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Aging under the one-child policy: long-term care needs and policy choices in urban China

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Abstract: China contains one-fifth of the world's aging population. It has been estimated that a total number of 33 million older adults have suffered activities of daily living (ADL) deficits, which consists of about 19% of the total aging population. To date, a national long-term care policy is not in place. This paper identifies and discusses key historical and contextual factors that affect long-term care policy development, including the one-child policy, cultural values toward family care, and the unbalanced development of health and social care. We show how two long-term care models developed in Beijing and Shanghai set a desirable benchmark for a balanced development of community-based and residential care. However, there is no consensus on key criteria that should be considered on needs assessment. Finally, we argue that a needs assessment including health, finances, and family aspects of needs, instead of age, should be considered in policy development.

Keywords: China; long-term care; needs assessment; one-child policy; family care.

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1 Introduction

China is an aging society that contains one-fifth of the world's aging population, according to the United Nation's estimation (United Nations Department of Economic and Social Affairs Population Division, 2008). According to the latest population census in China (National Bureau of Statistics of China, 2011), the total number of people aged 60 or above has reached 178 million and counted for 13.26% of the total population. Among them, 119 million people were aged 65 or above, which comprised 8.87% of the total population, and about half lived in urban China.

Even though aging is not bound to disability, it has been observed that aging is associated with an increased probability of disability. According to a nationwide study conducted by the China Research Centre on Aging (2011), it was estimated that a total number of 33 million older adults in China have suffered activities of daily living (ADL) deficits, which consists of about 19% of the total aging population. In urban China, on average, about 5% of the aging population had severe deficits in ADL; while the percentage in middle and western China was 2–3% higher, as compared to east coast of China. In the same study, it was estimated that this group of frail older adults would continue to increase in both total numbers and the percentage of the total aging population in the coming half-century in China. Thus, undoubtedly, long-term care needs and policy responses are a critical concern at the national level.

With the aim of exploring better policy responses to long-term care needs in urban China, this paper first examines the current aging policy in China and its association with long-term care needs. It then highlights historical and contextual circumstances for older adults who have been aging under the one-child policy in urban China and finally argues that one's health and finances needs, as well as family needs, should be taken into consideration as key criteria of needs assessment when developing long-term care policies in urban China.

2 The aging policy in China and its association with long-term care needs

The aging policy in China has been guided by the ‘Six Haves’ framework, which was stated in the People’s Republic of China Law on the Protection of the Rights and Interests of Older People (Steering Committee of the National People’s Congress of the People’s Republic of China, 1996). The ‘Six Haves’ policy objective framework aims to:

- 1 ensure that older people have been taken care of
- 2 have healthcare
- 3 have an updated knowledge about social development and the aging policy
- 4 have social participation
- 5 have learning opportunities
- 6 have happiness in late life.

This policy framework takes a holistic approach that covers the financial, physical, psychological, social, and spiritual aspects of aging.

Nonetheless, the ten prioritised policy directions were defined in the most recent guiding policy document “The twelfth five-year plan for aging policy in China” failed to differentiate long-term care policy objectives (China National Committee on Aging, 2011). These ten directions, which included:

- 1 enhancing social security
- 2 safeguarding healthcare
- 3 strengthening the family
- 4 developing an elder care system
- 5 bettering the living environment
- 6 promoting the silver market
- 7 enriching spiritual and culture life
- 8 consolidating community organisation management
- 9 ensuring legal protection
- 10 encouraging international research collaboration.

These ten directions can be interpreted as interrelated areas that target older people with or without long-term care needs. In this sense, to date, there has been no long-term care policy and/or framework at the national level in China.

Nevertheless, compared to “The eleventh five-year plan for aging policy”, this most recent five-year plan was dedicated, for first time under one prioritised policy direction, entitled “Developing an elder care system” to providing for the long-term care needs of frail older adults (China National Committee on Aging, 2006). Under this policy direction, it is clear that the government wishes to encourage older adults to age at home by integrating community resources into their care and developing community services. Residential care facilities are expected to be enhanced and secured for long-term care purposes (China National Committee on Aging, 2011). Even though the phrase ‘aging in

place' was not in use, the principle and spirit of aging in place was primed (Burgess and Burgess, 2006). Led by this national guiding policy document, the government, at municipal and provincial levels, is expected to develop policy objectives and initiatives, based on local social and economic development conditions in their corresponding twelfth five-year plan (Chan et al., 2008). Hence, it is timely to discuss key criteria that should be considered while developing a policy at various administrative levels.

3 Long-term care needs under the one-child policy

According to a World Health Organization study, the development and implantation of a long-term care policy in developing countries should take full consideration of a country's cultural and social context including epidemiology, available resources, cultural values, urbanisation, strength of informal care and the stage of development of health and social care (World Health Organization, 2003). We identified three key social cultural contexts that should have priority in China's consideration: the one-child policy and its impacts on the aging population, cultural values toward family care and filial expectations towards children, and the unbalanced development of health and social care in China.

3.1 The one-child policy and its impacts on the aging population

The one-child policy was initiated in the late 1970s as one of the most influential national policies in China's history, as it aims to decrease the fertility rate and, in turn, control population growth (Steering Committee of the National People's Congress of the People's Republic of China, 2001). Regardless of the debate on the policy's positive and negative impacts on China's development (Hesketh et al., 2005; Hvistendahl, 2010), three impacts can be recognised on the aging population. First, it speeded up the population aging process in China. While it took 115 years for the population aged 65 or above to increase from 7% to 14% in France, this happened in China over 27 years (National Institute on aging, National Institutes of Health, U.S. Department of Health and Human Services, & State, 2007). Consequently, China has been facing challenges of economic development parallel to its aging population. Within China, less developed geographic areas (e.g., the middle and western regions) are going to face greater challenges as compared to comparatively more developed geographic areas (e.g., the east region).

Second, as it is estimated that parents of the first generation of children born under the one-child policy in China will continue to being to age **till 2013**, family structure will be significantly impacted. A recent census reported that the average household size has decreased by 0.34 to be 3.10 people in 2011, as compared to 2000 (National Bureau of Statistics of China, 2011). The '4-2-1 family' (four grandparents, two parents, and one child) will become popular, together with older parents living separately with adult children, which will have serious implications on the capability and feasibility of families alone taking care of frail older adults (Settles et al., 2008).

Third, new urban, vulnerable groups emerged, which are different from the traditional 'Three Nos' (people with no income, no working ability, and no legal guardian) **and which deserve new policy responses**. For example, new urban poor, due to unemployment and old age combined with a lack of income protection, has emerged, and

a minimum standard of living scheme (MSLS) has been developed as a policy response in urban areas (Gao et al., 2009).

From a long-term care needs' perspective, in addition to older age and people with financial constraints, there is another vulnerable group – frail older adults made childless by the death of their only child – deserves policy responses as well. It was estimated that there were about 300,000 women aged 49 or above whose only child died in 2007, and this number will increase to 1.1 million women by 2038 (Wang et al., 2008). Using the 6% ADL deficit rate in an estimate, there will be about 137,000 frail, childless women in China in the coming three decades (China Research Centre on Aging, 2011). Until now, the financial needs of childless parents have been recognised, and a policy response is in place. The Population and Family Planning Commission (2007) designed a special cash allowance for parents who lose their only child when the mother reaches 49 years of age, at which their level of support was decided by different municipal and provincial governmental bodies. However, it can be estimated that financial aid will not be sufficient to support this group of childless parents as they handle their long-term care needs, and premature institutionalisation could be triggered.

3.2 Cultural values towards family care and filial expectations towards children

Chinese cultural tradition has emphasised the family's responsibility in taking care of older adults. Such tradition has been ensured at the ideological, institutional and behavioural levels in China. At the ideological level, the filial responsibility of children is implanted during the socialisation process and normatively expected in society. As a result, older adults are expected to be cared for at home by family members, children in particular (Chow, 2009; Tang, 2009). Even though the daily operations of filial responsibility has undergone changes, moving parents to institutions still causes negative feeling as it is violating the social norm (Zhan et al., 2006).

At the institutional level, the law on Protection of the Rights and Interests of Older People clearly describes that a family has the responsibility to provide financial and emotional support and daily care to older adults in health and/or ill-health conditions (Steering Committee of the National People's Congress of the People's Republic of China, 1996). A recent amendment enacted in July 2013, brought up 15 years after the enactment of the law, called for more emotional care from children towards their elders (Steering Committee of the National People's Congress of the People's Republic of China, 2012), revealing the government's intention to further strengthen the institutional power of a family's responsibility for taking care of older adults.

At the behavioural level, the family most certainly plays a significant role in taking care of frail older adults in China. According to recent statistics, there are about 4,000 elderly homes in China, which are housing around 2,109,000 older adults. Among them, only 17% have long-term needs. Hence, the majority of frail older adults are being cared for in families, within which spouses, children, and children-in-law are the three major family caregivers (China Research Centre on Aging, 2011; Ministry of Civil Affairs of the People's Republic of China, 2010).

In summary, family care has dominated and will continue to dominate long-term care arrangements in China. Children, followed by spouses, take key responsibilities in taking care of frail parents. For families that complied with the one-child policy, these parents lose family support in their old age if their only child dies prematurely. Hence, childless

older parents are an emerging vulnerable group with regard to the long-term care needs fulfilment, and the situation deserves a policy response.

3.3 *Unbalanced development of health and social care*

Under the open-door policy, healthcare in China has been transformed from a highly planned government supported and managed system into a decidedly decentralised and partially privatised system (Yip and Hsiao, 2009). Since the establishment of the People's Republic of China in 1949 through the late 1970s, China made great achievements in healthcare outcomes due to its comprehensive health policy and wide coverage of healthcare delivery. However, after the open-door policy was implemented, healthcare inequality has become a key, unintended consequence impacting China (Wang et al., 2007). Basically, healthcare resources are unbalanced across their distribution, with more resources allocated for the east coast of China than for middle and western China (Ministry of Health of the People's Republic of China, 2010). Since long-term care needs fulfilment cannot be separated from current available healthcare resources, it is reasonable to argue that the capacity and feasibility for the provinces in middle and western China to provide long-term care support at the community level for a huge and growing population is in doubt. A long-term care policy, at least in the short run, should adopt a selective approach that targets those most in need, instead of providing universal benefits.

With regard to the long-term care system, while the majority of the provinces have not developed social care policies, there are two dominant models: those developed in Shanghai and Beijing. Shanghai has had established a comprehensive policy in response to its citizens' long-term care needs since 2000. In Shanghai's 11th five-year plan, it set up policy framework '9073', which stated that 90% of older adults would depend on family care (including paid full-time and/or part-time home helpers, *Bao Mu*), 7% of older adults would use community-based services, and 3% of older adults would benefit from institutional care (Shanghai Committee on Aging, 2006). Under this framework, Shanghai developed a comprehensive assessment tool as a single entry point for eligibility assessment and a community long-term care voucher system, in which consumer direction was part of its merit (Shanghai Civil Affairs Bureau, 2009).

In 2010, the government of Shanghai also developed a service standard for a community-based, long-term care service, which, together with a service standard for residential care services, comprised a comprehensive long-term care standard (Shanghai Civil Affairs Bureau, 2010; Shanghai Government, 1988). In some districts in Shanghai, *Jin An* district for example, the Shanghai Gerontology Association was designated as an independent body to evaluate community-based long-term care services (Shanghai Civil Affairs Bureau, 2011).

Some provinces in China have recently mirrored the Shanghai model. In 2010, several cities and counties in *Zhe Jiang* province and *Tian Jin* started a trial on long-term care eligibility assessment (Zhejiang Civil Affairs Bureau, 2010). Regardless of the advantages of the Shanghai model, the Shanghai model is basically under the leadership and management of the Civil Affairs Bureau, with only limited integration with healthcare resources.

In 2009, Beijing developed a '9064' model that targeted both elderly people and people with disabilities (Beijing Civil Affairs Bureau, Beijing Disabled Persons' Federation, 2009). It stated that 90% of older adults depend on families, 6% depend on

community-based services, and 4% depend on residential care facilities. As compared to the Shanghai model, the Beijing model has the advantage of integrating resources for disabled people and the elderly with medical resources (Table 1). However, it did not include an eligibility assessment for people older than 80 and no service standard has been developed.

Table 1 A comparison of Shanghai and Beijing's long-term care model

	<i>Shanghai</i>	<i>Beijing</i>
Model (year of establishment)	9073 (2000)	9064 (2009)
Policy body	Shanghai Civil Affairs Bureau	Beijing Civil Affairs Bureau Beijing Disabled Persons' Federation
Eligibility criteria for government subsidy	60–99, fulfils needs assessment criterion, low income, MSLS family, or having special contributions	Disabled person (15 or above)
	80 or above, fulfils needs assessment, co-payment (15% government, maximum 150RMB per month)	Older person (80 or above)
Government subsidy mode	Voucher (can be used for both community and residential care services)	Voucher (can be used for community-service only) Elderly care Disability care
Benefits for those who are eligible for full subsidy (RMB per month)	Sliding scale based on level of disability Mild level: 300 Moderate level: 400 Severe level: 500	16–59 severely disabled, economic non-active: 100 60–79 severely disabled: 100 80–99: 100 100 or above: 100, medical supplement
Service scope	Personal care (meals, personal hygiene, bathing) Housekeeping (cleaning, laundry) Health and rehabilitation (escort for medical consultation, rehabilitation service) Social care (outings, reading books, chatting) Others (emergency call system)	Personal care (meal service, hair cut) Housekeeping (house cleaning, house repair, laundry) Health and rehabilitation (community health clinic, rehabilitation service) Social care (post office, reading books, chatting, community centre) Others (purposefully designed mobile device with telephone and other functions)

Table 1 A comparison of Shanghai and Beijing's long-term care model (continued)

	<i>Shanghai</i>	<i>Beijing</i>
Fee charges (RMB per hour)	Personal care: 25 Housekeeping: 12	No charges
Administration	Community-care centre	Community centre for elderly and disabled people
	Contracting out to people-run non-enterprise units (<i>Min Ban Fei Qi</i>)	Contracting out to various service providers in the community
Financing	Fee charge, welfare lottery fund, medical insurance designated fund, unemployment insurance, training fund for floating population, government revenue	Welfare lottery fund, employment fund for disabled people, unemployment insurance, government revenue
Service recipients	(2009) 219,000 people (129,000 government subsidised; 90,000 out-of-pocket pay)	(2010) 421,000 people (subsidise 0.43 million, reimbursed 0.41 million)

The above discussion showed that health and social care resources are unbalanced across their distribution in China. Even in the most richly resourced cities, such as Shanghai and Beijing, long-term care models target a select group of people to be provided with a government subsidy. This implies that a selective approach in regard with long-term care subsidies may be a future development direction.

4 Analysis and policy recommendations

Based on the previous discussion, we argue that while the balanced development in community-based and residential-based services is desirable, there is a need to consider not only an aging person's health and finances but also his or her family needs when developing a selective welfare model for a long-term care policy in urban China.

4.1 Where to provide care: community-based vs. residential-based programmes

As China is still lacking a long-term care policy, international experiences can be used as a learning tool, and mistakes can thus be avoided. It is promising to note that China's top leader, who is responsible for developing an aging policy, was aware that development balanced between community-based and residential-based long-term care policy is desirable for achieving aging in place (Yan, 2007). Learning from the two pioneered long-term care models in Beijing and Shanghai, it should also be noted that the initial trail set the institutional beds rate at 3–4%, while community care was targeted to serve 6–7%, which is almost doubled its capacity. Even though a national long-term care policy has not been fully present, for less developed geographic areas, including middle and western China, the two models can be regarded as setting a benchmark, which stands at

the lower end of the institutional rate from the international perspective (Organization for Economic Co-operation and Development, 2005).

4.2 Principles: universal vs. selective approach

Long-term care means long-term commitment, and hence, policy responses should consider the economic dimension of social policy. Two basic principles have been identified as playing significant roles in decision-making: economic efficiency and a welfare ideology of equity (Waldfoegel, 2000). After the decentralisation and marketisation of welfare in the late 1970s, universal benefits have been replaced by selective welfare, which targets people who join social insurance (e.g., pension, medical, housing, unemployment) or are vulnerable due to financial constraints (e.g., MSLS) in urban China (Lin, 2009). With regard to long-term care, there has been no consensus on key criteria that should be considered in policy development. Age, health needs, and financial constraints are considered in the Beijing and Shanghai models. For those aged 60-99, Shanghai targets people who show long-term care needs based on a standardised assessment and those people who have financial constraints. The Beijing model targets those who are severely disabled, aged 15 to 79. Universal benefits are targeted for those aged 100 or above in Shanghai and 80 or above in Beijing.

While many of those with long-term care needs belong to the highest age group in the population, long-term care basically is needed by those who “have become dependent on assistance with basic activities of daily living due to long-standing physical or mental disability” (Organization for Economic Co-operation and Development, 2005). Hence, it is unwise either to confine long-term care to a certain aged people (e.g., Shanghai) or to assume that every older person needs long-term care when they reach certain age (e.g., 80 in Beijing and 100 in Shanghai). When targeted service recipients are incorrectly directed, long-term resources, which are limited in any society, cannot be fully utilised, and the economic efficiency of the corresponding policy will be affected (Fujisawa and Colombo, 2009). Hence, it is desirable to define long-term care needs based on a needs assessment instead of age.

In addition to health and financial needs, we argue that family needs should be considered when developing a long-term care policy, in which childless parents should become a prioritised long-term care policy target. This group of frail older adults might or might not have financial difficulties, but they often will lack of support with regard to care management, including decision making in long-term care arrangement, liaising with care providers, and/or receiving family emotional support. They are vulnerable, in part due to their compliance with the one-child policy, which they followed for the sake of the country, and it would be legitimate for them to receive compensation so that equal opportunity for aging in place can be achieved (Engelman and Johnson, 2007).

5 Conclusions

With China housing one-fifth of the world’s aging population, long-term care is an urgent issue that deserves a policy response. We identified three historical and contextual factors that have unique impacts on the emerging long-term care needs: the one-child policy, traditional values and family care, and the unbalanced development of health and social care. Hence, we argued that in order to develop a better solution to fulfil the long-term

care needs in urban China, health needs, financial needs, and family needs should be simultaneously considered as key criteria so that limited resources can target those most in need for achieving aging in place.

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