>Supporting country planning and action</td>
</tr>
<tr>
<td>3.</td>
<td>Collecting better global data on healthy ageing</td>
</tr>
<tr>
<td>4.</td>
<td>Promoting research that addresses the current and future needs of older people</td>
</tr>
<tr>
<td>5.</td>
<td>Aligning health systems with the needs of older people</td>
</tr>
<tr>
<td>6.</td>
<td>Laying the foundations for a long-term care system in every country</td>
</tr>
<tr>
<td>7.</td>
<td>Ensuring the human resources necessary for integrated care</td>
</tr>
<tr>
<td>8.</td>
<td>Undertaking a global campaign to combat ageism</td>
</tr>
<tr>
<td>9.</td>
<td>Defining the economic case for investment</td>
</tr>
<tr>
<td>10.</td>
<td>Enhancing the global network for age-friendly cities and communities</td>
</tr>
</tbody>
</table>
With regard to ‘laying the foundations for long-term care system in every country’, three key areas have been identified for action [10].

1. Building an understanding and commitment to develop long-term care systems through global, regional and local policy dialogue.

2. Mapping the current situation in long-term care provisions to serve as a baseline for the countries to take an informed action with regard to the need, unmet need, type and quality of existing services, legislation, human resources and financing mechanisms.

3. Providing guidance, tools and technical assistance to countries at all levels of socioeconomic development, building sustainable and equitable systems to meet the needs of older people with significant loss of capacity.

The World Report on Ageing and Health recognized that ageing of the population is a rapidly accelerating global phenomenon, and demanded a comprehensive public health response and significant changes in the way health policies for ageing populations were formulated and services provided. The report emphasized that healthy ageing was more than just the absence of disease: the maintenance of functional ability had the highest importance.

The report examined in detail what was known about health and ageing, and built a strategic framework for taking public health action along with practical steps that could be adapted for use in countries at all levels of economic development. The recommended societal approach to population ageing, including the goal of building an age-friendly world, required a transformation of health systems – away from a disease-based curative model, towards the provision of integrated care centered on the needs of older people [11].

The report gave a new definition for healthy ageing. It stated: “Healthy ageing is the process of developing and maintaining the functional ability that enables well-being in older age.” It was understood that in healthy ageing, neither the intrinsic capacity nor the functional ability of an ageing individual remained constant. Although both these tend to decline with increasing age, choices of interventions at different points during the life-course would determine the path/trajectory of each individual. The report identified four priority areas for action to optimize the trajectories of functional ability and intrinsic capacity across the life-course, namely:

- aligning health systems to the needs of the older populations they now serve;
- developing systems for providing long-term care;
- creating age-friendly environments; and
- improving measurement, monitoring and understanding activities [11].

The World Report on Ageing and Health [11] recognized that all countries need to have a comprehensive system of long-term care. The central goal of these systems was to maintain a level of functional ability in older people who have or were at risk of significant loss of capacity, and to ensure that this care was consistent with their basic rights, fundamental freedoms and human dignity. Long-term care systems have many potential benefits beyond enabling care-dependent older people to live lives of dignity, such as reducing the inappropriate use of acute health care services, helping families avoid catastrophic
expenditures on care and freeing women to have broader social roles. Thus, systems of long-term care could help foster social cohesion [11].

As per the World Report on Ageing and Health, while only the national governments could create and oversee comprehensive long-term care, this did not mean that long-term care was the sole responsibility of governments. Long-term care would need to be based on partnerships with families, communities, other care-providers and the private sector, and reflect the concerns and perspectives of all these stakeholders [11].

Three approaches were identified as crucial to the development of systems for providing long-term care [11].

1. Foundation of a system of long-term care: To develop a system that helps older people to age in a place that is right for them and to maintain connections with their community and social networks.

2. Sustainable and appropriately trained workforce: The majority of caregivers in the long-term care system are currently family members, volunteers, members of community organizations and paid but untrained workers. Providing the training that allows them to do their job well, while relieving them of the stress that arises from being insufficiently informed about how to deal with challenging situations, will be central to building a system of long-term care.

3. Quality long-term care: To orient services towards the goal of optimizing functional ability that will require systems and caregivers to help older people maintain functional ability at a level that ensures their well-being.

Similarly, to develop comprehensive community-based approaches to include interventions that prevent decline in intrinsic capacity, foster healthy ageing, and support caregivers of older people, WHO has conceptualized the ICOPE programme, which provides guidance on comprehensive assessment and care pathways with regard to various physical and psychosocial issues of the older population.

ICOPE focuses on the integrated care of various domains of ageing which put older people at the risk of long-term care namely locomotive capacity, nutritional status, sensory disabilities, cognitive decline and psychological issues.

Long-term care policies face numerous challenges where they overlap with other health and social services, as well as with informal care provided at home by family and friends. Problems in coordinating acute health care, rehabilitation and long-term care can lead to unsatisfactory outcome for care recipients and can also result in inefficient use of both health and long-term care resources [12].

Even within high-income countries, the quality of long-term services varies widely (sometimes within countries) and in many instances, fails to meet the expectations of the public, the users of the services and their families. Issues that may contribute to such a situation include poor residential facilities, lack of privacy for recipients, and improper treatment of chronic ailments and disabilities. Chronic shortage of appropriately trained and qualified staff, unsatisfactory financial remuneration, and poor working conditions and environments would be the other concerns for policy-makers dealing with long-term care [13].
Since ageing is a universal concern, it is important to know the nature of a country’s long-term care for policy-making and planning. The determinants of demand for long-term care occur differently in different countries and country groups. Evidence from population-based research on long-term care from high- and middle-income countries should help understand about the health and social care demands of older people, and mechanisms to provide appropriate support [14].

Fig. 1. Health in the SDG era

Demographics
In 2017, the global population aged 60 years or above numbered 962 million, compared to 1980, when there were 382 million older people worldwide. The number of older people is expected to double again by 2050, when it is projected to reach nearly 2.1 billion [6, 15]. Asia is expected to experience a two-fold increase in the number of older people, with the population aged 60 years or above projected to increase from 549 million in 2017 to nearly 1.3 billion in 2050. The number of people at very advanced ages is increasing too, and the global population aged 80 years or above is projected to triple between 2017 and 2050, increasing from 137 million to 426 million [6]. Information on the total population and the proportion of population aged 60 years or above, as determined in 2017 and estimated for 2050 for the Member States of the SEA Region is given in Table 1 and Fig. 2.

### Table 1. Total population aged 60 years or above and the proportion of population aged 60 years or above (2017 and 2050) – Member States of the SEA Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Population aged 60 years or above (in thousands)</th>
<th>Proportion of population aged 60 years or above (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017</td>
<td>2050</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>12 036</td>
<td>44 501</td>
</tr>
<tr>
<td>Bhutan</td>
<td>59</td>
<td>235</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>3 436</td>
<td>6 963</td>
</tr>
<tr>
<td>India</td>
<td>125 693</td>
<td>316 759</td>
</tr>
<tr>
<td>Indonesia</td>
<td>22 743</td>
<td>61 729</td>
</tr>
<tr>
<td>Maldives</td>
<td>28</td>
<td>164</td>
</tr>
<tr>
<td>Myanmar</td>
<td>5 043</td>
<td>11 544</td>
</tr>
<tr>
<td>Nepal</td>
<td>2 569</td>
<td>6 510</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>3 109</td>
<td>5 984</td>
</tr>
<tr>
<td>Thailand</td>
<td>11 691</td>
<td>22 954</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>71</td>
<td>162</td>
</tr>
<tr>
<td>Total</td>
<td>186 478</td>
<td>477 505</td>
</tr>
</tbody>
</table>


In 2017, Member States of the SEA Region had a combined older people (aged 60 years or above) population of around 186 million. This number is estimated to increase to 477 million by 2050. It is estimated that all the 11 Member States will record increase in the number of older people aged 60 years or above between 2017 and 2050, a span of 34 years. Bangladesh, this increase will be from 12 million to 44 million; in India, from 125 million to 316 million; in Indonesia, from 22 million to 61 million; and in Thailand, from 11 million to 22 million [6].
However, in terms of the proportion of population of older people aged 60 years or above, by 2050, Thailand will have 35% of its total population aged 60 years or above, followed by Maldives and Sri Lanka (28%), Democratic People’s Republic of Korea (26%), Bhutan (23%) and Bangladesh (22%). The proportion of older people aged 60 years or above will be around 19% in both India and Indonesia because of their large population. The Region’s average will increase from 10% to 22% [6].

**Fig. 2.** Proportion of population aged 60 years or above in Member States of the South-East Asia Region [2017 and 2050]

<table>
<thead>
<tr>
<th>Country</th>
<th>2017</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>7.3</td>
<td>9.4</td>
</tr>
<tr>
<td>Bhutan</td>
<td>7.3</td>
<td>11.1</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>13.5</td>
<td>26.0</td>
</tr>
<tr>
<td>India</td>
<td>9.4</td>
<td>19.1</td>
</tr>
<tr>
<td>Indonesia</td>
<td>8.6</td>
<td>19.2</td>
</tr>
<tr>
<td>Maldives</td>
<td>6.3</td>
<td>28.4</td>
</tr>
<tr>
<td>Myanmar</td>
<td>9.4</td>
<td>18.5</td>
</tr>
<tr>
<td>Nepal</td>
<td>8.8</td>
<td>18.0</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>14.9</td>
<td>28.8</td>
</tr>
<tr>
<td>Thailand</td>
<td>16.9</td>
<td>35.1</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>5.4</td>
<td>6.7</td>
</tr>
<tr>
<td>SEARO</td>
<td>9.8</td>
<td>22.3</td>
</tr>
</tbody>
</table>


Similarly, it is observed that the life expectancy at birth and at 60 years is rising gradually in the world and in the countries of the SEA Region. Longer life expectancy is one of the reasons for the increase in the proportion of older people. Life expectancy will increase in more than 35 countries with the probability of at least 65% for women and 85% for men with variations across countries [6]. Despite having poorer health status as compared to men, it is globally observed that women live longer than men (sex morbidity–mortality paradox); the reasons for this phenomenon are poorly understood.
Table 2. Life expectancy at birth and at age 60 years, for both females and males, for the period 2010–2015

<table>
<thead>
<tr>
<th>Country</th>
<th>Life expectancy at birth (years) &lt;2010–2015&gt;</th>
<th>Life expectancy at age 60 (years) &lt;2010–2015&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>72.9</td>
<td>69.8</td>
</tr>
<tr>
<td>Bhutan</td>
<td>68.9</td>
<td>68.6</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>74.1</td>
<td>67.2</td>
</tr>
<tr>
<td>India</td>
<td>69.1</td>
<td>66.2</td>
</tr>
<tr>
<td>Indonesia</td>
<td>70.7</td>
<td>66.6</td>
</tr>
<tr>
<td>Maldives</td>
<td>77.4</td>
<td>75.4</td>
</tr>
<tr>
<td>Myanmar</td>
<td>68.3</td>
<td>63.7</td>
</tr>
<tr>
<td>Nepal</td>
<td>70.5</td>
<td>67.4</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>78.0</td>
<td>71.2</td>
</tr>
<tr>
<td>Thailand</td>
<td>78.4</td>
<td>70.8</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>69.5</td>
<td>66.1</td>
</tr>
</tbody>
</table>


Table 3 indicates that a majority of the older people from Member States of the SEA Region prefer to live with their children. Older women lived with their children than older men due to economic and personal insecurity more commonly encountered among the former than the latter. A small proportion lived alone or with their spouses. This pattern of household arrangements for older people points towards the need to provide health and social care at the household level rather than at long-term care institutions.

Table 3. Household living arrangements of older peoples

<table>
<thead>
<tr>
<th>Country</th>
<th>Alone</th>
<th>With spouse only</th>
<th>Independently (alone or with spouse only)</th>
<th>With children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Females</td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>3.4</td>
<td>0.4</td>
<td>7.0</td>
<td>13.5</td>
</tr>
<tr>
<td>India</td>
<td>7.3</td>
<td>2.6</td>
<td>11.7</td>
<td>19.3</td>
</tr>
<tr>
<td>Indonesia</td>
<td>12.7</td>
<td>3.6</td>
<td>11.3</td>
<td>20.9</td>
</tr>
<tr>
<td>Maldives</td>
<td>4.5</td>
<td>2.7</td>
<td>5.9</td>
<td>7.4</td>
</tr>
<tr>
<td>Myanmar</td>
<td>6.4</td>
<td>3.2</td>
<td>6.8</td>
<td>11.5</td>
</tr>
<tr>
<td>Nepal</td>
<td>5.1</td>
<td>2.7</td>
<td>10.3</td>
<td>14.4</td>
</tr>
<tr>
<td>Thailand</td>
<td>7.0</td>
<td>4.8</td>
<td>9.9</td>
<td>16.4</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>3.9</td>
<td>2.5</td>
<td>6.3</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Long-term care: General issues
3.1 What is long-term care for older people?

WHO defines long-term care as "The activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity".

Various risk factors predict the necessity and duration of long-term care that a person requires; old age, female gender, frail status, multi-morbidity, poor family support, disabling chronic diseases (for example, Alzheimer’s disease and other forms of dementia and Parkinsonism), elder abuse, etc., are the major factors that place individuals at the risk of long-term care requirements [14].

The goal of long-term care is to ensure that an individual who is not fully capable of long-term self-care can maintain the best possible quality of life with the greatest possible degree of independence, autonomy, participation, personal fulfillment and human dignity. Appropriate long-term care, whether home-based or institutional, includes respect for that individual’s values, preferences and needs. People who require long-term care may also need other services, such as acute physical or mental health care and rehabilitation; together with financial, social and legal support [16].
Formal components in long-term care [17]

- Medical and nursing care for long-term care and home care: This component of care is delivered by trained health professionals and can include administration of medications, complex care and procedures, and rehabilitative and preventive services.

- Social care needs are based on:
  - Personal care: Extending support to Activities of daily living (ADL) including feeding, bathing, ambulation, etc.
  - Assistance care: Extending support to Instrumental activities of daily living (IADL) including performing housework, preparing food, care in day centres, etc.

Models of long-term care:

Various models of long-term care are in practice worldwide. A few of them are given below.

1. Institution-based long-term care (for example, palliative care centres, hospital-based long-term care centres)
2. Community-based long-term care (for example, old-age homes, long-term care centres, physiotherapy centres, day-care centres, community-based rehabilitation facilities)
3. Home-based long-term care

Home-based long-term care can consist of the following sub-models.

- Informal services: Support the individuals in household chores – generally provided by an unskilled person.
- Formal personal care services: Support the individuals in personal care, such as bowel and bladder care and various components of ADL and IADL.
- Skilled home care: Support the individuals requiring a higher degree of care other than ADL and IADL, for example, bed sore care, tube-feeding, etc. It is usually provided by trained personnel.
- Home-based primary care: Support the individuals for medical conditions that do not prompt institutionalization, provided by skilled human resources with formal training, for example, vaccination, treatment of minor ailments.
- Hospital at home model: Support the individuals with complex, acute and chronic medical conditions, including the terminal illnesses, especially for patients who have transfer difficulty for various physical reasons. This facility is provided by skilled health personnel, for example, pain management in terminal cancer, home-based Continuous Ambulatory Peritoneal Dialysis (CAPD), thoracentesis, paracentesis, etc.

Home-based long-term care is expanding rapidly not only because of rapid increase in need but also for economic reasons. Public health services, particularly hospital services addressing the health needs of older people in developing countries, are unable to cope with the challenge. Cost considerations, thus, tend to shift the burden of both acute and long-term care to the family, who remain the major providers of long-
term care. These developments require the adoption of a very different approach to health sector policy and health care services, where a disease-specific approach is no longer appropriate. A well-managed and adequately supported home care can improve the quality of lives for the older people requiring care and their caregivers. Ideally, home-based care should be an integral component of all health and social systems [16].

Long-term care services are being increasingly delivered at the home of the recipients. Quality dimension used in the accreditation and standard-setting has evolved from inputs (ratio of skilled workers/long-term care users) to processes of care (management of medication, record-keeping and infection control), outcomes, quality of life, choice and human dignity. However, accreditation and standards for home-care and community-based care services are less common. Qualification requirements for long-term care workers are few and often do not extend to continuous education or ongoing monitoring.

The family remains a very important source of care at home. In addition, there are often strong community initiatives to promote voluntary work and self-help on behalf of those in need of care. The emphasis should be on providing advice and training to family caregivers, making basic supplies available, and undertaking selective curative functions [16].

The community is the next preferred location for the provision of long-term care services for disabled older people. Community care is responsive to the needs of older people, since they are surrounded by family members and friends in the community. Community care is less costly than institutional care, as private family care is assured in addition to formal care and support. Community-based care significantly improves the quality of life of beneficiaries [18].

Good quality long-term care improves the functional and health outcomes of the frail, the chronically and physically disabled old people. Three issues are considered critical to the overall quality of long-term care: effectiveness and safety; patient-centered approach; and coordination of care [16]. Long-term care includes a range of personal care services to help disabled people with basic ADL and basic medical services, such as nursing care, prevention, rehabilitation or palliative care. It may also include domestic help and help with administrative tasks [19].

3.2 Palliative care as a component of long-term care

WHO defines palliative care as “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification, and impeccable assessment and treatment of pain and other problems – physical, psychosocial and spiritual”.

Ageing populations are a characteristic of many countries. The pattern of diseases at the end of life is changing and more people are living with serious chronic conditions, including cancer. As a large number of people survive into old age and begin to suffer chronic illnesses, more will need some form of help towards the end-of-life care; at the same time, the age of potential caregivers is increasing [20].
Failure to develop appropriate palliative care policies for older people may lead to unnecessary suffering and increase burden on the families and older women involved in unpaid caring work. Palliative care offers a support system to help patients live as actively as possible until death. It affirms life and regards dying as a normal process.

Pain remains a common unmet palliative care need of older people and their families; an important requirement for over one third of older people. Older people are also at the risk of adverse drug interactions, and of iatrogenic illness and suffering from the additional problems of mental impairment, economic hardships and social isolation.

In 2014, the Sixty-seventh World Health Assembly called for a global resolution on palliative care titled ‘Strengthening of palliative care as a component of comprehensive care throughout the life-course’. Member States, partner agencies and the WHO Secretariat were called upon to improve access to palliative care as a core component of health systems, with an emphasis on primary health care, community-/home-based care and Universal Health Coverage (UHC) schemes. The resolution indicated the need to develop, strengthen and implement, where or when necessary, palliative care policies to support the comprehensive strengthening of health systems [21].

Palliative care was described as an approach that improved the quality of life of patients and their families facing the problems associated with life-threatening illnesses. This was to be achieved through the prevention and relief of suffering by means of early identification and accurate assessment, and treatment of pain and other problems – physical, psychosocial and spiritual [20].

It is not known whether specialist palliative care is the preferred and most appropriate model of care for older, non-cancer patients. Compared with cancer patients, the end-of-life experiences of older people are heterogeneous, reflecting the unpredictable nature of chronic and non-malignant diseases of older people. Referrals to specialist palliative care for older non-cancer patients need to be based on criteria, rather than survival alone, but better estimates of survival may facilitate decision-making about appropriate palliative care [21].

Palliative care for older people is a challenge to health-care systems around the world, as their population proportion increases rapidly. Delivering appropriate level of palliative care to older people is complicated by many factors. Multimorbidity in general, frailty, dementia and other forms of functional impairment complicate palliative care for older people. Taking care of dying older patients is a challenge in itself – a challenge that will continue to expand due to the demographic changes [22]. It is unlikely that one single model of palliative care delivery in long-term care settings will emerge as superior. The integration and outcomes of palliative care for older people under different situations, such as assisted living facilities, continued care of retirement communities, adult family homes and non-traditional nursing home models, should be considered.

There is, thus, an urgent need to improve end-of-life care for older people with non-cancer diagnoses, who have needs that have not been met by traditional palliative care services. High-quality care for older people living with multiple conditions and frailty must involve affirming life and promoting independence, as also recognizing and planning for death [23].
It is important to examine the effects of health policy and financing strategies on palliative care delivery and outcomes. It is to be noted that while nursing homes are often considered to provide what is equated to palliative care and are often seen as a setting for integrating palliative care into long-term care, a growing number of frail older people are increasingly being cared for in different settings [24]. Development of an interdisciplinary curriculum on palliative care for older people will be a useful tool for appropriate delivery of palliative care to older people [22].

It is worth mentioning that a few issues related to palliative care (including end-of-life care) have emerged in recent years, though a detailed discussion is beyond the scope of this document.

In 2002, an act regulating the end-of-life issues by a physician at the request of a patient with unbearable suffering came into effect in the Netherlands. These issues comprise euthanasia, physician-assisted suicide and other end-of-life practices. This was followed by the Dutch Euthanasia Act [24].

The provision of high-quality end-of-life care depends on the contribution made by social workers. This is particularly relevant for addressing the complex psychosocial needs of both patients and families. As the field of end-of-life care is changing with the expected increase in the proportion of older people, the profession of social work will need to be able to keep up with the demand and skills necessary to meet this challenge [25].

Do-not-resuscitate (DNR), which means refusal to accept Cardiopulmonary Resuscitation (CPR) when a patient suffers cardiac or respiratory arrest, is one of the commonly discussed advance directives in acute/chronic care health facilities. However, in situations where most end-of-life decisions are family-based, the formulation of a DNR-decision by family members is still not well established [26].

There are several issues related to the seamless alignment of palliative care with long-term care for older people. These may be tabulated as follows [23]:

1. understanding the needs of older people entering the last phase of life;
2. need for better communication and coordination of care of older people at the end-of-life;
3. collaboration and coordination between specialist palliative care, primary health care and geriatric medicine;
4. effective and efficient coordination between primary, community- and home-based care in the delivery of high-quality end-of-life care; and
5. care planning to ensure and safeguard independence, dignity and overall improvement in the quality of life and in the preparation for death.

**Essential components of palliative care interventions for older people:**

- Pain and symptom control: Adherence to standard clinical guidelines for pain control provides adequate pain relief to majority of older people with advanced medical conditions.
Communication skills: Effective communication skills between doctors and providers help improve health outcomes.

Psychological support (including spiritual support): Inclusion of spiritual needs as part of palliative care services due to their personal importance to many people at the end-of-life stage.

Services for caregivers and families: Inclusion of services, such as home care, respite and sitting services, social activities, support groups and individual psychotherapy or education.

Coordination and integration of care: Transfer of information between those with responsibility for their medical care and those providing social support services in the community.

Specialist palliative care: Multi-professional staff working at inpatient units, hospitals or the communities, dealing with older patients with complex needs.

Palliative day care: Activities for patients in need of advanced palliative care or end-of-life phase, who value participation at palliative day care units – such as meeting other patients, talking to the staff and becoming involved in activities.

Bereavement support: Assessment of the need for bereavement support and counselling should be regarded as an important part of palliative care.

Involvement of users in the design of services: Ensuring efficiency and effectiveness of patient-centered care.

Two additional aspects of palliative care for older people

Nurses specialized in the provision of palliative care to older people suffering from chronic diseases enhance the quality of care in the home-based approach to severe disease conditions of older people, while significantly reducing multiple admissions to acute health care facilities.

In several countries, where the Hospice Care programmes exist for older patients, particularly those afflicted with dementia, it has been found preferable to the traditional long-term care. Such an approach is associated with less discomfort for those suffering from dementia, who are unable to communicate their wishes adequately.

3.3 Multimorbidity and long-term care

People needing long-term care services are more likely to have chronic conditions or multiple morbidities. If the different types of care – health, social, acute or continuing – are not integrated properly result in dissatisfaction among the care recipients and lead to harmful events such as avoidable hospital readmissions. Some initiatives for improving care condition in the long-term care are: good case management on primary care coordination; interdisciplinary or integrated care; and multidisciplinary assessment teams [19].

The rapidly growing population of older people with multimorbidity now poses an ever-expanding and significant challenge to health (and social care) systems all over the world [25]. Multimorbidity may be defined as the co-occurrence of multiple chronic diseases or conditions in a single individual. Multimorbidity
prevalence is high and increases with age, affecting more than 60% of people aged 65 years or above. Multimorbidity is associated with numerous negative outcomes, including high mortality, disability and rapid functional decline, poor quality of life and high health care costs [12, 28]. Multimorbidity constitutes a challenge for the organization of health and social care, because the care for persons with multiple chronic conditions is often provided by multiple care providers from different sectors and sites, frequently lacking alignment [28, 29].

Multimorbidity affects more than half of older people, with prevalence increasing in very old people and in women and people from lower socioeconomic classes. Not much is known about the risk factors for multimorbidity (genetic or biological factors), although disability, poor quality of life and high health-care utilization are consequences of it [11].

Ageing is frequently accompanied by decreased taste, acuity and smell, deterioration of dental health, and a decline in physical activity because of lifestyle or accompanying disability. All of these factors may affect the nutrient intake and lead to undernourishment and its potentially serious consequences. Malnutrition has been reported to be common in hospitalized older patients [32]. Any integrated care model or approach to address multimorbidity in older people would need to ensure that proper nutritional care is provided to all older people.
Older people with multimorbidity have complex health needs which results in a fragmented form of care due to lack of integrated people-centered long-term care system, leading to inefficient and possibly detrimental clinical interventions. As such, fragmented delivery of care should be reduced with the improved use of resources and a better alignment between health and social care, acute and long-term care, and community and institutional care [18].

WHO has defined integrated care as the “management and delivery of health services such that people receive a continuum of health promotion, health protection and disease prevention services, as well as diagnosis, treatment, long-term care, rehabilitation and palliative care services through different levels and sources of care within the health system and according to their needs” [30].

Most elements of integrated care in multimorbidity pertain to the components of service delivery in the WHO health systems, information and research, leadership, governance and workforce [29].

Designing effective and efficient integrated care programmes for older people with multimorbidity requires knowledge about the key elements of an effective approach. These elements are: training and educating health and social care professionals; adequate financial incentives in the funding and payment methods; and a comprehensive data system. To achieve large-scale implementation, various partners (caregivers, formal care providers, recipients and their families) need to be convinced about the benefits of such integrated multimorbidity care [25].

In addition, any multimorbidity care model for older people would need to be assessed and validated in a real-life setting, to determine specifically how and to what extent older people with multimorbidity would benefit. Costs and benefits to the families and older recipients, as well as relevance of the model’s application within the existing health and social care settings, would also need to be considered [26].

There is a broad international consensus that multimorbidity is best addressed in primary care settings by a patient-centered approach, including regular appointments for comprehensive problems, with review and management options tailored to individual patient references. The care would need to be provided by a multidisciplinary team with a lead physician, and would have to be based on effective clinical systems [31].

However, this assumed causal link between patient-centered care and improved quality of life and health outcomes has been a standard assumption in primary care for many years, and is commonly seen as the underlying reason for holistic approaches to health care. This assumption needs to be reviewed. Given the competing models of service delivery providing equivalent health care, modes of delivery that are rated more highly by patients are intrinsically preferable [31].

### 3.4 Family caregivers’ role in long-term care

A rapid increase in the proportion of older people has been witnessed in all parts of the world and the need for their care affects all societies [32, 33]. Every day, a large number of older people manage their basic health and functioning needs with the help of family caregivers (spouses, relatives, friends or neighbours). These family caregivers arrange medical treatments, help with daily tasks such as bathing and dressing, while also ensuring that the older people’s needs for food and shelter are met [33]. By their late eighties, one in three older people have difficulties in undertaking five or more tasks of daily living unaided; above the age of 85 years, general frailty prevails. All these conditions lead to further extension of the tasks and responsibilities of family caregivers [34].

Family caregivers, overwhelmingly unpaid, bear a huge burden for society and the share of this burden grows every year [35]. For example, information from the United States of America indicates that family caregivers are responsible for producing 80% of the total estimated economic value of community-based...
long-term services and support for older people [33, 36]. In the United Kingdom, budgetary cuts for social care expenditures on older people has resulted in a marked reduction in the proportion of older people receiving formal care, a gap that has to be filled in by family caregivers [32, 34].

Yet, even as they continue to improve the quality of life for the older people they attend to, while reducing demands on the formal health and social services for older people at considerable personal costs, family caregivers remain unrecognized [32]. Informal care has indirect costs from lost or part-time income or reduced working hours. Such indirect costs are likely to have significant negative impacts at a social and macro-level in the socioeconomic development [17].

Greater proliferation of smaller families, rapid and frequent geographical dispersal of younger family members and ever-increasing participation of women in the labour force – all emerge as threats to the availability of family caregivers to address the needs of the growing number of older people [12, 37].

Global rise in life expectancies has also led to a situation where the average family caregivers are older people themselves. Such caregivers may frequently suffer from their own medical ailments, neither acknowledging nor seeking help [35]. In the United Kingdom, there were 2 million family caregivers in the country aged 65 years or above, and 417,000 of whom were aged 80 years or above. Nearly two-thirds of these older caregivers themselves suffered from cardiac ailments or physical disabilities [34].

In the past, families relied on female family members, such as spouses, daughters, daughters-in-law to provide care for the older people. Today, while the typical caregiver still remains a female, this pool will soon shrink with an increased entry of women in the workforce. Female family caregivers, who still take care of older people, now have the increasing task of juggling between work, household chores and upbringing of children [37]. This excessive load of work can take a heavy toll in terms of physical, emotional or economic harm for the female caregivers [33].

In recent years, advances in medicine have extended life expectancy and increased the duration and technical complexity of care required by older people [33]. However, family caregivers are seldom included in the medical and treatment decisions, and care planning. It is commonly assumed that family caregivers will be able to carry out the plan of care with little or no training, and will be able to address complicated technical procedures for older people at home. They are also expected to manage and monitor the medical condition followed by feedback to care providers [33, 37]. In today’s world, family caregivers cannot be expected to provide complex care and support on their own. They require greater recognition, information, and support to fulfil their roles and responsibilities as well as to maintain their own health, financial security and well-being [37].

Family caregiving of older people is both a personal and private issue, as well as a public and societal concern. From an individual’s perspective, caregiving to one’s elders is a personal, spousal or filial responsibility. It is also a public responsibility to help protect the well-being of a nation’s older people. The degree to which society cares for its older citizens is a reflection of its maturity, commitment and concern.

Several key actions have been identified for effective engagement and support of family caregivers requiring innovative programmes and policy reforms, including increased funding, skills, training and education [32, 33, 36, 37]. These are as follows:

- the need to support family caregivers would need to be recognized as an integral part of any national programme for older people;
person- and family-centered care should be addressed and linked with the universal health coverage;

family caregivers should be entitled to an appropriate form of financial support, which should be part of all modes of payment of care for older people;

monitoring and screening of family caregivers would allow the formal care providing sector to recognize and assess the caregiving circumstances, strengths, weaknesses, challenges and preferences of the family caregivers; and

skill enhancement and education would need to be developed and disseminated to better prepare health-care and social service providers in engaging family caregivers, while supporting their diverse needs and circumstances.

3.5 Health financing and long-term care

The ageing of any population is accompanied by their changing health-care needs, particularly the need for long-term care services. Throughout the world, countries are exploring financing options to ensure that their older people are not denied access to long-term care because they cannot afford it [17].

In the past, long-term care was provided almost exclusively by the direct families of older or disabled people. Only when no family networks were available, were people in need admitted to hospitals or specialized institutions. Later, as a result of increase in the proportion of older people, there was a demand to introduce chronic medical care programmes, particularly in high-income countries. This led to an escalation of costs in health expenditures, which resulted in the substitution of hospital care by less expensive home- and community-based programmes [38].

With shrinkage in family size, migration of young family members to other geographical locations and increased number of family members in the workforce, there has been a reduction in the capacity of informal caregivers in many countries. This situation has led to an increased demand for home-based formal long-term care, which has been proven to increase efficiency of the health system and satisfaction among the recipients. Long-term care is covered by public financing schemes in most high-income countries, while in middle- and low-income countries, this has yet to gain wider application. As such, if family or community groups are unable to provide long-term care, it is sought from private sources. In many instances, the extent of such care does not meet the actual need, leading to poorly met needs and the risk of higher spending [38].

Decision-makers, at all levels of socioeconomic development in the Region, need a balanced and comprehensive understanding of the economic implications of population ageing. It is essential to assess the current situation and provide a rigorous economic case for appropriate investment in older populations. This will consist of: information on economic contributions of older people; economic impacts of preventable declines in intrinsic capacity and the cost of inaction; economic benefits that might be achieved due to slow declines; and the likely future costs of these investments. It is also necessary to identify a range of models for financing long-term care systems for older people, particularly where resources are insufficient [10].

The key to protecting people from financial hardships is to ensure that funds for the health systems are prepaid, with few barriers to the redistribution of these funds (little fragmentation while pooling). Services are purchased from these pooled funds in such a way that the need for people to pay for out-of-pocket (OOP) services, at the time of use, is minimal.
Great interest in Universal Health Coverage (UHC) began with the Fifty-eighth World Health Assembly Resolution [39] on sustained health financing, universal coverage and social health insurance. Broadly defined, UHC means all people receive the quality health services they need, without being exposed to financial hardships. This resolution urged all Member States to ensure that health financing systems included a method for prepayment of financial contributions for health-care, with a view of sharing risks among the populations, avoiding catastrophic health-care expenditures and impoverishment of individuals because of seeking care [69]. WHO has advocated UHC as the best means of improving global health [40]. This remains a dynamic and continuous process that changes in response to shifting demographics, epidemiological and technological trends, as well as the expectations of people [45].

Strengthening health systems is the primary means by which countries can progress towards UHC. Thus, any monitoring of UHC would need to be integrated into a broader performance and assessment of health systems. It is only by evaluating the coverage of health services and financial protection jointly that one can reach appropriate conclusions, as to how effectively the health system is providing coverage. The first global monitoring report on tracking UHC shows that by using a core set of tracer indicators, it is possible to track progress in key areas of financial protection and coverage of health services [45].

It is important to consider the level of sophistication in financing, the infrastructure needed for long-term care within the context of a country’s economic development, the underlying structure of the health and social services and the availability of human resources. Long-term care should be kept as simple as possible and incrementally strengthened to ensure its long-term sustainability in developing countries [17, 38]. Although the ultimate goal of UHC should be 100% coverage, targets should be based on available data and past trends with regard to effective coverage. The WHO and the World Bank framework specifies a target of a minimum of 80% coverage of quality and essential health services, regardless of economic status, place of residence or gender [2].

Funding should ensure that individuals can access effective long-term care services. Inadequate support for social care may lead to increased use of more expensive acute care hospitals for long-term care purposes [17]. However, within the tight fiscal environment, UHC provides a framework for an equitable and sustainable health financing strategy. As such, effective financing is important in providing UHC to all individuals with long-term care needs [17].

There is a lack of coherent national policy responses in most developing countries to meet the needs of long-term care. Policy reforms would be needed to recognize the importance of investing in long-term care, aligning financing to the provision of long-term care and building coherence towards the integration of long-term care into the health-care system [17].

A summary of issues related to financing of long-term care:

- Fragmented health financing schemes should be avoided and focus should remain on the financing function as a tool to support health-care organization.
- The extent of stakeholders’ involvement in the decision-making process should be expanded.
- Provider payment mechanisms for long-term care should be realistic and appropriate [38].

Long-term care accounts for a small but significant portion of total health expenditure in most developed/high-income countries [41]. In Organization for Economic Co-operation and Development (OECD) countries, the main source of public financing for care of older people is taxation. Some have also opted for solutions, such as social insurance, for funding long-term care. In 2005, the total expenditure on long-term care in these countries ranged from 0.2% to 3% of GDP (Gross Domestic Product), although most
countries spend less than 1.5% of GDP. Large variations in the public coverage of long-term care costs among countries reflect variations in choices among countries in the way long-term care is financed and provided [13]. Relevant information on the financing aspect of long-term care from high-income countries is summarized in Table 4.

**Table 4. Financing of long-term care (LTC) in high-income countries**

<table>
<thead>
<tr>
<th>Country</th>
<th>Financing system</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>- Public spending on LTC as % of GDP: 1.89% (20% via cash benefits, 80% in kind) &lt;br&gt; - LTC as a share of current health-care expenditure: 17.1%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>- Public spending on LTC as % of GDP: 3.96% &lt;br&gt; - LTC as a share of current health-care expenditure: 37.4%</td>
</tr>
<tr>
<td>Sweden</td>
<td>- Public spending on LTC as % of GDP: 3.46% (4% via cash benefits, 96% in kind) &lt;br&gt; - LTC as a share of current health-care expenditure: 31.5%</td>
</tr>
<tr>
<td>Portugal</td>
<td>- Public spending on LTC as % of GDP: 0.96% (1% via cash benefits, 99% in kind) &lt;br&gt; - LTC as a share of current health-care expenditure: 10.7%</td>
</tr>
<tr>
<td>Spain</td>
<td>- Public spending on LTC as % of GDP: 0.90% (33% via cash benefits, 67% in kind) &lt;br&gt; - LTC as a share of current health expenditure: 31.5%</td>
</tr>
<tr>
<td>Germany</td>
<td>- Public spending on LTC as % of GDP: 1.91% (31% via cash benefits, 69% in kind) &lt;br&gt; - LTC as a share of current health-care expenditure: 17.1%</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>- LTC insurance using social insurance framework and a tax-based system</td>
</tr>
<tr>
<td>Japan</td>
<td>- Long-term care insurance funded by tax revenues (50%) and co-payments and premiums from adults &lt;br&gt; - Tax revenues derived from central and local taxes – national, prefectures and municipalities</td>
</tr>
</tbody>
</table>

Source: Adapted from [13, 42, 43]

Some examples of long-term care insurance are:

- cash benefits for exceptional cases such as remote locations or places without infrastructure;
- residential care benefits consisting of caring in facilities and group homes; and
- home-care benefits, including home help, home bathing, home nursing, day/night and short-term care.
It is important to ensure that the national medical insurance and the national long-term care insurance are not separate, as it is impossible to separate long-term care from health-care [44].

As public and private pension schemes mature, pensioners in several of these countries are now being asked to contribute to the funding of long-term care, both by direct contribution to the public systems and in the form of substantial private cost-sharing. Private insurance, in addition to a basic universal public insurance could concentrate on risks that are easier to calculate and insure, compared to a full coverage of all the care needs of older people [13].

Most developed countries have relied on public funding and informal care. Countries are now looking for an alternative source to fund long-term care. Private long-term care insurance has been identified as a possible source. To help increase the involvement of private long-term care insurance, various incentives are offered, such as private-public partnerships, tax credits and relaxation in governments’ regulation of private long-term care insurance [41].

A systematic approach is critical in establishing person-centered, integrated long-term care delivery across different financial resources. A study undertaken in Republic of Korea compared long-term care funded by the National Health Insurance (NHI) and long-term care insurance. It reported that the delivery of long-term care under the two insurance schemes was not coordinated well, with the two overlapping at times. Also, the two long-term care institutions are likely to be in competition with each other for older people with similar needs [45]. Policy reforms, creating a clear distinction between the roles of the two, are necessary to enhance coordination and integration of care for older people.
Long-term care: Global situation
The experiences of several high- and middle-income countries in establishing long-term care along with appropriate financing, provide valuable lessons for the introduction of long-term care for countries at similar levels of development as well as for low-income countries [42]. Long-term care benefits can lead to high public satisfaction if properly designed, and a highly functional system can be implemented with a variety of benefit designs that fit the goals of policy-makers and the fiscal and economic situation of the country [42].

Table 5 provides the main characteristics of long-term care system in selected eight high-income countries – France, Germany, Japan, Netherlands, Portugal, Republic of Korea, Spain and Sweden [12, 13, 42, 43]. All older people in these countries are beneficiaries of long-term care activities. Coordination of activities is undertaken by the national government, assisted by the regional, provincial and local authorities. In some countries, the Ministry of Health and the Ministry of Social Solidarity are identified as coordinators. Some countries have established specific legislation for funds and medical expenses, which provide financing for long-term care. Other mechanisms exist to enable payment to the private sector for providing long-term care.

Long-term care is provided at all levels starting from homes, residences, nursing homes and institutions. The needs of older people are assessed through various standardized and validated instruments. The dimensions commonly assessed are biological, psychological and social, as well as the ability to perform ADL and IADL. Based on the assessments, older people are categorized into different levels of dependency with appropriate provisions of long-term care.
<table>
<thead>
<tr>
<th>Country</th>
<th>Beneficiaries</th>
<th>Coordination</th>
<th>Organizational structure</th>
<th>Needs assessment instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>Dependent persons (mainly older people)</td>
<td>Regional authorities, municipalities, county councils</td>
<td>◦ Home care/home adaptation/day activities</td>
<td>The instrument used differs according to each region. The multidimensional assessment is based on validated international standards.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Nursing homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Meal services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Personal safety alarms</td>
<td></td>
</tr>
<tr>
<td>Portugal</td>
<td>Dependent persons (mainly older people)</td>
<td>Ministry of Health and Ministry of Social Solidarity</td>
<td>◦ Nursing homes – convalescence units, medium-term and rehabilitation units, long-term and maintenance units</td>
<td>Dimensions assessed: biological, psychological and social</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coordinated by central, regional and local authorities</td>
<td>◦ National Network of Palliative Care</td>
<td>Instrument used: Integrated Biopsychosocial Assessment Instrument</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Home care</td>
<td>Four dependence levels (incapable, dependent, autonomous and independent)</td>
</tr>
<tr>
<td>Spain</td>
<td>Dependent persons (mainly older people)</td>
<td>Central government, regional and local entities</td>
<td>◦ Tele-care</td>
<td>The instrument used differs according to each region. The multidimensional assessment is based on validated international standards.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Home/residential care services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Personal care help</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>All insured persons depending on the extent of long-term care needs, regardless of age</td>
<td>Central Association of Health Insurance Funds</td>
<td>◦ Home care (in cash and in kind)</td>
<td>Dimensions assessed: ability to perform ADL and IADL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Association of LTC Insurance Funds</td>
<td>◦ Day-/night-care institutions</td>
<td>Four dependence levels (I, II, III and Hardship cases)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confederation of Municipal Authorities Associations</td>
<td>◦ Nursing homes</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Beneficiaries</td>
<td>Coordination</td>
<td>Organizational structure</td>
<td>Needs assessment instrument</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>France</td>
<td>Dependent persons (mainly individuals aged ≥60 years)</td>
<td>Central government (National Solidarity Fund for Autonomy) and departments</td>
<td>Personalized allowance for autonomy, households and long-term inpatient units</td>
<td>Dimensions assessed: ability to perform ADL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Instruments used: (i) Individuals aged up to 60 years (no dependence levels); (ii) individuals aged over 60 years (four dependence levels)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Dependent persons (mainly older people)</td>
<td>Exceptional Medical Expenses Act</td>
<td>Home care</td>
<td>Under responsibility of the Centre for Care Assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regional care offices and municipalities</td>
<td>Nursing homes</td>
<td>Dimensions assessed: somatic, psycho-geriatric, physical, sensory or intellectual handicap, psychosocial problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cash benefits</td>
<td>There are no levels of dependence</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>Age 65 years or above/ or less than 65 years but suffering from a “geriatric disease”</td>
<td>National government in collaboration with local government and private sector</td>
<td>Four categories of benefits: facility benefits; in-home benefits; assistive device benefits; special cash benefits</td>
<td>Dimensions assessed: physical and psycho-cognitive functions; need for nursing; rehabilitative treatment</td>
</tr>
<tr>
<td></td>
<td>Age 65 years or above</td>
<td></td>
<td></td>
<td>Ability to perform ADL and IADL</td>
</tr>
<tr>
<td>Japan</td>
<td>Younger age group eligible for benefits in cases of “age-related disability”</td>
<td>National government with involvement of municipalities</td>
<td>Long-term care and preventive benefits; institutional care; chronic care hospitals; community-care services</td>
<td>Eligibility is determined by a combination of assessment tools administered by the government</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Care plan is established based on entitlement level and need</td>
</tr>
</tbody>
</table>

Source: Adapted from [12, 13, 42, 43]
A quantification and comparison of levels of social protection for long-term care in 14 OECD and European Union (EU) countries focused on five scenarios with different long-term care needs and services.

- It was assessed that long-term care is often expensive in these countries, which results in the reliance of many people on social protection. The cost of home or institutional care for severe needs is equal to, or greater than, the median disposable income for those aged 65 years or above. Those without independent financial capacity would be reliant on the national social protection systems.

- The cost of long-term care varies widely between countries. This could be due to stricter qualifications or higher salaries of staff providing long-term care or geographically dispersed locations of care recipients. Excessive overheads resulting in high long-term care costs should be considered for possible reduction.

- Where resources are limited, only those with the most severe long-term care needs are targeted as these persons will be in greatest need of protection. However, countries would need to consider whether even older people with lower levels of long-term care needs would be able to afford those services on their own. Otherwise, it could lead these countries towards further deterioration in the extent and reach of their care.

- Long-term care policies in many OECD countries aim to help older people live independently in the community for as long as possible. Rates of home care have increased in recent years.
Some countries limit access to home on grounds of affordability when institutional care is the cheaper option and can improve value for money and free up resources to be used elsewhere in the long-term care system. Since some older people with relatively severe needs prefer to remain with the community, there is a trade-off between controlling public expenditure and offering choice and independence to long-term care recipients.

In some countries, older people with low incomes can, in principle, access institutional care which is covered by the existing public social protection systems. Thus, institutional care acts as a “safety net” for those who do not have the family or financial resources to remain with the community. However, eligibility for publicly funded institutional care is often limited to those with the most severe needs.

Some countries expect people in institutional care to contribute all of their income except for a “pocket money” allowance, which can be very small in some countries. A low amount of allowance may risk undermining the dignity and independence of the recipients, but a higher amount could significantly increase costs to the public funding.

A small number of countries studied consider people’s assets when determining levels of social protection for long-term care. However, these rules are more common for institutional care and generally people with higher assets still receive some social protection. Although views may differ on the degree to which it is reasonable for people to pay for care from their assets, there is a strong case that the ability to pool this risk would be beneficial.

A recent assessment ‘Towards long-term care systems in sub-Saharan Africa’[1] mentioned that 46 million older people live in sub-Saharan Africa; a number that is expected to increase to 165 million by 2050. A significant proportion of these people will require long-term care. This implies that older people with or at risk of loss of intrinsic capacity, will require sustained care to ensure that they maintain a level of functional ability consistent with their basic rights, fundamental freedom and human dignity [1].

In almost all settings, provision of care is left to families who lack support and guidance on what care might be appropriate or how this might be provided. Such informal type of care also places an unnecessary burden on caregivers who, in a majority of cases, are women. This reliance on women places a heavy burden on women relatives who are called upon to forego education, employment or other economic engagement in order to care for older relatives. This practice perpetuates and sometimes deepens household poverty and hinders efforts to expand education, employment and economic opportunities to women and girls [1].

Such practices often result in poor quality of care. In the process, a large number of vulnerable older people do not have their basic needs met and in several instances experience flagrant abuses of their fundamental rights [1].

Provision of organized long-term care is patchy in sub-Saharan Africa. National efforts to develop long-term care systems exist only in Mauritius, Seychelles and South Africa. In other situations, organized care is mostly clustered in urban settings and two major service models appear to dominate: (i) charitable care for the most destitute older people, typically operated with few resources by faith-based/civil society or public welfare bodies; (ii) private-for-profit services in the form of residential homes for those who are able to pay. There appear to be few, if any, organized services for the majority of older people who live between these extremes of the spectrum [1].
Long-term care initiatives in the South-East Asia Region
In 2012, the Yogyakarta Declaration on Ageing and Health was adopted at the Thirtieth Meeting of Ministers of Health of Member States of the WHO South-East Asia Region [48]. The Health Ministers acknowledged the issue of ageing and health as a priority public health challenge and committed to 14 action points (Table 6), including action point 7 which mentioned “strengthening the primary health-care system to address the health needs of the older people population and social support system for long-term care, including through formal and informal capacity-building mechanisms to develop and assist health professionals and social support caregivers” [48].

In 2013, a regional consultation on long-term care of older people was organized by the WHO Regional Office for South-East Asia, with the objective of promoting long-term care of older people in the Region. The consultation also provided an opportunity to review the status of long-term care of older people in the Member States of the Region; examine and identify the major determinants of successful policies and practices, including relevant laws, legislation and acts, in long-term care of older people; and develop a roadmap for strengthening and promoting long-term care of older people in the Region [49].

The consultation called upon all Member States of the Region to immediately address the issue of long-term care; create an enabling environment to embed programmes of long-term care within their countries; and adhere to a life-course approach with a continuum of care between home and institution. Adherence to the components of the Yogyakarta Declaration on Ageing and Health was recommended. The consultation reported that all Member States had accepted WHO’s definition of long-term care, with a few Member States adapting and modifying it to suit the needs of their particular countries. All Member States demonstrated similarities in their approaches to long-term care. They had established a number of projects or programmes on long-term care for older people, ranging from initiatives or pilot projects to national programmes [49].

A regional meeting on ‘Health of older women: Policy, gender, and delivery of service issues’ was organized by the WHO Regional Office for South-East Asia in 2014 [50]. The objective of the meeting was to promote the health of older women in countries of the Region. The meeting provided an opportunity to review the status of health, health-care needs and accessibility of health-care services to older women in Member States of the Region; examine and identify successful policies and practices, including relevant laws, legislation and acts related to the promotion of gender and rights issues related to older women; and develop a framework of action for strengthening and promoting the health of older women in South-East Asia [50].

As the proportion of older women in the Member States of the SEA Region increases, they would continue to face poverty, social isolation, discrimination and violence. Chronic diseases remained the main cause of morbidity and mortality among older women. Member States of the Region recommended:

- the development of a multisectoral programme for improving the health of older women;
- the provision of appropriate age-friendly health services; and
- the provision of UHC to ensure optimum accessibility and availability of preventive, promotive, curative and rehabilitative health services [50].
Table 6. Action points of Yogyakarta Declaration on Ageing and Health, 2012

<table>
<thead>
<tr>
<th>Action Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Raising healthy ageing as a national priority with strong political and social commitment</td>
</tr>
<tr>
<td>2. Instituting a coherent, comprehensive and integrated approach to promoting healthy ageing</td>
</tr>
<tr>
<td>3. Developing and strengthening national databases, with support from the Regional Office for South-East Asia, for reporting on older people and healthy ageing, and providing regular information to the Regional Office for appropriate guidance and assistance</td>
</tr>
<tr>
<td>4. Developing and strengthening national policy, promoting effective implementation for healthy ageing and formulating multisectoral national alliances for promoting healthy ageing with special attention to older women</td>
</tr>
<tr>
<td>5. Ensuring the provision of sufficient financial, human and technical resources for programmes at all levels and addressing the special needs of disabled older people</td>
</tr>
<tr>
<td>6. Advocating for a multidisciplinary approach to ageing and health by all sectors of the government in partnership with civil society and the private health sector</td>
</tr>
<tr>
<td>7. Strengthening the primary health-care system to address the health needs of the older population and social support system for long-term care, including through formal and informal capacity-building mechanisms to develop and assist health professionals and social support caregivers</td>
</tr>
<tr>
<td>8. Supporting, where possible, the development of new skills for existing and/or the creation of dedicated cadres of health and social support caregivers, as appropriate, within the existing health and social support systems</td>
</tr>
<tr>
<td>9. Enhancing the use of standardized advocacy, information education and communication (IEC) and training materials adapted as per country-specific needs, and translated into local languages</td>
</tr>
<tr>
<td>10. Advocating for healthy lifestyles including healthy diets, physical activity and health measures to reduce the disease burden of old age</td>
</tr>
<tr>
<td>11. Strengthening appropriate clinical and diagnostic capacity at all levels of health facilities to address the health problems of the very old, as well as their long-term care</td>
</tr>
<tr>
<td>12. Encouraging basic and operational research in all aspects of ageing and health, and facilitating incorporation of evidence-based best practices into the national programmes</td>
</tr>
<tr>
<td>13. Instituting, as appropriate, legal frameworks to ensure the health entitlements of the older people</td>
</tr>
<tr>
<td>14. Participating in regular inter-country consultative processes to monitor, evaluate, review and discuss issues related to ageing and health, taking into account events and developments at the international level</td>
</tr>
</tbody>
</table>

Although action plans and programmes had been established in the Member States of the Region to respond to the health needs of older women, harmonization and consolidation of interventions were lacking in many instances, along with limited coordination between the different categories of service providers.

With the launch of the Global Strategy and Action Plan on Ageing and Health (2016–2020), the need to align the existing Regional Strategy with the Global Strategy was felt. Therefore, the WHO South-East Asia Regional Framework on Healthy Ageing (2018–2022) was formulated to align with the Global Strategy [51].
The Regional Framework is based upon a number of guiding principles that have been recognized at both global and regional levels. It aims to impact healthy ageing by:

- ensuring the rights and fundamental freedom of older people and eliminating all forms of age discrimination, neglect, abuse and violence against older people;
- fostering the development of interventions that are gender-sensitive and promote gender equality to address the healthy ageing of women;
- reducing inequities;
- addressing ageism through greater involvement of older people in activities for their well-being, enactment of suitable legal instruments and ensuring administrative measures;
- providing age-friendly primary health-care, which is imperative to ensure good health for older people;
- providing a comprehensive system of long-term care at home, in communities or within institutions in the Member States, so that older people continue to maintain a level of functional ability consistent with their basic rights, freedom and dignity; and
- adopting a multidisciplinary and multisectoral approach to ensure an effective and appropriate delivery of care to older people.
Table 7. Strategic elements identified in the Regional Framework on Healthy Ageing [51]

<table>
<thead>
<tr>
<th></th>
<th>Strategic Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Developing an evidence-based integrated policy and plan of action for healthy ageing</td>
</tr>
<tr>
<td>2.</td>
<td>Developing age-friendly environments</td>
</tr>
<tr>
<td>3.</td>
<td>Aligning health systems to the needs of older people</td>
</tr>
<tr>
<td>4.</td>
<td>Developing sustainable and equitable systems for long-term care</td>
</tr>
<tr>
<td>5.</td>
<td>Developing appropriate human resources necessary for meeting the health-related care needs of older people</td>
</tr>
<tr>
<td>6.</td>
<td>Improving measurement, monitoring and research for healthy ageing</td>
</tr>
<tr>
<td>7.</td>
<td>Ensuring sustainable and progressive financing to enable a path towards Universal Health Coverage (UHC)</td>
</tr>
</tbody>
</table>

The Regional Framework on Healthy Ageing identifies seven strategic elements with regard to healthy ageing. “Developing sustainable and equitable systems for long-term care” (Table 7) has been identified as one of its strategic elements with the overall objective of ensuring that all older people in need of care have access to long-term care services regardless of age, gender, financial and other considerations [51]. This has been enumerated in Table 8, where six actions have been identified to assist in the introduction of long-term care in Member States. Several regional- and national-level indicators have been proposed to assess progress in implementation [51].

Table 8. Six actions to assist in the introduction of long-term care in Member States

<table>
<thead>
<tr>
<th></th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Designing and establishment of a multisectoral system, including a sound regulatory framework, training and support for caregivers, coordination and integration across various sectors (including the health sector), mechanisms such as accreditation and monitoring to assure quality</td>
</tr>
<tr>
<td>2.</td>
<td>Advocacy and communication to recognize long-term care as an important public health priority, including acknowledging the rights of older people with significant loss of capacity to appropriate care and support and the requirement of support for caregivers</td>
</tr>
<tr>
<td>3.</td>
<td>Access to long-term care (whether at home, in communities or in institutions) as part of UHC, without the risk of financial hardships for older people, caregivers or families, through resourcing and appropriate prioritization</td>
</tr>
<tr>
<td>4.</td>
<td>Implementation and adaptation of self-care programmes for long-term care of older people, including development of training activities in self-care</td>
</tr>
<tr>
<td>5.</td>
<td>Programme development to support activities of informal and formal caregivers, including the introduction of incentives, training, information and support to those opting to provide long-term care</td>
</tr>
<tr>
<td>6.</td>
<td>Implementation of long-term care programmes that promote community involvement so as to ensure local ownership, sustainability and the ability of older people to age in a place that is appropriate for them</td>
</tr>
</tbody>
</table>
WHO undertook an assessment of the Mid-term Progress on the Global Strategy and Action Plan on Ageing and Health in the Member States in early 2018. It found that seven of the 11 Member States (64%) of the South-East Asia Region have a national policy on long-term care in comparison to the global average of 45%. Table 9 gives the findings from the assessment [52].

Table 9. Mid-term progress on the Global Strategy and Action Plan on Ageing and Health

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 1</td>
<td>Focal point on ageing and health</td>
<td>9 of the 11 (82%) Member States of the South-East Asia (SEA) Region have established a national focal point on ageing and health in the Ministry of Health compared to the global average of 57%.</td>
</tr>
<tr>
<td>Indicator 2</td>
<td>National plans on ageing and health</td>
<td>9 of the 11 (82%) Member States of the SEA Region have formulated a national plan on ageing and health compared to the global average of 45%.</td>
</tr>
<tr>
<td>Indicator 3</td>
<td>National multistakeholder forum</td>
<td>6 of the 11 (54%) Member States of the SEA Region have a national multistakeholder forum compared to the global average of 54%.</td>
</tr>
<tr>
<td>Indicator 4</td>
<td>National legislation and enforcement mechanisms against age-based discrimination</td>
<td>9 of the 11 (82%) Member States of the SEA Region have developed national legislations and enforcement strategies against age-based discrimination compared to the global average of 45%.</td>
</tr>
<tr>
<td>Indicator 5</td>
<td>National regulations/legislation to support access to assistive devices</td>
<td>7 of the 11 (64%) Member States of the SEA Region have national regulations/legislation to support access to assistive devices compared to the global average of 64%.</td>
</tr>
<tr>
<td>Indicator 6</td>
<td>National programme to foster age-friendly environments</td>
<td>5 of the 11 (45%) Member States of the SEA Region have a national programme to foster age-friendly environments compared to the global average of 14%.</td>
</tr>
<tr>
<td>Indicator 7</td>
<td>National policy to support comprehensive assessments of health and social care needs</td>
<td>3 of the 11 (27%) Member States of the SEA Region have a national policy to support comprehensive assessment of older people compared to the global average of 13%.</td>
</tr>
<tr>
<td>Indicator 8</td>
<td>National policy on long-term care</td>
<td>7 of the 11 (64%) Member States of the SEA Region have a national policy on long-term care compared to the global average of 45%.</td>
</tr>
<tr>
<td>Indicator 9</td>
<td>Cross-sectional data on healthy ageing</td>
<td>4 of the 11 (36%) Member States of the SEA Region have cross-sectional data on the health status and needs of older people compared to the global average of 27%.</td>
</tr>
<tr>
<td>Indicator 10</td>
<td>Longitudinal data on healthy ageing</td>
<td>2 of the 11 (18%) Member States of the SEA Region have longitudinal data on the health status and needs of older people compared to the global average of 18%.</td>
</tr>
</tbody>
</table>

Long-term Care for Older People

Long-term care in Member States of the South-East Asia Region
BANGLADESH

The Ministry of Social Welfare in Bangladesh has adopted the National Policy in 2013 with the goal to ensure poverty-free, safe and healthy lives for the older population. The policy has identified several directions that have relevance to long-term care. These include ensuring a citizens’ charter; establishing geriatric departments at specialized institutions and at district and subdistrict hospitals; introducing referral cards for the older people; ensuring home care for the disabled; ensuring assistive devices (hearing impaired, dental and ear, nose, throat [ENT] services); and initiating health insurance schemes [49, 53].

The health sector addresses the control and management of chronic diseases of old age. It is proposed to formulate an action plan on long-term care with the involvement of all partner agencies and stakeholders [49, 54].

Several essential services for older people are provided through the different tiers of national health services. Free medical services and pension schemes for the eligible groups ensure that older people in need can access and benefit from the services without incurring financial burdens. Screening and treatment for non-communicable diseases (NCDs) are available through primary health centres. Palliative care is available for older people only at the Bangladesh Sheikh Mujib Medical University (BSMMU) [53].

A number of initiatives have been taken as part of the Older Adults People/Senior Citizens by Operational Plan (OP) 2017–2022 under the fourth Health, Population and Nutrition Sector Programme (HPNSP), of the Ministry of Health and Family Welfare through the Noncommunicable Disease Control (NCDC) programme, Directorate General of Health Services. These initiatives accord priority to the health-care of older people...
Long-term Care for Older People

while ensuring respect and dignity for them; providing support and assistive devices such as walking sticks and wheel chairs; developing guidelines for training; and organizing seminars at different levels of the administration, particularly at the primary health-care level [53].

A number of provisions exist for providing financial resources to the ageing population through different avenues: formal pension schemes; old age pension schemes; various retired officers’ welfare associations; service centres for older people; national NGOs (Probin Haiteshi Sangha); Development Initiatives; and Elder Rehabilitation Centres. Another financial support scheme, Bayoshko Bhatta, is designed for older people with disabilities. Services that are not included in the universal or voluntary packages are generally provided by NGOs. Government health services provide knowledge about older people’s care, free medical facilities and financial support [53].

There are several constraints to the implementation of a successful older adults’ care programme in Bangladesh: widespread poverty; low literacy levels; rapidly increasing population with a large proportion of youth; poor coordination between different ministries; and changing social and family structures. However, many opportunities exist to improve the situation, such as strengthening community health clinics, and incorporating the inputs from various national and international initiatives for long-term care [49].
BHUTAN

An estimated 33,759 people are aged 65 years and above in Bhutan, with a dependency ratio currently estimated at 7.6 and a total dependency ratio of 56, as per a national study conducted in 2009. Life expectancy at birth has been increasing over the years: 65.3 years in 2010; 67.4 years in 2011; 68.1 years in 2012 and 68.6 years in 2015. It is estimated that life expectancy at birth between 2005 and 2030 will continue to increase for both men and women. Although the population pyramid in 2005 showed a high proportion of adolescents and young adults, by 2030 a higher proportion of adults and older people will be reflected in the age pyramid [49].

The national interpretation of long-term care is the care provided to old aged citizens to improve their health and reduce morbidity, disability and dependence. This approach will require the integration of older people’s care, including geriatric care in primary health-care and increasing of health access for older people through telemedicine, home visits and outreach clinics [42].

Advocacy for healthy ageing policies and programmes at the national and community levels will be required along with adequate community participation. Various options for providing long-term care to older people have been considered in the country, such as holistic and multidisciplinary approach to promote healthy ageing; focus on effective disease prevention and health promotion; empowering community to provide care to older people; capacity-building for health professionals to provide better care to older people; provision of home visits, screening and follow-up for those who are disabled; and appropriate referrals [49].
Several agencies are involved in the provision of long-term care for the older people: the Ministry of Health for policy formulation and resource mobilization for ageing care; national, regional, district and community level facilities to provide care and support; health professionals practicing at the community level, NGOs, family and community care-providers. More than 90% of the population receives health-care through the 30 hospitals and 181 Basic Health Units (BHUs) [49].

All health services are available at the BHU and district hospitals, and are coordinated at the BHU level. However, social services from local governments need strengthening. Several awareness and advocacy programmes on healthy ageing, independent living and social care responsibility have been well-received. An essential service list exists as part of the UHC programme, but is not targeted specifically for older people [54].

Guidelines for community-based medical check-up for older people have been in existence since 2001 and are included as part of in-service training of health staff. Other than screening guidelines, there are no communication, education or training materials available relating to healthy ageing or health-care of older people [54].

Two pilot projects on older people’s health-care were implemented successfully at Khaling in Tashigang district and Samtegang BHU in Wangdue district of Bhutan. However, several constraints were encountered, such as poor awareness about long-term availability of older people’s care; inadequate funding and shortage of health infrastructure; and insufficient skills and knowledge of health staff involved in care of older people.

Currently, Bhutan does not have any standards for assessing long-term care. This may be introduced in the proposed National Policy on Healthy Ageing. A national law for protecting the older people was formulated in 2004, and the rights of older people are enshrined in the National Constitution. Surveys are conducted at periodic intervals to assess standards of living, health problems in old age, and review of the overall health status of older people. Similarly, training protocols and actual training of community and clinical health professionals in older people’s health-care are yet to be introduced on a regular basis.

As part of the Eleventh Five-Year Plan, health-care services will be extended to 10 health centres, combined with intensified awareness programmes for the public; training of health staff and village health workers; integration of older people’s health-care programme with the primary health-care programme; and introducing a policy on old age benefits and incentives for the population [49].

Financing of long-term care would need to be included in the five-year plans. In addition, assistance would be sought from communities and through development aid from donors [42]. Provision of financial resources for older people’s health is not specific but is covered as part of UHC, which is free and provides all essential or key services to older people. As there is no OOP health expenditure incurred by older people, disaggregated information by different age groups is not known. The extent of the availability of non-health-care services (outside the UHC package) is also not known [54].
DEMOCRATIC PEOPLE’S REPUBLIC OF KOREA (DPR Korea)

In accordance with the law on the Care for the Older Adults 2007, the Democratic People’s Republic of Korea established a National Commission for Care of the Aged at the central, provincial, municipal and regional levels. The Minister of Labour is the chairperson at the central level, while the vice-ministers from various ministries and representatives from different central organizations related to older adults’ care programmes are commissioners. At provincial, municipal and country levels, the head of the commission is among the chairpersons of all-level people’s committees, and commissioners are directors and managers from various programmes involved in the care of older people [49].

In DPR Korea, the age of entitlement for pension is 60 years for men and 55 years for women. At this age they can receive pensions in proportion to their terms of service and work rendered to the society. All citizens aged 90 years and above are registered and paid additional subsidies apart from pensions; a Korea Elderly Care Fund was also established in 2010 [49].

Several interventions to address the long-term care needs of older people have been introduced successfully. These include universal coverage of free medical care for all citizens; improved quality of long-term care at the primary level, in specialized hospitals, at old-age homes and at community and family levels; introduction of geriatrics and gerontology in the curriculum and teaching; and strengthening of pre-service training in medical universities and colleges [49].

Several constraints are encountered, such as lack of sufficient funds and multisectoral cooperation. There are plans to conduct in-depth research on longevity of older people in relation to international trends and standards. Efforts will be made to understand multisectoral approaches, partnerships and networking, as well as to obtain technical assistance from international organizations and donor agencies. Development of a national strategy on healthy ageing in line with the regional healthy ageing strategy and the Yogyakarta Declaration on Ageing and Health [49] is also planned.
INDIA

India will soon become home to the second-largest population of senior citizens’ in the world. As per the 2011 Census, the total population is 1.21 billion, while the older people’s population is 103.9 million (8.6%). The projected older people’s population in India is 198 million by 2030 and 324.3 million (20.6%) by 2050.

In more than 30% of the states and union territories in India, the proportion of older people population exceeds 7%. The life expectancy at birth in India currently stands at 69 years, and is projected to increase to 76 years by 2050 [55].

As the population ages, the sex ratio (number of women per 1000 men) also increases. The ageing index, which was 22.7 in 2000, is projected to increase to 105 by 2050. The dependency ratio will increase to 22.6 and potential support ratio will decline to 4.4 persons aged 15–64 years per older people [55].

Common health problems among older people are often chronic, disabling, and life-long, requiring multiple drug treatments, physical therapy and long-term rehabilitation. These include infectious diseases as well as NCDs, such as coronary heart disease, hypertension, diabetes, stroke, osteoarthritis, postural instability including falls, loss of mobility, urinary incontinence, eye problems (cataract, glaucoma), dementia and other neurological problems, neoplasms, respiratory diseases and bowel dysfunction [55].

It is estimated that around 75.7% of the older people in India have one or more of these diseases, and 40% have one or more disability. About 25% of older people have mental health-related issues and 8% are bedridden and need home-based care [54].
Long-term Care for Older People

The challenges faced by India are multipronged. In economic terms, older people mostly do not have any source of independent income and rely on family for support, and to a lesser extent, on government programmes. This excessive reliance on family networks to provide older people’s care and support puts a strain on such families. As the number of older people who are at greater risk of chronic health problems or living with disabilities will be increasing, and the treatment and management of increasing NCDs will be a burden on the health-care infrastructure and costs in India. There will be an increase in the number of people with dementia, such as Alzheimer’s disease, as people live longer. Many older people are also at risk of maltreatment, especially in emergency situations. Hence, there is a need for long-term care [49, 55, 56].

India spends a mere 0.032% of its GDP on older people. By 2050, the population of older people in India is likely to reach 324 million. Yet there are not enough dependable community support systems to match this growth [57, 58].

It has been seen that inpatient care is obtained at significant OOP costs [59]. Older people are often grouped with the adult population, and as a result some key issues they face are neglected. The allocation of resources within households in settings where fertility may still be above replacement, especially among the poor, could potentially lead to an overall lack of funds for the older members of the family, as attention would remain focused on the young [59].

Several government initiatives have been undertaken over the years [55]:

- National Policy on Older Persons (NPOP), 1999, formulated by the Ministry of Social Justice and Empowerment (MoSJ&E)
- Maintenance and Welfare of Parents and Senior Citizens Acts (MWPSC), 2007
- National Programme for Health-Care of the Elderly (NPHCE)

The National Policy on Older Persons (NPOP), 1999 seeks to assure older people that their concerns are national concerns and they will not live unprotected, ignored or marginalized. Its goal is the well-being of older people, and it aims to strengthen their legitimate place in society and enable them to live the last phase of their lives with purpose, dignity and peace.

The NPOP has the following components to benefit older people: support for financial security; health-care; shelter; welfare and other needs; protection against abuse and exploitation; opportunities for development of potential; and improving their quality of life.

As per the NPOP, the Ministry of Health and Family Welfare was entrusted to attend to the health-care needs of older people with the following agenda:

1. establishment of a geriatric ward for older patients at all district-level hospitals;
2. expansion of treatment facilities for chronic, terminal and degenerative diseases;
3. provision of improved medical facilities to those not able to attend medical centres;
4. strengthening of community health centres (CHCs)/primary health centres (PHCs)/mobile clinics;

5. inclusion of geriatric care in the syllabus of medical courses, including courses for nurses;

6. reservation of beds for older people in public hospitals;

7. training of geriatric caregivers; and

8. setting up of research institutes for chronic old-age diseases, such as dementia and Alzheimer’s.

The MWPSC Act, 2007, Article 20, requires that state governments ensure that government hospitals are fully or partially funded by the central government and, to the extent possible, provide beds for all senior citizens. Separate queues should also be arranged for senior citizens and facilities for the treatment of chronic, terminal and degenerative diseases and research on chronic diseases expanded. Facilities are earmarked for geriatric patients in every district hospital, duly headed by a medical officer with experience in geriatric care [55, 70].

In consonance with the commitment envisaged under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), NPOP 1999 and the MWPSC Act, 2007, the Ministry of Health and Family Welfare launched the National Programme for the Health Care of the Elderly (NPHCE) during 2010–2011 to address various health-related problems of older people. The programme is state-oriented and its basic thrust is to provide dedicated health-care facilities to senior citizens (>60 years of age) at various levels of primary, secondary and tertiary health-care [49, 54, 55].

Vision, objectives and strategies of the NPHCE [55]:

- provide accessible, affordable, high-quality, long-term, comprehensive and dedicated care services to an ageing population, by creating a new architecture for ageing, an enabling environment for a society of all ages and promotion of the concept of active and healthy ageing;

- To provide dedicated health-care facilities for older people at various levels of state health-care delivery systems with referral support;

- To provide promotional, preventative, curative and rehabilitative services to older people through a community-based primary health-care approach, including home visits by trained health-care workers;

- To build capacity in the medical and paramedical professionals, as well as the caregivers within families for providing health-care to older people;

- To encourage human resource development through the introduction of postgraduate courses in geriatric medicine and in-service training of health personnel at all levels;

- To promote IEC activities using mass media, folk media and other communication channels to reach out to target communities;
To conduct research in geriatrics and reorient medical education to support geriatric issues;
To converge with programmes for older people by various other ministries such as the Ministry of Social Justice and Empowerment (MoSJ&E), Ministry of Home Affairs and the Ministry of Law; and
To involve with private partners and NGOs working in the field of geriatric care.

Major components of the NPHCE programme [55]:

- Dedicated geriatric health care in all districts of the 36 states/Union Territories with geriatric units with outpatients’ department (OPD), inpatients’ department, physiotherapy and laboratory services at district hospitals
- Rehabilitation units along with biweekly OPDs at CHCs
- Weekly geriatric clinic at PHCs
- Home visits to older people by health workers
- Maintenance of records
- Provision of supportive devices and equipment at subcentres
- Establishment of Regional Geriatric Centres – Geriatric departments in 19 government medical colleges
- Development of centres of excellence in ageing, such as two National Centres of Ageing at the AIIMS, New Delhi and at the Madras Medical College, Chennai.

Regional Geriatric Centres (RGCs) are to be the first level tertiary care centres under the NPHCE and will perform the following key functions [55]:

- Provide tertiary level services for complicated/serious geriatric cases referred from medical colleges, district hospitals and below
- Conduct postgraduate courses in geriatric medicine
- Impart training to the trainers of identified district hospitals and medical colleges
- Develop evidence-based treatment protocols for geriatric diseases prevalent in the country, as well as develop and update training modules, guidelines and IEC material
- Research on specific older people's diseases

Activities till date under the NPHCE:

- The NPHCE has been sanctioned for roll out in 599 districts as on date.
- Geriatric OPDs have been established in 250 district hospitals.
At the district level, 221 indoor wards, 216 physiotherapy units and 211 laboratories have been strengthened to provide geriatric care.

837 CHCs are providing biweekly OPDs and rehabilitation services while 1909 PHCs are delivering weekly OPDs, screening and referral services.

A total of 32 173 sub-centres are extending home-based care and providing supportive appliances.

16 RGCs are extending OPD services while 13 of these RGCs have a dedicated or earmarked 30-bedded geriatric ward, 8 RGCs have established rehabilitation units and 7 have set up dedicated laboratories.

The National Centre for Ageing (NCAs) at the Madras Medical College, Chennai and at the AIIMS, New Delhi are in the final stage of construction.

Several components of the NPHCE support long-term care. These are: geriatric wards to manage acute illnesses and home visits by multipurpose and rehabilitation workers for bedridden patients; coordination with related national programmes which also address some aspects of long-term care such as the National Blindness Control Programme; the National Deafness Control Programme; the National Programme for the Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke; and the National Mental Health Programme. Isolated and scattered efforts are being made by the private sector and civil society to establish long-term care homes, but these efforts are at an early stage of development.

However, at this stage, long-term care is not defined, nor is it an organized component of NPHCE. The Ministry of Health and Family Welfare is the implementing agency for the health components. All welfare aspects of older people are addressed by the MoSJ&E. This ministry also supports over 500 old-age homes and the involved NGOs that provide residential and non-residential care to the elderly people.

Similarly, the National Institute for Social Defence (NISD), and the MoSJ&E through Regional Resource and Training Centres (RRTCs), are also involved in conducting training and awareness programmes pertaining to the care of older people. The key responsibilities of RRTCs include monitoring and providing technical support, advocacy and networking, and training and capacity building for the effective delivery of service by the Centre for Senior Citizens, funded by the MoSJ&E.

The NISD conducts the following programmes pertinent to old-age care:

- One-year diploma on integrated geriatric care
- Three months’ and six months’ certificate course on geriatric care
- Three-day orientation training programme on geriatric health
- Three-day orientation training programme on dementia care and management
- Three-day orientation training programme on geriatric counselling
Long-term care in India is the need of the hour, but it requires a well-thought-out multisectoral, multipronged strategy with a robust implementation and monitoring mechanism, which needs to be developed in consultation with all stakeholders (government, NGOs and charitable organizations) involved in providing long-term care. It also needs to be decided whether such a system should be a part of the Ministry of Health or a part of the MoSJ&E [55].

It is known that Indian families prefer to have old-age care within homes. Despite the availability of old-age care facilities across India, old-age homes continue to be associated with the abandonment of relatives and symbols of social degeneration. Part of the stigma against old-age homes is based on legitimate concerns, such as limited resources at such locations, lack of standards and assessment, and prevailing authoritarian attitude of the staff. However, institutional care does have an important role to play in the Indian context, provided minimum standards and monitoring criteria are established and implemented [56].
INDONESIA

Indonesia is heading towards an ageing population, and the demographic transition poses challenges for policy-makers on how to maintain older people’s quality of life. Physical ailments and disability increase with age, with morbidity affecting more women than men. Increasing disability leads to income loss, as well as exclusion from engaging in social activities, thereby leading to loneliness and isolation. Indonesians place importance on the value of extended family, and in 2017, 36% of older people lived with three generations in one household providing potential support [60, 61]. Indonesia has established strong community and civil society involvement in the care of older people. The existing guidance on old age care has a holistic and comprehensive approach, emphasizing promotive, preventative, curative and rehabilitative aspects [49].

National Act Number 13 (1998) ensures the rights of older people with regard to religion, health, education, protection and security. Article 5 of the Act stipulates that the government is obligated to guarantee the provision of health and socioeconomic support to the older people. Act Number 36 (2009) is a further development in ensuring health to older people [49, 61].

The national interpretation of long-term care suggests that services should be given to older people who are unable, or have reduced ability, to take care of themselves and require help from others for their care. Basic needs comprise support for ADL and IADL, particularly for those with chronic illness or disability, along with support for social and economic needs. All services have to be delivered in a holistic and comprehensive manner, targeting the older population aged 60 years and above who have health problems, are living alone, and with or without functional/mental/cognitive dependency [49, 61].
In Indonesia, the Ministry of Health is assisted by several agencies, including faith-based organizations, for delivering care to older people [49]. The Ministry of National Development, Planning and Coordinating, Ministry of Human Development and Cultural Affairs coordinates all related ministries such as Law, Transport, Communication, Labour, Social Welfare, Education, Manpower, Population and Family Planning, Health and Universities, as well as civil society and NGOs; in monitoring, evaluation, advocacy and development of policy recommendations [49]. The Ministry of National Development Planning coordinates the development of the document on Elderly National Strategy in 2019–2024. One strategy in this document is to expand the coverage of older people’s long-term care by involving all related sectors [61].

In Indonesia, long-term care is considered a continuing process, extending from the hospital to the community, with components such as control of the acute phase, discharge and care at home/nursing, promotive, preventative and rehabilitative activities; and involvement of institutions and social system-based home care [49]. Services relating to long-term care have been in existence in some provinces in Indonesia, such as Yogyakarta, Jakarta and West Java province [54]. In the future, services relating to long-term care for older people will be developed to become a national programme. The guidelines for older people’s long-term care for primary health-care and the guidelines for older people’s long-term care for caregivers, have been developed. For the first phase, pilot projects would be developed in Bengkulu, Bangka Belitung, West Java, Jakarta, Bali and Yogyakarta provinces, in addition to socialization of the programme to other provinces of Indonesia [61].

Locations providing long-term care services to older people [42, 72]:

- Hospital – services provided by the geriatric team include geriatric/gerontological nursing care; psychosocial care/counselling; and palliative care
- Health centres – services provided by the home-care team include supervised home care; training home caregivers; and providing nursing care at home
- Day care centre/ special support group/ civil society – services provided by public health nurses/volunteers/family members include personal care; domestic assistance; and satisfying social and spiritual needs
- Home care – services provided by the health worker/formal caregiver/informal caregiver (family, neighbour, volunteer) at the homes of older patients
- Residential – services provided by the health worker/social worker/formal caregiver/informal caregiver (volunteer)/nutritionist assistant with facilities for meeting daily basic needs and daily drug administration at the residence of older people
- Nursing home – services provided by the health worker/social worker/formal caregiver/informal caregiver (volunteer). Services are delivered to older people who need professional health-care for long durations
- Transitional care/ sub-acute care – services provided by the health worker/nurse/formal caregiver. These services are provided to the older people who are unable to return home and require ‘post-hospital care’
Health-care financing is provided by the central government through the NHI plan for basic care. Local governments provide financial support for older people’s care, but exclude long-term health-care. Communities have established a limited number of interventions in support of long-term care. In most instances, OOP expenditures for long-term care remain the usual practice [49]. Financial resources for long-term care are available from the national, provincial and district budgets. Funds are made available from time to time, by international agencies, NGOs and the private sector. Co-payments available for treatments are not included in the UHC [54]. The existing pension system has limited coverage [60].

The number of informal caregivers has been on the decline due to reduced family size and increasing number of women entering the workforce. The Ministry of Health and the Ministry of Social Affairs, in collaboration with academia and civil society, have conducted training for health providers and caregivers. However, most health providers and caregivers in Indonesia are untrained, particularly those working at the family-care level. Training of trainers is usually conducted by the Geriatric Team from the main hospitals and some provincial hospitals; the Ministry of Social Affairs and the Ministry of Health; HelpAge Indonesia; and other NGOs. At the same time, the extent of coordination among the different parties is not adequate [49].

Training in geriatrics for undergraduate medical students during the seventh and eighth semesters is provided at the Faculty of Medicine. Postgraduate training in geriatrics is part of internal medicine specialization training. There is also an annual continuing education programme on gerontology and geriatrics for general practitioners. Recently, geriatric medicine has been introduced as a subspecialty at the Faculty of Medicine. The training lasts for 3 years and enables the trainees to set up geriatric medicine teams at hospitals. Training in various aspects of geriatrics and gerontology is also provided to nurses [49].

There are standardized advocacy training, communication and availability of educative materials such as leaflets, flipcharts, older people’s health handbooks, information kits and guidelines for integrated services for older people. These are availed by several categories of users, ranging from family members, community workers to health professionals [54].

There are many constraints in the effective delivery of long-term care to the older population [49].

- Long-term care is not considered a priority health or social issue and, as such, receives limited funding from the national government.
- Coordination between the different agencies involved in the delivery of long-term care to the population is weak.
- Long-term care for health is not covered by the NHI plan.
- There are no standard comprehensive guidelines on long-term care at any level of health services delivery, and the number of appropriate categories of health/social workers is limited.
MALDIVES

The life expectancy at birth for a Maldivian man is reported to be 73.1 years whereas the life expectancy at birth for a Maldivian woman is 74.8 years, as per the Maldives Health Statistics of 2014. The life expectancy trends in the population show marked improvement in the health status of the population. The life expectancy at birth has increased for men from 72.0 years to 73.13 years and for women from 73.2 years to 74.77 years, from 2000 to 2012 respectively [62].

There is no national interpretation of long-term care [49] in the Maldives. In a manner of speaking, long-term care is available at all the regional tertiary care facilities till the end of life [54]. However, every person who is aged 65 years or above, as specified in the Pension Act, is considered an older person and is eligible for all the rights that are allocated for such people. The Pension Scheme was initiated in 2010 as part of the Pension Act.

The government has enacted legal provisions to ensure that the monthly allowance/pension reaches the eligible older people. All senior citizens aged 65 years or above are entitled to an old-age pension of Maldivian Rufiyaa (MVR) 2300. The government has also introduced a Senior Citizen Allowance to top-up the pension amount received by senior citizens, a sum of MVR 5000 equivalent to US$ 325 [62]. The National Mental Health Policy also has provisions to benefit older people. Additional benefits are provided through the disability scheme and general health scheme for the entire population. There are special services for bedridden older patients, and health schemes for all kinds of disability. Those aged 65 years or above are eligible for social welfare allowance [54].

The Bedridden Patient Programme was launched in 2014; it focuses on providing basic health-care services for bedridden patients above 65 years of age within the Male city and all islands. Through this programme, registered bedridden older people are visited at their homes by medical professionals and provided basic medical care and counselling if necessary [62].
The Ministry of Gender and Family (MoGF) was established in 2016 with the mandate to protect and promote the rights of vulnerable groups in the Maldives. The vulnerable groups comprise children, women, persons with disabilities and the older population [62].

The benefits for older people in the Maldives are: (i) older adults’ allowance of MVR 2300 since 2010; (ii) universal health-care scheme (Aasandha) since 2011; (iii) institutional care for the older people (Home for People with Special Needs) since 1976; and (iv) National Pension schemes since 2010. The Pension Scheme is administered and monitored by the Pension Administration [49].

The MoGF has launched a nation-wide awareness campaign in 2016 called Ranveyla, which translates as “Golden Age” and targets the overall well-being of senior citizens [62]. Awareness sessions are conducted for senior citizens on protection measures, and how to report all forms of abuse, in addition to information on how to maintain an independent, healthy and active lifestyle. Health screening programmes are organized for senior citizens to detect health issues requiring further medical interventions. Moreover, special interactive sessions are conducted, to bridge the intergenerational gap between the older people population and the youth. These sessions promote interaction between youth and senior citizens, encourage youth to treat older people with respect, and help create conditions for these senior citizens that enable them to participate in and contribute to societal development. Ranveyla campaign activities have been successfully conducted in all islands of Baa, Meemu, Lhaviyani, Dhaalu and Faafu Atoll and in some islands of Laamu, Kaafu, Adh and Addu City. The campaign has received positive response from the communities [62].

Through the Ranveyla campaign, the MoGF conducts training programmes targeted for health workers and social service workers at the island level, to build their capacities to cater to the needs of senior citizens requiring assistance and support. So far, 235 social workers and health-care workers from 10 atolls have participated in this training programme.

As of June 2012, a total of MVR 433 million have been spent for 15,300 older people; a sum of MVR 7.6 million is spent monthly for the Pension Scheme; while for the Home for Special Needs (HPSN) programme, administered and funded by the government, donations are also received on a regular basis [49].

Aged Care Maldives, a non-profit NGO, works with the older people and their families. Aged Care Maldives also provides some training to family caregivers and helps to increase awareness among health professionals [49].

The current Husnuvaa Aasandha has been in use since January 2014 without annual individual financial limits. At present, the scheme is administered by a state-owned company, Asandha Private Limited, for which the Ministry of Health is the main provider of health-care and the National Social Protection Agency (NSPA) is the governing agency. Private sector provides curative services on a fee-for-service basis and package prices for curative care received from health facilities abroad. Additional services not included in the UHC package are obtainable through the National Social Protection Act [54, 62].

Training on various aspects of healthy ageing is carried out by the NCDs Unit of the Ministry of Health. Topics include awareness, rights and issues of ageing; basic skills development; and promotion of physical activity. Skills development and awareness training programmes are available for health and social care support caregivers in formal settings since 2015. Public awareness on healthy ageing is provided through the general media and various information, education and communication avenues [54].
The government has also inaugurated the first-ever National Elderly Policy in October 2017, focusing on four main areas: care and protection; independence and participation; health and well-being; and preparation for old age. A workshop was held in August 2018 to finalize the National Elderly Action Plan (NEAP) to implement the National Policy on Older peoples, with participation from 23 government, private sector and civil society organizations. The NEAP has included multiple action points to increase the long-term care of senior citizens in the Maldives such as: (i) strengthening bedridden care at home; (ii) training of health-care professionals in geriatrics and gerontology; (iii) training and licensing older people home-care assistants; and (iv) establishing safe nursing homes [62]. Moreover, the Pension Act that was adopted in May 2009 established an old-age pension scheme and a retirement pension scheme [49].

A number of constraints are encountered in the effective implementation of older people’s care programmes, such as the absence of supportive legislation and specific support and services for older people at the provincial and local levels, and limited range of services available from the NGO sector [49]. The HPSN scheme accommodates some older people who do not have options of care with their families or communities [62].

Several activities are planned for the future. For example, various policies and strategies designed to protect the rights of older people have been included in the government Strategic Action Plan along with the National Healthy Ageing Policy with a regulation to ensure family responsibility of the older people. Plans have been drawn up to build separate housing facilities for the older people population in four zones in the Maldives. In addition, advocacy and awareness building activities have been undertaken at the community level [49].
According to the 2014 national census, the population of people above 60 years of age in Myanmar is 4.47 million, which is 8.74% of the total population. By 2050, this proportion of the population will rise to 22.3%. With an increasingly ageing population, health-care services for older people will become a priority in Myanmar [63].

The national interpretation of long-term care in Myanmar is a system of activities undertaken by informal caregivers (family, friends and neighbours) and/or professionals (health, social and others) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation fulfilment and human dignity [42]. Several options are available for the older people, such as homes for the aged; the ASEAN–Republic of Korea (ASEAN–ROK) home-care programme; older people self-help group; health-care projects for older people; day-care centres for older people; and paid home care, which is currently being operated as a pilot study [49].

As of now, two key long-term care programme options are available for older people in Myanmar. The Homes for the Aged is a volunteer-based home care provided at 70 homes for the aged covering about 2300 older people. Food items, particularly rice, clothes, salary for the administrators and funds for the purchase of food are provided along with appropriate technical assistance at the locations. The second
option is the ASEAN-ROK home-care programme which was undertaken in three phases between 2004 and 2012 and comprises pilot projects in two townships with home-care activities, followed by eventual expansion in 154 townships with 10 partner organizations [49]. Exact information is not available on the national, provincial or local level programmes or services for long-term care and palliative care for older people [54]. The Department of Social Welfare provides institutional care including old-age home care.

The high spirit of volunteerism among the public, respect and value for older people, extensive community-based, CBO run day-care centres and centres for the care of older people are some examples of the success achieved in the provision of long-term care in Myanmar [49].

Standardized advocacy, communication and training materials promoting healthy ageing are available in the country, which are provided to local authorities, health workers, health volunteers and relevant NGOs. The Department of Social Welfare conducts training on health and social support for caregivers only in Yangon. Information on training, capacity or skills development activities for the formal or informal care sector in other parts of the country is not available. An essential service list has been prepared in collaboration with the World Bank but is not yet finalized. Once finalized, the essential list will be available throughout the country [54].

No specific financial resources are allocated for health-care of older people. The national curative, preventative and promotive health-care programme, part of the UHC of the government, is expected to address the health needs of older people. All services are provided free [54].

The Department of Human Resources for Health, Ministry of Health and Sports is planning to train nurses in long-term care for older people. Also, the Department of Public Health is organizing the Community Health Clinic in Rural Health Centres and Urban Health Centres every Wednesday, to serve the health needs of the ageing population [63].

The Department of Social Welfare provides institutional care, including old-age home care. HelpAge International provides services for older people in pilot projects in coordination with the Department of Social Welfare and the Department of Public Health. However, no national-level information is available on OOP expenses by older people and their families to obtain the necessary services [54].

There are several constraints to establishing effective long-term care, such as the need for a national policy on long-term care; inadequate financial support for long-term care; ensuring sustainability of long-term care activities; low community participation and public awareness for long-term care; inadequate multisectoral and multidisciplinary participation; and the need for sufficient human resources for health and social care [49]. WHO is providing support to the Ministry of Health in developing a national strategy for healthy ageing [63].
NEPAL

The total number of persons aged 60 years and above is estimated at 2.09 million, or approximately 8% of the total population of 26.62 million in Nepal. The majority of the older people live in rural areas (≥85%), with more than 75% living with their children.

Health problems, low socioeconomic status, lack of security and social networking affect the morbidity and mortality of older people in Nepal. The older population in the country is socioeconomically active, particularly in the areas of cattle-herding, child care, agriculture and handicrafts. However, the dependency ratio has increased, possibly because of an increase in the proportion of older people, and a reduction in the proportion of young family members, who migrate for economic opportunities [49, 64].

Like some other countries of the WHO SEA Region, Nepal does not have a long-term care policy. The government provides a monthly allowance of Nepali rupees 3000 to people more than 70 years of age. The government also provides Nepali rupees 2000 per month to widows aged 60 years or above. In addition, the government also provides health services and medication equivalent to Nepali rupees 100 000 to older patients with diseases such as Alzheimer's disease, dementia, Parkinsonism, cancer, etc. It also provides haemodialysis services free of charge to patients with end-stage chronic kidney disease, who need renal replacement therapy through select institutions.
The National Health Training Centre (NHTC) in Nepal has started training nurses for geriatrics as well as long-term care in collaboration with the Patan Academy of Health Sciences (PAHS) situated in Lalitpur district of Nepal. The PAHS is the only institute in Nepal which has a geriatric care and training facility led by a certified geriatrician. Apart from the PAHS, seven other institutions are running geriatric care facilities in the form of inpatient geriatric wards in Nepal.

With regard to long-term care facilities, the government runs only a single old-age care home — the Pashupati Briddha Ashram — where older people with physical and cognitive deficits live indefinitely. According to a 2018 survey by the National Human Rights Commission of Nepal (NHRC), as many as 141 old-age homes are operational in 64 districts of Nepal. Most of them are charity-based and run by the community. A few privately-run care homes, day-care centres, and home-based nursing care services are also operational. A total of 1,577 senior citizens were living in old-age care homes in Nepal as of mid-October 2018. Of them, 965 were women and 612 were men. Data shows that the number of women living in old-age homes is 44.7% higher as compared to men. This study was based on the monitoring of 86 old-age homes and 30 day-care centres in 64 districts [71].

Care to the older population is provided by the Ministry of Health at the central level, with support from the regional, zonal, and district hospitals, along with health and the subhealth posts. No specific protocols and guidelines exist for training relevant staff in long-term care, although there are treatment protocols for older patients, which are used at various health facilities. Many such health facilities are supported by national and international NGOs.

One session on care of older people is included in the annual training of district-level health workers for caregivers from the informal/formal sector. Similarly, one session on care of older people is included in the annual training of district-level health workers [54]. No specific budgetary allocations are made for long-term care of older people. There is an urgent need to increase the number of health personnel trained in geriatrics [49].

A number of challenges are encountered in ensuring adequate health and related care to the older population in Nepal, namely: (i) absence of a suitable policy and a plan of work for providing care to the older population; (ii) reduction in the size of the workforce, which has led to an increased dependency ratio for the older population; (iii) a negative attitude from the younger generation towards the older population; (iv) changes in family structure and lifestyle due to the disappearance of extended families and increased out-migration of the younger population; (v) insufficient staff to address the emerging geriatric and gerontological needs of the older population; and (vi) a lack of appropriate health facilities and geriatricians to provide special care to the older people [42].
SRI LANKA

In 2012, 10% of the total population in Sri Lanka was aged 60 years and above, which was estimated to reach 21% by 2025, resulting in Sri Lanka becoming one of the countries with the fastest ageing population in the world [49]. One third of the older people is affected by different types of functional disabilities [65].

The government has introduced several measures, including: the National Policy and National Charters on Elders; Rights of the Elders Act Number 9, 2000 (revised 2011) and; establishment of a National Council for Elders, a National Secretariat for Elders, a National Fund for Elders and a Maintenance Board for Elders.

The Human Rights Commission of Sri Lanka has given special attention to the protection of older people’s human rights and the Ministry of Health has taken the initiative to develop appropriate health-care policies for older people in the country.

The national government has taken legal measures against public institutions not providing accessible facilities for disabled people, including older people who are disabled. In addition, any institution providing residential care for older people must be registered with the National Secretariat for Elders. Identity cards enable older people and their caregivers to receive benefits, such as discount on the cost of medicines, higher interest rates for fixed-term deposits in banks and priority in obtaining public and private sector services [66].

Older people’s health care is considered a priority in the Health Master Plan, and services have been planned and implemented according to the national action plan at the national and provincial levels. A postgraduate training programme in geriatrics has been introduced by the Post-Graduate Institute of
Medicine, and a doctoral programme in gerontology is being planned. The Ministry of Health is in the process of training more therapists in physiotherapy, and occupational and speech therapy. At the same time, topics on aspects of older people’s care have been incorporated into the curricula of undergraduate medicine programmes and into the basic training of health personnel. Age-friendly wards and stroke-care units have been established at hospitals, while training for community-based caregivers has also been introduced [49, 66].

Health-care for older people at the community level is provided by community health-care teams in collaboration and coordination with interested partners, such as NGOs and civil society, donors and the private sector. Special camps for the prevention of blindness and deafness have been organized, along with improved accessibility to mental health-care services. There is a pre-retirement health promotion programme in public and private sector organizations, as well as screening programmes for early detection of common NCDs, including cancer [49]. Selected secondary and tertiary care health institutions provide palliative care to older people [54].

The National Secretariat for Elders has resulted in the formation of a network of thousands of village elders’ committees throughout the country, and remains a powerful resource in the development of community services for older people. There are around 246 divisional older people’s committees and 19 district-level committees, which are linked with their local-level health authorities for health-related activities, as also with social services for all social welfare needs [66].

In addition to the state provision at the community and primary care levels, many NGOs and private sector organizations are involved in the provision of care services for older people. This positive development, however, points to a clear need for systematic monitoring and evaluation of existing and new services for the older people [66].

Financial resources for all essential and key health services for older people are assured through the national preventive, curative and rehabilitative health services, which are free and comprehensive in scope. An essential service list is under preparation. The Health Income and Expenditure Survey of the Department of Census enables an assessment of the extent to which older people can have access and benefit from the services without incurring a financial burden [54]. Despite several promotive measures, a significant portion of older people may not have adequate access to social protective measures. Insurance coverage among older people has been found to be low (3.2%) and considerably less than that for the general population (11.3%) [65].

Standardized advocacy, communication and training materials promoting healthy ageing are available in the country, including different agencies and outlets providing health-care for older people. Training, skills and capacity development is a subject included in the basic training conducted by the Institute of Training in the informal/formal sectors. Knowledge on various aspects of long-term care and palliative care for older people is imparted through the bereavement programme provided to families and communities who provide care to the older people [54].
The Post-Graduate Institute of Medicine of the University of Colombo conducts a training, skills and capacity development programme for healthy ageing as part of a diploma course for physicians. For nurses, care of older people is a subject in basic and post-basic training, while for public health midwives, it is also a part of the basic training. Additionally, training for caregivers has been initiated [54].

Transportation costs to reach health-care facilities and medicinal supplements are provided to reduce the OOP expenses of older people. Additional support services are often provided by NGOs. Other related essential services are the NCD control programme, palliative care and special financial assistance, depending on the situation [54].

The existing health infrastructure and systems in Sri Lanka still require considerable strengthening and reorientation to meet the needs of the growing population of older people [66]. Several tasks need completion in the short term: wider and more effective implementation of the health-care policy; promoting advocacy and awareness about older people's care; improved geriatric health-care services; establishment of more age-friendly wards in hospitals and age-friendly communities; human resource development for older people's care; research on elders; and promotion of community-based rehabilitation [49].
THAILAND

By 2016, over 14% of the total population or 10.67 million Thais had reached the age of 60 years, thus rendering Thailand as an ageing society. By 2027, this proportion of the population will rise to 25% and by 2035, the older people population will be 30% [67]. The fourth National Health Examination Survey of Thailand (2008–2009) reported that dependency for both men and women increased with age and was encountered more among older women. With regard to living arrangements, 56.7% older people lived with their children (59.4% in urban areas and 55.4% in rural areas). Around 17.6% of older people lived with their spouses only, while 8.5% of the older people lived alone [49].

The national definition of long-term care (2010) is the provision of medical, social and personal care services on a recurring or continuing basis to persons, who are not fully capable of self-care due to chronic physical or mental disorders. Such care may be provided in environments ranging from institutions to private homes. Long-term care services usually included symptomatic treatment, maintenance and rehabilitation for patients of all age groups. Thailand defines basic medical care as occasional medical needs that can be met by most medical personnel. It defines ADL and IADL as everyday needs that are generally provided by family members [49]. The authorities responsible for the provision of long-term care are: (i) National Plan for Older Persons(2002–2021); (ii) National Commission for Older people; (iii) National Health Assembly; (iv) Ministries of Public Health, Social Development and Human Security, Labour and Interior; and (v) the 20-year national strategy (2017–2036) [49, 68].

The following government sectors and agencies are responsible for providing and supervising long-term care [49, 68]:

<table>
<thead>
<tr>
<th>Ministry of Public Health</th>
<th>National Health Security Office – financial system for older people and long-term care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Department of Health – older people's home health-care, care manager training, caregiver training, certificate of training for formal care manager, certificate of training for formal caregiver, caregiver curriculum and care manager curriculum</td>
</tr>
<tr>
<td></td>
<td>Department of Medical Services – chronic care model/ disability care model/standard nursing home</td>
</tr>
<tr>
<td></td>
<td>Department of Mental Health – mental care model</td>
</tr>
<tr>
<td></td>
<td>Office of Permanent Secretary – implementation of intermediate care in the hospitals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ministry of Social Development and Human Security</th>
<th>Regulating residential home standards</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regulating social caregiver standards and training</td>
</tr>
<tr>
<td></td>
<td>Training older people’s care volunteers</td>
</tr>
<tr>
<td></td>
<td>Regulating older people’s development centre</td>
</tr>
</tbody>
</table>

| Ministry of Labor | Certificates for Formal Caregivers |
### Ministry of Interior
- Local administration – 77 provinces, 878 districts, and 7255 subdistricts

### Provincial Level
- Screening for dependent older people, including need assessments for long-term care, service options, assistive devices and personal assistants for persons with disabilities

#### In Thailand, the long-term care options for the older population are as follows [49]:

| Stay-in facilities | ◆ 741 community hospitals providing intermediate care and managed by the government  
◆ 60 privately managed nursing homes and 2 managed by the government  
◆ Eight residential homes maintained by the government, another eight by local authorities and 24 residential homes operated by the private sector  
◆ 15 sheltered/community homes;  
◆ Inpatient hospice care and respite care with few nursing homes |
| Day-care centres | ◆ 57 day-care centres for seniors (social events), expected to increase to 877 centres. The Ministry of Welfare, the local administration and communities are involved in management  
◆ Day rehabilitation centre as part of PHCs;  
◆ Dementia day-care centres. |
| Care at home | Comprehensive home health-care programme for older peoples with chronic diseases and disabilities |
| Other services | Provided by health-care/older people’s care volunteers, including home visits, counselling, neighbourhood links, senior activity centres, and social companionship |

Public financing of long-term care is categorized under three groups: universal coverage within a single programme; mixed systems; and means-tested safety-net schemes. Mixed systems include parallel universal schemes, which rely on different coexisting coverage schemes, each providing universal coverage for a different type of care. Typically, universal nursing care is financed through the health system while universal personal care is through a separate scheme [49].

Sources of funds for long-term care of older people in Thailand are through various avenues: (i) older people’s allowance; (ii) Public Welfare Department (PWD) allowances; (iii) volunteer compensations; (iv) Community Health Promotion Fund (National Health Security Office – NHSO); (v) PWD Rehabilitation Fund – NHSO; and (vi) PWD Personal Assistance Fund [49].
Among Thailand’s 1.3 million housebound and bedbound older people, around 10% have received long-term care from the state. In 2016, the government allocated Baht 600 million to provide long-term care to 100,000 older people who have the right to medical services under the country’s universal health-care scheme [67].

As part of the national long-term care project, each care-manager tends to between 35 and 40 older people, while each caregiver takes care of 1 to 10 older people in her/his community. The government has earmarked Baht 5000 per year for every older adult covered by the project. Activities of caregivers are planned and monitored by care-managers. Additionally, an annual budget of Baht 1000 is provided by the district-level hospitals for each older adult covered by the project. Volunteers are provided training in older people’s care by the local administration. The long-term care project provides various services including functional training, psychological support, vital checks, daily-living assistance and personal hygiene care, among others. The long-term care programme was developed for registering care-managers, caregivers and formulating care plans by the Department of Health [67, 68].

Training in different aspects of long-term care, including protocols and guidelines development, is supervised by the Ministry of Labour, Ministry of Education and Ministry of Health. Training for all categories of caregivers is imparted by relevant institutions and hospitals, whereas registration of trainees is undertaken by the Ministry of Commerce assisted by the local administrations [49, 68].

Evaluation of different long-term care options are undertaken through several channels such as social assessment that examines the overall living environment, caregivers and financial status; activities of daily living; medical assessments of special senses, dementia and depression, frailty; resident assessment instruments such as minimal data sets and the resident assessment protocols; and long-term care needs assessment (in collaboration with implementing partner) [49, 68].

Thailand undertook an exercise to identify an integrated model of care to develop a comprehensive set of programmes for long-term care at the community level, while also mobilizing potential resources in the community for supporting older people. At the initial stage, 12 subdistricts (Chiang Rai, Chon Buri, Khon Kaen, Lumpang, Nakhon Ratchasima, Nakhon Sawan, Nonthaburi, Ratchaburi, Saraburi, Surat Thani, Ubon Ratchathani and Yala) were selected. This was followed by the establishment of a working committee, training of relevant counterparts, assessing the capacity for providing support, conducting questionnaire survey of the older population, and analysing and identifying the problems. Extensive networking was established with local administrations, older adults’ clubs, volunteers, community members, and government agencies at various levels [49].

With support from the Department of Health, older adults’ clubs have been established, which are presently 25,314 in number. In recent years, 6,212 clubs have come up with inputs from volunteers. Supporting partners of the Older Adult Clubs initiative are the Department of Health, Provincial Health Offices, Senior Citizens Council Association of Thailand, National Health Security Office, local administrations and others [49].

The key factors for success have been: (i) setting up of long-term care for older people as a comprehensive policy for all levels of the government – central, provincial, district and community; (ii) good collaboration
of all involved sectors; (iii) periodic monitoring, evaluation and enforcement; (iv) recognition of good practice model and exchange of experiences between all levels of the government; and (v) involvement of local administration for the sustainability of the project [49].

At present, considerable responsibility lies with families as caregivers. As the capacity to provide long-term care to older family members will decline with the reduction in family size, this fact has to be taken into consideration. Secondly, the communities need to be strengthened along with an increase in the cadre of paid caregivers. The medical aspect of long-term care will also require social and state support [49].

Health problems of older people living in rural and remote areas are multiple and complex. Awareness of health and related social problems and needs is required, in order to plan and design appropriate programmes and interventions for the care of older people residing in rural and remote areas of the country. This will necessitate cooperation between the local administrations, the health and social sector, and the community [64].

There have been several achievements in the provision of long-term care to older people in Thailand, such as elevating the older people's issue as a national agenda; creation of a database for older people's long-term care; screening for physical and mental conditions of older people and the Long-Term Care Needs Assessment Screening; creation of Older Persons Association (OPA) and volunteer schemes; Community-Based Rehabilitation Program (CBR); older people development centres; institutional long-term care comprising geriatric clinics, intermediate care units, preventive long-term care and faith-based nursing care; National Savings Fund Act, etc. [49, 68].
TIMOR LESTE

Extended families continue to remain the strongest traditional social networks for Timorese people, with the core family unit consisting of a married couple and their unmarried children. In recent years, there has been considerable movement of the population with older family members moving to remain with their families [49].

The focus of health policies in Timor Leste has been on the control and prevention of communicable diseases and improvement of maternal and child health. Health services are delivered through 475 integrated community health service posts (Serviço Integrado de Saúde Comunituária, or SISCA), 216 health posts, 67 CHCs, 5 referral hospitals, and 1 national hospital located in the capital, Dili. Chronic illnesses are on the increase and the government is developing appropriate intervention measures [42]. The Constitution of Timor-Leste gives all citizens the right to security and social assistance, and the State has the obligation to promote an economically sustainable social security system that provides a guaranteed income and support for citizens when they are unable to work. Since 2008, all citizens of Timor-Leste aged 60 years and above, or with proven inability to work, are entitled to a benefit of US$ 30 per month [49].

There is no separate policy, plan of action or strategy for promoting healthy ageing. However – the National Strategic Development Plan (2011–2030), the National Health Sector Strategic Plan (NHSSP) (2011–2030), and the Fifth Constitution of the Government of Timor Leste (2012–2017) – all have mentioned the need for older people’s care and support. The government intends to provide better access to age-friendly and old-age-specific health services, with a focus on improving the skills of primary health providers and introducing community service models, such as home-care programmes [49]. All health and social care services provided by the government are free [54].
Since the issuance of the Decree Law No. 19/2008 Allowance for The Older Adults and Disabled, the number of beneficiaries and the budget have been increasing (Table 10). This benefit is non-contributory in type, and entitlement is based only on the age of the beneficiary [49].

**Table 10. Number of beneficiaries (older people and disabled) and allowances [49]**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of beneficiaries</th>
<th>Budget (US$) in millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>66,799</td>
<td>16.03</td>
</tr>
<tr>
<td>2009</td>
<td>72,675</td>
<td>17.80</td>
</tr>
<tr>
<td>2010</td>
<td>86,977</td>
<td>30.79</td>
</tr>
<tr>
<td>2011</td>
<td>89,230</td>
<td>31.61</td>
</tr>
</tbody>
</table>

The Chronic Disease and Disability Unit in the NCD Department of the Public Health Directorate is the nodal agency for healthy ageing programmes. This unit supervises the conduct of the Livrinho Saude Amigavel ba Idosus (LISAI) for people aged 60 years and above at all health facilities. Under this programme, health services are provided to the older people, information is collected on a regular basis on the health status of the older people, and the home-care component of primary health-care is promoted. The national plan on NCDs control emphasizes health promotion and primary prevention to reduce risk factors for NCDs, including the determinants outside the health sector, and for strengthening the health system for early detection and management of NCDs [49]. Information on NCD-related issues in old age is provided to older people, their families and caregivers [54].

There is no specific long-term care institution or programme for the older people. Community-level care is provided through Timor-Leste’s LISAI or the Age-Friendly Health Care Programme (AFHCP) for those aged 60 years and above. Similarly, no specific training programme for the health-care of older people has been developed so far. The Chronic Disease and Disability Unit provides training to health workers on the implementation of LISAI or the AFHCP for those aged 60 years and above. There is no special health and social support programme for older women; therefore, these women avail the health services provided through the usual health system and the LISAI. The usual social benefit of US$ 30 per month is also applicable for older women [49].

The government emphasizes on home-care programmes, which have been found to be cost-effective with regard to care delivery and are preferred by older people. Health staff have found that addressing the health issues of the older people at home provides better information on the status of older people, as well as on the prevalent social and economic conditions [49]. As part of the integrated services for family health, monthly routine home visits are conducted for the delivery of health services to the older people [54].

A proposal has been made to develop a national strategy for healthy ageing, including long-term care along with improvement in the quality of health-care for older people [49].
Conclusion

Long-term care is a key component of the 10 priorities set by WHO for the Decade of Healthy Ageing. This priority will support countries to develop effective, sustainable and equitable systems and services to improve care for the older people with significant loss in intrinsic capacity, and to reduce the burden on caregivers. Similarly, the Regional Framework on Healthy Ageing, 2018–2022, proposed by the WHO Regional Office for the SEA Region also prioritizes long-term care as one of its major guiding principles.

Demographic and epidemiologic transitions are resulting in dramatic increases in the proportion of older people in the world, where longer life expectancies and chronic disabilities of old age are impinging upon the health and social fabric of the countries. Increasing prevalence of chronic disabilities and morbidities of long duration among older people, and dwindling capacities of the informal/family support mechanisms in taking care of rising long-term care needs of older people, urgently require public policies to address the consequences of these changes.

While the issue of long-term care was previously associated with high-income/developed countries, a rapid increase in the proportion of older people in most parts of the developing world has resulted in a situation where the need for long-term care of older people becomes a significant public health challenge. Moreover, these developing countries are experiencing increases in long-term care needs at levels of income that are far lower than what existed in the industrialized world when these needs emerged.

Seven of the 11 Member States of WHO SEA Region have national policies concerning long-term care. The formal as well as informal demand for long-term care has been on the rise, with a paradigm shift in the pattern of morbidities and the changing caregiver system in the Region. With increasing life expectancy, increasing prevalence of NCDs and resulting complications such as stroke, increasing prevalence of neurodegenerative diseases such as Alzheimer’s disease and other forms of dementia, and Parkinsonism, the need for a long-term care policy cannot be ignored.

In Member States of the Region, most of the responsibility of long-term care is borne by the family, especially by the women of the family who are neither acknowledged nor paid for their contribution. On the one hand, the lack of skills in the family-based caregivers leads to a suboptimal and under-quality care of frail, dependent and disabled older people; on the other hand, the burden of enormous care takes a toll on the caregivers resulting in physically as well as mentally devastating caregiver burn-out. It also deprives them of their access to education, employment as well as recreation, which in the long run, has a negative impact on family, society and the nation as a whole.

The absence of formal long-term care initiatives poses challenges in the successful achievement of the goals set for healthy ageing, as long-term care is an integral component of the healthy ageing initiative. It should be noted that as the countries are struggling against communicable diseases, maternity and child-
related issues, holistic old-age care has emerged as another big challenge. A number of challenges are
countered in ensuring adequate health and related care to older people in the Region. It is the reduction
in the size of the workforce which has led to an increased dependency ratio for the older population; a
change in the family structure and lifestyle due to the disappearance of extended families; increased
out-migration of the younger population; and an insufficient number of human resources to address the
emerging geriatric and gerontological needs of the older population. These are topped up by a lack of
appropriate health facilities and geriatricians to provide special care to older people.

In most countries, the minimally existent formal long-term care system is managed by community-based
organizations, which survive on charity and donations. In recent years, privately run old-age homes and
day-care centres, and home-based nursing agencies are also sharing a smaller proportion of the overall
mammoth burden of long-term care. The primary issue with regard to such organizations is quality-control
resulting from the unavailability of national guidelines governing them.

Thus, the countries of the WHO SEA Region need a fully integrated sustainable long-term care system,
which should be incorporated into the existing health-care system. Governments can facilitate meetings
among stakeholders to discuss and decide what needs to be done, and who will be responsible for what.
Though a wide range of stakeholders will be involved in the process, only governments can manage long-
term care systems. UHC should be an integral component for the sustainability of long-term care strategies.
Formal long-term care is in a state of infancy in many countries of the Region. Therefore, all Member States
of the Region should formulate policies for long-term care, which would be effectively implemented for
successfully achieving the goals of Healthy Ageing.
References


57. The state of elderly in India 2014: HelpAge India. New Delhi, India; 2015


<table>
<thead>
<tr>
<th>Page</th>
<th>Photo description</th>
<th>Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover page</td>
<td>Lady doctor checking up an old man in Indonesia</td>
<td>WHO/Budi Chandra</td>
</tr>
<tr>
<td></td>
<td>Ladies sitting on a mat in Thailand</td>
<td>WHO/SEARO/MoPH</td>
</tr>
<tr>
<td></td>
<td>Old man in a museum in India</td>
<td>WHO/Anuradha Sarup</td>
</tr>
<tr>
<td></td>
<td>A group of older people in DPR Korea exercising</td>
<td>WHO/DPR Korea</td>
</tr>
<tr>
<td></td>
<td>Women in Thailand exercising</td>
<td>WHO/SEARO/MoPH</td>
</tr>
<tr>
<td></td>
<td>An old man in Indonesia walking</td>
<td>WHO/Budi Chandra</td>
</tr>
<tr>
<td></td>
<td>Two women in Myanmar sewing</td>
<td>WHO/Myanmar</td>
</tr>
<tr>
<td></td>
<td>A group of ladies in Sri Lanka exercising</td>
<td>WHO/Sri Lanka/SUVEE</td>
</tr>
<tr>
<td></td>
<td>An old woman helping a girl child in India</td>
<td>WHO/Anuradha Swarup</td>
</tr>
<tr>
<td></td>
<td>Older women selling vegetables in Sri Lanka</td>
<td>WHO/Sri Lanka/SUVEE</td>
</tr>
<tr>
<td>Page 1</td>
<td>An old woman measuring blood pressure in India</td>
<td>WHO/Anuradha Sarup</td>
</tr>
<tr>
<td>Page 7</td>
<td>An older-aged couple riding a bike in Thailand</td>
<td>WHO / SEARO /MoPH</td>
</tr>
<tr>
<td>Page 11</td>
<td>A woman in Timor Leste exercising</td>
<td>WHO/SEARO/Joao Soares GUSMAO</td>
</tr>
<tr>
<td>Page 25</td>
<td>A mother and a friend at a resettlement camp in Galle, Sri Lanka</td>
<td>WHO/ SEARO / Gary Hampton</td>
</tr>
<tr>
<td>Page 26</td>
<td>A group of old-aged people in DPR Korea exercising</td>
<td>WHO/DPR Korea</td>
</tr>
<tr>
<td>Page 29</td>
<td>A group of ladies sitting on a bench in a park in India</td>
<td>WHO/Anuradha Sarup</td>
</tr>
<tr>
<td>Page 31</td>
<td>A group of older males in Indonesia sitting</td>
<td>WHO/Budi Chandra</td>
</tr>
<tr>
<td>Page 37</td>
<td>An old-aged couple dancing at a ceremony in Thailand</td>
<td>WHO / SEARO /MoPH</td>
</tr>
<tr>
<td>Page 38</td>
<td>An old man sitting in a makeshift shanty in Bangladesh</td>
<td>WHO/Bangladesh</td>
</tr>
<tr>
<td>Page 40</td>
<td>An old woman with a young girl and a child in Bhutan</td>
<td>WHO / SEARO /Nani Nair</td>
</tr>
<tr>
<td>Page 42</td>
<td>An older woman with a young girl and a boy in DPR Korea</td>
<td>WHO/Whitney, Dale</td>
</tr>
<tr>
<td>Page 43</td>
<td>A few people exercising in an open gymnasium in India</td>
<td>WHO/SEARO</td>
</tr>
<tr>
<td>Page 49</td>
<td>People cycling in Indonesia</td>
<td>WHO/Budi Chandra</td>
</tr>
<tr>
<td>Page 52</td>
<td>An older woman sitting under a tree in Maldives</td>
<td>WHO Maldives</td>
</tr>
<tr>
<td>Page 55</td>
<td>An older man measuring blood pressure in Myanmar</td>
<td>WHO Myanmar</td>
</tr>
<tr>
<td>Page 57</td>
<td>An older lady getting a check up from a doctor in Nepal</td>
<td>WHO Nepal</td>
</tr>
<tr>
<td>Page 59</td>
<td>Nurse distributing medicines to women in Sri Lanka</td>
<td>WHO Sri Lanka/SUVEE</td>
</tr>
<tr>
<td>Page 65</td>
<td>A group of older women dancing in Thailand</td>
<td>WHO / SEARO /MoPH</td>
</tr>
<tr>
<td>Page 66</td>
<td>An old woman sitting in Timor Leste</td>
<td>WHO Timor-Leste/Shobhan</td>
</tr>
</tbody>
</table>