"Characteristics of Urban Elderly Care Recipients in Singapore, China and Indonesia"

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Abstract

Using large datasets on elderly care in Singapore, China and Indonesia, this paper will describe and compare the characteristics of elderly care recipients in an urban setting. The datasets used are the Singapore Informal Caregiver Survey 2011, the Chinese Longitudinal Healthy Longevity Survey 2008 and the Indonesia Family Life Survey 2007. The minimum individual age covered in the Singapore and China datasets is age 75 and individuals observed have at least 1 ADL limitation. The minimum individual age covered in the Indonesia dataset is age 60 and individuals observed have at least 1 ADL limitation. We describe the demographics, living arrangements, physical health, self-rated health, health and social care utilization; and socio-economic status of the elderly care recipients and their care givers. Given the different levels of economic growth, institutional contexts and the extent of healthcare in each country, we will explain for the different patterns of care that the elderly receive.

1. Introduction

Given the twin demographic challenges of longer life expectancy and decreasing fertility faced by Asian countries, families are under pressure in their role as care providers of aged parents and relatives. The Asian family is the traditional cornerstone of care for elders, being the primary source of care. They provide time, money, goods; and instrumental and emotional support for older adults. However, with economic growth in the Asian region, younger members of the family may no longer co-reside with older members, may be of further proximity or may have to manage the time tradeoffs between employment and caregiving. Consequently, the elder may not only receive care from a primary or sole care-giver but also from others within the elder's family or larger family network. Also with higher household income, the care recipient or family will then have the choice to purchase available community care services. But the availability of community care may be dependent on how public institutions are set up. The extent to which a national level healthcare system and social welfare system are established to provide old-age care will be dependent on a country's existing institutions.

This empirical paper examines the characteristics of urban care recipients in Singapore, China and Indonesia in terms of care recipient family networks, household income and types of old-age benefits available. While Asian values and practices of filial piety drive the extent of informal care received in all three countries, it is predicted that how public institutions are set up to provide healthcare and social welfare will influence how much informal and formal care are received. In this paper I focus on only comparing older adults with at least one limitation in activities of daily living (ADL); and residing in the urban centers of the three countries. Singapore, a developed country is fully urbanized and given the size of the city state, home and community based care (HCBC) is widely available (Wu and Chan, 2012). The urban centers of the large developing country China provide public old-age pensions, a legacy of the socialist state's retirement program from the early 1950s (Lee and Xiao, 1998). Rural old-age insurance was only recently introduced in 2010 (National Bureau Statistics of China). The urban Chinese with retirement income will then have a different set of old-age care choices compared to their rural counterparts. In contrast, the other large developing country Indonesia has minimal old-age care provisions. Older adults in Indonesia mostly receive care through social assistance programs such as health, education and rice subsidies. The elderly have benefitted from these programs on account of being heavily concentrated among poor households (Schröder-Butterfill, 2002). Only urban dwellers in government, the military and industry receive pensions (Phillips, 2002). As such, urban Indonesians are more likely able to access health and social care services.

Upon having described the institutional context of Singapore, China and Indonesia, I examine the characteristics of urban care recipients using comparable survey data from each country. I then proceed to study how care outcomes may be similar or different in each of the three countries. Using linear regressions, I analyze the relationship types of the informal care providers that make up the family networks; and how income and old-age benefits may affect the care mix received, given the older adults' health status, measured using ADL limitations and self-reported health (SRH).

2. Healthcare and Social Welfare Systems

2.1. Singapore

The current population of Singaporean citizens and permanent residents is 3.9 million and 8.9% of the population is aged 65 and over. The GDP per capita of the country was US$36,738 in real US dollar terms in 2008 (World Bank). Annual health expenditure as a percentage of GDP was 3.6% in 2008 (World Bank). Public expenditure on health as a percentage of total health expenditures was 31.9% in 2008 which was lower than China and Indonesia (World Bank). By gender the life expectancy for men is 79 years while for women it is 84 years (Singapore Census of Population, 2010). The current total fertility rate (TFR) is below replacement rate at 1.16. To finance healthcare, Singapore developed an individual medical savings account (MSA) system for the population. The individual MSA system consists of private healthcare financing which includes savings in individual accounts that are restricted to specific health care spending such as hospitalization expenses. These accounts are a part of the country's social security Central Provident Fund (CPF). Kin members such as adult children can make transfers from their MSA to their aged parents' MSA to pay for health care spending. This cost containment system has enabled public expenditure on healthcare as a proportion