第二届
世界养老院院长领导大会
暨2012年APIAS-TSAO-ILC
积极老龄化研讨会

从政策与实践
促进老年人的健康与福祉

The 2ND
INTERNATIONAL LEADERSHIP ASSEMBLY of Nursing Homes
CUM **APIAS-TSAO-ILC SYMPOSIUM**
for Junior Researchers on Active Ageing 2012

ADVANCING HEALTH AND WELLBEING OF OLDER PERSONS
THROUGH POLICY AND PRACTICE

June 27-28, 2012

Harbour Plaza Resort City, Hong Kong
2012年6月27–28日 香港嘉湖海逸酒店

场刊 Programme

ORGANIZERS
主办单位

亞太老年學研究中心
Asia-Pacific Institute of Ageing Studies

Lingnan 嶺南大學 University

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Welcome Message
欢迎辞

It is our pleasure to invite you to the 2nd International Leadership Assembly of Nursing Homes cum APIAS-Tsao-ILC Symposium for Junior Researchers on Active Ageing 2012 in Hong Kong this summer.

The Asia Pacific region is currently at the forefront of a global demographic transformation with the number of old3er persons rising at an unprecedented pace and a scale unmatched by that of any other region in the world. The year 2012 marks the 10th anniversary of the Madrid International Plan of Active Ageing and serves as prime time for gathering all regional stakeholders for the sharing of best practices through resaerch, experience and policy.

The Asia-Pacific Institute of Ageing Studies, Lingnan University, China International Association of President of Nursing Homes, together with the International Longevity Centre (ILC) Singapore are confident that this will be successful event with your full participation.

We look forward to meeting you all!

Mrs. Yunhua LIU
Prof. Alfred Cheung-ming CHAN PhD BBS JP

Chairman & Co-Chairman of the Conference Organizing Committee

我们诚邀阁下参加今夏于香港举行之「第二届世界养老院院长领导大会暨2012年APIAS-TSAO-ILC积极老龄化研讨会」。

亚太区正站在全球人口结构改变的前缘，老年人口急速增长属前所未见，规模之大实全球其他地区不能比拟。2012年是《马德里老龄问题国际行动计划》签订后的第十年，正好汇聚地区贤达，就研究、实践及政策上所累积的优良经验交流分享。

在您的鼎力支持下，岭南大学亚太老年学研究中心、中国国际养老院院长协会、以及新加坡国际长寿中心（ILC）深信，会议定能取得空前成功。

我们恭候您的莅临！

刘蕴华女士
陈章明教授BBS太平绅士

筹委会主席及联合主席

"Officiating Address"

SECRETARY-GENERAL, RETIRED STAFF MANAGEMENT BUREAU, MINISTRY OF CIVIL AFFAIRS, CHINA
MR. GUOYING WANG (MRS. ZHIHONG YU)

Commissioners, distinguished guests and presidents of nursing homes,

Welcome!

First, on behalf of the Retired Staff Management Bureau of Ministry of Civil Affairs, I sincerely congratulate on the successful opening of the symposium, and would like to pay tribute to all commissioners, guests, presidents and friends who attended the symposium. Meanwhile, I would like to express my gratitude to the concerns and support of aged care industry from both at home and abroad. With every good wish for complete success of the symposium.

Today we are here to participate the international leadership assembly of nursing homes, which I think is a significant action. We are inspired, excited and encouraged to achieve the goal of aged care industry in our country under the "Twelfth Five Year Plan". The aged care industry has a broad space for development, the successful opening of this symposium indicates the development of aged care industry in China is now in line with international aged care industry, and also reveals our exploration and innovation of new ideas, new methods and new models for aged care. This has great significance and acts as a meaningful guidance to launch activities of nursing and caring of elderly by presidents of Chinese nursing homes.

This symposium focused on the trend and developmental needs of aged care in China, as well as the implementation of measures of aged care planning from the "Twelfth Five Year Plan". During the time of the "Twelfth Five Year Plan", by using families, communities and institutes as solid foundation, China will establish a social aged care service system to satisfy multi-level and diversified needs of the elderly care services, which is able to cope with the growth of ageing population and also able to reach the high standard set by socio-economical development. The "Twelfth Five Year Plan" proposed to encourage communities to set up nursing homes for elderly, to increase the number of nursing home beds by 300 millions, as result doubling the total number of nursing home beds. This plan brought a lot of development opportunities. I think the association of nursing home presidents will play the role as bridge and link, to provide leadership for all nursing home presidents and for those who work in the aged care industry, to continuously improve the management standard and nursing care quality of nursing homes, and to promote the development of aged care industry along with the harmonious social development in creating a prefect social environment. I hope the association can help all presidents in learning new concepts and ideas, finding out development needs that suitable for themselves quickly, and paving path to innovation.

In order to build a harmonious society, more and more concerns and supports from all sectors of our society are needed. We need more people with love and care to work for the aged care industry. By fully utilizing the social status and policy advantageous of nursing homes, together with the support from our country and civil affairs system, we are trying to promote a modern concept and model of elderly care, advocate the leisure and lifestyle of elderly living in nursing homes.

Aged care industry is an industry with certain risk that requires huge investment, but can only generate small income with long periods before investment return. Management and operation of nursing homes is also a process that needs long term accumulation of experiences, we all know that there are many problems pending to be solve. Government is now encouraging communities to set up their own nursing institutes, allowing private capital investment of the aged care industry and operation of profit making nursing homes. However, there are still some regulations and rules that need to be developed and refined, like how to deal with the management risk of nursing home, how to tackle the compensation problems caused by medical disputes, how to monitor caregivers of nursing institutes and train them up to standards, how to protect the legitimate rights and interests of elderly and so on. In order to establish comprehensive measures, we need mutual communications and learning, so that we can avoid unnecessary set back and promote positive growth of nursing institutes to ensure stable long term development of nursing homes.

Respect for elderly. To guide and to prompt the orderly development of aged care industry is a big issue for Party and government. Guests and nursing home presidents who attended this symposium are very experienced with great love and care, they will surely contribute to the innovation and development of the aged care industry, as well as will become a driving force to build a harmonious society. Through this international leadership assembly, I hope everyone can learn about new concepts and models of aged care and devote their own efforts in the aged care industry of China.

Thank you!

「在第二届世界养老院院长大会暨积极老龄化研讨会上的致辞」

中国民政部离退休干部局局长
王国英（于志宏）

尊敬的各位领导及嘉宾、各位院长朋友们：

大家好！

首先，我谨代表民政部离退休干部局对此次大会的胜利召开表示热烈祝贺，并出席此次盛会的各位领导、嘉宾、院长、朋友们表示由衷的敬意，同时，真诚感谢国内外各界人士对养老事业的关注和支持。衷心的预祝本次大会取得圆满成功。

今天，我们在这里召开世界养老院院长的国际会议，我认为是十分必要的，「十二五」时期，我国养老事业的目标任务令人鼓舞，也更加令人期待，蕴藏着巨大的发展空间，此次大会的胜利召开预示着我国养老事业的发展将与全球的养老行业接轨，以及我们对于养老新思路、新方法、新模式的探索与创新。这对于中国养老院院长养老事业与护理工作的开展，具有十分重要的指导意义和深远影响。

召开此次大会，是着眼国家养老形势发展要求、落实「十二五」养老规划的一项重要举措。「十二五」时期，我国将基本建立起与人口老龄化进程相适应、与经济社会发展水准相协调，以居家为基础、社区为依托、机构为支撑的社会养老服务体系，满足老年人多层次、多样化的养老服务需求。「十二五」规划提出鼓励社会兴办养老机构，增加机构养老床位300万张，实现养老床位总数翻一番。这给我们带来很大的发展机遇。我想，养老院长协会必将更好地发挥桥梁纽带作用，带动全国养老院长和社会各界参与养老事业的有志之士，不断提高完善养老院的管理水准和护理工作，促进我国养老事业和社会和谐发展创造良好的社会环境。也有助于各位养老院长学习新的理念、新的思想，加快找到更适合自己发展需求和开拓创新的便捷途径。

养老行业在构建和谐社会方面，更需要社会各界和广大群众的关注和支援，需要更多富有爱心的人参与养老行业。我们要充分发挥养老院的社会地位与政策优势，结合国家和政府民政系统支援，大力宣扬养老院里老人们的生活方式与休闲方式，宣导现代养老新理念新模式。

养老产业是一个投资大、收益低、投资回报期长，且有一定风险的产业。养老院的经营管理也是一个需要长期积累经验的过程，有许多的矛盾问题亟待研究解决，大家感同身受。政府鼓励社会兴办养老机构，允许民间资本进入养老领域开设营利性养老机构，但一些法规制度亟待建立完善。如养老院管理风险问题，如何处理医疗护理纠纷所引发的赔偿风险、如何规范养老机构服务人员培训教育和监管、如何维护老年人的合法权益等等，需要大家相互沟通、探讨学习，减少彼此不必要的挫折与弯路，能更快更好的良性发展养老机构，才能确保养老院长期稳定的健康发展。

人间重晚情。如何引导并促进养老事业健康、有序发展，既是摆在党和政府面前的重大课题。各位与会的嘉宾、院长们有着博大的爱心和丰富的实战经验，必将为我国的养老事业创新发展、在构建和谐社会中作出更大贡献。希望各位院长，通过此次养老院院长国际会议学习到新的养老理念与模式，为我国养老事业的发展增砖添瓦，贡献力量。

谢谢大家！

CONFERENCE PROGRAMME

DAY 1 - Wednesday, 27 June 2012

08:30 - 09:10	**Registration**
09:10 - 09:40	Welcome and Opening Remarks • Ms. Yunhua LIU CHAIRWOMAN OF THE COFERENCE ORGANIZING COMMITTEE VICE-CHAIRWOMAN & SECRETARIAT-GENERAL OF CHINA INTERNATIONAL ASSOCIATION OF PRESIDENT OF NURSING HOMES • Mr. Qingchun YAN DEPUTY DIRECTOR OF THE NATIONAL COMMITTEE ON AGEING, CHINA • Mrs. Ping ZHOU DEPUTY DIRECTOR-GENERAL, DEPARTMENT OF SOCIAL RELIEF, MINISTRY OF CIVIL AFFAIRS, CHINA • Mrs. Zhihong YU SECRETARY-GENERAL, RETIRED STAFF MANAGEMENT BUREAU, MINISTRY OF CIVIL AFFAIRS, CHINA • Mr. Yunfu LI DEPUTY CHIEF, SOCIAL WORK DIVISION, LIAISON OFFICE OF THE CENTRAL PEOPLE'S GOVERNMENT IN THE HONG KONG SAR • Dr. Che Hung LEONG EXECUTIVE COUNCILLOR & CHAIRMAN OF ELDER ACADEMY DEVELOPMENT FUND, HKSAR • Dr. Mary Ann TSAO PRESIDENT OF TSAO FOUNDATION, SINGAPORE Photos Taking & Souvenir Presentation
09:40 - 10:10	***"From the 11th Five-Year-Plan to the 12th"*** • Mr. Qingchun YAN DEPUTY DIRECTOR OF THE NATIONAL COMMITTEE ON AGEING, CHINA
10:10 - 10:30	Break
10:30 - 12:10	[CHAIRPERSON] • **Dr. Mary Ann TSAO** **PRESIDENT OF TSAO FOUNDATION, SINGAPORE** [KEYNOTE 1] ***"Regional Analysis on Madrid International Plan of Action on Ageing"*** • Prof. Alfred, Cheung Ming CHAN CHAIR PROFESSOR & DIRECTOR OF ASIA-PACIFIC INSTITUTE OF AGEING STUDIES, HK [KEYNOTE 2] ***"Health and Social Care for Older Persons from Culturally and Linguistically Diverse Backgrounds: Australian Policy and Practice"*** • Prof. Helen BARTLETT PRO VICE-CHANCELLOR AND PRESIDENT (GIPPSLAND CAMPUS), MONASH UNIVERSITY, AUSTRALIA [KEYNOTE 3] ***"Growing Demand for Elderly Care and the Capacity Building of Elderly Carers in China"*** • Prof. Peng DU PROFESSOR & DIRECTOR OF THE GERONTOLOGY INSTITUTE, RENMIN UNIVERSITY OF CHINA Discussion & Conclusion
12:30 - 14:00	Welcoming Lunch

	Symposium A: Active Ageing in Long Term Care Model	Symposium B: Active Ageing in Community Care Model
14:00 - 16:10	[CHAIRPERSON] • **Prof. Peng DU** Professor & Director of the Gerontology Institute, Renmin University of China	[CHAIRPERSON] • **Prof. Alfred, Cheung-Ming CHAN** Chair Professor & Director of Asia-Pacific Institute of Ageing Studies, HK
	[SPEAKER 1] ***"The Function of Chinese Medicine in Elderly Care"*** • Mr. Qixin SUN President of Kangfu Elderly Home, Jiading District, Shanghai, China	[SPEAKER 1] ***"The Implications of Active Participation among the Elderly to Care Giving"*** • Prof. Sta. Maria MADELENE Associate Professor, Department of Psychology & Director, University Research Coordination Office, De La Salle University, Philippines
	[SPEAKER 2] ***"Thoughts on the Shortage of Elderly Carers"*** • Mr. Shihao WANG President of Dongshan Welfare Home, Yuexiu District, Guangzhou, China	[SPEAKER 2] ***"Types of Support Received by Co-resident & Non Co-resident Older Malaysians"*** • Dr. Rahimah IBRAHIM Head, Social Gerontology Laboratory, Institute of Gerontology, University of Putra Malaysia, Malaysia
	[SPEAKER 3] ***"Exploring the Models of Social Care"*** • Mrs. Zhiping GU President of Jinqiu Elderly Home, Fuzhou City, Fujian, China	[SPEAKER 3] ***"Informal Caregiving Patterns in Korea and European Countries: A Cross-National Comparison"*** • Prof. Soong-Nang JANG Assistant Professor, Department of Nursing, Red Cross College of Nursing, Chung-Ang University, South Korea
	[SPEAKER 4] ***"The Thinking of Presidents of Nursing Homes in China"*** • Mrs. Yunhua LIU Vice-Chairman & Secretariat-General of China International Association of President of Nursing Homes	[SPEAKER 4] ***"Characteristics of Urban Elderly Care Recipients in Singapore, China and Indonesia"*** • Dr. Treena WU Postdoctoral Fellow, Duke – NUS Graduate Medical School, Singapore
	[SPEAKER 5] ***"The Development of Private Homes for the Elderly in Hong Kong"*** • Mr. Kenneth Chi Yuk CHAN Chairman of The Elderly Services Association of Hong Kong and Chief Executive of the Oasis Nursing Home	[SPEAKER 5] ***"Ethnographic Studies on the Role of Caregiver in Providing Care for Older Persons in Citengah Village, Sumedang, West Java and Its Implication of Care Giving Program"*** • Ms. Vita Priantina DEWI Head of Secretariat Office of Centre for Ageing Studies, Universitas Indonesia
	[SPEAKER 6] ***"How Elderly Homes Can Serve as a Platform Providing 'Through-Train' Services in Hong Kong"*** • Mr. Henry Wai Hung SHIE Executive Director of Hiu Kwong Nursing Centre, Hong Kong	
16:10 - 16:30	Break	
16:30 - 17:00	Discussion & Conclusion	

End of Day 1

CONFERENCE PROGRAMME

DAY 2 - Wednesday, 28 June 2012

08:30 - 09:00	Registration
09:00 - 09:20	Welcome and Opening Remarks ***"COMMENDATION CONGRESS FOR CARE WORKER OF EXCELLENCE"*** • Mr. Qingchun YAN Deputy Director of the National Committee on Ageing, China • Prof. Zhenyao WANG Director of Philanthropy Research Institute, Beijing Normal University, China • Prof. Alfred, Cheung-Ming CHAN Chair Professor & Director of Asia-Pacific Institute of Ageing Studies, Hong Kong
09:20 - 10:50	[CHAIRPERSON] • **Dr. David, Lok Kwan DAI** Department of Medicine & Therapeutics, Prince of Wales Hospital, Hong Kong [KEYNOTE 1] ***"Enabling Ageing-in-Place: Experience of Tsao Foundation's Community Service Model"*** • Dr. Mary Ann TSAO President of Tsao Foundation, Singapore [KEYNOTE 2] ***"China's Situation of Elderly Care and the 12th Five Year Plan: An Analysis of the Elderly Care Provision System in China"*** • Prof. Zhenyao WANG Director of China Philanthropy Research Institute, Beijing Normal University & One Foundation, China Discussion & Conclusion
10:50 - 11:10	Break
11:10 - 12:30	[CHAIRPERSON] • **Prof. Helen BARTLETT** Pro Vice-Chancellor and President (Gippsland Campus), Monash University, Australia [KEYNOTE 1] ***"Silver Hair Market in Japan? Good Quality of (Whose) Life with Silver-to-Black Consumption?"*** • Prof. On-Kwok LAI Professor, Graduate School of Policy Studies, Kwansei Gakuin University, Japan [KEYNOTE 2] ***"Older Consumers in Malaysia: Spending Pattern, Leisure Activities and Consumption Preferences"*** • Prof. Fon-sim ONG Professor & Head of Marketing Department, Taylor's University, Malaysia Discussion & Conclusion

12:30 - 12:50	Present Lingnan Declaration Closing Ceremony
12:50 - 14:30	Lunch
14:30 - 16:00	Site Visit or Thematic Workshop

Site Visit

- **[SITE 1] Oasis Nursing Home**
- **[SITE 2] Housing Society Enhancement (Elderly) Resource Centre**
- **[SITE 3] Senior Citizen Residences (Cheerful Court)**

Thematic Workshop

"How to Increase Your Acceptance Rate of Journal Submissions"

Prof. Kwok Keung HO

Editor, New Horizon in Education, HKTA

SITE 1: OASIS NURSING HOME

Oasis Nursing Home, founded in May 2008, is a Contract Home of the Social Welfare Department sponsored by the Hong Kong Government's Lotteries Fund. It has medical equipment and human resources equivalent to private hospitals providing professional healthcare service. With their belief in offering people-oriented service, the Home evaluates the situation of every intake and designed for the elderly a personalized care plan.

The premise consists of 6 stories, providing a total of 205 places. Each floor is superintended by an experienced registered nurse as care manager, and there is a staff of over 120 professionals, with 25 enrolled or registered nurses in addition to a number of full-time physiotherapists, occupational therapists, pharmacists, registered social workers, health workers as well as care workers.

Utilizing various latest information technologies supported with a comprehensive quality management system, the Home aimed at creating a satisfactory and comfortable living environment for its residents. In the meantime, through incorporating the concept of hotel service into the business, they provide an all-round service to the elderly.

SITE 2: HOUSING SOCIETY ENHANCEMENT (ELDERLY) RESOURCE CENTRE

Housing Society Enhancement (Elderly) Resource Centre, founded by the Housing Society in 2005, is the first centre in Hong Kong which promotes and assists elderly to achieve "Ageing in Place" at the community level such that they can live comfortably and safely and enjoy their late lives.

The concept of "Home Rehabilitation" (Ageing in Place) is to allow elderly to stay in their homes or in a familiar community after their retirements. The Centre advocates the followings to achieve the objective:

1) Adequate living environment: Suggesting suitable home environment and age friendly furniture and equipment to target various needs of elderly as brought by the physiological and psychological changes throughout ageing.

2) Healthy and active ageing: Helping elderly acquire a better understanding of the ageing process, while encouraging them to face their retirements positively and live a pleasant second-life.

3) Safe habits: Assisting elderly to identify the potential dangers in the home environment as well as hazardous habits so as to prevent the happenings of accident.

SITE 3: SENIOR CITIZEN RESIDENCES (CHEERFUL COURT)

"Senior Citizen Residence Scheme (SEN)" is one of Housing Society's (HS) housing initiatives to serve the community. In 1996, a survey conducted by HS showed that there was strong demand for purpose-built housing for the elderly in the middle-income group who have the means to live an independent life. This prompted the HS to further pursue the SEN housing concept aiming to benefit the elderly by way of "healthy ageing" and "ageing in place".

All SEN units are self-contained, incorporating special "software" and "hardware" elements to meet the changing needs of the elderly as they frail. The operator will make use of the facilities at the podium of the SEN project in providing all sorts of "software" elements covering recreational, social and care services for the residents.

Cheerful Court is built under the concept of "home with living support" and "lease for life", inaugurated in 2004 and their target group is the middle income elders. The participants can have a look on this newly designed housing program and apart from residential care units, they will also see the clubhouse facilities, restaurant, wellness centres including clinical and Chinese Herbalist medical services, dental and beauty services etc. Most importantly, the participants will know more on the concept of "seamless care" and "long lease" arrangement after this site visit.

End of Day 2

论坛流程

第一天 - 2012年6月27日（三）

08:30 - 09:10	登记
09:10 - 09:40	欢迎及开幕辞 . 刘蕴华 筹委会主席 中国国际养老院院长协会副会长兼秘书长 . 闫青春 常务副主任 中国国家老龄工作委员会办公室 . 周 萍 副司长 中国国家民政部低保救助司 . 于志宏 局长 中国民政部离退休干部局 . 李运福 副部長 中國中央人民政府驻香港特別行政区联络办公室社会工作部 . 梁智鸿 医生 香港行政会议成员及长者学苑发展基金委员会主席 . 曹慰萱 博士 新加坡曹氏基金会主席 致送纪念品及留影
09:40 - 10:10	**「回顾十一五．展望十二五」** . 闫青春 常务副主任 中国国家老龄工作委员会办公室
10:10 - 10:30	小休
10:30 - 12:10	[主持人] . **曹慰萱 博士** **新加坡曹氏基金会主席** [主讲1] **「马德里国际老龄问题国际行动计划地域性分析」** . 陈章明 教授 香港岭南大学社会老年学讲座教授及亚太老年学研究中心总监 [主讲2] **「多元文化及语言背景的长者健康与社会护理：澳洲的政策与实践」** . 海伦．芭特莉特 教授 澳洲蒙纳殊大学 (吉普斯兰分校)副校长 [主讲3] **「中国老年照护需求的增长与养老护理人员能力建设」** . 杜鹏 教授 中国人民大学人口学系教授及老年学研究所所長 总体公开发言／交流 主持及台上所有嘉宾及所有参加者
12:30 - 14:00	欢迎午宴

	论坛A：长期照护模式的积极老龄化	论坛B：社区照护模式的积极老龄化
14:00 - 16:10	[主持人] . **杜鹏　教授** **中国人民大学人口学系教授及老年学教研所总监**	[主持人] . **陈章明　教授** **香港岭南大学社会老年学讲座教授及亚太老年学研究中心总监**
	[讲者1] **「中国医学在养老护老中的作用」** . 孙启新 上海市嘉定康福敬老院院长	[讲者1] **「老有所为对提供护理的启示」** . 圣玛利亚．玛特莉娜　教授 菲律宾德拉萨大学心理学系副教授暨研究联络办公室主任
	[讲者2] **「养老护理员队伍紧缺的思考」** . 汪世灏 广东省广州市越秀区东山福利院院长	[讲者2] **「为马来西亚独居和非独居长者提供的多种支持」** . 拉希默．伊布拉欣　博士 马来西亚博特拉大学老年学学院社会老年学研究中心主管
	[讲者3] **「对社会养老模式的思考与探索」** . 顾志萍 福建省福州市金秋老人院院长	[讲者3] **「韩国与欧洲国家的非正式照顾模式：跨国比较」** . 张淑琅　教授 南韩中央大学红十字看护大学助理教授
	[讲者4] **「中国养老院长的思考」** . 刘蕴华 中国国际养老院院长协会副会长兼秘书长	[讲者4] **「新加坡、中国及印尼的长者护理服务使用者特色分析」** . 吴雪莲　博士 杜克．新加坡大学医学研究院博士后研究员
	[讲者5] **「香港私人营办安老院的发展趋势」** . 陈志育 香港安老服务协会主席及紫云间沁怡护养院行政总监	[讲者5] **「印尼西爪哇苏美当希丹格村长者照顾者角色的人种志研究及其对护理项目的启示」** . 维达．布莉安蒂娜．迪维 印度尼西亚大学老年学研究中心秘书长
	[讲者6] **「香港安老院如何成为一条龙服务的平台」** . 谢伟鸿 香港晓光护老服务有限公司执行董事	
16:10 - 16:30	小休	
16:30 - 17:00	总体公开发言／交流 主持及台上所有嘉宾及所有参加者	

第一天完

论坛流程

第二天 - 2012年6月28日（四）

08:30 - 09:00	登记
09:00 - 09:20	欢迎及开幕辞 「优秀护理员表彰大会」 . 闫青春　常务副主任 中国国家老龄工作委员会办公室 . 王振耀　教授 北京师范大学壹基金公益研究院 . 陈章明　教授 香港岭南大学社会老年学讲座教授及亚太老年学研究中心总监
09:20 - 10:50	[主持人] . **戴乐群　医生** **韦尔斯亲王医院老人科顾问医生** [主讲1] **「实践原居安老的理念: 新加坡曹氏基金会的小区服务模式」** . 曹慰萱　博士 新加坡曹氏基金会主席 [主讲2] **「中国基本养老形势与『十二五』规划——中国养老服务体系解析」** . 王振耀　教授 北京师范大学中國公益研究院 总体公开发言／交流 主持及台上所有嘉宾及所有参加者
10:50 - 11:10	小休
11:10 - 12:30	[主持人] . **海伦. 芭特莉特　教授** **澳洲蒙纳殊大学 (吉普斯兰分校) 副校长** [主讲1] **「日本的银发市场：从银发到黑发的优质生活消费」** . 黎安国　教授 日本关西学院大学政策研究学院教授 [主讲2] **「马来西亚的银发市场：消费模式、休闲活动与消费偏好」** . 王华新　教授 马来西亚泰莱大学市场学系系主任 总体公开发言／交流 主持及台上所有嘉宾及所有参加者

12:30 - 12:50	闭幕仪式 发表「岭南宣言」
12:50 - 14:30	午餐
14:30 - 16:00	机构参访或主题工作坊

机构参访

- [机构1] 紫云间沁怡护养院
- [机构2] 房协（长者）安居资源中心
- [机构3] 长者安居乐住屋计画

主题工作坊

「如何提高学术期刊投稿的被接受率」
贺国强　教授
教育曙光香港教师会
教育学报总编辑

机构参访1：紫云间沁怡护养院

护养院为社会福利署合约院舍，由政府奖券基金拨款资助开办，于2008年5月开始投入服务。紫云间沁怡护养院无论在医护设备和人手编制方面，都具备了私家医院级数的专业医护服务，院方重视以人为本的服务理念，为每名入住的长者，进行专业评估及制订个人化照顾计划。

整座院舍楼高6层，提供205个宿位，每层由富经验的注册护士担任护理经理，全院专业医护人手编制超过120人，当中25人为注册及登记护士，另有全职的物理治疗师、职业治疗师、配药员、注册社工、保健员及护理员等。院舍采用各项最新的电子资讯科技设备，配合完善之质素管理系统，为院友营造一个优越而舒适的生活环境。同时，把酒店服务概念融入院舍服务中，让长者获得全方位的优质服务。

机构参访2：房协（长者）安居资源中心

房协（长者）安居资源中心是香港房屋协会在2005年成立，为香港首创，并由经验丰富的职业治疗师及社工主理，目的是在社区层面推广及协助长者居家安老，让他们的起居生活更安全舒适，过一个愉快晚年。

服务理念：

居家安老的意义就是让长者能在自己家居或熟悉的社区内安享晚年。该中心提倡 从以下三个层面去帮助长者达致居家安老的宗旨：

1. 合适的居住环境：针对长者在老化过程中身心的转变所带来的不同需要，在长者居住环境、家具用品及相关服务上提供专业咨询。
2. 健康及积极晚年：帮助长者认识老化过程，并以积极乐观方法去面对退休生活，过一个愉快的黄金岁月。
3. 安全的生活习惯：帮助长者认识潜在的家居危机和导致危险的日常生活习惯，减少意外的发生。

机构参访3：长者安居乐住屋计划

社会需要：

「长者安居乐住屋计划」是房协为公众提供的另一崭新房屋计划。房协于1996年进行的调查显示，中等收入长者对专为其设计的房屋需求甚殷。有见及此，房协再接再励考虑推行「长者安居乐住屋计划」，务求达到让长者「安枕无忧」及「颐养天年」的目的。

一站式服务：

「长者安居乐住屋计划」所有单位均为设备齐全的独立式单位，附设各项特别的「软件」及「硬件」，务求迎合长者因身体逐渐衰弱而对生活的不同需要。营运机构将会善用「长者安居乐住屋计划」位于平台的辅助设施，为住户提供各类「软件」，例如康乐、社交活动及健康护理服务等。

第二天完

Conference Rules and Etiquette
议事规则

Conference Arrangement:
Except for the Symposiums, the time allocation for chairperson and speakers will be as indicated below:

1. Chairperson will introduce speakers and topics for 10 minutes.
2. Each Keynote will present for 30 minutes.
3. Discussion & Conclusion will last for 20 minutes.
4. The speakers in Symposium A & B are given 20-25 minutes for presentation.
5. The first reminder will be given to the speaker 3 minutes prior the end of his/her allocated time.
6. The second reminder will be given to the speaker 1 minute prior the end of his/her allocated time.

7. Please switch off / turn silent all mobile devices
8. Please do NOT shout or make loud noises
9. Please do NOT smoke;
10. Comply with directions given by venue staff for the purpose of keeping order.

Notes: Selected papers will be published in the New Horizon in Education, Vol. 60, No. 3. 2012.

会议安排：

除论坛之外，所有主持人与讲者的时间分配如下：

1. 主持人10分钟。
2. 每位讲者30分钟。
3. 总体公开发言 / 交流 20分钟。
4. 论坛A和B讲者有20-25分钟发言。
5. 讲者于时间完结前3分钟会收到第一次提示。
6. 讲者于时间完结前1分钟会收到第二次提示。

7. 必须关掉流动电话和其他电子产品的响闹装置；
8. 不要喧哗或发出滋扰性嘈音；
9. 不可吸烟；以及
10. 必须服从场地职员为维持秩序及保持场地清洁而发出的指示。

註：優秀論文將會收錄於教育曙光，第六十卷，第三期。

Guests, Speakers & Chairpersons

主礼嘉宾、讲者及主持

Qingchun YAN
闫青春　常务副主任

Deputy Director of the National Committee on Ageing, China
中国国家老龄工作委员会办公室常务副主任

"From the 11th Five-Year-Plan to the 12th"
「回顾十一五．展望十二五」

簡歷

阎青春，男，汉族，中共党员，辽宁人，早年毕业于吉林大学经济系政治经济学专业，后在东北师范大学政治系攻读中国革命史专业的研究生课程毕业，接着又在山东曲阜师范大学文史学院攻读历史专业的研究生学业，获硕士学位。现任全国老龄工作委员会办公室党组成员、副主任（正司级），中国老龄协会副会长。

该同志大学毕业后在部队院校任过政治理论课教官，后到总参机关从事政治理论宣传工作。1989年4月转业到民政部后,先后做过人事工作和社会福利工作，历任人教司机关干部处副处长，社会福利司办公室主任、社区服务处处长，1998年机构改革后任社会福利和社会事务司副司长职务，2005年10月调全国老龄办任现职。他先后参加过《残疾人保障法》、《老年人权益保障法》、《未成年人保障法》、《收养法》以及《殡葬管理条例》、《城市生活无着的流浪乞讨人员救助管理办法》等法律法规的草拟与修改工作，参加过《中共中央关于加强老龄工作的决定》、国务院办公厅《关于加快推进社会福利社会化的意见》、《关于加快发展养老服务业的意见》、《关于加快推进居家养老服务的意见》、十一五、十二五期间《全国老龄事业发展规划》以及《社会福利机构管理办法》、《养老护理员国家职业标准》等政策规章的起草与制定工作。结合本职业务撰写并出版了《当代世界政治经济》、《中国革命史重点问题研究》、《中国共产党70年》、《国民党台湾50年》、《中国社会福利》、《民政助理员实用手册》等数十部书稿，主编了《社会保障与社会福利》、《中国社会福利生产管理大全》、《社会福利丛书》、《养老护理员国家职业标准系列培训教材》等专业书籍，在各类报刊杂志发表了有关社会福利、老龄事业、老龄工作等领域的数百篇论文，并有多篇入选相关的优秀论文集。参加了国家应对人口老龄化战略研究的组织协调工作，亲自带领写作组编写完成并由国务院下发了《中国老龄事业发展"十二五"规划》。

Biography

Qingchun Yan, a member of the Chinese Communist Party, graduated with a bachelor degree in Political Economy from the Department of Economy, Jilin University, China. He then pursued his research post-graduate degree in Qufu Normal University in Shandong Province, China and attained Master in History. He is currently the Deputy Director and Party Leadership Group Member of the National Committee on Ageing of the PRC Government, as well as the Vice-Chairman of the the Gerontological Society of China.

Upon his graduation from the university, Yan taught Political Theories in military academies, who hence worked in the General Staff Department responsible for the propaganda campaign of political theories. In April 1989 he moved to the Ministry of Civil Affairs and was assigned duties in human resources and social welfare. He has been Deputy Head of the Government Personnel Division, Human Resources and Education Department; Officer of the General Office, Department of Social Welfare; and Head of the Community Service Division. After the institutional reform in 1998 he served as the Deputy Director-General of the Social Welfare and Social Affairs Department. He was then transferred to the current position in the National Committee on Ageing in October 2005.

Yan has participated in the drafting and amending of various laws and regulations, which include: "Disabled Persons Protection Law", "Elderly Rights Protection Law", "Underage Persons Protection Law", "Adoption Law", " Funeral Management Regulations", and "Management Guidelines for Assisting Vagrant Beggars in Urban Areas", etc. He was also responsible for the formulation of policies including: "The Central Committee of CPC's Decision on the Strengthening of Elderly Work"; "Suggestions to the Progressing of Social Welfare Socialisation", "Suggestions to the Progressing of Elderly Industry" and "Suggestions to the Progressing of Residential Elderly Care Service" of the General Office of the State Council ; "National Development Plan for Elderly Industry", "Management Guidelines for Social Welfare Organisations", and "Elderly Care Workers National Occupation Standards", etc.

Throughout his career, he has several dozens of publications: Contemporary Global Political Economy, A Study in Critical Issues of Chinese Revolutionary History, 70 Years of CPC, 50 Years of KMT in Taiwan, Social Welfare of China, Practical Manual for Civil Servants, etc. He was also the Editor-in-Chief for professional books such as: Social Protection and Social Welfare, A Collection of China Social Welfare Production Management, Social Welfare Reader, and Elderly Care Workers National Occupation Standards Training Materials Series, etc. Yan has also published several hundreds of articles widely in journals and periodicals in relation to social welfare, elderly industry, elderly work, of which many have been included in relative journals of outstanding articles.

He has participated in the coordination of the National Strategic Research in Responding to Population Ageing. He has also led a team to compile The Development of China Eldelry Industry: The 12th Five-Year-Plan, which was distributed by the State Council.

Guoying WANG
王国英　局长

SECRETARY-GENERAL, RETIRED STAFF MANAGEMENT BUREAU,
MINISTRY OF CIVIL AFFAIRS, CHINA
中国民政部离退休干部局局长

"Officiating Address"
「在第二届世界养老院院长大会暨积极老龄化研讨会上的致辞」

簡歷

王国英，现任国家民政部离退休干部局党委书记、局长，长期从事基层政权建设、离退休干部工作，坚持从严治局，狠抓服务，努力提升为老服务管理水准；积极研究以民为本、为民解困、为民服务的科学路径，撰写和发表很多调研论文，着眼做好新时期离退休干部工作，构建了「一个中心、两个基本点」：即以身心健康为中心、落实好老同志政治和生活待遇，积极为老同志办实事、做好事、解难事，赢得老同志满意，促进了离退休干部工作创新发展。

BIOGRAPHY

Guoying Wang is the Secretary-General and Party Commission Secretary of the Retired Staff Management Bureau, Ministry of Civil Affairs, China. He has extensive experience in the establishment of basic level political rights and Retired Staff Management work. He insisted to lead the bureau with prudence, and to pay close attention to service provision, in order to enhance the management quality of elderly services. He enthusiastically researches for scientific ways to serve and help the citizens based on their needs. Wang has also published a significant number of surveys and research articles. He has aimed to excel in his work for the retired staff.

Wang followed the concept of "One nuclear, two basic points", which is to ensure the political and living quality of retired staff as well as to serve and help them according to their needs, based on the central consideration of the elderly's health and wellbeing. His work is highly appraised amongst the retired staff and he has contributed to the innovation and development of the retired staff management work.

Dr. Che Hung LEONG
梁智鸿　医生

Executive Councillor & Chairman of Elder Academy Development Fund, HK
香港行政会议成员及长者学苑发展基金委员会主席

簡歷

梁智鸿医生为私人执业医生，专科为泌尿科。梁医生曾出任多项公职，现时为行政会议非官守议员、香港大学校务委员会主席、爱滋病基金会主席。梁医生是前安老事务委员会长者学苑发展基金委员会主席。梁医生特别关注长者的需要，致力鼓励长者活出丰盛晚年。

梁医生于2002年至2004年出任香港医院管理局主席，并在1988年至2000年出任立法会议员。在学术方面，梁医生是英国皇家外科医学院的享特讲座教授，并曾任香港医学专科学院主席。梁医生亦为香港医学专科学院、香港外科医学院、香港内科医学院、香港社会医学院及香港牙科医学院的荣誉院士，并为英国皇家外科医学院的荣誉院士。

Biography

Dr. Che Hung Leong is a doctor in private practice, specialised in urology. Dr. Leong is active in public services and he is now a non-official member of the Executive Council HKSAR, and Chairman of Council of the Hong Kong University and Hong Kong Aids Foundation. He currently also chairs the Elder Academy Development Foundation. Dr. Leong is the former Chairman of the Elderly Commission HKSAR. He pays particular attention to the needs of elderly, while advocating the senior citizens to live fruitfully their later years.

Dr. Leong has been chairman of the Hospital Authority in Hong Kong from 2002 to 2004, and has served as legislative councilor from 1988 to 2000. Academically, Dr. Leong is a Hunterian Professor of the Royal College of Surgeons. Locally, he has been the chairman of the Hong Kong Academy of Medicine. He is the honorary fellow of the College of Surgeons of Hong Kong, College of Medicine of Hong Kong, College of Community Medicine of Hong Kong, and College of Dental Surgeons of Hong Kong. He is also the honorary fellow of the Royal College of Surgeons.

Dr. Mary Ann TSAO
曹慰萱　博士

PRESIDENT OF TSAO FOUNDATION, SINGAPORE
新加坡曹氏基金会主席

"Enabling Ageing-in-Place: Experience of Tsao Foundation's Community Service Model"
「实践原居安老的理念：新加坡曹氏基金会的社区服务模式」

簡歷

曹慰萱博士为新加坡非牟利组织「曹氏基金会」创会主席，该行动基金为长者护理及应对老龄问题而设立。曹博士现兼任「护老易（国际）」顾问委员会地区顾问，并时常获邀出席多项新加坡及国际间的会议及论坛，就老龄化、公民社会和慈善事业等发表演说。最近，她联同另外两位国际专家应邀于联合国非政府组织联络署社会发展委员会第四十五次会议发表讲话，启动《马德里老龄问题国际行动计划》第五年评检。多年来，曹博士服务新加坡及国际众多的政策及技术委员会。为表扬她在新加坡于老龄议题上的贡献和成就，她分别于2000年和2004年获政府颁赠「公共服务勋章」及「公共服务星章」。

BIOGRAPHY

Dr. Mary Ann Tsao is the President Founding Director of the Tsao Foundation, a Singapore-based not-for-profit operational foundation dedicated to aged care and ageing issues. Dr. Tsao Tsao is a regional advisor on the EASY-Care International Advisory Board, and is a frequent invited speaker at conferences and seminars on ageing, civil society and philanthropy both in Singapore and internationally. Most recently, she was one of three international experts invited to address the United Nation's 45th session of the Commission on Social Development to launch the fifth year review of the Madrid International Plan of Action on Ageing (MIPAA+5). Over the past years, Dr. Tsao has served on numerous policy and technical committees in Singapore and internationally. For her work on ageing in Singapore, she received the Public Service Medal in 2000 and Public Service Star in 2004.

Prof. Alfred Cheung Ming CHAN
陈章明　教授

Chair Professor & Director of Asia-Pacific Institute of Ageing Studies, HK
香港岭南大学社会老年学讲座教授及亚太老年学研究中心总监

"Regional Analysis on Madrid International Plan of Action on Ageing"
「马德里国际老龄问题国际行动计划地域性分析」

簡歷

陈章明教授除了是社会老年学学者外，更是一位长者福利服务的实践者。他护士出身，及后转为服务长者的社会工作者。陈教授擅长于健康及社会护理服务及其政策制订，研究兴趣广泛，包括跨代关系阐释、亚太区老年及长期护理政策、开发健康及社会发展量度指标、生活质素和护理指数等，研究更于众多经同行评审的期刊刊登。他现为岭南大学亚太老年学研究中心及服务研习处总监。

陈教授现服务香港特别行政区政府多个顾问组织，公职包括安老事务委员会主席、最低工资委员会委员、关爱基金督导委员会委员、中央政策组人口政策专家小组委员等。他亦担任世界卫生组织香港生活质素指数（长者）研究员，联合国亚洲太平洋经济社会委员会老龄政策专家小组顾问。2011年6月，他获新加坡曹氏基金会及新加坡国立大学委任为国际长寿中心顾问。

香港特区政府于2001年委任陈教授为太平绅士，并于2006年颁授铜紫荆星章，以表扬他对社会多年来的贡献。

Biography

Prof. Chan Cheung Ming Alfred has been both a practitioner in welfare services for older persons and an academic in social gerontology. Starting his career as a nurse and later on as a social worker in serving older persons. Prof. Chan has extensive skills and knowledge in health and social care services and policy making. His academic interests, such as the interpretation of intergenerational relationships, ageing and long-term care policies in Asia Pacific, the development of health and social care measurements, Quality of Life, Caring Index, etc. are closely related to this area and have been widely published in refereed journals. He is currently the Director of Asia-Pacific Institute of Ageing Studies and Office of Service-Learning.

Prof. Chan sits on many Government advisory bodies, including the Chair of Elderly Commission, Member of Minimum Wage Commission, Member of Steering Committee on the Community Care Fund, and Member of Population Research Expert Group of Central Policy Unit, etc. in Hong Kong. He is a member of the Hong Kong World Health Organisation Quality of Life Instruments (Elderly) Study Team, and a consultant on ageing and social development issues for the United Nations Economics and Social Commission for Asia and the Pacific (UNESCAP). He has recently been appointed by Tsao's Foundation of Singapore and National University of Singapore (NUS) to be the Advisor for their International Longevity Centre (ILC) from June 2011.

In recognition of Prof. Chan's invaluable contributions to the community, he was appointed a Justice of Peace in 2001, and was awarded the Bronze Bauhinia Star (BBS) by the HKSAR Government in 2006.

Prof. Helen BARTLETT
海伦．芭特莉特　教授

PRO VICE-CHANCELLOR & PRESIDENT (GIPPSLAND CAMPUS), MONASH UNIVERSITY, AUSTRALIA
澳洲蒙纳殊大学（吉普斯兰分校）副校长

"Health & Social Care for Older Persons from Culturally & Linguistically Diverse Backgrounds: Australian Policy and Practice"
「多元文化及语言背景的长者健康与社会护理：澳洲的政策与实践」

簡歷

海伦．芭特莉特教授于老年学的国际性研究卓著，重点研究人口老化的政策启示、健康老龄化以及社区护理。她积极参与澳洲老龄研究的能力建构，并指导提携老龄研究的新进学者。芭特莉特教授发表论文众多，并有多本着作，曾指导超过35位研究生。她职业生涯中曾获澳洲研究议会（ARC）以及国家健康及医疗研究议会（NHMRC）委托进行主要研究项目、并得到拨款资助，亦于国家及联邦政府担当顾问。

芭特莉特教授于高等教育的工作经验丰富，于英国、澳洲及香港的大学的健康及社会科学等学系扮演领导角色，她于英国牛津布鲁克斯大学创立了牛津老人痴呆症中心和牛津健康护理研究及发展中心。2008年，芭特莉特教授获委任成为澳洲蒙纳殊大学（吉普斯兰分校）副校长。她亦于该校设立老龄化及生命历程研究组。于澳洲蒙纳殊大学任职前，她也在澳洲昆士兰大学以澳亚老年研究的创办总监的身份工作8年。

BIOGRAPHY

Prof. Bartlett has an international research record in gerontology, with a particular focus on the policy implications of population ageing, healthy ageing and community care. She is actively involved in national capacity building for ageing research in Australia and directs the Australian Emerging Researchers in Ageing initiative. Prof. Bartlett has published widely – including several books – and supervised over 35 higher research degree students. Over her career, she has been awarded major ARC and NHMRC project and program grants, and state and federal government consultancies.

Prof. Bartlett's career in higher education has included extensive senior leadership experience in health and social sciences at universities in the United Kingdom, Hong Kong and Australia. She established the Oxford Centre for Health Care Research & Development, and the Oxford Dementia Centre at Oxford Brookes University in the UK. In 2008 she was appointed to the role of Pro Vice-Chancellor and President (Gippsland campus) at Monash University, where she has also established the Ageing and Lifecourse research group. Prior to working with Monash, Professor Bartlett was the Foundation Director of the Australasian Centre on Ageing at the University of Queensland for eight years.

Prof. Peng DU
杜鹏　教授

Professor & Director of the Gerontology Institute, Renmin University of China
中国人民大学人口学系教授及老年学研究所所長

"Growing Demand for Elderly Care and the Capacity Building of Elderly Carers in China"
「中国老年照护需求的增长与养老护理人员能力建设」

簡歷

杜鹏，1992年毕业于中国人民大学人口研究所，法学博士。现任中国人民大学社会与人口学院教授、老年学研究所所长，民政部专家委员会委员、中国老年学学会副会长、北京市人口学会副会长兼秘书长。同时亦担当联合国国际老龄研究所董事、国际助老会（Help Age International）董事。国际老年学与老年医学学会亚太地区主席。

主要研究领域：人口与发展、人口老龄化与老龄问题、老龄政策。

主要著作：《中国人口老龄化过程研究》、《人口老龄化过程中的中国老年人》（合著）、《社会老年学》（副主编）、《中国谁来养老》（主编）、《欧盟国家的老龄问题与老龄政策》、《人口老龄化与老龄问题高级公务员读本》（主编）、《老年学课程教学大纲》（主编）、《人口老龄化：变化与挑战》（合著）、《21世纪老年学译丛》（主编）、《中国农村残疾人及其社会保障》（主编）。

Biography

Prof. Peng Du, LLD, graduated from the Department of Demography and Institute of Population Research, Renmin University, China in 1992, is at present professor of The School of Sociology and Demography and Director of the Institute of Gerontology in Renmin University, Commissioner of the Expert Committee in the Ministry of Civil Affairs, China, Vice-chairman of the Gerontological Society of China, as well as the Vice-president and secretariat of the Beijing Association of Gerontology. Internationally, Prof. Du is Board Member of the United Nations International Institute on Ageing and Board Member of Help Age International. He is also the Chairman of The International Association of Gerontology and Geriatrics - Asia-Pacific Region.

Prof. Du's research focuses on: population and development, Population ageing and ageing issues, and ageing policy.

His main publications include: *A studies in the Process of China's Population Ageing*, *China's Elderly in the Process of Population Ageing* (Co-Author), *Social Gerontology* (Vice-Editor-in-Chief), *Who take care of the aged?* (Editor-in-Chief), *Ageing Issues and Policies of Countries in the European Union*, *Population Ageing and Ageing Issues: A Reader for Senior Civil Servants* (Editor-in-Chief), *Curriculum for Gerontology* (Editor-in-Chief). *Population Ageing: Changes and Challenges* (Co-Author), *Gerontology for the 21st Century* (Editor-in-Chief), *Disadvantaged in Rural China and Their Social Security* (Editor-in-Chief).

Qixin SUN
孙启新

President of Kangfu Elderly Home, Jiading District, Shanghai, China
上海市嘉定康福敬老院院长

"The Function of Chinese Medicine in Elderly Care"
「中国医学在养老护老中的作用」

簡歷

上海嘉定康福敬养院院长孙启新，曾经的军旅生涯塑造了他为人民服务的思想，勤奋钻研，使他成了医德兼备的医生、担任过宝山区社区医院院长。对孙启新而言，敬养院是自己事业的一次全新启航，亦是奉献自己爱心，体现人生价值的地方。由于孙启新对医学的独到领悟，更融入了多年的医药心得，使他所运营的上海嘉定康福敬养院别具一格：以中医养身为特色，重在提高老人生命和生活品质的养老方式，具有很强的医护实力的扎实基础，处处体现了「以老为本」「以老为尊」的理念。

经过多年的实践积累，在对老年人股骨胫骨骨折的非手术治疗、脑梗塞、老年痴呆症护理及调养、老慢支（肺气肿）护理及调养等方面已成为了康福敬养院的特色。众多因为以上疾病失去自理能力的老人在康福敬养院经过一段时间的中医药治疗和护理后，都得到了奇迹般的康复效果。

Biography

Qixin Sun is the President of Kangfu Elderly Home, Jiading District, Shanghai, China. Sun's military career has shaped his mentality to serve others. He studied hard to become a doctor and has been director of the Community Hospital of Baoshan District. For Sun, working in an elderly home is a new departure in his career, where he has contributed his love and realised life values. His professional background has helped Kangfu Elderly Home to stand out from other service providers: Utilizing Chinese Medicine and its solid medical support, the Elderly Home aimed to provide elderly-oriented services to enhance the life and living quality of its residents.

Through the accumulation of years of experience, Kangfu Elderly Home has been well appraised for its non-surgical treatment for elderly femur and tibia fractures, and elderly care for stroke, dementia, and pulmonary emphysema. The situations of many who suffered from the aforementioned illnesses have improved after receiving treatments of Chinese medicine and care.

Shihao WANG
汪世灏

President of Dongshan Welfare Home, Yuexiu District, Guangzhou, China
广东省广州市越秀区东山福利院院长

"Thoughts on the Shortage of Elderly Carers"
「养老护理员队伍紧缺的思考」

簡歷

汪世灏，1964年12月出生湖北省红安县。1988年大学毕业，获医学学士。1998年5月起担任武汉钢铁公司大冶铁矿医院业务院长。2004年5月调入广州东山福利院，任副院长。2008年6月任院长。自领导东山福利院以来，他实行了「一切以老人为本，同时兼顾员工利益」的服务和管理理念。重点促进内部改进管理，探索干部的考核管理新模式，施行合理有效的绩效考核机制。整顿员工工作风，落实工作实绩考核，提高其服务意识和服务品质。首开院行政总值班制度加强了全院巡查，第一时间掌握全院新动态，督促各岗位员工工作，并能及时排除安全隐患。完善多项劳资管理等制度，有效地改善各项管理工作。根据相关人事管理制度及时与聘用员工签订劳动合同，并按照有关法规为员工办理缴纳社保五险（养老保险、失业保险、医疗保险、重大疾病保险、生育保险）的各项手续，为在职员工进行一次性补缴社会保险，及时为员工解除后顾之忧，协助稳定队伍。加强员工队伍的建设，在夯实基础工作的前题下探索养老服务管理新模式。坚定不移地实施人才战略，坚持引进与人才培养有机结合，有重点地逐步培养骨干坚持规范化培训，努力建设一支高素质、业务精的实用型的服务队伍，增强福利院发展后劲。全院开展了“从细节着手提升服务品质”的护理竞赛活动，使全院的整体护理工作品质有了较明显的提高。努力提高员工福利待遇。在注重社会效益同时兼顾经济效益，为可持续的发展，福利院探索养老特需服务市场，寻找经济新增长点。

他赢得老人们的普遍赞赏，连年获得越秀区政府嘉奖，2011年荣获越秀区优秀共产党员，并被推荐全国「我身边文明模范——爱岗敬业」候选人。越秀区东山福利院也连续获得「全国模范养老机构」、「全国养老服务放心十佳单位」、「养老爱心服务金心奖」及「金典奖——全国服务业公众满意典范品牌奖」。

Biography

Shihao Wang, born in December 1964 in Hungan County, Hubei Province. He graduated with a bachelor of medicine in 1988. He was Operation Director of the Wuhan Iron and Steel Corporation Daye Iron Miner Hospital. In May 2004 Wang was transferred to Dongshan Welfare Home in Guangzhou as Vice President and was later promoted to the post of President in June 2008. He led Dongshan Welfare Home by providing elderly-oriented services while accommodating to employees' benefits". He focuses on the internal training and evaluation of staff to manage and improve employees' service orientation and the quality of services provided. A general duty roaster has been employed to the management team to foster the inspection of the premise, that any incidence happens in the home can effectively be monitored. Supervising all staff at work allows the management team to eliminate in time any potential safety threats. The perfection of the relationship between the employer and the employees through the protection of contracts and the provision of social insurances (retirement insurance, unemployment insurance, medical insurance, critical illness insurance, and maternity insurance) can stabilise the working team while advocating teamwork amongst employees by sharing their burdens. It is crucial to have a solid foundation before exploring new modes of elderly care service provision, that Wang insists in attracting and nurturing talents to fortify human resources. Systematic training for backbone staff is effective in building a sustainable, high quality, professional and practical service team. A care provision competition of "Improving Quality through Details" held has significantly raised the overall service quality standards of the working team. Dongshan Welfare Home has strived to enhance the benefits and salary of its employees. While stressing on social efficiency, it is necessary to attend to economic efficiency. In order to ensure the sustainable development of the Home, Wang explores the special service market of the elderly for a new branch of economic growth.

Wang has received praises from many elderly and for years he has been awarded by the Yuexiu District Government for his contributions. He has been elected Excellent Member of the Communist party of China (Yuexiu District) in 2011, and was nominated in a competition of "My Civilise Model - Hardworking and Job Loving". Donshan Welfare Home has also been awarded consecutively "National Model of Elderly Care Organization", "Top Ten National Assuring Elderly Service Provider", "Golden Heart Award for Elderly Caring Service", and "Golden Brand Award - National Model Brand of Public Satisfaction in Service".

Zhiping GU
顾志萍

President of Jinqiu Elderly Home, Fuzhou City, Fujian, China
福建省福州市金秋老人院院长

"Exploring the Models of Social Care"
「对社会养老模式的思考与探索」

簡歷

顾志萍女士于1934年生于江苏省江都市，多年来服务于护理及养老行业。顾女士于1952年毕业于中国人民解放军第二军区大学医科毕业，并服务于军中多所医院，历任护士长及科副主任。1976年她转到南京军区福州医学高等专科学校任职护理教研室主任，投入教学及研究工作，于1993年离休。退休后她于1998年及2001年先后创办了「天年老人护理中心」及「福州市金秋老人护理院」。

顾女士亦一直活跃于学术研究，她先后于军内、外杂志、大型学术会议发表论文39篇，主要论文包括：《现代护理——生命、心理、环境、模式》及《护理专业教书育人思想与实践研究》。

为表扬顾志萍女士于护理及养老方面的贡献，她于1996年被南京军区授予「优秀名老医学专家」，并于2007年经中国社工协会老年福利服务工作委员会评审被授予「全国养老机构优秀院长」，而其创立之福州市金秋老人院则被评为「全国模范养老机构」。

Biography

Mrs. Zhiping Gu, born 1934 in Jiangsu, China, has pursued a life-long career in the medical and healthcare sector. Graduated from the PLA Second Military Medical University in 1952, Gu joined the army as Head Nurse in various military hospitals. In 1976, she took up the position as Officer in Teaching and Research Centre of Nursing in Fuzhou Medical College of Nanjing Military Region. After her retirement in 1993, Gu founded in 1998 the Tiannian Elderly Care Centre and in 2001 Jinqiu Elderly Home.

Mrs. Gu has also been active in academic research by publishing 39 articles in journals of and apart from the military, and in various conferences. Featuring articles includes: "Modern Caring - Life, Psychology, Environment, and Mode" and "Education in the Nursing Profession: A Study in Theories and Practices".

In recognizing her contribution in nursing education and elderly care, Mrs. Gu was awarded "Medical Professional of Excellence" in 1996 and "National President of Elderly Care Organization of Excellence" in 2007. Her Jinqiu Elderly Home was credited as the "National Modelling Elderly Care Organization".

Yunhua LIU
刘蕴华

Vice-Chairman & Secretariat-General of China International Association of President of Nursing Homes
中国国际养老院院长协会副会长兼秘书长

"The Thinkings of Presidents of Nursing Homes in China"
「中国养老院长的思考」

簡歷

刘蕴华在清华大学继续教育学院毕业，研究生学历。曾在北京市政府重点工程指挥部工作，并荣立一等功。2004年至2008年在中国社工协会老年福利服务工作委员会执行主任工作岗位上，与香港芦峯狮子会组织了多届耳聪行动，为中国内地耳聋老人送去了福音，在香港各院长的帮助和民政部外事司的支持下，成功的在香港举办了多期「实战型养老院院长培训班」，在民政部社会福利与慈善事业促进司和部办公厅的支持帮助下，创办了《中华人民共和国养老指南网》，并在协会支持下，出版了《中国老年福利服务》一书，并于2007年经社工协会同意，报民政部办公厅批准，在全国养老机构中开展了「三个一百」活动，中国100个养老院、100名院长和100名优秀护理员，分别获得全国模范养老机构、优秀养老院长和优秀护理员称号，并在中国北京人民大会堂颁牌。2007年11月率团到柏林参加了《第一次世界养老院院长领导大会》。

刘蕴华时时为院长们解困分忧，深受全国养老院长们的欢迎和尊重，并多次荣获「孝星」和「养老机构建设工作先进个人」。

Biography

Mrs. Yunhua Liu graduated from The School of Continuing Education, Tsinghua University, Beijing with a research post-graduate degree. She has attained First Class Merit whilst her working at the Key Construction Project Headquarter of the Beijing Government. From 2004 to 2008 she was the Executive Officer in the Working Committee on the Old-Age Welfare, China Association of Social Workers (CASW), of when she has organised a series of "Hearing-in-Action"project with Leo Club of The Peak, Hong Kong, to provide assistance to elderly in China who suffered from hearing disability. With the support from presidents of various nursing homes in Hong Kong and the Department of International Cooperation, Ministry of Civil Affairs, Mrs. Liu organised several occasions of "Practical Training Course for President of Nursing Homes". With the assistance from the Department of Social Welfare and Charity Promotion, Ministry of Civil Affairs, she set up the website of "PRC Elderly Care Index". Mrs. Liu has also published *China's Elderly Welfare and Services* supported by her CASW. In 2007, agreed and approved by her Association and the Ministry, the "Three-One Hundred" Campaign was launched amongst all elderly service providers throughout China to elect 100 each the nursing homes, Presidents of nursing homes, and elderly carers of excellence, where the elected where decorated in the Great Hall of the People, Beijing. Liu has led a mission to Berlin, Germany to attend "The First International Leadership Assembly of Nursing Homes".

Mrs. Yunhua Liu is always ready to offer her helping hand to the Presidents of Nursing Homes and is thus widely respected and welcomed nationally. She has been awarded several times the "Star of Filial Piety" and "Advance Individual in the Development of Elderly Care Service".

Kenneth Chi Yuk CHAN
陳智育

Chairman of The Elderly Services Association of Hong Kong & Chief Executive of the Oasis Nursing Home
香港安老服务协会主席及紫云间沁怡护养院行政总监

"The Development of Private Homes for the Elderly in Hong Kong"
「香港私人营办安老院的发展趋势」

簡歷

陈志育先生为香港安老服务协会主席，于二零零五年至二零一一年获行政长官委任为安老事务委员会委员，就制订全面的安老政策，向政府提供意见。陈先生现在亦担任多项政府公职，他目前是教育局安老服务业培训咨询委员会委员、食物及卫生局医护人力规划和专业发展策略督导委员会-牙医小组成员、香港学术及职业资历评审局学科专家、雇员再培训局健康护理业行业咨询网路委员。

自二零零零年起，陈志育先生积极参与和推动香港安老服务业的发展。他曾任教育局安老照顾业技能提升计画行业小组成员、香港老年学会香港安老院舍评审计划督导委员会委员。此外，陈先生也参与多项社会服务，他现任香港童军总会新界地域名誉会长和拓展基金委员会主席、香港职业发展服务处服务发展委员会委员。

企业事务方面，陈志育先生现任中国安老集团副主席、紫云间沁怡护养院行政总监和钻的(香港)有限公司董事。

Biography

Mr. Kenneth Chan is now the Chairman of The Elderly Services Association of Hong Kong. Between 2005 and 2011, Mr. Chan was appointed by the HKSAR Chief Executive as the Member of Elderly Commission, who provided advice to the HKSAR Government on the formulation of all-rounded elderly policies. Currently, Mr. Chan holds a number of public service positions including Member of the Elderly Care Service Industry Training Advisory Committee of Education and Manpower Bureau, Member of the Dental Sub-group of the Steering Committee on Strategic Review on Healthcare Manpower Planning and Professional Development of Food and Health Bureau, Sector/Subject Specialist of the Hong Kong Council for Accreditation of Academic & Vocational Qualifications and Member of the Healthcare Services Industry Consultative Network of Employees Retraining Board.

Since 2000, Mr. Chan has been playing an active role in pushing forward the sustainable development of elderly service. To achieve such development, Mr. Chan has served as the Member of Industry Working Group on Elderly Care Skills Upgrading Scheme of Education and Manpower Bureau and the Member of Steering Committee of Accreditation System for Residential Care Services for the Elders in Hong Kong of Hong Kong Association of Gerontology. Besides, Mr. Chan actively participates in community services including Honorary President of New Territories Region and Chairman of New Territories Region Development Fund Commission of Scout Association of Hong Kong and Member of Service Development Sub-Committee of Hong Kong Employment Development Service.

Regarding corporate affairs, Mr. Chan is currently Deputy Chairman of Sino Care Enterprise Limited, Chief Executive of Oasis Nursing Home and Director of Diamond Cab (Hong Kong) Limited.

Henry Wai Hung SHIE
谢伟鸿

EXECUTIVE DIRECTOR OF HIU KWONG NURSING CENTRE, HONG KONG
香港晓光护老服务有限公司执行董事

"How Elderly Homes Can Serve as a Platform Providing 'Through-Train' Services in Hong Kong"
「香港安老院如何成为一条龙服务的平台」

簡歷

谢伟鸿先生早于大学毕业前，在1990加入其家族经营之安老院，投身安安老服务行业。其父为香港执业医生、其母则为香港安老业界备受敬重的安老院经营者，受双亲启发，谢先生立志提升安老院的质量及口碑，遂将其家族生意重组为晓光护老服务有限公司，成为自90年代起香港首数家在营运时采用质量管理系统及服务的企业。至今，晓光护老服务有限公司是香港唯一同时荣获以下质量评定认可的私营安老院：

- RACAS——安老院舍评审计划（香港老年学会）
- ISO9001——安老服务设计提供质量管理（香港品质保证局）
- SQM——安老服务管理认证计划（香港品质保证局）
- SQS——服务质素标准（香港社会福利处）

谢伟鸿先生亦积极参于政府及公共事务，他是安老事务委员会委员、教育局安老服务行业培训咨询委员会委员、香港老年痴呆症协会副主席、东华书院顾问委员会成员、香港职业发展服务处课程质量保证委员会委员、以及香港安老服务协会执行委员会委员。

BIOGRAPHY

Henry Shie joined in the elderly care service before 1990 via his family business of a private Old Aged Home (OAH) before he graduated from university. Inspired by his parents, father as a doctor in Hong Kong and mother as a respected OAH operator, Henry then started striving his company towards both Quality and Recognition. He re-structured his family business as Hiu Kwong Nursing Service (HKNS) and it was one of the first in field implementing the idea of Quality Management System and Service (QMS+S) in their service provision since 1990s. Until now, HKNS is the only private elderly service provider in Hong Kong which is co-granted with following quality standards.

- RACAS – Residential Aged Care Accreditation Scheme
- ISO9001 – Quality Management in Design and Provision of Elderly Care
- SQM – Service Quality Management Certification Scheme in Elderly Care
- SQS – Service Quality Standards

Henry Shie also contributes in Government advisory bodies and public services, he is a Member of Elderly Commission, Member of Elderly Care Service Industry Training Advisory Committee; Vice-Chairman of Hong Kong Alzheimer's Disease Association (HKADA), Member of Advisory Committee of Tung Wah College, Member of Course Quality Assurance Committee of HK Employment Development Service, Member of The Elderly Services Association of HK.

Prof. Sta. Maria MADELENE
圣玛利亚．玛特莉娜　教授

ASSOCIATE PROFESSOR, DEPARTMENT OF PSYCHOLOGY & DIRECTOR, UNIVERSITY RESEARCH COORDINATION OFFICE, DE LA SALLE UNIVERSITY, PHILIPPINES
菲律宾德拉萨大学心理学系副教授暨研究联络办公室主任

"The Implications of Active Participation among the Elderly to Care Giving"
「老有所为对提供护理的启示」

簡歷

圣玛利亚．玛特莉娜教授现为菲律宾马尼拉德拉萨大学心理学系副教授，任教人文发展、文化及心理学和应用社会心理学等课程。她于菲律宾大学修毕心理学学士及硕士学位，并于德国科隆大学完成博士学位。

玛特莉娜教授主要研究文化与自我、文化与情绪、冲突与文化以及对发展的适应力、危机因素和保护机制。她在青年发展和文化与心理两方面的研究都有在本土及国际出版。她亦曾参与有关街青成长的风险及保护因素的研究。现玛特莉娜教授现正研究菲律宾青年的价值观、以其成长发展多方面的保护及风险因素。

BIOGRAPHY

She is currently an associate professor at the Department of Psychology of De La Salle University in Manila handling the courses on human development, culture and psychology, and applied social psychology. She obtained her undergraduate (cum laude) and masteral degrees in Psychology from the University of the Philippines. She completed her doctorate degree (magna cum laude) at the University of Cologne in Germany.

Her researches have focused on culture and self, culture and emotion, culture and conflict, and on resilience, risk factors, protection mechanisms to development). Her researches in the areas of youth development, and culture and psychology have been published in both local and international publications. She has participated in the conduct of cross-country research on the risk and protective factors to developmental outcomes of street youth. She is now involved in a study investigating Filipino youth values, protection and risk factors in various contexts of their development.

Dr. Rahimah IBRAHIM
拉希默. 伊布拉欣 博士

HEAD, SOCIAL GERONTOLOGY LABORATORY, INSTITUTE OF GERONTOLOGY, UNIVERSITY OF PUTRA MALAYSIA
马来西亚博特拉大学老年学学院社会老年学研究中心主管

"Types of Support Received by Co-resident & Non Co-resident Older Malaysians"
「为马来西亚独居和非独居长者提供的多种支援」

簡歷

拉希默．伊布拉欣，马来西亚博特拉大学老年学学院社会老年学研究中心主管，主要研究如何改善老龄人口在私人及公共领域的经济、社会及文化参与。她现在亦是博特拉大学人类生态学院人类发展及家庭研究学系高级讲师，教授学士及硕士程度有关成人发展及社会老年学课程。她研究兴趣包括老人的区域支援和正规与非正规的长者护理提供。现时她伊布拉欣博士正参与多项研究项目，包括「亚洲家庭综合比较」（京都大学）、「跨代关系中的孝」（联合国教科文组织）、「马来西亚长者家居护理设施标准化及质素」（高等教育部）以及「长者福祉」（科学、科技及创新部）。

BIOGRAPHY

Rahimah Ibrahim is the Head of Social Gerontology Laboratory at the Institute of Gerontology, Universiti Putra Malaysia (UPM) that focuses on research to improve the economic, social and cultural participation of older persons in private and public spheres. She is also a senior lecturer teaching undergraduate and postgraduate courses on adult development and social gerontology at the Department of Human Development and Family Studies, Faculty of Human Ecology, UPM. Her research interest is in the area support for the elderly and also the relations between formal and informal care provisions for older persons. Currently she is involved in research projects on comparative study on Asian families (Kyoto University), filial piety in intergenerational relations (UNESCO), standardization and quality of care in residential care facilities for elderly in Malaysia (Ministry of Higher Education) and elderly well being (Ministry of Science, Technology and Innovation).

Prof. Soong Nang JANG
张淑琅　教授

Assistant Professor, Department of Nursing, Red Cross College of Nursing, Chung-Ang University, South Korea
南韩中央大学红十字看护大学助理教授

"Informal Caregiving Patterns in Korea and European Countries: A Cross-National Comparison"
「南韩与欧洲国家的民间照顾者：跨国比较」

簡歷

张淑琅教授是南韩中央大学红十字看护大学公共卫生及护理学系助理教授。张教授身兼韩国长寿研究顾问委员会的顾问，与韩国劳工学院的团队紧密合作，主力开发及修订韩国长寿研究的健康问卷有关健康、功能性身份以及保健的部份。张教授现时的研究方向集中于影响健康的社会因素、健康的不平等、伤残以及国际性比较研究。她毕业于首尔国立大学，并于同校修毕公共卫生硕士及博士学位。张教授的「护士社区探访伤健人士计划」以及「韩国老年人口的贫穷与健康」均获南韩政府颁赠多项研究奖项。她现亦担任韩国健康平等协会的委员。

Biography

Soong Nang Jang, is an assistant professor of Public Health and Nursing, Department of Nursing, College of Nursing in Chung-Ang University, Korea. Dr. Jang is an advisory committee member of Korean Longitudinal Study of Ageing (KLoSA) and has collaborated tightly with KLoSA team of Korea Labor Institute. Dr. Jang had a key role for developing and revising questionnaires of health, functional status and health care section in KLoSA. Her current research interests focus on the social determinants of health, health inequality, disability, and international comparison study. Her undergraduate studies were completed at Seoul National University and received an MPH and a doctoral degree (Public Health) from same University. Dr. Jang has received several research awards including "Community based Nurse's visit program for vulnerable population" and "Poverty and health in Korean older population" from Korean Government. Dr. Jang is a committee member of Korean Society for Equity in Health.

Dr. Treena WU
吴雪莲　博士

Postdoctoral Fellow, Duke - NUS Graduate Medical School, Singapore.
杜克．新加坡大学医学研究院博士后研究员

"Characteristics of Urban Elderly Care Recepients in Singapore, China and Indonesia"
「新加坡、中国及印尼的长者护理服务使用者特色分析」

簡歷

吴雪莲博士现为杜克．新加坡大学医学研究院健康服务及系统研究计划的博士后研究员。她以欧洲执行委员会居礼夫人学人身份于荷兰马斯垂克大学修毕经济学博士学位，她亦于美国纽约大学修毕公共行政及经济学的文学硕士学位。于2010年，吴博士是美国柏克莱加洲大学的访问学人。她研究专攻东南亚及东亚的健康、老龄化及退休问题，以及其对公共政策的启示。

Biography

Dr. Treena Wu is a Postdoctoral Fellow in Health Services and Systems Research Program (HSSR) at Duke-NUS Graduate Medical School Singapore. She holds a PhD in Economics from Maastricht University where she was a European Commission Marie Curie Fellow. She received a MA in Public Policy and Economics from New York University. In 2010, she was a Haas Visiting Scholar at the University of California at Berkeley. Her main research focus is on health, aging and retirement in Southeast Asia and East Asia; and implications for social policy.

Vita Priantina DEWI
维达．布莉安蒂娜．迪维

HEAD OF SECRETARIAT OFFICE OF CENTRE FOR AGEING STUDIES, UNIVERSITAS INDONESIA
印度尼西亚大学老年学研究中心秘书长

"Ethnographic Studies on the Role of Caregiver in Providing Care for Older Persons in Citengah Village, Sumedang, West Java and Its Implication of Care Giving Program"
「印尼西爪哇苏美当希丹格村长者照顾者角色的人种志研究及其对护理项目的启示」

簡歷

维达．布莉安蒂娜．迪维女士，澳洲默尔本大学社会健康及医疗人类学硕士，现为印度尼西亚大学老年学研究员，并自2012年3月起，担任印度尼西亚大学老年学研究中心秘书长。她研究兴趣包括：老年护理提供、老年居家及日间护理、护理提供者角色、老年友善社区及城市、跨代关系、老龄化及工作能力和长者健康。

迪维女士研究经验丰富，包括：「长者居家及日间护理及其护理提供研究」、「长者照顾者角色研究」以及「印尼西爪哇苏美当希丹格村长者照顾者角色研究及社会服务」。她亦于其他护理提供研究担当研究助理。

她的出版包括：

- 「印尼西爪哇苏美当希丹格村长者照顾者角色」维达．布莉安蒂娜．迪维着，ACPEL 2012
- 「印尼的跨代关系：家庭结构及供养照顾的检视」斯里．拉斯米迪札、维达．布莉安蒂娜．迪维、迪尼．奥古斯丁及迪里．布迪．拉克约合着，《印度老年病学期刊》，第8卷，第1册，2012
- 「长者护理提供的局限：印尼三个社区的偏好与实践」，伊丽莎伯．史奈达巴特菲尔、藤古．沙维拉．菲特利及维达．布莉安蒂娜．迪维合着，《NSC-IIAS欧亚公共及私人老年保障安排会议》，荷兰海牙，页5-7，2007年9月

BIOGRAPHY

Ms. Vita Priantina Dewi is a Master of Social Health/ Medical Anthropology degree from University of Melbourne, Australia. She is a researcher in Gerontology at University of Indonesia, Indonesia. Since March 2010 she has also been Head of Secretariat of Centre for Ageing Studies University of Indonesia (CAS UI). Her current research interests include the fields of: Care giving for older persons, Home care and day care for the elderly, The role of caregiver in providing care for older persons, Age friendly communities and cities, Intergenerational relationships, Ageing and work ability, and Health of the elderly.

Her professional experiences include research on Home Care and Day Care for the Elderly Including the Care Giving for Older Persons; research on The Role Of Caregiver In Providing Care For Older Persons, research and community service on The Role Of Caregiver In Providing Care For Older Persons In Citengah Village, Sumedang, West Java; and research Assistant in Research on Care Giving.

Her publications include:

- Vita Priantina Dewi. 'The Role Of Caregiver In Providing Care For Older Persons In Citengah Village, Sumedang, West Java'. ACPEL 2012
- Sri Lasmidjah D, Vita Priantina Dewi, Dinni Agustin, and Tri Budi W. Rahardjo. Intergenerational Relationships in Indonesia: A Review on Family Structure and Reciprocal Care and Support. In Journal of The Indian Academy of Geriatrics Vol. 8, No. 1, 2012.
- Schroeder-Butterfill, Elisabeth, Tengku Syawila Fithry, and Vita Priantina Dewi. The Limits of Old-age Care Provision: Preferences and Practices in Three Indonesian Communities. NSC-IIAS Conference On Public and Private Old-Age Security Arrangements In Asia and Europe. Den Haag, the Netherlands 5-7 September 2007

Dr. David, Lok Kwan DAI
戴乐群　医生

DEPARTMENT OF MEDICINE & THERAPEUTICS, PRINCE OF WALES HOSPITAL, HONG KONG
韦尔斯亲王医院老人科顾问医生

簡歷

戴乐群医生从医30载，专攻老人、复康及胸肺医学。他自2002年起担任香港威尔斯亲王医院老人科顾问医生，亦是香港中文大学及香港大学的名誉教员。戴医生亦为香港政府劳工及福利局中多个督导委员会及工作组的委员，主力研究长者的社区护理及居家护理服务。他也任职社会福利署的多个委员会及专案小组和监护委员会的委员。另外，戴医生现任香港老年痴呆症协会的荣誉秘书，而他亦是该会上届主席。载医生積极进修，于2009年修毕法律学士学位，并于2010年成为认可调解员，而此两项专业资格更协助他更好地处理医院管理局的投诉管理工作。自2009年起，他担任社会福利署的独立处理投诉委员会委员。载医生深信，每一个普通人都能透过服务、勇气和热情为人服务。

BIOGRAPHY

During his 30-year career in the medical profession, Dr. David Dai Lok Kwan, MBBS, FHKAM, FRCP, LLB (Hons.) has specialised in geriatric, rehabilitation and pulmonary medicine. He has been the Consultant Geriatrician in the Department of Medicine at Prince of Wales Hospital, Hong Kong, since 2002, and he holds honorary teaching positions at the Chinese University of Hong Kong and Hong Kong University. In addition, Dr. Dai was a member of several Hong Kong Government Labour and Welfare Bureau steering committees and working groups studying issues relating to community care and residential care services for the elderly. He was a member of several Social Welfare Department committees and panels, and of the Guardianship Board's Panel. Besides, he serves as the Honorary Secretary of the Hong Kong Alzheimer's Disease Association, and he is its Immediate Past President. In 2009, Dr. Dai obtained his LLB as a personal enrichment, and became an accredited mediator in 2010. These two qualifications enhanced his work in complaint management in the Hospital Authority. Dr. Dai is also a panel member of the Independent Committee for Handling Complaints of the Social Welfare Department since 2009. Dr. Dai believes that an ordinary person can contribute to his fellow human through service, courage and passion.

Prof. Zhenyao WANG
王振耀　教授

Director of China Philanthropy Research Institute, Beijing Normal University, China
北京师范大学中國公益研究院院长

"China's Situation of Elderly Care and the 12th Five-Year Plan: An Analysis of the Elderly Care Provision System in China"
「中国基本养老形势与『十二五』规划——中国养老服务体系解析」

簡歷

王振耀教授生于1954年，河南省鲁山县人，2001年毕业于北京大学政府管理学院，获法学博士学位。历任民政部救灾救济司及国家减灾中心，现为北京师范大学中国公益研究院院长及社会发展与公共政策学院教授，主力研究公益与慈善，社会保障政策与实务，应急管理以及社会救助。

王教授在民政部基层政权建设司副司长任上，极大地推动了中国农村村民选举；在救灾救济司任上，推动建立了城市居民最低生活保障制度和国家自然灾害救助四级回应体系。在福利和慈善事业促进司任上，推动了孤儿保障工作，实现了孤儿救助标准提高到最低600元每月。

在公益慈善领域内，首倡并大力推广「平民慈善」、「以善治促慈善」等理念，广泛号召全社会的共同参与。他率先提出了「通过五年努力，争取使我国人民捐款数额接近或达到年人均50元的目标，力争使我国的慈善年捐款额达到500亿元。」这一我国慈善事业发展的阶段性目标。2006年10月，在他的大力支持和具体指导下，民政部中民慈善捐助资讯中心正式成立，力图通过促进资讯公开和行业自律，推动中国的慈善事业步入良性发展的轨道。

王振耀教授推动了慈善公益事业的资讯公开，在促进慈善公益事业的发展、提高和维系民众的公共道德水准方面进行了制度化创新。

Biography

Prof. Zhenyao Wang, born 1954 in Henan Province, China, has obtained his LLD from the School of Government, Peking University in 2001. Prof. Wang has worked in China's Department of Disaster Relief, Ministry of Civil Affairs and the National Disaster Reduction Centre. He is currently the Director of Philanthropy Research Institute and Professor in the School of Social Development and Public Policy, Beijing Normal University, who focuses in the research in philanthropy, policies and practices of social security, emergency management and public assistance.

During his office in the government, Prof. Wang has advocated democratic elections in rural China, the establishment of Urban Social Security System, and Orphanage Security (lifting minimum assistance to RMB600 per month).

In philanthropy, Prof. Wang enthusiastically promotes the concepts of "public charity" and "administration with love in advocacy of charity", to lobby public participation. He suggested to "strive for a national target of RMB50 per capita per annum donation in five years totalling 50 billions", a milestone of the philanthropical development in China. In 2006, Wang leaded and supported the establishment of China Charity and Donation Information Center, Ministry of Civil Affairs, to enhance transparency of information and self-regulation of China's philanthropy.

While improving the information disclosure of China's philanthropy, Prof. Wang has contributed systematically in the development, proliferation and sustaining of the public moral standards.

Prof. On Kwok LAI
黎安国　教授

PROFESSOR, GRADUATE SCHOOL OF POLICY STUDIES, KWANSEIGAKUIN UNIVERSITY, JAPAN
日本关西学院大学政策研究学院教授

"Silver Hair Market in Japan? Good Quality of (Whose) Life with Silver-to-Black Consumption?"
「日本的银发市场：从银发到黑发的优质生活消费」

簡歷

黎安国，香港大学社会科学学士、硕士、德国不来梅大学社会科学博士。曾任香港社工及大学讲师。现任日本关西学院大学综合政策研究科教授、香港大学社会工作及社会行政学系荣誉教授、香港大学城市规划及环境管理研究中心荣誉研究院士。他亦是联合国大学高等研究所(UNU-IAS)访问教授。

黎教授出版超过100份有关亚洲及欧洲的环境、社会及城市课题的期刊及书籍文章。他曾获邀于多个国际会议发表演讲，主办机构包括：联合国教科文组织、联合国大学高等研究所、世界卫生组织、国际社会福利联会、日本国际协力机构、马来西亚策略及国际研究学院、匈牙利科学院，以及韩国广播及传理研究协会。他最近的研究为：「资讯社会及全球化与社会发展」。

BIOGRAPHY

On-Kwok LAI, Professor at Graduate School of Policy Studies, Kwansei Gakuin University, Japan, honorary professorship in Social Work & Social Administration and honorary fellowship in Urban Planning & Environmental Management, both at The University of Hong Kong. Visiting Professor at United Nations University – Institute of Advanced Studies. Graduated from The University of Hong Kong (B.Soc.Sc., M.Soc.Sc.), and University of Bremen (Dr.rer.pol.), Germany under DAAD Fellowship, he has taught/researched in Germany, China and New Zealand.

He publishes over 100 journal papers and book-chapters on environmental, social and urban issues and policy in Asia and Europe; and has been invited as speaker for conferences of UNESCO, UNU-IAS, WHO, International Council of Social Welfare, Japan International Cooperation Agency (JICA), and Malaysia's Institute of Strategic & International Studies, Hungarian Academy of Sciences and Korean Association of Broadcasting & Communication Studies. His recent research is on: social development issues of information society and globalization.

Prof. Fon Sim ONG
王华新　教授

PROFESSOR & HEAD OF MARKETING DEPARTMENT, TAYLOR'S UNIVERSITY, MALAYSIA
马来西亚泰莱大学市场学系系主任

"Older Consumers in Malaysia: Spending Pattern, Leisure Activities and Consumption Preferences"
「马来西亚的银发市场：消费模式、休闲活动与消费偏好」

簡歷

王华新教授为马来西亚泰莱大学市场学系系主任，亦是该校理事。加入泰莱大学前她于2009至2011年间曾任马来西亚敦亚都拉萨大学的商学研究院院长，及后她辞去有关职务专注研究工作。

王教授研究范围包括老龄化与高龄消费者、消费行为、物质主义、宗教狂热以及市场策略，而她近期主要研究社会保障。她发表多份国际评审论文、书藉文章和专论。

王教授研究网络覆盖本地及海外院校，她现担任：

1. 马来西亚敦亚都拉萨大学商学研究院之资深研究员
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贺国强博士于香港、美国及加拿大接受教育。他现为教育曙光香港教师会教育学报总编辑，并同时担任两份国际论文的编辑委员会委员，亦是香港两所高中及基督教团体的董事会成员。

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BIOGRAPHY

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He was a high school teacher (1970-81) and principal (1981-94), a visiting scholar to U.K., USA and Australia.

He becomes a tertiary educator since 1994, served in 4 universities. He is now a research fellow of Lingnan University in Hong Kong.

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He has more than 200 pieces of publications, including books and reports, book chapters, journal, magazine and newspaper articles, editor of books and journals. He has been invited to speak in conferences and churches. His major areas of interest are medium of instruction, research, creativity, policy, curriculum, assessment, and religious education.

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Keynote Articles

主讲论文

*English Version
英文版本

"Regional Analysis on the Implementation of Madrid International Plan on Ageing"

Chair Professor & Director of Asia-Pacific Institute of Ageing Studies, HK
Prof. Alfred Cheung Ming CHAN
Senior Project Officer, Asia-Pacific Institute of Ageing Studies, HK
Ms. Phoebe Pui Yee TANG

Abstract

The world's population is rapidly ageing, are countries all geared up to withstand the impacts brought by the demographical changes? 2002 marked an historical moment for the ageing world, where the Madrid International Plan of Action on Ageing (hereafter 'MIPAA') was adopted by 159 countries worldwide at the Second World Assembly on Ageing held in Spain. Countries pledged their commitments to building a society for all ages by means of institutional arrangement, policies and programmes. The document sets out objectives and priority areas in dealing with the ageing population, which serve as guiding principles to policymakers and service providers. 10 years since MIPAA was adopted in 2002, how much progresses countries have made since then? How far countries are from the goals established in 2002? The paper will provide a detailed account the progress on the implementation of MIPAA in regard to ageing policies and programmes based on the responses from 30 countries and areas s in Asia and Pacific region under three priority directions (1) Older Persons and Development; (2) Advancing Health into Old Age; and (3) Ensuring Enabling and Supportive Environments .

Ageing Asia-Pacific and the 10th Anniversary of Madrid International Plan of Action on Ageing (MIPAA)

Asia is the home of two of most populated countries in the world – China and India, the region will age at an unprecedented pace, where the 438-million older persons recorded in 2010 will triple to 1.26 billion by 2050 and becoming the region with the largest number of older persons in the world. Countries in the Asia-Pacific region vary greatly in terms of economic, social, cultural and political developments which further complicate the challenges brought by the demographic change.

In 2002, 159 countries in the world pledged commitments to the Madrid International Plan of Action on Ageing (MIPAA) at the Second World Assembly on Ageing, in response to the opportunities and challenges brought by the population ageing as well as to promote a society for all ages through policies and services. MIPAA provided guidelines for governments to address key ageing issues.

To assess countries' progresses since 2002 and to move forward with MIPAA in the coming 5-year implementation cycle, the second global review and appraisal of MIPAA have begun in different regions and will be concluded in 2013. APIAS was appointed as the regional consultant agency by the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) to look into countries' institutional arrangement, legislation, policies and services for ageing or older persons.

APIAS collected information on national mechanisms, legislations, policies, programmes and services related to ageing or older persons by means of self-administered questionnaire survey. The questionnaire translated MIPAA into operational items and was distributed to all member states and associate members of UNESCAP. As at July 2012, 30 countries and areas in the region, including Armenia, Australia, Republic of Azerbaijan, Bangladesh, China, Democratic People's Republic of Korea, Fiji, Georgia, Hong Kong China, India, Indonesia, Japan, Republic of Korea, Lao People's Democratic Republic, Macao China, Malaysia, Maldives, Mongolia, Myanmar, Nepal, New Zealand, Papua New Guinea, Philippines, Russian Federation, Samoa, Sri Lanka, Thailand, Turkey, Uzbekistan and Viet Nam, participated in the exercise. The survey inquired four main areas of work, including (1) institutional arrangement on ageing; and the three priority directions of MIPAA–(2) Older Persons and Development, (3) Advancing Health Into Old Ageing; and (4) Ensuring Enabling and Supporting Environment for the Older Persons.

National coordination and policy framework

Most surveyed countries have established either a focal agency or a coordinating body as an instrument to mainstream ageing into government action and also to oversee issues concerning ageing or older persons (Table 1). It ranges from a more permanent government structure at the ministerial level to a single-agency or inter-agency/ committee on ageing, or a division or a branch or a function of the implementation department. The wide range of coordinating body in these countries shows the different strategies used to tackle the needs of older persons in specific countries and areas.

Australia and New Zealand have made specific institutional arrangement and set up offices that dedicated to ageing issues or older persons. The Office for Senior Citizens in New Zealand operates on its own budget and the Minister for Senior Citizen is tasked to take the leadership to steer, to direct and to coordinate interdepartmental strategy, manpower and resources in dealing with issues surrounding ageing and older persons. Data shown countries/areas are moving inter-departmental, inter-agency and inter-ministerial approach in its establishment to ensure government respond appropriately and coherently to the challenges of ageing. Close to one-third of surveyed countries/ areas, more commonly seen in developing economies, the responsibilities for ageing issues are not clearly ascribed to a coordinating body but being subsided into governmental departments on health, social welfare, labor issues and alike. A number of countries such as Bangladesh, Hong Kong and Indonesia have established councils, committees or commissions that serve as advisory bodies to governmental institutions and to coordinate the planning and development of various programmes and services for the older persons.

Priority Direction 1: Older persons and development

The participation of older persons in decision making will ensure the provisions in age-specific policies are designed to and implemented for the needs of older persons. Countries/areas have distinctive measures not only to ensure voices of older persons are heard but also to allow them to actively participate in the process of policy making and/or decision making at different levels. The voices of older per-

sons are infiltrated by means of membership in high-level consultative body to community-level committee that advises policy-making and its implementation and evaluates service provisions. New Zealand government has launched a nation-wide Voluntary Community Coordinators Program which now has 44 coordinators. The coordinators will consult older persons in their local communities and gathering information through their connections and older persons' organizations and feed into the Office of Senior Citizens to provide government agencies with an older persons' perspective in policy development and service evaluation.

MIPAA recognized the importance of having social protection and social security for all people which is a very complicated subject that appear in various forms and means – to name a few, such as pension, health insurance, disability insurance, minimum income for older persons with no other means of support – but serving the same purpose. Pensions are important source of income in old age. The pension system in developed economies tended to be more developed, of wider coverage. Universal coverage retirement protection for older persons, meaning a flat-rate benefit to all retirees (provided that they meet the criteria on age and the length of required residency) is only available in a few countries/areas in the region.

Social protection and social security system in many countries and areas in the Asia-Pacific region, especially the developing ones, have a rather short period of development, leaving a majority of workers either enter old age without a pension or work outside the formal economy. Efforts was being made in most countries and areas to ensure a social floor for everyone, ensuring a basic income regardless if he/she has continued to a scheme in his/her working years except Myanmar. Albeit being comprehensively developed, the pension systems in developed economies such as Japan, New Zealand and Australia, have been recently reformed to keep up with the increasing number of aged population with ever-changing needs so as to stay strong against the criteria suggested by the World Bank: (1) Adequacy; (2) Affordability; (3) Sustainability; and (4) Robustness. A few countries and areas in the region provide long-term care insurance to citizens. However, it should be noted that each country has their distinctive social protection or social security systems which might be highly dependent on their socio-economic and cultural circumstances.

In the area of increasing elderly employment opportunities, unlike other countries and areas which mainly provide training programmes or modify the laws of retirement age, Australia, China, Republic of Korea, the Philippines, Vietnam, Macao China, Mongolia, Indonesia, Samoa are exceptional in a way that provides substantial support to help older persons to continue working or to run their own businesses.

Priority Direction 2: Advancing health and wellbeing into old age

The promotion of health and welling is 'the cornerstone of healthy ageing'[1]. The promotion of good health would not only add years to life, but add life to years. In this respect, MIPAA calls upon countries to: Firstly, reduce 'the cumulative effects of factors that increase the risk of disease and consequently potential dependence in older age'[2]; Secondly, develop 'policies to prevent ill health among older persons'[3]; and thirdly, provide 'access to food and adequate nutrient for all older persons'[4]. The analysis therefore looks at policies and programs of two ends: prevention of non-communicable disease (NCDs) and promotion of adequate nutritional intake of older persons.

The data revealed one-third of the surveyed countries and areas have policies and programs in place for the promotion of healthy and active ageing. 24 surveyed countries and areas have policies and plan in place to ensure the provision of accessible and affordable health care services except Armenia, Lao People's Democratic Republic, Bangladesh, Fiji, Papua New Guinea, and Uzbekistan who did not provide any information in this area for the analysis. Evidence revealed that among the 24 surveyed countries and areas, there are basically two types of provisions: The first type is universal health care coverage either fully or partially funded by the government and integration of older persons in various health care schemes. The second type is preferential arrangement and provided free health care services to older persons but at different age and other requirements to qualify the benefits, for example, Vietnam starts at 80 years old or above; Armenia; Macao China; and Nepal start at 65; and Malaysia and Georgia starts at 60. Only a few countries in the region, including Japan, Mongolia, Republic of Korea and Thailand have universal healthcare systems in place to ensure free access to services for all citizens.

In the area of geriatric and gerontologist training for health care providers, most surveyed countries/areas are prone to have either tertiary education institutes to provide diploma-/degree-level courses– a more theoretical-based and academic approach – or have local units to provide tailor-made in-house service training, as characterized by short-term, skill-based, goal-orientated approach). Countries like China, New Zealand and Australia operate geriatric and gerontology using a life-long learning approach under the vocational training category. Competency is clearly articulated into qualification framework with built-in career ladder. This is explicated in Australia's Aged Care Workforce Fund that provides a continuum of basic to advanced level of training and education which encourage people to enter the elder care workforce at different levels with well- defined job description.

In the promotion of self-care in older persons and involving of older persons in the development of social and health care programmes, most surveyed countries/areas recognized the importance of promoting self-care in older persons and have relevant initiatives in place. New Zealand has pioneered a seamless care service model (an integrated service delivery model) to support older people to live at home. To promote rehabilitation in home environment, the government is collaborating with community therapy service provider and specialist geriatric medical care professionals to supply education and training to the patients, care-giver and family members. Australian government, under the National Health Reform Agreement, has seen putting much effort into strengthening consumer engagement and their voice in health care services. Legions of work have been done in building health literacy, fostering community participation, and empowering consumers especially to make fully informed decisions on choice of aged care services. All these actions are seldom viewed in other countries.

Priority Direction 3: Ensuring enabling and supportive environments

The concept of 'ageing in place' is the core concept that encourages governments to introduce measures to enable older persons to continue living in their own homes. Only a few surveyed countries or areas have specific policies to enable older person to remain in their own homes such as Hong Kong, Thailand, New Zealand and Macao. One-third of them were however seen investing great effort into the provision of homes for the older persons, from public housing to residential homes. In Korea, Philippines and Japan, laws and regulations were passed to govern the supply of housing units for the older persons. Developing countries such as Armenia and Uzbekistan with economies still in transition, rapid demographic ageing is taking place in a context of continuing urbanization where a large number of persons are ageing in isolation in rural areas, being left alone, without adequate transportation and support systems.

The provisions of affordable and accessible transportation to older persons were seen in 19 surveyed countries/areas by means of concessionary/free fare or/ and priorities

1 United Nations, Political Declaration and Madrid International Plan of Action on Ageing, New York, 2003, P.28.
2 Ibid. P. 28-29.
3 Ibid.
4 Ibid.

seats on public transports to older persons. Australia and New Zealand offers travel concession or free discounts to older persons through an income-tested membership. The membership includes an array of business discounts on top of transportation, which removes the financial barrier of using public transport and facilities older persons' access to essential services and encourages participation in recreational and leisure activities. Legal enforcements were found in Korea, Japan, Philippines, Thailand, Vietnam, Sri Lanka and Japan to guide and to ensure barrier-free and easy access facilities to old persons.

Well-coordinated formal and informal care with well-trained caregivers ensures a continuum of care and services for older persons. Measures to develop training programmes for formal and informal caregivers were found in most surveyed countries/areas. Evidence shows trainings were mostly carried down by specialized institutions or universities targeting formal caregiver, whilst little effort was found on training up informal caregivers. Concerning accreditation system for care training, only China and Hong Kong have such establishment. Neither accreditation systems allow portability of qualified local trainees to work in other Asia-Pacific countries or areas. Philippines have developed a similar model enforced via educational bureaucracy.

MIPAA recognizes the risk of potential neglect, abuse or violence and calls for action to eliminate all forms of elder abuse by creating support services to address the problem. It is noted that demographic and economic challenges in Asia-Pacific region give rise to abuse, which usually happens within the family against older women. Only four surveyed countries/areas have specific legislations to protect older persons against any forms of abuse. Efforts to address the problem in form of public education, training for frontline professionals and non-professionals, research, provision of counseling service, shelter and financial assistance to victims were seen in Hong Kong, Korea, Samoa, Macao, Russia, Indonesia, New Zealand and Australia.

Conclusion and recommendations

Ten years have passed since the MIPAA was adopted at the Second World Assembly on Ageing, it is assuring to learn that most countries and areas in the Asia-Pacific region have paid close attention to the ageing situation and have taken initiatives and measures of various magnitudes to tackle the emerging challenges. Considered the ageing situation and characteristics peculiar to the region, special attention should be given to the following aspects:

1. Gender-sensitive approach to ageing policies and programs

Older women will account for some 60% of the elderly population (age 60+) and 70% in the oldest-old cohort. Different life events happened over the course of woman's life will increase their vulnerabilities as they age especially in male-oriented Asian society such as discrimination against girls leading to inequitable access to food and care with restrictions on education at all levels, childbirth without adequate health care and support, low incomes and inequitable access to decent work due to sex-discrimination in the labor force, caregiving responsibilities associated with mothering, grandmothering and looking after one's spouse and older parents that prevent or restrict working for an income and access to an employee-based pension, domestic violence, which may begin in childhood, continue in marriage and is a common form of elder abuse, widowhood leading to a loss of income and may lead to social isolation, cultural traditions and attitudes that limit access to health care will pose serious threat to their health and well-being. Policies and programs should further place a special emphasis on women, especially, the poor and the lowly educated ones.

2. Resurrecting family value and care function for better aged care

Despite the tradition of Asian families (i.e. big family with many people living in a household and members are able to draw on each other's resources to meet psychological, social and physical needs), family support for the elderly is on the decline due to urbanization, the emergence of the nuclear family, and the increasing likelihood that women will become educated and join the labor force. Surveys in Chinese societies have consistently shown that both younger and older generations currently hold less traditional attitudes toward family support for older persons. The role of the informal social network becomes especially important. The family, along with other informal caring networks such as friends and neighbors, can provide essential assistance to meet the needs of older persons. It is therefore important to revitalize traditional family values in the years to come. The demeanor and attitude should be nurtured at an young age through formal and informal education

3. Capacity building for informal and formal elder care worker

Most countries identified trainings for caregivers and professionals as the grand challenge in the face of ageing population. An accreditation system for care training should be in place for Asia Pacific which, on one hand, allows portability of qualified local trainees to work in other Asia Pacific countries and, on the hand, attract, recruit, protect and reward informal care-givers (such as family members and community care-giver) to care for the older persons by recognizing their care competence.

4. Moving forward with Madrid International Plan of Action on Ageing (MIPAA)

MIPAA is a non-binding document that lacks an independent monitoring and accountability mechanism to ensure systematic review of implementation. This might be one of the factors explaining the slow progress in relation to some areas, the disparity of issues prioritized and outcomes achieved from country to country, area to area. Macao SAR Government has developed the Ageing Policy Integrative Appraisal System (APIAS) - a tool that translated the essence of MIPAA into operational items that enable policy makers, service providers and service users to monitor, to evaluate and to appraise aging policy in a bottom-up participatory manner – in 2008 for the purpose. The APIAS has two main components: First, a comprehensive indicator of policy implementation and; Second, a validated instrument for elders' appraisal on ageing services and their quality of life as a result of policy implementation. The APIAS has been the first of its kind, in terms of its design and scale, in Asia Pacific Region to tap on and to move forward the implementation of MIPAA policy directives in local arena from two ends, i.e. Providers' and Receivers'. It is multi-functional, applicable to the whole region/country as well for specific functional areas to enhance regional cooperation and advancement for the implementation of MIPAA.

Table 1: Overview of national coordinating body/committee/agency on ageing in selected countries and areas in the Asia and the Pacific

Type	Name	Founding Year	Country/ Area	N	%
Minister for Ageing/Office for Senior Citizens	1. Office for an Ageing Australia 2. Office for Senior Citizens	1986 1990	Australia New Zealand	2	6.67
Inter-agency **Inter-ministerial Committee on Ageing**	3. China National Working Commission on Ageing 4. Inter-Agency Working Committee on the Elderly 5. The Aged Society Measures Council 6. Presidential Committee on Low Fertility and Ageing Society, Ministry of Health and Welfare 7. National Committee on Elderly 8. Central Senior Citizen Welfare Committee 9. National Coordinating and Monitoring Board 10. National Older Persons Commission 11. Vietnam National Committee of Ageing 12. National Council of Elders	1999 2009 1995 2005 1999 2006 2004 2004 2004	China Fiji Japan Korea Lao PDR Nepal Philippines Thailand Vietnam Sri Lanka	10	33.33
National Committee on Ageing/Elderly **Commission**	13. Bangladesh National Committee on Ageing 14. Central Committee of Korean Federation for Care of the Aged 15. Elderly Commission 16. National Commission for Older Persons	2002 2003 1997 2004	Bangladesh Democratic People's Republic of Korea Hong Kong, China Indonesia	4	13.33
Ministry/Department of Social Welfare/Social Justice/Labor	17. Division of Elderly Issues, Ministry of Labor and Social Issues 18. Ministry of Social Justice and Empowerment 19. Social Services and Child Protection Agency, Ministry of Family and Social Policy 20. Ministry of Health and Social Development	N/A 1999 2011 N/A	Armenia India Turkey Russia	8	26.67

Table 1: (cont'd)

	21. Elderly Service Division, Social Welfare Bureau	1999	Macao, China		
	22. Department of Social Welfare, Ministry of Women, Family and Community Development	2001	Malaysia		
	23. Home Care Project Advisory Committee, Department of Social Welfare[7]	2004	Myanmar		
	24. Disability and Elderly Division, Department for Community Development,[8]	2010	Papua New Guinea		
No information/Nil			Georgia Maldives Mongolia Samoa Republic of Uzbekistan Republic of Azerbaijan	6	20
				30	100

1. The committee will be transformed into the National Committee of Ageing in August 2011.
2. The National Elderly Persons Coordinating Committee was established in 2002 and became defunct later on. The Disability and Elderly Division organized a meeting with relevant stakeholders in July 2011 and set up an interim committee in place.

"Health and Social Care for Older Persons from Culturally and Linguistically Diverse Backgrounds: Australian Policy and Practice"

Pro Vice-Chancellor and President (Gippsland Campus), Monash University, Australia
Prof. Helen BARTLETT

Introduction

In an increasingly globalised world, the challenges of meeting the health and social needs of older people from culturally and linguistically diverse (CALD) backgrounds is becoming increasingly important, with the World Health Organisation stating that designing for diversity is a primary characteristic of an age friendly city (World Health Organization [WHO], 2007). In Australia, the importance of meeting the needs of CALD older people has been recognised at all levels of government and is one of the features of the current proposed Australian Government aged care reforms (Chenoweth, Jeon, Goff & Burke, 2006; Commonwealth of Australia, 2012; Radermacher, Karunarathna, Grace & Feldman, 2011). This paper explores the challenges and opportunities of CALD ageing, building on an earlier scoping study of ageing and cultural diversity (Bartlett, Rao & Warburton, 2006) which included a comprehensive review of the literature (Rao, Warburton & Bartlett, 2006) and analysis of the implications for policy and practice (Warburton, Bartlett & Rao, 2009). In addition to consideration of the health and social needs of diverse groups, this paper reviews a range of other factors impacting upon the wellbeing of CALD older people, outlines selected innovation and good practice, and highlights areas for further research, policy and practice development.

CALD population trends

Australia is experiencing population ageing as a result of decreased fertility rates, increased life expectancies, and migration patterns. The number of people aged 65-84 years is expected to more than double in Australia by 2050 (rising from 2.6 million in 2010 to 6.3 million in 2050, with a trebling in those aged 85 years and over (rising from around 400,000 in 2010 to 1.8 million in 2050) (Commonwealth of Australia, 2010). Australia has a diverse population with, 26.8% of the total population born overseas (Australian Bureau of Statistics [ABS], 2011), making it one of the most diverse countries in the Organization for Economic Cooperation and Development (OECD, 2011). As a result of the timing of migration waves, the CALD population is ageing at a faster rate than the general community, with 17.9% of the overseas-born population aged 65 years and over compared to 11.8% of the total population (ABS, 2011). The advanced ageing of migrant groups is predominantly in those cohorts which emigrated from European countries following World War II (e.g. 56% of Italian-born Australians are aged 65 years and over), with those from later migration waves from Europe and Sub-Saharan Africa having a younger age profile. These migration waves have been influenced by changing migration policy, including the abolition of the White Australia Policy in the mid-1970s (Warburton et al., 2009). A recent report has emphasised the level of diversity within older CALD groups in Australia and that these differences should be considered when planning service delivery (National Seniors Australia Productive Ageing Centre, 2011).

Current policy approaches

Under the Aged Care Act 1997 (2012), people from non-English speaking backgrounds were identified as a special needs group in terms of residential and community care. In addition, the 2007 Home and Community Care (HACC) National Program Guidelines (Commonwealth of Australia, 2007) identify people from CALD and ATSI backgrounds as special needs groups. There are two main Australian Government programs related to the provision of culturally appropriate care - the Community Partners Program (CPP) and the Partners in Culturally Appropriate Care (PICAC) Program (Department of Health and Ageing, 2009).

The CPP was established in 2005 to provide funding for organisations supporting CALD communities to help make aged care services more accessible and supportive. The first round of CPP funding saw $2.4M provided to 40 organisations across the country (Bishop, 2005). The demand for CALD aged care services has clearly grown since then with $15.6M in funding over three years provided in 2009 to 77 CPP projects (Elliot, 2009b).

The Partners in Culturally Appropriate Care (PICAC) Program was developed to improve the capacity of aged care services to respond to the differing needs of older people from CALD communities (Department of Health and Ageing, 2009). Through the PICAC program one organisation is funded in each Australian State and Territory to provide this support to aged care providers, CPP projects and CALD communities. This includes the provision of training for the aged care sector on quality culturally appropriate care. Like the CPP, PICAC funding has increased, rising from $2.7M over two years in 2009 (Elliot, 2009a) to $6.6M over three years in 2011 (Butler, 2011). The CPP and PICAC programs primarily play a linkage role in connecting community organisations, service providers and government and while the programs funded direct costs such as training, they did not cover indirect costs such as those associated with staff and back filling (Aged and Community Services Australia, 2007).

In response to concerns about the current aged care system in Australia and its capacity to respond to the expected increases in demand resulting from increasing numbers and expectations of older people, the Australian Government requested that the Productivity Commission conduct a wide ranging review of the aged care sector (Productivity Commission, 2011). One of the key recommendations of the Commission was that access to aged care should be simplified through the introduction of a single gateway. The Commission recognised that one of the drivers for change in the aged care sector was the increasing diversity of the older population including people from CALD and ATSI backgrounds, recommending that:

The proposed Gateway should cater for diversity by establishing access hubs for older people from CALD backgrounds, providing interpreter services and ensuring its diagnostic tools are culturally appropriate for the assessment of care needs. Greater recognition in aged care standards of the rights and needs of older people from diverse back-

grounds. (Productivity Commission, 2011, p. LXXXVII)

In response to the Productivity Commission Review, the Australian Government has released its proposed Living Longer Living Better - Aged Care Reform package (Commonwealth of Australia, 2012) which includes an increase in funding for services for people from CALD backgrounds ($24.4M), ATSI backgrounds ($43.1M), as well as further assistance for veterans, older people from sexually diverse groups and the homeless. The reform package has received qualified support from the aged care sector but has yet to be passed by Parliament.

The health and social needs of CALD older people

Health needs

The health of migrants to Australia is noted to be better than their Australian-born counterparts (Australian Institute of Health and Welfare, 2010; Draper, Turrell & Oldenburg, 2004). This 'healthy migrant effect' is due in part to selective nature of immigration policies which favour those in good health and, in some cases, higher socioeconomic status.

Nevertheless, the circumstances surrounding migration can have an impact on healthy ageing. There is evidence that those people who migrated to Australia because of war, political and economic unrest, or religious conflicts, find it harder to adapt to their new country and this impacts on their future health (Rao et al., 2006). Furthermore, the reason for migration, based on visa type (refugee, family reunion, and skilled labour) has been linked to level of psychological distress (Chou, 2007). The length of time in Australia post- migration can also impact on health and social outcomes – both positively and negatively. While Terry, Ali, and Le (2011) report that it can take 2-3 years to become acculturated to the health system, Alizadeh-Khoei, Mathews, and Hossain (2011) found that the level of psychological distress was associated with acculturation (as indicated by whether or not they spoke English at home) but not by length of time in Australia. Interestingly, it has been noted that small migration groups and those from earlier migration waves which have not been replenished are more at risk of isolation (Warburton et al., 2009).

While generally in better health, socioeconomic, cultural and genetic factors mean that certain immigrant groups do face particular health issues. For instance, recent studies have found that older people from Northern European countries and Asia are more likely to be diagnosed with diabetes mellitus (AIHW, 2010); older Iranian immigrants had higher levels of psychological distress, lower feelings of well-being, greater functional limitations and need for help or assistance with activities of daily living (Alizadeh-Khoei et al., 2011); and older Italian-born men suffering from back pain were more likely to report that it was more frequent, severe and debilitating than that reported by Australian-born men (Stanaway et al., 2011). With regards to the latter findings about self-reported back pain, the authors suggested that these differences could be explained by socioeconomic factors such as years of education and occupation history.

Generally, the evidence suggests that CALD older people are more likely to require greater levels of hospitalisation during the final year of life, have a higher rate of mental disorders, particularly psychological distress, and are more likely to present to the health system in advanced stages of dementia (Rao et al., 2006). Increased levels of psychological distress have been confirmed in longitudinal research of people aged 50 years and over who migrated to Australia in 1999-2001, which found that their levels of distress increased over the course of the following year and that this increase was closely related to their country of origin (categorised as Western and Developed, Asian, and other) and visa type (refugee, family reunion, and skilled labour) (Chou, 2007).

Social needs

While it is commonly believed that CALD older people live with their family, Warburton et al. (2009) have suggested this is a myth. In particular, recently migrated families may be too busy establishing themselves to have the time to care for their parents. In an increasingly urbanised world, traditional approaches such as filial piety are breaking down, with multigenerational families being replaced by nuclear ones (Bartlett & Liu, 2009). Nevertheless, CALD families are more likely to have greater levels of involvement with their older family members and, in some cases, this can reduce the capacity of older people to access the care and support they need because of the reticence of their family members to seek external support or their lack of awareness of available resources (Boughtwood et al., 2011; Warburton et al., 2009; Xiao, Haralambous, Angus & Hill, 2008).

The language barriers faced by those from non-English speaking backgrounds and the loss of former social networks can place CALD older people at greater risk of social isolation (Rao et al., 2006). The level of isolation may be increased in cases where isolated older people revert to their first language (Warburton et al., 2009). Other risk factors identified for increased social isolation related to migration, with people from new and small migration groups and those from past waves which are now ageing and not being replenished by new migrants, having less opportunity to connect to peers from their cultural group. It has also been found that language barriers are likely to deter CALD older people from volunteering to work in for mainstream volunteer organisations (Warburton & McLaughlin, 2007).

Use of health and community services

There is ample evidence to show that CALD older Australians do not receive adequate health and community services (Johnstone & Kanitsaki, 2008; Millichamp & Gallegos, 2011; Rao et al., 2006). While there is a general reduction in the uptake of services by CALD older people, where they do utilise services, there is a preference towards community-based over residential care services (Rao et al., 2006). CALD older people are also less likely to have had Aged Care Assessment Team (ACAT) referrals which are often the precursor to admission to residential care, perhaps because families are not aware of services or reluctant to use them. Some differences have been identified with specific groups, for example, while older Iranians were found by Alizadeh-Khoei et al. (2011) to have greater health and psychological needs compared to the general population, they were less likely to use services. It was also reported that those with lower levels of English language competency had more health problems and greater need for services but that language level was not related to service usage level, perhaps because of a general lack of awareness in the Iranian community of available services or a cultural predisposition towards family-based care.

There is also evidence that geographic location has an influence on service use, specifically that there may be less

capacity to provide culturally appropriate care in rural and remote locations (Rao et al., 2006). In a review of service use of older Asian migrants in the Australian state of Tasmania, it was reported by Terry et al. (2011) that some participants found the Tasmanian health care system to be inferior to that of mainland Australia, with limited CALD-specific care options, leading some participants to travel to the mainland and even to their homelands for better and more culturally appropriate care. It has also been reported that participants with lower levels of English competency have more difficulty navigating the complicated health care system (Terry et al., 2011). In another study of Asian migrants, Xiao et al. (2008) found that older Chinese immigrants were less aware of health services, particularly allied health services, perhaps because these services were less common in their birth countries.

The provision of culturally appropriate care

As noted earlier, the importance of providing culturally appropriate aged care services has been accepted by all levels of Australian government. This involves taking into consideration a number of factors, including the following:

Perceptions of ageing

Cultural differences in the way that ageing is perceived can also play a role in how CALD older people respond to ageing and take up health and community services. A study of older Chinese Australians found that they viewed ageing as an inevitable process and identified a belief-system that encourages self-enforced seclusion and introversion, including a reluctance to engage in physical activity (Koo, 2011). The concept of 'successful ageing' is a Western one which may have little meaning in other cultures. This point is illustrated by the work of Tan, Ward, and Ziaian (2010) which compared Anglo- and Chinese-Australians. It was found that the former group focused on growing old gracefully, whereas the latter were more concerned with financial security and active and meaningful lifestyle. As the concept of 'active ageing' can marginalise those in non-dominant cultures, including aboriginal elders, Ranzijn (2010) suggests that the focus should be on 'ageing well' or 'authentic ageing'.

Gender differences

Gender can play an important role in healthy ageing for CALD older people. For example, older CALD women have been found to rely more on their husbands for financial dealings, transport etc. and have had less access to English language classes, leading to considerable barriers should they lose that spousal support through death, ill-health or divorce (Warburton et al., 2009). Conversely, a study on the impact of translated public health messages noted that Asian men were more likely to rely on their wives for health information (ThuyTrinh, Stephenson & Vajda, 2011). Different perceived barriers to participating in physical exercise have also been identified in research of women from different cultural backgrounds, with Vietnamese-born women reporting that they were too self-conscious about their looks whereas Italian-born women reported being too unhealthy, too tired or not liking exercise (Bird et al., 2009). Another gender-related aspect of ageing is the increased expectation that CALD women will take on caring responsibilities (Boughtwood et al., 2011).

Access to culturally appropriate food

The available research is limited, but suggests that the provision of culturally inappropriate foods can be discriminatory in community and residential care services and that greater flexibility is needed (Warburton et al., 2009). Inability to access appropriate foods has been identified as a cause of food insecurity and poor nutrition in older CALD people (Millichamp & Gallegos, 2011; Radermacher, Feldman & Bird, 2010). This can be compounded by other factors such as financial pressure, poor health and mobility, and lack of social support (Radermacher et al., 2010). CALD people may drive long distances to locate culturally appropriate food, and have concerns about being able to access suitable foods should they enter residential care. A recent review of the literature on CALD food needs (Millichamp & Gallegos, 2011) found that while some Australian states have made food supplied through the Home and Community Care (HACC) program more culturally appropriate, a greater effort was needed, including the development of culturally appropriate food services and more research to evaluate the effect of such services and to direct future service delivery.

Needs of indigenous Australians

The challenges of providing culturally appropriate care to older people of Aboriginal and Torres Strait Islander (ATSI) descent, particularly those living in remote communities, are increasingly recognised. A fundamental issue is the cultural dissonance that exists between the values of the HACC program, service, community and clients. In the Northern Territory, inconsistent assessment procedures across HACC service providers and a minimal evidence base to inform practice have been identified (Lindeman & Pedler, 2008). Community initiatives to address such cultural dissonance include the establishment of a 'family model' of aged care within the indigenous Warlpiri community in Yuendumu in the Northern Territory (Smith, Grundy & Nelson, 2010). The 'hands on' care services are generally provided by local community members who speak Warlpiri and are known to the clients. This close connection allows them to be sensitive to local needs such as gender roles and avoidance relationships (i.e. the need for community members within a specific kinship or ceremonial relationship to avoid coming face-to-face). In order to navigate these complex issues, 'common sense' solutions have been adopted such as separate areas for men and women and the provision of two doors with viewing windows in each room to enable those in avoidance relationships to avoid entering the same room.

Language barriers

The language barriers faced by many CALD older people have been clearly identified as a major hurdle in navigating the health system and accessing appropriate care. Communication barriers are known to impact on all facets of care including access, diagnosis, assessment, treatment, and the ultimate level of care provided (Wish Garrett, Forero, Grant Dickson & Klinken Whelan, 2008). A need for the provision of more translated documents, access to translators, and greater access to English-language lessons has been identified (Warburton et al., 2009) and the need for professional translation assistance appears to increase with the level of complexity of the healthcare interaction (Wish Garrett et al., 2008).

In addition to providing access to professional translators, access to bilingual care staff within community and resi-

dential care services has become a priority (Boughtwood et al., 2011; Howe, 2009; Millichamp & Gallegos, 2011; Warburton et al., 2009). Between 25 to 33 per cent of the aged care workforce has been estimated to be born overseas, with migrants from the earlier European migration waves found to be more likely to work in the community care sector, while more recent Asian migrants were more likely to work in residential care. Unlike other countries where there is a large unskilled migrant workforce in aged care, it has been noted that there are no differences in the skills and training of Australian and overseas-born aged care workers (Howe, 2009). It has also been pointed out that that existing bilingual staff could be better utilised, including having input into aligning care procedures with cultural preferences (Chenoweth et al., 2006; Warburton et al., 2009).

Ethno-specific versus mainstream services

The debate about whether services should be ethno-specific or mainstream has highlighted the different value systems between Australian health care workers (characterised by Western values) and their CALD clients (Chenoweth et al., 2006). For example, the Western focus on client-centred care and self-determination can be a source of conflict for people from cultures which are more family or community focused.

While the majority of CALD older people continue to receive care from mainstream services (Howe, 2009), there is support for both mainstream and ethno-specific services (Radermacher, Feldman & Browning, 2009). In Australia, the CALD population is so diverse, including within different cultural groups, that it would be impossible to provide separate services to meet all their needs (Radermacher, Feldman & Browning, 2008). They also highlight the debate that funding ethno-specific services can perpetuate marginalisation and racism, while mainstreaming services can marginalise CALD groups by overlooking their specific needs. Even cultural competency guidelines may run the risk of stereotyping cultures (Radermacher et al., 2009; Warburton et al., 2009). The recent evidence would suggest that a balanced partnership of mainstream, multicultural and ethno-specific services is required to ensure the best possible services for aged care clients in the future.

Examples of good practice and innovation

Development of screening tools for CALD groups

It is increasingly recognised that measurement tools developed for and validated on the wider community may not be adequate for CALD groups (Anderson, Sachdev, Brodaty, Trollor & Andrews, 2007; Low et al., 2009). With the increasing prevalence of dementia in Australia in both the general and CALD populations (Access Economics, 2009), there is particular interest in the development of screening tools appropriate for CALD groups, with two distinct approaches being taken. One approach to this issue provides correction strategies for the Mini-Mental State Examination, taking into consideration CALD status, age, socioeconomic status etc. (Anderson et al., 2007). In contrast, LoGiudice (2011) outlines the development and validation of a culturally appropriate screening tool for Aboriginal people living in remote and rural areas of Australia - the Kimberley Indigenous Cognitive Assessment (KICA) scale. Another innovative screening tool is the Communication Complexity Score, Ethnicity and Health, developed by Wish Garrett et al. (2008) to help clinicians working with CALD patients identify when translation support is required.

The New South Wales (NSW) CALD Planning Ahead Strategic Model:

The NSW Department of Ageing, Disability and Home Care (DADHC) recognised that older CALD people faced serious barriers in making plans in the eventuality of declining health and death (e.g. wills, enduring power of attorney, and advanced health care directives) and so established the Planning Ahead in CALD Communities project (Cultural and Indigenous Research Centre Australia, 2008). This project included a review of the literature, development of a strategic model, and development of communication frameworks and associated resources for three target groups (Italian, Arabic and Croatian older people). These materials, along with related materials for people from ATSI backgrounds and the general community, are available on the DADHC website (http://www.adhc.nsw.gov.au/individuals/ageing_well/planning_for_the_future) and there are plans in place to develop the resources for other communities.

Promoting health to CALD groups

In response to evidence that CALD older people have more adverse medicine events due to language and literacy barriers, radio marketing campaigns targeting Italian, Mandarin and Cantonese speakers were delivered (ThuyTrinh et al., 2011). Radio advertisements and interviews were run on ethnic-language programs on radio stations broadcasting in Sydney, Melbourne and nationally. Households in the three language groups in Sydney and Melbourne were randomly surveyed before and after the marketing campaign and it was found that there was an increase in awareness of quality use of medicines, particularly in the Cantonese and Italian-speaking communities (ThuyTrinh et al., 2011). It was noted by the researchers that even within these language groups the populations were too diverse and that different messages may need to be developed for those of more advanced years (aged 70 years and over).

The development of practice guidelines for working with CALD older people

As noted earlier in the paper, there have been various attempts to develop practice guidelines for different aspects of the aged care sector and that it is important to avoid cultural stereotyping. One such approach focuses on the clear exchange of information and provides a useful guide to the information staff need to provide clients and their families, as well as the information that they need to seek from them, and highlights the use of available resources, including from overseas trained staff (Chenoweth et al., 2006). Based on their discussions with service providers and policymakers, Warburton et al. (2009) identified the following key elements of culturally appropriate practice:

- Recognising the diversity within - noting that diversity can be a strength as well as a challenge;
- Building on existing strengths - including utilising the expertise from existing services, community champions and older people themselves - many of whom are caring for others;
- Developing cultural competencies - including capitalising on bilingual staff
- Cultivating tolerance and antidiscrimination – noting that we can't assume that racism doesn't exist;
- Providing information and improving communication - including English lessons, translated documents and access to translators;
- Working in partnership – in the earlier scoping study report

(Bartlett et al., 2006), a range of key stakeholders involved in providing support services to CALD older people were identified (Figure 1).

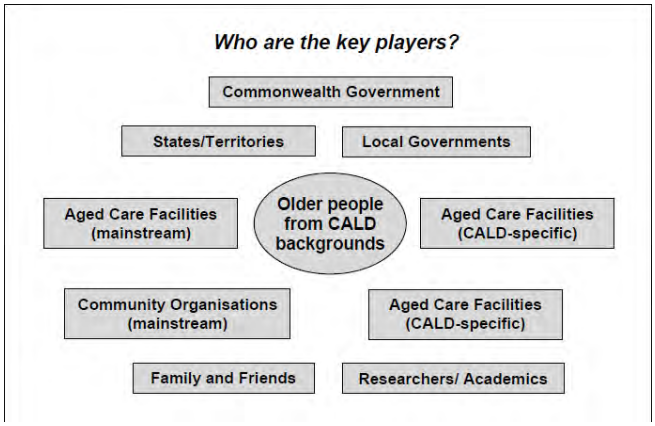

Figure 1. Key players in the provision of services to older people from CALD backgrounds (Bartlett et al., 2006, p. 51)

These broad principles have been incorporated into a practice briefing paper developed for the community aged care sector (Social Policy Research Centre & The Benevolent Society, 2010).

Conclusions

It is clear from this review that CALD older Australians face serious challenges now and into the future. A continuing cause of the disparities in the health and social care of CALD older Australians is recognised to be cultural racism and this needs to be systematically addressed as a structural problem (Johnstone & Kanitsaki, 2008; Warburton et al., 2009). It will require the concerted effort of government, researchers, care providers, community organisations and CALD older people and their families to address these issues. The Australian Government has recognised the diverse nature of ageing in Australia and made commitments to significant reform of the aged care system. First and foremost among these challenges is breaking down the language barriers faced by CALD older people. This includes greater access to translated materials (Cultural and Indigenous Research Centre Australia, 2008; ThuyTrinh et al., 2011), as well as greater access to professional translation services, and to English-language courses.

There is a paucity of research in the area of CALD health and social services with much of the evidence drawn from grey literature which may lack scientific rigour (Radermacher et al., 2008). It is imperative that a research agenda be developed in consultation with policy, practice and the CALD community to address the gaps in our knowledge, particularly with regards to the community care (Radermacher et al., 2009) and dementia issues (Boughtwood et al., 2011; Low et al., 2009).

In the same way as a partnership approach has been emphasised in the development of CALD ageing services (Radermacher et al., 2011; Warburton et al., 2009), it is important that a robust partnership approach is adopted to ensure that the policy and practice outcomes meet the needs of all stakeholders. These efforts could include strategies to develop greater links between CALD communities and researchers (such as a consumer network), and increased access to relevant materials through the establishment of a clearing house.

While the issues and responses outlined here are focused on CALD older Australians, these experiences offer useful insights for other countries. Many of the themes identified in this paper are likely to resonate elsewhere as the challenges of population ageing give rise to a similar range of consequences for aged care policy, planning and service provision across the world.

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"Growing Demand for Elderly Care and the Capacity Building of Elderly Carers in China"

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Abstract

The elderly population of 60 years old or above has nearly reached 190 million, and as the population ages quickly, the proportion and the absolute number of elderly needing care in daily life will also rise. Among these elderly there will be over 10 million of them who cannot take care of themselves, who are bringing new challenges to the capacity and to the elderly carers both in society and in families. The 12th Five-Year-Plan of China has clearly illustrated the development plan of the country until 2015, that it is to fortify the capacity of nursing homes and communities in elderly care, to change the functions of government, to expand the provision of basic public services, and to gradually attach greater importance to family development.

With the aforementioned background, this article analyzed the major problems arisen from the current needs and proposed relative policies in response, that there is a need to increase the magnitude in training elderly carers who are promising, so as to form a multi-strata training and education system comprising of schools, institutions, and communities. It is also neccessary to create a mobility system adding on to the existing institutional mechanism, such that the organisational stability and service quality of elderly carers can thus be enhanced. Within the framework of active ageing policies, it is vital to realise the crucial role played by family in taking care of elderly, hence there should be increases in supportive context towards family carers in community services. The capacity building of elderly carer needs long term and continuous development, which requires the support from the government and society in the areas of strategy, policy and law, and service provision.

"Silver Hair Market in Japan? Good Quality of (Whose) Life with Silver-to-Black Consumption?"

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1. Japanese Society (Silver Market?): Exceptionalism in Socio-Economic Sense?

What You See is Not What it is in Japan! This question was my Japanese colleagues and informants confronting me, and I concur with them as I completing this brief.... Perhaps this synopsis could help to realize the limited understanding of we have on another Asia society (despite frequent travels and information exchange in the mobile-Internet age), particularly the enigma about Japanese society's traditionalism embedded into its supra-modernization trajectories of socio-economic development since 1868!

Compared with the Euro zone crisis (led by Greek's problematic state finance, followed by Spain of the PIGS), juxtaposing the success of China (+9% GDP growth) economic development since its Open Door Policy in late 1970s and Hong Kong's incredible public finance conditions (say the least having billions of foreign reserved and frequent public budgetary surplus), Japan is not a "functional" economy in neoliberal economic terms: after its economic bubble burst in 1990s, it has been in some form of recession after recession with some limited (GDP 1-2%) growth throughout the last three decades. Perhaps more problematic is the public financing of Japanese national (much worse even for 34 regional and over a thousand municipalities) government: in 2012, its national debts are more than 200% of GDP! For the 2012-13 national government budget; 30% of its expenditure is for debts-interest repayments and over 30% of the government revenue is debt-financing.

Hong Kong is a neoliberal economic paradise! Men live longer (life expectancy of age 80) than Japanese counterparts (79.5) – top the global survival rate! Women rank second (85) after the Japanese age 85.6! Hong Kong's superb economic power and dynamics have been praised not just by the late Nobel Laureate Milton Friedman, but ranks top frequently say, the IMD's World Competitiveness Rankings (2011-12) but Japan is at 25+ position. Furthermore, it's civil society is vibrant with daily protests and NGOs (or NPOs) or the newly fashionable social enterprises) per capita is definitely more active in Hong Kong than Japan.... Isn't Hong Kong better than ageing-aged Japanese society? And the question is: If Japan is such a weak position in both neoliberal economic and public finance terms (measured against Hong Kong and China bench-marking of success), why should we still study this problematic debt-financing, aged (silver) society's market activities? Or, anything we can (un-)learn from these enigmatic islands-society with such a seemingly high quality of life as seen from outside – the reason so many middle class people from Hong Kong choose Japan as the admirable destination for overseas travel?

This short paper (analytical than the presentation which is more about elderly lifestyle) attempts to reveal part of the enigma and myths, with a specification of the contradictory dynamics in the socialized (the partially de-commodified) "market" and specific reference to the aged (or ageing) cohorts – our observation so far is that Japanese "silver market" is more social than (neoliberal) economic sense and business financing per se. In particular, the Japanese terms for "economics" embraces socio-economic benefits for common good: 經世濟民. Historically, the term "economics" is derived from Greek oikonomia, managing a household, but the term in Chinese is borrowed from Japanese Kanji, □□□□, at the end of 19th Century; the term was originally from traditional Chinese classic text (ca. 317 A.D) yet was exported to Japan thousand years ago exported. Will our discussion on silver consumption (use money, time and other resources during aged life course) enshrine the essence of such cross-cultural learning?

The socio-cultural foundation of the economics of ageing society in Japan should be stressed here, which is very different, if not the anti-thesis, of the one prescribed by neoliberal economics on supply, demand and price with a dynamic equilibrium occurs at the market per se. The unique developmental trajectories of Japanese (exceptionalism) society since Meiji Restoration (1868- onwards) and post WWII has been instrumental in defining socio-economic and policy response to ageing society. An indicative but not exclusive snapshot of the uniqueness is as follows:

Evolutionary Social (In-)Security System (Insider-Outsider Difference):

- Universal pension (PAYG) system, universal health insurance, and long term care insurance (LTCI) within a wider framework of occupational welfare model (say, family wage!).
- Post WWII new model for gender division of labours for a job-place-time differentiation with "salaryman" at work place and housewife's home caring tasks.
- Slow ageing process throughout 40 years with planned policy evolutionary changes within a closed population system; contrasting other East Asia's hyper-modernization-driven ageing.
- Evolutionary detailed and sophisticated supplies to meet articulated needs for silver (niche) consumption provided by civic, public and market forces.
- Public and institutional sponsored regime of (grey and silver but not black) procurement for, and elderly's needs and necessity-based, consumption of health (nursing) care product and services.
- Silver consumption is (once) phenomenal at the historical conjuncture for one cohort (surviving 1950s cohort) of ageing; future ageing cohorts (1970s) are unlikely to be so positive.
- Paradise for whom (Outsider vs. Insider of the Occupational Welfare) between "heaven for users" versus "hell for suppliers" (insecurity vs. security).

Individual and Family Adaption to Ageing:

- Well developed, experienced and smart consumption embedded in detailed family budgeting- accounting

(family account book-keeping) and socio-familial reciprocities (exchange-registration) system – these are the basic tasks for house-keeping by housewife!

- Living is expensive and life is hard for many Japanese: hard working of men at work and housewife at family; but sense of security is ensured when you are employed – Occupational Welfare Model (for insiders vs. outsiders; permanent tenure vs. temporary PT contract).
- Life is even harder for those not fit into either work (NEET) or family (as housewife, son or daughter) protection.
- Change of lifestyle: silver consumption is mostly driven by ageing needs and necessities;
- Sophisticated consumption (function+beauty+timing) as a result of planned-budgetary calculation.
- Spending spree follow socio-family timing: university students (forever!) and newly retirees!
- Budgeting of all kinds; though somewhat relaxing at certain period, 1-5 years after good retirement = but the budgeting exercise continues as "austerity" measure given.
- Differential stratification within a high cost-high quality of lifestyle society without much choice within the given socio-economic strata or within a particular locality or network…
- Middle-class driven consumption: the missing of underpriced or low-quality (even 2nd hand) goods and services
- High costing of living for ageing-aged group; in spite over-supplies of good but shortage of services.
- Full commercialization and industrialization of traditionalism of rituals during and post-EOL; funeral and faith related worship after one's life are high cost (e.g,, TEARS web).

Structural relationship with clientele and socio-cultural embeddings of doing Business:

- Derived from locality-based SME business ethos, business relationship is more social than financial.
- Products and (User-)Services are mostly structurally packaged and loop-cycled by Suppliers
- Precautionary measure to achieve no-complaint or flaw; and post-defect astronomical remedies
- High intensity and deep embeddedness of Clientele Relationship (not just CRM per se).
- B2B and B2C relationship are structurally coupled and bound with long term relationship, for good and bad economic time.
- Labour process has been corporatist but more moving towards "free market" recently; but still the ethos for good employment is the norm (Wage [Price] is the least to consider).
- Silver consumption is a highly differentiated (sometime fragmented) with niches of specifications (supplier-customer relationship is more or less one-to-one or one-to-few) beyond outsider's comprehension.

Unresolved Social Problems for Ageing in Hyper-Urbanized Spaces:

- Prolong (2-decade) economic recession – still surviving but for how long (another decade)?
- Lost of socio-familial contacts for solo redundant aged workers in metropolitan areas
- Lost of (permanent)Job loses everything: disciplined homeless (with no place to return) in cities
- High costing burden for some elderly out-of-the-occupations for unemployed and homeless.
- Pre-retirement (50s and 60s) suicide (national total: over 30,000 p.a.) is not uncommon
- Solo death (though uncommon dying process) is more obviously these days.
- All testing the Limits of municipality administrative-framed social security observatory

Obviously, there has been, and still, euphoria from outside (more than the insiders) about Japanese ageing-aged society, the business-oriented worldview on the energetic "silver market" – embracing, grey (ageing), silver and gold (those rich ageing-aged consumers) and black market (funeral and faith-related familial rituals) is questionably non-debatable (not many interested) in Japan! For instance, one key Taiwanese business magazine (using Nikkei information) claimed that, thanks to accumulated wealth and more leisure time for the aged, there has been, and will be continuing, booming of the silver market…: isn't it ironic, another joke or economic bubble? My Japanese colleague questioned when I show her (working professional but also housewife) the news-clippings….

Along the same line of sanguinity, visitors in Japan must by surprised by not just the scale, scope and volume of nursing care product and services for the ageing-aged, but also by the detailed sophistication, tailor-made services in the silver consumption. All these are a representation of Japanese socio-cultural differential specification on lifestyle, integrating function and beauty with specific timing – it is almost common to other age cohorts and locally produced goods and services.

Catalogues of elderly care products and services are not uncommonly with over 150 pages; with introductory chapter on policy brief for nursing care, health insurance, LTCI and consumers' rights… the purchase of anything is usually come after detail-lengthy consultations with users, their family members and the LTCI nursing care manager. But all these fancy and well-prepared information have been partially blinding our visions and exploration to the dynamics and under-current of Japanese aged (still ageing) society with 23% of its total population is aged 65 or above – it is just the beginning of the supra-aged society; silver consumption will prevail for long but socio-economic conditions are changing as well….

2. Silver Consumption as Extended (or Alternative) Lifestyle in Family Life-Course

Japan is not a neoliberal economic paradise for the fact that there are less than 2,000 imported labours for nursing care!

Not as "liberalized" and "free" for foreign labours to serve as domestic or nursing care worker or home helper as the case in Hong Kong (ca. 280,000), Taiwan (ca. 180,000) and Singapore (ca.170,000), Japanese silver market is totally failed (in neoliberal economic bench-marking) for flexible labour market! Its human power for aged society is by its under-developed labour volume, greying, ageing and aged local (mostly part-time female) workforce. Experimental pilot scheme for importing foreigners to cope with aged population is absolutely nano-minimal: through Free Trade Agreements with Indonesia, Thailand and the Philippine, there are now less than 1500 foreign trained nursing (trainee-)workers undergoing another four-year on-job training to meet Japanese qualification by state examination. In this year, less than 30% of the first cohort has passed the state (professional and Japanese cultural linguistic) examination; the scheme is more or less fail totally by design: the scale of imported foreign labours has, and will have, no contribution to the overall human resources shortage of (estimated 200,000 for) nursing care workers and home helper (estimated 500,000) in the coming decade! In this regards, Hong Kong and other nursing care worker importing societies should be thankful for those guest-worker working 7-24 to solve the family's time-bomb of the urbanization-modernization driven demand for caring the aged (mostly by women again)!

Without foreign (lady) workers for domestic and nursing care, Japanese elderly care is somewhat as a normal (traditional) society which female members, mostly daughter-in-law, have to take an expected gender role to caring for the aged and children, as well as the breadwinner – but this has strong ramification when the salaryman completed his mission and retiring back home after 60+ age. How to settle the "veteran" has been a critical problem (say, retirement-triggered marital/familial stress, ending up with divorce) for baby-boomers' retirement. Without this settlement problem resolved, it is unlikely any good ageing for the family system as a whole.

Indeed, surviving one's life for ageing must continue…. There are four major distinct but inter-related arenas (as some form of classification scheme to understand silver consumption) where old people focus on their socio-economic activities, with respect to social and policy differentiation of silver consumption in Japanese ageing-aged society:

- New free (leisure) time and availability of pension for the pursuit of new, experimental lifestyle at the beginning of (the preparation for) retirement.
- The policy-driven, but needs-assessment-based, products and services availability.
- Re-engaging breadwinners back into family life and retiring couples' community participation.
- Socio-cultural defined rituals for ageing, aged and the end-of-life (EOL) process.

What we have observed so far is that there is a trilogy of, the adaptation phases to, retirement life for solo and coupled family alike: stress upon retirement, followed by re-learning process with spending spree and subsequently family re-union (or de facto separated autonomy or divorce) with community participation.

2.1. New Free Time and Spare Money for Experience New Lifestyle (for a while!)

The offering of more free time is a new gift; offered by retirement benefits of pension, for most salaryman. Obvious, this is more or less like a paradise for the wealth-off, who have spent over three decades to accumulate the wealth (though a significant portion has been spent on younger generation's education and up-bringing) – and it is now the time to be free with spending spree.

Given the deferred (30 something years) gratification-calling (endured by both the retiree and his/her spouse), the newly available free time and some extra spare money are obviously exploited by business enterprises, with the provision of all kinds of new, sometime exotic, consumption experience with new products and services. But the spending spree is based upon a somewhat resolved crisis on the prolonged gender-divided life for the spouses, to be re-union under the same roof again.

In actuality, the most visible part of the so-called Silver Market is the new wave of consumerism and its temptation, targeting to those salarymen (and their housewives) who are from occupational (domestic) imprisonment serving for the societal good with Japanese puritan ethics in both work and family arena!

For instances, we have all kinds of age 50+, 55+, 60+, 65+ and 70+ discounts and benefits from all kinds of suppliers of goods and services – obviously there is an ecstatic optimism for ageing-aged population to kick-up the recessionary-prone Japanese economy. But how are it can go is now certain yet; different empirical studies have contradictory findings.

Free from work-and-family constraints, some retirees and their spouses have been the driving forces for alternative, green and eco-friendly activities in community: new ideas for sustainability hence become part of the Silver Market. Green consumption and the related procurements have been mooted as future lifestyle for health and sustainable (LOHAS) for saving the Earth and become global movement – perhaps this "back-tracking" from mass consumerism is new for new cohorts of ageing retirees now and for future. But if conservation and Reduce+Reuse+Recyle become the norms for now and future cohorts of ageing-aged group, the neoclassical optimism for spending-spree driven demand for the market will be evaporated sooner than expected!

In addition to Japanese ageing society's moving toward smart green consumption, there is rejuvenation for the development of non-market (governmental and NGOs, public, societal and community and civic) alternatives for consumption based upon social reciprocities, like some local exchange experimental projects for revitalizing neighbourhood, and community patrols for security of school kids…

2.2. Policy-driven, need-(necessity)-based new production and consumption for Aged Society

Health services re-orientation towards aged population is obvious: more and more of private medical clinics and hospitals turn into long term care rehabilitation centres or hub – this trend becomes a permanent institutional framework within LTCI community care. Yet, it should be stressed that the new development is still within the state sponsored universal health insurance and LTCI, which enable elderly to use the services within the accredited (2+5) levels of coverage for goods, services and small scale house renovation for universal designs; though most of these services are not very generous and somewhat for maintenance of the existing quality of life.

Historically, public and private sectors in Japan take a long

term and engaging perspective for ageing society (e.g., new privately funded projects for health and welfare professional training in the midst of recessions). Corporate, governmental and communal bodies have been embracing ageing population with many initiatives for promoting the needs -and- necessity based new products and services – e.g., railway companies extend their services from transportation to the logistics for long term care services (day and "shuttle" care alike).

Policy-driven and socialized silver market with traditions -and needs based consumption (say, assistive device for tatami □-ridden frail aged and mobile "ofuro" お風呂-spa bath), within a specific established or newly invested network of supplies chain. New initiatives are taken up also by those non-age group specific enterprises, like railway companies: Hankyu and Hanshin alike are now developing LTC nursing care services for those within their catchment, taking advantages of their logistics support and the location-advantage of railway (and department store) networks. Obviously, more and more suppliers are born due to a positive, supportive and stable policy environment.

"Silver procurement" has vital important for sustainable development of the Silver Market: the upgrading (in Japanese: the "reforming") of public and private spaces towards universal designs, barriers-free access and participation. These initiatives have been consolidated and formalized in both policy (regulations, laws and service standards) and actual practices (of goods and service providers); and the quality enhancement therefore is a natural organic outcome of the policy framework.

In other words, the Silver procurement regime for expansionary nursing care services and productions is instrumental for better consumption options. Thanks to the revitalization of public and social care within LTCI initiatives, the new regulatory framework promotes supply-side dynamism. Hence, the two most important factors for an extension of offering, from ageing to aged society, are the long term policy perspective and social consensus to promote new products and services (usually with financial loss at the beginning and medium phases of such initiative). Given a mature market operation, evolution for elderly specific goods and services has been taking a stable course of development with new ideas driven, and feedback-based, innovations.

2.3. Re-Engaging back into Family and Community Life

Compared to other sphere of silver consumption, this arena is the most uncertain and contesting one, particularly the breadwinner's re-union with the spouse (housewife) and to spend time as a permanent family member in presence!

Due to the decades-long functional "exit" from familial time and spaces, the return of salayman has been a headache for most, if not all, housewives who have been preoccupied by all domestic affairs by default. Mis-understanding and conflicts over trivial domestic matters are not uncommon during the first phase of the retiree's return, as the following notes are representative for many housewives:

> "My salaryman husband knows nothing about life other than his company work for long…. not even knowing their own size for clothing and shoe…. I have to educate him (too old to learn anything new at home!) everything how to live again in my home! I have done this for twenty something years for my kid now grown up, but from now on, I have to repeat the same again to bring-up an aged salaryman… it makes me very tired!... If possible I would like to spend the time outside my home to enjoy life [for travelling and visits], at least I don't have to teach him everything… just follow somebody's [tour] guiding …" (quoted from a case interview).

Given the difficulty to re-union new, normal, family life after retirement at the very beginning and the euphoria for retirement life, going-out for spending spree therefore is not uncommon to sort out the re-adjustment process….

Relatively speaking, it is easier for ex-breadwinners to be outside family and find something engaging outside familial sphere as if they were still employed and go-out for work hour. Or some men join community group and back to their own community – this certainly fits, or just continues, their 30-year habits for working life (work for money or not is not their major concern anymore) outside the home ("bed-place") where they have been not-belonging for decades.

Retirement is a new career for life course, having more (free) time to be engaging in different ways of social and community participation is the norms in Japan – this is somewhat an extension of the (not-in-labour market) women specific "free time": as an experienced users of public and private services, they are just extending, and sometime instrumental helping their retired spouses, to re-engaging in individual (hobbies) and community group activities.

Activating community participation is a social consensus: facilitating retirees' active participation in community is one of the active ageing policy initiatives in Japan; say the Silver Human Resource movement (シルバー人材センター; http://www.zsjc.or.jp/), aiming to have one million members to engage in community-level labour market, and for community development as well. For this, municipalities in Japan have been actively to providing public spaces for their community-returnees (retirees) and mobilize them work part-time with the existing or re-trained skills.

Having extra time and spare resources are the basic conditions for re-engaging back into community life. Group activities (self-help and mutual help in particular) in Japan are more or less self-financing and self-sufficient, subsidise from (mostly local) government are more or less in terms of spatial (venues) and kind (within a larger framework of festival and events promotion) within the municipality. This is juxtaposing the blossom of NGOs (NPOs as called in Japan) activities, which have been belatedly developing in Japan, mostly after the Hanshin-Awaji Earthquake on 17.January 1995. Since then, NPOs movement has gain more momentum with more recognition and repercussions – NPOs become a major arena, juxtaposing various community groups, for experimenting new social re-engagements of Japanese; women and the retired (men) are key activists for liberalization of public sphere.

Overall speaking, the retirees' emphasis is non-profit, or the less-than-profit-maximization, targeting for community and business engagement, as many of the retirees have been secured by pension and universal insurances of health and long term care. Thanks to the new bloods of those ageing-aged, there is a booming of alternative community life experimental projects, like time-bank and local exchange trading system for inter-generational dynamics promotion, within the movement of self-help and mutual-help community activities. The seemingly meaningful social participation of the ageing and aged population, in variety ways, is attributed to the fundamentals of any society, sense of security and

consensus derived from pension system and universal health (including long term care) insurance. Perhaps this socio-economic contribution of silver consumption - smartly for greater benefits of the commons, is undervalued by predominant neoliberal economic discourse on/for the Silver Market!

2.4. Socio-Cultural-Economic Differentiation of the Ending-of-Life (EOL) in Advanced Capitalism

Social rituals perform only functional continuation of human society at large, shaping the vitality and resilience of socio-family system in particular. Among all rituals, those attached to funeral and ancestor- worship are the most instrumental one, as they provides both epistemological and ontological anchorage and linkage for inter-generational succession: past, present and future! Compared to any ritual in Japan, the EOL is the most imperative and precious one (for social values and monetary terms) which deserve our special attention. Obviously, a demonstrative part of it should show the extent of the sophistication of the Silver-turned-Black market.

The most important market for aged business is the so-called "black" (not the romantic and positive silver or golden aged) business of funeral rituals and post-EOL (Buddhist variations of longetivity and for eternity, with memorial services after decades)… All these are related to funeral industry and the faith-related business for the after human life. Funeral business has been industrialized for long, and more recently funeral supplies have been extended with more funeral home set up by transportation provider. For instance, more funeral homes are sited near railway station or transport transits, e.g. the "TEARS" (http://www.tear.co.jp/) has one of its funeral home locates next to the Nankai Line station in Kishiwada.

Obviously, their business-logistics sense to cater the needs of the EOL and those surviving is more than business as usual!

In Japan, to respect and high value someone's death is a norm with many possible rituals – and the industrializing of funeral (and its follow up faith-based activities. For its superb ontological appeal (for Asian belief that life can be in existence though in different form, but it is still life after one's life so to speak), Buddhist practice of rituals for one's death is always preferred: funeral activities and the follow up faith-base practices. But it is highly competitive (market?) with high price for these ritual-practices in Japan: each item of the funeral is counted and priced; more even so for those post-funeral prayers and worships follow-up the funeral and the decade-long worshiping contribution….

Not like Christianity naming of the newly born with Christian name, in Japan, to differentiate and make a distinction between the life-and-death, the posthumous name of the deceased is normally changed to a new one by (quasi-) religious agent of a faith-based organization, according to one's affiliation to the branch/school of Buddhism. For instance, the fee for (Buddhist) posthumous (after-life) name 戒名(Kaimyo; 法号/法名), given to a dead person as recognition by Buddhist-sect monk that the deceased become a disciple of Buddha, for famous a four-decade Showa Period (1925-1989) enka queen-singer Misora Hibari (美空 ひばり) is 慈唱院美空日和清大姉… is obviously high-priced (estimated over □500,000. contribution 布施) having such an ordination by Buddhist agency for new identity after-life….

The contribution-cost 布施 (ranging from□200,000 to ￥.1,000,000.) for Kaimyo is becoming at issue (not normally raised in the public arena) that whether Kaimyo should be given out for free. Accordingly, The Asahi-Shimbun (27.July 2011) interviewed some chief Buddhist priests in disasters region and discovered that though some chief priests gave out Kaimyo for the death free, some also had secured financing for the Buddhist temple:

> "In these two months, I have earned amounts that are equivalent to what I obtained in the past three or four years," one chief priest said.

But there are different, if not opposite, views on the pricing of Kaimyo:

> "It is a matter of course to lower Kaimyo fees in affected areas….But temples are supported by offerings from parishioners. If the move of giving Kaimyo free of charge spreads, some temples could not survive. It is important to establish trusts with parishioners and convey the meanings of Kaimyo and funerals to them properly."

Funeral (much like wedding) practice in Japan is limited participants, unless you are so wealth-off to accept any unsolicited / not-invited guest: the number of participants determines how much the funeral cost (the per-head costing is a norm for accounting-budgeting purpose – it is somewhat a business like, but the choreography for EOL is more than business, as the surviving ones have to taken into account of the family register (socio-familial reciprocity account-book) for who is in ,or out of the invited list.

Recently, there are controversies around the standardization of the cost for funeral, and its follow up memorial services which can last for several decades-long with specific rituals practice. One of the conflicts is the standard funeral cost agreed by the Aeon (credit) card, in May 2010, had made agreement with 600 temples from eight major Buddhist branches, with a standard cost for its members. But it attracted protests against the standard cost, particularly from those non-involving faith-based groups which alleged this agreement as intrusion against faith-based (religious autonomy) activities by commercial interests. After some unsuccessful negotiations, the agreement was cancelled in September 2010. Nowadays, the funeral market is free to price again!

The EOL process is indicative for silver-to-black consumption in Japan as a whole; there are two contesting forces in operation, shaping the course of the development of the Silver Market (as business sector understands), socio-economic dynamics and their dynamism for social security versus the competitive war-of-position to secure business and financial gain.

One last question for conference participant: isn't funeral costing a part of the so-called silver market logics-driven business and financing, and if yes, how should it be price? Hence, the obvious challenge for us is how achieve a better ageing and aged life and the after-aged life (for the surviving and deceased alike), given the socio-economic differentiation of socio-cultural virtues, customs and rituals-driven social practice -- in advanced capitalism uneasily coupling with the for-profit business (and financial leverage of the social) operation from the silver-to-black consumption?

"Older Consumers in Malaysia: Spending Patterns, Leisure Activities and Consumption Preferences"

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Abstract

This paper brings consumption activities into the domain of active ageing by proposing that consumption process engages older people physically, socially, and emotionally in line with the concept of active ageing. In Malaysia as in elsewhere in Asia, the number of older adults is growing and the attractiveness of this market segment is expected to grow in the years to come since the newer cohorts of older consumers have higher levels of educational achievement and income, and adopt a lifestyle that is different from their parents. In spite of this, marketers have largely overlooked this market segment.

The focus of this paper is on grocery shopping since older people spent a large proportion of expenses on food and beverages. The study also examined the evaluative criteria that older people used for making purchase decisions. Their sources of information for various products and services which aid them in information search are also covered in the study. This paper also highlights leisure activity participation and media habits of these older consumers.

Household survey which covered Peninsula Malaysia was conducted in urban and rural areas. Data from a total of 537 sets of responses were analysed. Urban respondents made up 68.3% of the sample with the remaining 31% from rural areas. The mean age of respondents was 64 years (SD = 7.3). Male respondents made up 57% of the sample while females made up 43%. The Malays made up 56% of the sample, Chinese 29% and the Indians 12.1%. About 56% were retired or not employed, whereas about 225 were still gainfully employed either on a full-time or part-time basis. Another 22% were retired but continue to work on either a full-time or part-time basis. About 38% had monthly income of less than RM1500. Slightly more than one quarter had monthly income of between RM1500 to RM2499.

Results showed that older adults commonly shopped at sundry shops, wet markets, supermarkets and weekend/night markets. They tended to shop alone or with their spouse. The most important reason for their choice of outlets for grocery shopping was ease of locating items or merchandise as reported by 83% of the respondents. The results showed that the most important criterion for purchase decision is quality followed by durability, safety features, comfort and price, while brand was the least important. Close to 100% had participated in at least a leisure activity. The common leisure activities were: watching television, reading, gardening, and exercising. As for sources of information for various products and services, their reliance on their children was evident. They had confidence in interpersonal communication while their tendency to ignore advertised information was also apparent.

From the results of this study, implications for marketers are many folds. Older adults are not passive consumers; they are active and discerning in knowing and expressing their preferences. Since the study suggests a two-step flow in communication, i.e., older adults rely on their children for information marketers need to re-strategies their marketing communications to reach this market segment. It would be wise to consider potential and profitable segments not just for their basic needs, but for other leisure related products or services since older people are active in leisure activity participation. An understanding of these older consumers could possibly make a difference, resulting in more accurate targeting and delivery of services.

Introduction

Among the aspirations of growing old is to have quality of life in old age. Towards this end, older people must be allowed to realize their potential for physical, social, and mental well-being (World Health Organisation 2002). This is active ageing which is defined as the process of optimizing opportunities for health, participation and security in order to enhance quality of life (World Health Organisation 2002, p.12). Consumption and the ability to make decisions relating to consumption activities are everyday matters that must be viewed as part of active ageing since consumption activities engage older people physically, socially, and emotionally such as emotional affiliation to the products they like or their favourite television programmes. The competence that is associated with cognitive functioning in planning involving financial and purchase decisions in consumption testifies the engagement of older adults. Thus, although the theory of disengagement suggests that the gradual withdrawal of older people from work roles and social relationships as inevitable and natural process (Powell, 2001), older persons continue to function as consumers long after their retirement. Older persons like people in younger age groups are part of the economy, they form a market segment for goods and services and at the same time they are also a segment for specialised products. These older adults make up what is commonly known as the "silver" market.

However, older persons in many Asian cultures appear to be thought of by marketers as "invisible consumers" (Ong and Phillip, 2007). Their consumption needs and choices are often taken for granted and assumed to be catered for by their family members under traditional Asian family value norms (Phillips, 2000). This neglect of the "silver market" and older persons as consumers can be costly to marketers in view of the pervasive influence on consumption brought on by the consumer culture of the 21st century. Many of the older consumers today were once the young consumers of the post war period and were regarded as innovators in the consumption of products (Higgs et al. 2009). With time some have moved from the "marketplace" to the "market space", engaging in the most modern form of retail format. This group of older consumers are techno-savvy as we commonly observe them using mobile phones, iPad and participating in the social media. Therefore, there is evidence that consumption and the ability to consume and exercise choice have important effects on identity in later life (Gilleard, 1996). Kontos

(2005, p.33) sums up a complementary view succinctly that a spirit of an 'information society', a 'postindustrial society' and a 'postmodern culture' combine in an emergent consumer culture discourse that 'elderhood has been reconstructed as a marketable lifestyle that connects the commodified values of youth'.

The Silver Market in Malaysia

Malaysia, like many other Asia-Pacific countries, has been experiencing improved health, longer life expectancy, low mortality and concomitant declining fertility resulting in the ageing of population. According to the Department of Statistics (2010) 2,251,216 of the Malaysian population are classified as older adults. In 2020, Malaysia will be an aged society with 9.9% of population aged 60 years or older. Although the size may appear small in percentage terms, it must be appreciated that the absolute numbers of older adults is growing. By 2030, the 55+ market segment will gain dominance as it is expected that a significant jump will occur when the baby-boomers begin to reach their retirement age (while the early boomers are already into their golden years). The attractiveness of this market segment is expected to grow in the years to come since the newer cohorts of older consumers have higher levels of educational achievement and income, and adopt a lifestyle different from their parents. They will have access to substantial disposable and discretionary income. Looking at older consumers as a growing market segment, they can be substantial consumers, a point sometimes previously overlooked (Ong and Phillips, 2007). In the United States, for example, the over-55 market segment purchased 30% of all food consumed in the home and older consumers may tend to stay more loyal (Moschis et al. 2004). The silver market provides abundant business opportunities provided marketers understand the needs and wants of older people, their media habits and sources of information that allow them to make informed decisions. Knowledge about who they are and what they want will help firms develop communication and marketing programmes that better appeal to this segment of the market.

In Malaysia, attention on older consumers remains somewhat low (Ong, Kitchen, and Jami 2008). The basic marketing literature seems characterized by the assumption that older adults' consumption patterns and lifestyles remain largely the same over their life cycle, ignoring the possibility of changes in preferences due to biological ageing, occurrence of major life events for which coping could involve changes in consumption habits or simply a change in preferences brought about by changes in lifestyle. Not only may older consumers be different

from the younger age groups, they are also heterogeneous as consumers among themselves (Silvers 1997; Dychtwald 1997). In fact, later life consumption is not undifferentiated (Higgs et al. 2009:103). It was against this broad background that the present paper intends to provide insights into the silver market of Malaysia.

The main objective of this paper is to examine the household expenditures of older adults, their grocery shopping behaviour and the evaluative criteria used when making purchase decisions. In line with the concept of active ageing, we attempt to find out if older adults in Malaysia are active in terms of their pursuit for leisure activities, and their media habits as well as programmes they watch on television. Since information is fundamental to decision making for everyday consumption activities, it is imperative to understand how older consumers obtain their information. In addition, this paper also explores if older adults are happy consumers and seeks to test the relationship between consumption satisfaction and life satisfaction.

The Study

This paper draws data from a large study[1] conducted on older adults in Malaysia. The study collected data from the northern, central, southern and eastern regions of West Malaysia where choices for a myriad products and services are abundant. The method for data collection is the survey method using a close-ended questionnaire that collects data on a range of issues relevant for older adults. Household survey was conducted based on a list of randomly generated enumeration blocks from the Department of Statistics, Malaysia. Face-to-face interviews were conducted by a team of trained enumerators. The questionnaire was translated into the Malay language and Mandarin using the back-to-back translation method. A total of 537 sets of responses were collected from older adults aged 55 years or older.

The Sample

Table 1 describes the demographic profile of respondents. Urban respondents made up 68.3% of the sample with the remaining 31% from rural areas. This is close to the urbanisation rate in Malaysia. The mean age of respondents was 64 years (SD = 7.3). Male respondents made up 57% of the sample while females made up 43%. In line with the age cohort of these baby boomers, the majority of the respondents had low level of education with almost 75% of them completed primary or secondary school level of education. Only 8.6% had diploma or university education. The Malays made up 56% of the sample, Chinese 29% and the Indians 12.1%, which roughly represents the composition of Malaysians since the sample consisted of a large percentage of urban respondents. In terms of religion, the Muslims made up 56%, Buddhists 24%, Christians about 10% and the Hindus, 8%. About three quarter of the respondents were married with children and in line with their life cycle stage, 58% lived with spouse and children while 17% lived with children only due perhaps to the widowhood among respondents that stood at 18%. A small percentage 16% lived with spouse only as it is not uncommon to find adult children living away from their parents. About 56% were retired or not employed, whereas about 225 were still gainfully employed either on a full-time or part-time basis. Another 22% were retired but continue to work on either a full-time or part-time basis. Consistent with the retired status of respondents, about 38% had monthly income of less than RM1500[2]. Slightly more than one quarter had monthly income of between RM1500 to RM2499, while a small percentage (11.5%) had monthly income of RM4500 or more.

Expenditure Patterns and Grocery Shopping

The items that were included in the study are similar to those items used in the household expenditure survey in Malaysia. Table 2 shows the results. The average monthly expenditure amounted to RM1327.4 (SD = 850.8). Of the various expenses, food made up the largest percentage (34.9%) followed by gross rent, fuel and power (12.4%) and transport and communications (10.2%). Taking into consideration the expenditure on beverages, together with expenditure on food, theses two categories made up 40.7% of total expenditure. The large percentage of expenditure on food and beverages is to be expected as these are common items for retired households. Since Malaysia provides a universal subsidy for fuel, including petrol, diesel, and cooking gas, the amount of expenditure on this category was fairly low. Expenses for food away from home is the next major item as eating out is a popular way of life in Malaysia. Results show that medical and health care expenses as the fifth major item in the spending pattern among older adults in Malaysia.

Whilst older people in Malaysia may share a common macro

1 The study collected 1356 from East and West Malaysia, funded by the Government of Malaysia.

2 Exchange rate, USD 1 is roughly equivalent to RM 3.

environment such as the economic, culture and societal influences, it is of interest to examine the urban and rural respondents since products and services available in the urban and rural areas differ in terms of product assortment, brands and types of services. Comparing expenditure patterns among the urban and rural older adults, t-test showed that the two groups differed significantly in many categories of expenses: food, furniture and furnishing, medical, transport and communication, entertainment, food away from home and miscellaneous expenses (Table 2). Older adults in urban areas tended to spend significantly more on these items compared to rural older adults. The differences could be explained in part by the different lifestyle led by urban and rural persons who tend to live a simpler lifestyle with contentment for basic needs fulfilment.

In view that food and beverages made up a major proportion of household expenses this study examins the patterns of grocery shopping among these older adults, their preferences for retail outlets and the reasons for their patronage behaviour. The respondents were asked to tick three of their preferred outlets from a list of eight possible outlets for grocery shopping. Places they commonly shopped at were: sundry shops, wet markets, supermarkets and weekend/night markets (Table 3). Close to 58% shopped at sundry shops (also known as convenience stores or neighbourhood stores), 38% at wet markets and 36% at supermarkets. Comparing urban and rural adults, the results showed that although sundry shop was the preferred outlet among the urban and rural respondents, 78% of the rural respondents indicated preference for sundry shops compared to 49% at $p < .001$. Since supermarkets and hypermarkets are modern retail outlets found mainly in urban centres, a higher percentage of older adults in urban areas shopped at these outlets compared to rural respondents. As for wet market and weekend/night markets, such open air markets are more popular among the rural respondents (46%) who continue to rely on these markets for their needs for groceries. Only 36% of the urban respondents reported wet market as their favourite grocery shopping outlet.

Respondents reported the reasons for their preference of outlets. The most important factor was ease of locating items or merchandise as reported by 83% of the respondents (Table 3). Ease of locating items was the main reason for the choice of retail outlets for both the urban and rural respondents. This suggests their tendency to shop at familiar outlets where hassles to locate items could be minimised. The factor "ease of locating items" could enhance effective decision-making. It could also be interpreted as a trait of utilitarian shoppers. Price was the next most cited reason for patronage followed by product assortment and comfortable environment, again a reason common to both urban and rural consumers. No significant difference was found between these two groups of respondents. Loyalty card was the least cited reason for patronage for both groups of respondents.

For the urban respondents, the most cited reasons were: ease of locating items/merchandise, price, product assortment and special deals. The first three reasons were also the reasons cited by the rural respondents. They differed from the urban respondents since special deals have never been a strategy for sundry shops which emphasise their personalised services in home delivery. The fourth most cited reason for rural respondents was comfort. They liked to shop at outlets that they feel comfortable about.

Comparing the urban and rural respondents, significantly more rural respondents (91%) as compared to 80% of urban respondents, cited ease of locating items/merchandise as the reason for their choice of grocery shopping outlet at $p < .01$. Interestingly, significantly more urban respondents cited special deals compared to rural respondents ($p < .05$) as their reason for the choice of outlets. The special deals are likely to be a characteristic of supermarkets/hypermarkets, largely found in urban areas that tend to adopt everyday low price strategy to attract traffic to their store. More of the rural respondents cited services such as carry out service and home delivery as their reason for patronage compared to urban respondents. Retail format such as the sundry shops in the neighbourhood provide personalised services, available up till the present time.

Product-related Evaluative Criteria

Curasi (1995) found that older consumers valued customer service and price highly in terms of retail patronage. In a study on grocery shopping, Hare, Kirk and Lang (1999) indicated that key elements were either merchandised-related: sizes, prices, promotions, and quality and/or store-related: layout and check-out system. Lipke (2001) remarkably found that brands were not that important to the grey market since this group of consumers was apparently not brand oriented. In a study of consumers aged 60 years or older, Duizer et al. (2009) find that the factors important for the purchase of food products are price, safety, pack size, and recycling whereas factors of least importance are pack colour, shape and material. Although it is evident that previous research results support the argument for product specific evaluative criteria, we explore if consumers have a tendency to use a common set of evaluative criteria for product-related purchase decision. In the same vein that we test for urban-rural differences in grocery shopping behaviour, differences in evaluative criteria for purchase decisions are also expected.

For the present study, a list of product-related evaluative criteria commonly used for purchase decision making was included (Table 4). The respondents were asked to indicate the importance of each factor on a Likert-type scale of 1 to 5, "1 = not important at all", to "5 = very important". The results show that the most important criterion is quality (mean = 4.39, SD = 0.72), followed by durability (mean = 4.38, SD = 0.77), safety features (mean = 4.35, SD = 0.77), comfort (mean = 4.32, SD = 0.71) and price (mean = 4.25, SD = 0.84). In support of Lipke (2001), results of this study showed that brand was the least important. This hints at the possibility that common threads could be found for consumption behaviour among older adults in developed and developing countries.

For urban respondents, the factors that were important for purchase decisions were in line with the total sample. However, for older adults in rural areas, price was the single most important factor as indicated by the mean value of 4.94 (SD = 0.25). The next most important factor was quality followed by durability, safety features and comfort (Table 4). Comparing the urban and rural respondents, they differed in the importance given to most of the factors: safety features, durability, clear label, after sales service, quality, environmental friendly, and comfort. No significant difference could be found for design, user friendliness, brand and price. Significant differences found among urban and rural respondents suggest that marketing strategies will have to be aligned with the preferences of these consumers.

When asked about their companions for grocery shopping, the response suggested that the older respondents usually shopped alone or with spouse. Less that 20% reported shopping for groceries with their children or other members of family. This is hardly surprising as 70% of them spent their mornings on grocery shopping, only about 20% shopped in the evening. Afternoon was not the preferred time for grocery shopping. Close to 60% of them shopped during weekdays and the rest reported weekends as their preferred shopping day. There were no significant differences between the urban and rural respondents in terms of the preferred day and time for grocery shopping as well as their shopping companions.

Leisure Activity Participation

In line with the concept of active ageing, this study attempts to examine if older adults engaged in leisure activities which could measure the extent of social involvement of older adults. Results showed that at least 531 (or 99%) of them had at least one leisure activity (Table 5). The mean number of activities these older adults engaged in was 1.8 (SD = 1.1). Watching television was the most popular activity followed reading, gardening, and exercising. About one quarter of them cited other activities such as engaging in religious activities, handicraft work, socialising with friends, and visiting. The results provided evidence that these older adults were clearly active. Comparison older adults in urban and rural areas, research results showed urban respondents to be significantly more active (p<. 001) with a mean of 1.92 activities (SD = 1.20) while the rural respondents participated in 1.57 activities (SD = 0.86). Due to the availability of land, a higher proportion of the rural respondents engaged in gardening which traditionally has been an activity for the rural people since Malaysia was historically an agrarian society. For all other activities for which participation rate were significantly different between the urban and rural respondents, the urban residents had a more active participation compared to the rural folks.

Since watching television was reported as the most popular leisure activity, the television stations that are popular among older adults were examined alongside the viewership habits of the urban and rural respondents. TV 3 was the most watched television station, followed by RTM2 and RTM1 (Table 6). NTV7 was the next most popular. Astro the only paid television station that screens movies and drama series was popular with the urban respondents. Since significantly more urban respondents watched television compared to rural respondents, it was not surprising to find that significantly more older adults watched the televisions on most of the stations except NTV7. Besides watching news as reported by one third of the respondents, they liked programmes with entertaining value such as movies and dramas. A small percentage (7%) liked to watch documentaries. The results on television viewing behaviour had profound implications for marketers in marketing communications especially for grocery products that are targeted for the mass market.

For newspaper readership, results showed that about one fifth of the respondents did not read any newspapers (Table 6). Dailies in the Malay language were the most popular among the sampled respondents. Additional analyses showed no significant difference in terms of readership of the Malays Dailies between the urban and the rural respondents. As for the English dailies, the study found that there was significant difference in terms of readership between the urban and rural respondents at p <.001 with significantly more urban respondents reading the English dailies. For the Chinese dailies, while there was no significant difference in terms of readership for Sin Chew Jit Poh, there was significant difference for Nanyang, with only a low percentage in the rural areas that read it compared to the urban respondents. This has implications for advertising for marketers who target the Chinese market.

Source of Information for Products and Services

As consumers, older adults will have to rely on certain sources of information to make informed purchases. The present study collected data on the possible sources of information that older adults relied on for a list of commonly used products and services: travel, financial matters, grocery products, fashion, appliances and furniture, medical and health care, and shopping. Table 7 shows the results. Children (sons and daughters) formed the major source of information for these older adults across all categories of products and services included in the study. Next, friends were relied upon for information needs. The results clearly point to the reliance on interpersonal source for information. As shown above, although these older adults tended to shop for groceries alone or with spouse, information for grocery products flowed from either sons or daughters to these older adults.

The mass media, radio and television as well as newspapers did not feature as popular source of information across categories of products and services except for shopping, indicating that older adults relied on these mass media for shopping-related information. The Internet was the least used source for information among older adults.

Since the focus of the study is on grocery shopping behaviour, urban and rural differences with regards to the use of information sources were examined. Analyses showed no significant differences with regards to the use of all information sources except for spouse. A higher percentage of rural respondents (N=99, or 58.2%) obtained information from their spouse compared to the urban respondents (N = 180 or 49%).

Are They Happy Consumers?

To gauge consumption satisfaction among older adults, the respondents were asked to indicate on a 5-point Likert-type scale, "1 = not satisfied", to "5 = satisfied" on a list of items: shopping facilities, consumer protection, elderly friendly products, customer service, complaint channels, check-out counters, rest areas, stairs and security. The response could range from 9 to 45. Over all, they were not particularly satisfied as indicated by the mean score of 25.56, (SD = 7.1). They were not happy with all of the items covered in the study except rest areas and customer services that had a mean score of greater than 3.0. The results have strong implications for marketers intending to serve the older segment. In the present study, life satisfaction was measured by using the Satisfaction with Life Scale (SWLS) (Diener et al. 1985). Respondents were asked to indicate on Likert-type scale, "1= strongly disagree" to "7 = strongly agree". The mean score was 25.13 (SD = 5.7). Using Pearson correlation, satisfaction as consumers and life satisfaction showed a positive significant relationship with r = .173 (p <. 001). Comparing the level of satisfaction with consumption and life satisfaction among the rural and urban older respondents, results showed that there was no significant difference.

Discussion and Conclusion

This paper provides an insight into the expenditure patterns of older adults in Malaysia. It is obvious that they spend a large proportion of expenditure on food and beverages that encouraged a more detailed examination on grocery shopping among these older people. As has been evidenced in the paper, marketing grocery products to older adults in Malaysia should begin with an understanding of where and when they buy, and an appreciation of the evaluative criteria they adopt, and the sources of information they rely on for purchase decision. Results of the study show that older adults in Malaysia are active; they know what they want and are judicious about what to look for in a purchase. Their attitude towards purchase decisions is not different from older adults in more advanced countries (e.g. Biren 1994; Duizer et al. 2009). Their independence is evident in shopping activities as they tend to shop alone or with spouse. Less than 20% shopped with their children even though they relied on their children for information relating to various categories of products and services, including grocery products. Advertising by marketers are hardly given attention except when they look for news for shopping, suggesting the importance to gain the confidence of these older consumers when targeting them. They could be described as active in leisure activity participation.

Marketers should avoid a narrow and inaccurate stereotyping of them (i.e., they are older consumers and no longer active). As the market for older consumers expands over time as a result of an aging populace, marketers would be wise to consider potential and profitable segments not just for their

basic needs, but for other leisure related products or services has been found in the UK where households headed by retired persons who belong to the younger cohorts of older adults spent more on leisure, but their expenditure on food and fuel declined (Higgs et al. 2009). Based on the trend found in more advanced countries, it is expected that in time to come, Malaysia will experience a similar trend. In fact, this is already happening. We observe that more of the urban older adults are spending on leisure and products that provide self gratification.

For communication strategy, marketers must take cognizance of the information sources used by older adults. Appeals adopted in advertising message must incorporate aspects that could appeal to both the younger adults (children) and older adults to create a strong message since older adults rely on their children for information. The likely roles played by children of older adults are information gatherer and influencer. They are the gate-keepers and opinion leaders in the households of older people. Marketers, when deciding on television stations and newspapers as vehicle of advertising message must take into account the stations watched and the newspapers read. In particular, advertisers targeting the ethnic Chinese market must understand that newspaper readership habit in urban and rural areas can be different.

In this study, the lack of a clear control group might be seen as a limitation. In the future, we would propose to extend the study with a control or at least a comparison group from younger age ranges, so that we can make stronger statements about consumer attitudes and purchase behaviour of older adults, for within and between age groups differences. Behaviour patterns may be product specific. Thus future research should examine different product categories specific to older adults and those that are age neutral.

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Table 1: Demographic Profile of Respondents

	N	%		N	%
Age:					
55-60	221	42.8	**Education:**		
61-70	191	37.0	No education	91	16.9
71 or older	104	20.2	Primary	217	40.4
Mean age = 64, SD = 7.3			Secondary	183	34.1
			Diploma/University	46	8.6
Gender:					
Male	306	57.0	**Ethnicity:**		
Female	231	43.0	Malay	300	55.9
			Chinese	157	29.2
Religion:			Indians	65	12.1
Islam	304	56.6	Others	15	2.8
Buddhism	129	24.0			
Christianity	52	9.7	**Marital Status:**		
Hinduism	45	8.4	Single	11	2.0
Others	7	1.3	Married	23	4.3
			Married with Children	405	75.4
Employment:			Widowed	98	18.2
Full-time	76	14.2			
Part-time	42	7.8	**Living Arrangement:**		
Retired/Not employed	301	56.1	Alone	36	6.7
Retired employed part-time	84	15.6	With spouse	86	16.0
Retired employed full-time	34	6.3	With spouse & children	207	38.5
			With spouse & married children	110	20.5
Income:*			With children only	91	16.9
< 1500	204	38.0	With parent(s)	7	1.3
1500-2499	143	26.6			
2500 – 3499	91	16.9	**Location of residence:**		
3500- 4499	37	6.9	Urban	367	68.3
4500 or >	62	11.5	Rural	170	31.7

*Income refers to estimated monthly household income measured in Ringgit Malaysia

Table 2: Expenditure Patterns among Older Adults

	Total		Urban		Rural	
Items	**Mean (RM)**	**SD**	**Mean (RM)**	**SD**	**Mean (RM)**	**SD**
Food	463.6	325.5	516.18***	330.69	350.18	283.12
Beverages and Tobacco	76.2	109.3	80.10	118.17	69.11	87.14
Clothing and footwear	47.5	72.0	50.47	70.92	41.24	74.23
Gross rent, fuel, and power	164.6	193.8	189.39***	222.33	111.18	88.45
Furnishings and household equipment and operations	35.3	69.2	41.16**	69.76	22.71	66.41
Medical care and health expenses	100.7	98.9	108.82**	107.39	83.33	74.86
Transport and communications	135.4	125.7	143.23*	124.64	118.59	126.65
Recreation, entertainment, education and cultural services	90.3	248.5	107.35**	294.05	53.64	81.27
Food away from home	129.1	169.0	142.22**	191.03	100.72	101.88
Beverages away from home	28.4	47.9	30.74	50.30	23.22	41.87
Other miscellaneous goods and services	55.6	114.7	67.04***	130.22	31.04	63.84
Total	**1327.4**	**850.8**				

***Significant at .001, ** significant at .01, * significant at .05

Table 3: Grocery Shopping: Preferred Outlets and Reasons for Patronage

	Total		Urban		Rural	
Place	**N**	**%**	**N**	**%**	**N**	**%**
Sundry Shops	311	57.9	179	48.8	132***	77.6
Wet market	209	38.9	131	35.7	78*	45.9
Supermarket	195	36.3	155***	42.2	40	23.5
Weekend/night market	132	24.6	73	19.9	59***	34.7
Mini market	120	22.3	87	23.7	33	19.4
Hypermarket	118	22.0	105***	28.6	13	7.6
Wholesale market	78	14.5	52	14.2	26	15.3
	Total		**Urban**		**Rural**	
Reasons for Patronage	**N**	**%**	**N**	**%**	**N**	**%**
Ease of locating items	447	83.2	293	79.8	154**	90.6
Special deals	191	35.6	140*	38.1	51	30.0
Payment method	92	17.1	60	16.3	32	18.8
Fast check out	121	22.5	77	21.0	44	25.9
Services, e.g. carry out, home delivery	110	20.5	63	17.2	47*	27.6
Price	319	59.4	212	57.8	107	62.9
Helpful assistants	108	20.1	71	19.3	37	21.8
Comfortable place to shop	204	38.0	135	36.8	69	40.6
Product assortment	287	53.4	188	51.2	99	58.2
Loyalty card incentives	52	9.7	39	10.6	13	7.6

***Significant at .001, ** significant at .01, * significant at .05

Table 4: Evaluative Criteria

	Total		Urban		Rural		Sig.
Criteria	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	
Design	2.76	1.32	2.80	1.37	2.66	1.22	ns
User friendliness	4.07	0.93	4.10	0.95	3.99	0.89	ns
Safety features	4.35	0.77	4.40	0.77	4.22	0.75	$p<.05$
Durability	4.38	0.75	4.45	0.76	4.24	0.72	$p<.01$
Clear labels	3.66	1.26	3.85	1.17	3.24	1.36	$p<.001$
After sales service	3.42	1.22	3.58	1.20	3.06	1.18	$p<.001$
Brand	2.63	1.39	2.64	1.40	2.59	1.36	ns
Quality	4.39	0.72	4.45	0.73	4.26	0.70	$p<.01$
Environmental friendly	3.28	1.21	3.38	1.19	3.08	1.22	$p<.01$
Comfort	4.32	0.71	4.37	0.70	4.20	0.72	$p<.01$
Price	4.25	0,84	4.25	0.88	4.94	0.25	ns

Table 5: Leisure Activity Participation (N=537)

	Total		Urban		Rural		Sig.
Leisure Activities	**N**	**%**	**N**	**%**	**N**	**%**	
Travel	36	6.7	31	8.4	5	2.9	$p<.01$
Reading	168	31.3	119	32.4	49	28.8	ns
Exercise	111	20.7	76	20.7	35	20.6	ns
Shopping	33	6.1	30	8.2	3	1.8	$p<.01$
Watching television	279	52.0	214	58.3	65	38.2	$p<.001$
Going to movies	31	5.8	28	7.6	3	1.8	$p<.01$
Listening to music	29	5.4	23	6.3	6	3.5	ns
Gardening	148	27.6	87	23.7	61	35.9	$p<.01$
Others	136	25.3	96	26.2	40	23.5	ns
Mean number of activities	1.8 (SD = 1.1)		1.92 (SD = 1.2)		1.57 (SD = 0.86)		
531 participated in at least one activity							

Table 6: Media Habits

Television Stations	**N (%)**	**Newspapers***	**N (%)**	**Newspapers***	**N (%)**
RTM1	232 (43.2)	**English Dailies:**		**Malay Dailies**	
RTM2	262 (48.8)	The Sun	12 (2.2)	Berita Harian	117 (21.8)
TV3	321 (59.8)	The Star	78 (14.5)	Utusan Melayu	122 (22.7)
NTV7	195 (36.3)	The New Straits Times	63 (11.7)	Others	24 (4.5)
8TV	67 (12.5)	Malay Mail	22 (4.1)	**Chinese Dailies:**	
Channel 9	78 (14.5)	**Indian Dailies:**		Sin Chew Jit Poh	56 (10.4)
Astro (Paid TV)	171 (31.8)	Malaysia Nanban	8 (1.5)	Nanyang Siang Pao	38 (7.1)
		Tamil Nesan	29 (5.4)	Others	41 (7.6)

***Do not read newspapers N=115 (21.4%)**

Table 7: Source of Information for Products and Services

Sources	Travel	Financial matters	Grocery products	Fashion	Appliances and furniture	Medical and health care	Shopping
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Sons	304	302	213	231	214	254	232
	(56.6)	(56.2)	(39.7)	(43.0)	(39.9)	(47.3)	(43.2)
Daughters	237	287	279	229	269	252	250
	(44.1)	(53.4)	(52.0)	(42.6)	(50.1)	(46.9)	(46.6)
Radio and television	72	25	48	50	55	67	128
	(13.4)	(4.7)	(8.9)	(9.3)	(10.2)	(12.5)	(23.8)
Newspapers	99	46	64	69	78	75	127
	(18.4)	(8.6)	(11.9)	(12.8)	(14.5)	(14.0)	(23.6)
Salesperson	24	26	45	43	53	109	36
	(4.5)	(4.8)	(8.4)	(8.0)	(9.9)	(20.3)	(6.7)
Friends	189	64	78	77	59	137	137
	(35.2)	(11.9)	(14.5)	(14.3)	(11.0)	(25.5)	(25.5)
Internet	13	3	1	3	0	4	3
	(2.4)	(0.6)	(0.2)	(0.6)	(0)	(0.7)	(0.6)

Keynote Articles

主讲论文

*Chinese Version
中文版本

「回顾十一五．展望十二五」

中国国家老龄工作委员会办公室常务副主任
闫青春

我说开幕式完了我就别致词了，最后准备给大家提提气，给大家简单说说，会上让我讲十二五规划，因为规划的内容很多，时间又非常有限，所以我只能是加速，大家也不用记，实际有很多地方大家都清楚，如果你结合我们老龄事业发展的情况和我们做的十二五期间有一些基本的设想，给大家做一个简要的介绍：

老龄化快速发展，老年人口快速增长，因此养老服务的需求也在日益增长，我们的养老事业在十一五期间应该说发展很快，无论是养老保障，还是养老服务，老年团体社会管理都取得了显著的成就。特别是人们的观念发生变化，健康老龄化，积极老龄化的理念已经化为国家、社会和老年人群应对人口老龄化的实际行动。全社会尊老敬老的优良传统不断发扬光大，老龄宣传深入人心，老龄意识不断增强。

把老龄事业十一五期间的状况给大家介绍一下：

十一五期间老龄事业发展很快，具体地说，就是十一五时期是我国老龄事业发展中非常重要的五年，我们落实十一五老年事业发展规划、老龄工作的稳步推进，老年人的晚年生活明显改善，老龄事业在国际上的地位和影响力在不断提高。十一五规划的内容基本上完成，为十二五老龄事业快速发展奠定了很好的基础。

首先是养老社会保障体系在不断建立健全，养老保障制度在不断地完善，覆盖范围不断扩大，保障水准进步提高，我只是给大家介绍几个数字吧！因为内容很多，时间非常有限，现在是十点，差不多我用一个小时到十一点。

到2010年10月，我们国家的养老保险已经是2.45亿，与十一五期末相比增长了56%，其中领取养老保险金的是5782万，从2005年起，国家连续6年提高企业退休人员基本养老金水准，现在我们国家人均养老金每个月领取养老金平均值是1369元，也有的说1400元，都是大约的数。

1、新型农村养老保险开始试点，逐步扩大范围。现在是838个县，3745万人。

2、医疗保障制度不断完善。到2010年9月，医疗保险城镇职工基本医疗保险是4.21亿人，比十一五期末增加了2倍。特别是有很多地方创造了很多很好的经验。另外农村的“新农合”的参合率已经达到90%。

3、社会救助制度进一步健全。到2010年底，我们全国有2307万城市居民和5180万农村居民被纳入到低保范围内，人均救助的水准城市的达到240元，补助水准达到168元。全国的农村五保物件533万生活得到有效保障，集中和分散供养的标准分别达到2804元和1990元，分别比2007年增长44%和39%，各地也有一些经验。这是第一。我不能介绍的很详细，我把主要的数位说一下。

二、养老服务体系建设的稳步增长

1、养老服务设施的不断推进。现在我们全国各类社区服务中心是17.5万个，便民、利民服务网店69.3万个，80%的农村乡镇建有养老服务设施和场所。养老机构的床位数大幅度增加，现在全国养老机构38060个，床位266.2万张。我看民政部又有一个最新的统计，说到2010年底，床位数达到301万张。应该说一年就增加50万，这个数量是很快的。当然，这个统计有没有水分很难说。各地在加大财政投入的同时，民办养老机构也在迅速的增长。根据我们的统计和调查，全国民办养老机构是登记注册的4141家，床位数是41.2万，收养23.8万人。但是，据我们统计和调查的结果，还有差不多这样数量的民办养老机构没有经过登记注册，差不多还有4000家。

养老服务水准的不断提高，特别是推进居家养老的服务意见不断地贯彻落实，各地在推动居家养老服务，加大财政投入，加快养老服务专业化建设，加快养老服务资讯网路建设等也创造了一些经验。现在我们各地，全国养老服务机构的专职服务人员是27.9万人，取得养老护理员资格的是3万人，拥有社工职业资格的是24840人，助理社工26440人。

第三，老年权益保障和优待工作进一步加强。法规建设的不断加强，特别是老年法修订步伐的加快，已经列入到人大和国务院法制办的立法程式。全国现在有老年法律援助中心是16493个，老年维权协调的组织是95734个，另一点是老年优待政策的不断完善。31个省市自治区都出台了老年的优待政策和措施，对老年人的挂号、看病、就诊、乘坐公共交通、参观博物馆、美术馆、科技馆、文化馆、纪念馆以及公园等等，给予全免或半价的优待。

第四，老年文化体育事业快速发展。老年文化活动丰富多彩。现在基层老年文化活动设施是70多万个。另外我们还有几个固定的形成品牌的、全国性的老年文体活动，像老年合唱节、老年文化艺术节、红叶风采，还有老年体育健身大会等等。老年教育事业快速发展。现在全国的老年大学是4.2万多个，到去年底，又增加，已经达到4.6万所，在校的老年学员430多万。老年体育活动蓬勃开展。现在社区的老年健身路径是12000多条。另外首届老年人健身展示大会在前年就举办了，并且三到四年要举办一次。我们说，有工人运动会、有农民运动会、城市运动会、少数民族运动会、青少年运动会，那么我们也跟国家体委、老年体协共同研究并成功举办第一届老年人的运动会。为了淡化这种竞赛的色彩，我们叫“体育健身大会”。

第五，老年人参与社会发展取得显著成效。现在基层老年人协会的组织发展非常快，像老年人协会已经有80多万个，入会老年人3500万，社区的老年人协会是1679万个，农村老年人协会11912个，分别覆盖了绝大多数的社区和农村。

第六，老龄科研和国际交流日趋活跃。现在我们正在进行国家应对人口老龄化的战略研究，22个课题目前都已取得了阶段性成果；并对中国城乡老年人口状况的抽样调查和追踪调查，我们都在不断地延续推进。另外人口计生委进行了人口政策和人口老龄化战略研究，卫生部开展人口老龄化对卫生体系但来的挑战与对策研究；妇联开展老年妇女状况调查研究等等，另外我们发表了“中国老年人状况白皮书”，这在国际社会上产生了极大的反响。

这是十一五的成就吧！经验我就别说了，一是党政主导，为老年事业发展提供组织保障。第二加强老龄政策法规体系建设，为老龄事业发展提供政策依据。第三创新体制机制，为老龄事业发展提供有益探索。第四加强舆论宣传，为老龄事业发展创造良好的社会环境。这是十一五的成就和经验，问题也很严重，我列了几个主要的：

第一，对老龄工作重要性的认识还有待进一步提升。你比如说，有的地方连五年规划都没有，像海南、西藏，我们去年查十一五规划执行的时候，发现这个问题，当即严肃地向他们省里和自治区指出，他们也感觉到很抱歉。

第二，老年社会保障体系建设亟需完善加强。现在我们老年

社会保障有几个空白点，比如说城市无收入居民的基本养老保险到现在还没有建立起来，还是一个空白，农村的新农保虽然忆经试点800多个县，但是呢，推进速度还是太慢，广大农民有意见，按照中央原来的设想，一年增长10%，10年才能把全覆盖，结果，人家10年前就已经享受了，我还没享受到呢，等我享受到，我死了呢？我根本没享受，所以从这个角度农民希望加速。另外，医疗卫生体系不适应老龄化发展要求，看不起病，看不上病，吃不药，因病致贫等现象时有发生。

（三）、老年服务体系建设严重滞后。我们还是以刚才的那个例子来说，现在全国老年人100个或者1000名老人只拥有1.6张床位，这跟国际社会指标5%左右，发达国家可能8、9%这个差距太大，另外我们社区的养老服务设施覆盖程度比较底，档次也比较差，服务品质可能就更谈不上，从这个角度呢，我们都需要有一个快速的发展。

（四）、投入机制没有真正形成，投入方式没合理。就是我昨天说的，政府是每年都在增加养老服务事业的投入，但是投入的预算跟国民经济快速增长的比例比起来严重落后，落后于经济社会发展的这个速度，另外投入的方式基本上还是延用计划经济年代抽投入政府办政府管，所以呢，高投入低产出这种弊端就没有克服，同时这种投入造成了一种市场经济状况下养老服务发展不均衡和不合理，国办的、公办的什么都给了他，给你建房子，给你添设备，给你养服务人员，结果呢，你跟民办的，民办的要自己建房子或租房子，自己买设备，自己顾服务人员，但是在市场上同样的价格，你是无成本的竞争，因此在市场竞争当中不是平等的起步，违背了市场上公开、平等的这样的一个竞争规率，使得我们民营养老机构呢，应试说举止维艰。

（五）、老龄工作机构和队伍建设有待加强。这个是我们从工作的角度，各地老龄工作机构的建设滞后，工作机构不完善，发展水准参差不齐。具体就不细说了。我想重点说后面两个问题。

三、人口老龄化发展的严峻态势

根据我们国家应对人口老龄化战略研究取得的初步成果。研究表明，人口老龄化将贯穿21世纪始终，综合考虑人口老龄化发展态势和经济社会承受能力，我国是世界上老龄问题最严峻的国家之一，未富先老，将是我国长期面临的基本国情，因此，老龄化为我国经济发展带来的挑战和机遇是并存的，但是，从长远来看，机遇不断减少，挑战迅速增长，所以有人说：挑战、机遇老龄化，人多了市场范围空间也大了，那么这不是机遇吗？但是我们是有机遇，但是挑战更大，老龄问题的重要性和迫切性大家都说了很多，我就不再重复了。我只是列了一下。

我想把我们研究阶断性研究成果给出了几个基本的判断给大家简要的介绍。

（一）、老龄化的形势比我们过去知道的和估计的更加严峻，我们现在按照1.83的总和收益率来进行预测，并且考虑到城镇的快速城镇化持续的低生育水准，我们的寿命延长，出生性别比失调，第三次的人口出生高峰深刻影响，对未来人口老龄化发展趋势作全面预测并从技术上避免失误，但是我得告诉大家，我们是按照1.83的总和收益率，实际上我们国家目前总和收益率达不到1.83，考虑到人口政策的调整才把他放到一个中位数的水准进行评估和判断，现在我们实际达到的是1.74。2014年，那么按照1.83来判断，到2014年我们老龄人口突破2个亿，2034年突破4个亿，2054年达到最高峰4.72亿，原来我们预测是2051年达到高峰期4.37亿，但是新的预测比原来增长了3000多万，大家看，另外老龄人口比重也在发生变化，目前是1.76亿，有的人说是1.74亿，6字一直没有公布，因次今年十三次全会，我们开全会的时候也没有对全国老龄人口的多少做一次准确的公布，还有将来6字公布的时候按照6字来计算，2024老龄人口比重超过20%，2042年超过30%，这个是重度老龄化的警戒线，就是30%，2057年达到峰值34.5%，过去我们说最高的峰值是31.4%，现在峰值是34.5%，超过1/3，过去接近1/3，所以现在的估计比过去重严重，劳动人口的年龄2012年达到峰值9.28亿之后就开始低下，2030年我们的劳动力人口减少为8.4亿，2050年减少为7.2亿，并且，年龄结构老化，从现在到2050年，我国劳动力人口，或者说人口年龄的中位数从36岁提高到47岁，整个人口的结构都呈现老化局面，总人口的扶养比2009年达到最低点是44.2%，之后持续上升，2015年前后突破一半，人口机会视窗开始关闭，2030年扶养比达到72.2%，2048年突破90%，2054年接近100%，进入到世界上社会扶养比压力最沉重的国家，刚才我说了按照1.73的总和收益率预测比这个还要严重，我们不是危言耸听，这是在一个科学的规划和一个模型的框架基础上计算出来的，这是第一个问题。

（二）、21世纪将成为我国人口长期均衡发展。21世纪人口老龄化成为我们人口均衡发展面临的主要矛盾，1999年我们进入老龄化行列，2030年人口贯性增长向负增长发生一个历史性的转变，人口安全方面面临的矛盾更加复杂，长远看，人口数量剧增和骤减和过度老龄化都不利于经济社会的持续发展，因此，我们要解决人口问题必需要在战略上留出一个充分的时间的提前量，错过个这个战略机遇，将付出沉重的代价，所以，我简单的一个小的结论：在继续稳定低生育水准，努力解决人口老龄，解决人口数量的问题的同时必需　　统筹实施人口能够长期均衡发展的战略，即时完善生育政策，避免人口过度的老龄化，说白了我们就是给计生委提供一个调整政策的建议，要调整你的一孩化的生育政策，要适度的放松人口的生育政策，不然的话，老龄问题带来的压力，人口安全问题就成为我们一个非常重要的社会问题。

（三）、人口老龄化将成为深刻影响我国宏观经济基本面的重要因素。因为我们做战略研究首先国家最关键说人口老龄化跟社会经济有什么影响。因此我们从宏观的角度对经济的影响作了一个测算，从2020年对经济发展的影响还不显著，但是从2020年到2030年受老龄化快速发展的影响，我国经济增长率可能要减少约1.9个百分点，也就是说老龄化对经济示增长的影响是2个百分点左右，2030年以后，老龄化伴随人口负增长对经济发展的影响就更为显著和深刻。这是第三，我们用一个数字来说明，老龄化对经济发展是有影响的，如果国家领导人看到了，他也会重视的这个问题，不然的话都觉得老龄化？过去我们不召唤老年人不也养着吗？怎么现在召唤得这么厉害。它对经济确实是有影响。

（四）、老龄化将持续冲击我国养老保障体系。我们现在独生家庭的数量是1亿，约占全国家庭总量的40%，65岁以上独居空巢老人的数量将由现在的5000万增加到2050年的2亿，家庭结构、家庭规模，居住的方式变化将严重削弱家庭养老的功能，传统的家庭养老模式给许多家庭造成了难以维计，目前还是5个劳动力养一个老年人，40%的扶养比，那么还有少年儿童，现在少年儿童的人口还多于老年人，但是到2025年左右，老年人口将超过少年儿童，成为第一大被扶养的人，2050年将面临1个半劳动力养1个老人的严重态势，因此，现行的养老保障体制面临沉重支撑的压力，我们现在的养老保障是现收现付，这手把劳动力的养老保险金收进来，那边又要发出去给那些领取养老保险金的老年人，中间基本上没有多少结余，现在呢因为劳动力交钱的人比较多，领钱的人相对还要较少一些，因些除了收进来发出去之后每年都有1000多个亿的结余，但是这种状况到2020年以后或者说2025年以后就难以维计了，交进来的钱已经不足以发出去，还有一个大窟窿，2030年养老金支出将达到24.5万亿，这是我们的预测，2050年达到148万亿，其中养老财政资金2011年我们支出的是3277亿，2050年将增长到24万亿，增长73倍，大家想想，我们的经济承受能力能不能承受得住。总体看，我们的养老保障体系可持续发展面临着人口老龄化持续挑战。

（五）、人口快速老龄化给我国健康知识体系可持续发展带来压力。可以说是卫生吧，从现在到2050年我国老龄人平均两周患病例数将由7801万例增长到30911万例，约增4倍，老年人就诊的次数从12.4万亿人增长到33.5亿人次，约增2.7倍，负

担将由7513亿增长到31.4万亿，增长41倍，总体看，我国建立应对人口老龄化健康知识体系的任务也是十分艰巨的。

（六）、养老服务需求对建立健全老龄服务体系这个任务更加艰巨。高龄化、空巢化、失能化大幅增长，庞大的老龄人口其数，而家庭养老功能的弱化使养老服务需求的压力增大并将长期存在，2011年到2050年，80岁以上的高龄人口将从2000万增加到1亿，增长5倍，无子女的老人将从1600万增长到7900万，增长5倍，失能老人需要的护理费用将从3715亿增长到4.72万亿，增长15倍，因此老龄服务面临的挑战在全世界独一无二，建立健全老龄服务体系的任务是非常艰巨的。

（七）、老龄化加剧了我国解决三农化问题的难度。大家都知道农村长期二元化体制造成农村的养老服务事业发展严重滞后于城市，我国农村的老龄化水准洽洽高于城市，现在农村的老龄化水准是15.4%，全国平均是12.5%，2050年将迅速提升到40.2%，超过城市同期9个百分点，为我国解决三农化问题带来挑战，另外本世纪前30年农村向城市累计转移3.5亿劳动力，青壮年劳动力大幅减少，老龄化迅速发展，导致农业劳动力素质下降，农业生产技术的推广又受到影响，农业生产力提高速度也受到影响，农村劳动人口的年龄2011年是4.63亿，到2050年下降到时1.59亿，劳动力人均耕地现在不到4亩，到但到那个时间就要增加到11亩，一个老头耕地11亩，压力太沉重了，所以，如果在现有的基础上农业劳动力再减少10%以上，农业生产将呈现负增长，大家都知道，农业是国民经济的基础，如果我们粮食安全都得不到保障的话，那你这个国家的发展，社会的安全肯定是要出问题的，另外，农村养老保障为老服务体系建设的压力巨大，目前5个劳动力养1个老人，2050年，1个劳动力养1个老人，另外，二元化造成的农村养老服务设施建设严重滞后，老龄服务严重短缺急待快速赶上。

最后，体制机制的不健全，制约了我国统筹应对人口老龄化能力的提升，我们应对老龄化必需健全体制，统筹动员政府、市场、社会三种力量共同行动，但是我们目前的老龄工作管理体制、运行机制存在着综合决策、协调机制不健全，检查监督机制不到位，投入保障机制不完善，基层老龄工作薄弱等问题，总体看，政府职能转换滞后，市场作用发挥不足，社会力量动员不够，应对挑战的体制机制不充分，难以适应老龄化的发展和客观要求。随着老龄群体民主参与意识和社会参与的愿望不断提升，老龄群体社会团体任务更加繁重，管理体制管理方式和内容都必需要做根本性的调整，所以我的结论，要打破瓶颈，从战略上对体制机制问题做根本性的改革，不然的话，解决不了我们人口老龄化的快速发展，对社会保障、社会服务和社会管理等各方面的要求。那么，对我们老化的态势做一个小结。2030年，老龄问题全面显现并日益突出的重要时间拐点，从现在到2030年还有20年，准备时间也非常紧迫，既是战略机遇期，也是重要的战略准备期，必需要在　　和社会发展面突出矛盾和问题的同时，从物质、精神、文化、体制机制等方面做好全方位的准备，要抓紧制定实施国家老龄事业中长期发展纲要，加强组织领导，动员各方面力量，形成全民应对老龄化挑战的良好局面。

四、解读十二五规划老龄事业发展的前景

我们按照中央的统一部署，正在制订老龄事业发展的十二五规划，那么十二五规划的总体框架给大家简单介绍一下，毕竟还没有确定最后下发，规划的背景我刚以已经介绍了，规划的指导思想、目标和原则，指导思想从理论基础上讲是邓小平的理论、三个代表、科学发展观，从方针上就是老调常谈，党政辅导、社会参与、全民关怀，实施积极老龄化，健康老龄化的发民战略，工作重点就是发挥家庭和社区功能，优先发展社会养老服务，培育壮大老龄服务事业和产业，同时完善老龄事业管理体制运行机制，营造良好的社会环境，维护老年合法权益，实现六个老有。总体目标，应该说我们总体目标就是确定了六个体系的建设，老龄战略对策体系，老龄经济供养体系，老龄健康知识体系，老龄医居环境体系，老龄服务体系，老龄工作体系，这六个体系有的是建立完善健全，有的是初步构建，搭建框架，但是总体上是六个体系的建设。基本原则我们确认了5项原则，坚持老龄事业与国民经济的发展，协调发展这么个原则。立足当前，规划长远相结合的原则，政府主导与政策参与相结合的这么个原则，家庭养老和社会养老相结合的原则，统筹监督和分类指导相结全的原则。主要任务，我们确定了10个方面，养老保障、医疗保健、家庭建设、养老服务、人居生活环境、老龄产业、精神文化生活、社会管理、权益保障、老龄科研和国际合作。

下面我想就主要任务分开简单的说一说，养老保障，我们主要想举跟过去相比我们认为是有点亮点或者有点亮色的地方。1.农村新农保全面覆盖，刚才我说了，农民嫌我们推进速度太慢，那我们跟劳动部现在人力资源社会保障部进行了协商和沟通，我们说，你十二五期间再不补贴农民就要造反，他说，我们计画三到五年一定要补贴，所以这个新农保的补贴没有问题，城镇职工的基本养老保险要不断的完善，实现养老金全国统筹，这上也是正在努力，另外有一个正常的增长调整期，另外建立实施城镇居民的基本养老保险制度，刚才我说了这是一个空白点，我们要把这个空白填补上，另外要推动机关事业单位养老保险制度的改革，还有就是建立企业年金和企业年金制，发挥商业保险的普通性作用，医疗保险是提高统筹的层次和保障的水准，降低个人负担的水准，做好基本医疗保险关系着转移接续工作，以异地退休安置人员为重点，解决老龄人异地就业的各种保险，发展新农合制度，提高筹资水准和保障水准，减轻农村老龄人口医疗费用负担，完善老年社救助制度，那么就是最低生活保障制度怎么样进一步完善，现在，各地创造了很多好的经验，民政部也在推广，一个是非民地失保，我们周司长也在这里，他是专家，还有一个就是以支出来确定保障的数额，而不是以现在的收入来定保，现在以支出的水准，比方说你病了，支出突然加大，你如果单靠家庭的收入，可能两个家庭的收入都是2000块，你要享受低保的时候，比方说1000块的低保，但是我家有一个长期的病人或者一个突发性的病人，一下子支出好几万，我这些钱全放进去还不够呢，因此，保障的时候就需要有一个不同的对待措施。

老年医疗卫生保健，就是加强医疗卫生网点建设，开展老年人一病一防开展老年保健，特别是对老年的痴呆、抑郁精神疾病的早期发现将达到60%以上，提升70%以上的死亡概率。

老年家庭建设，要改善居住条件，也要学习西方社会一些成功的经验和作法，政府、社会、个人共担来帮助高龄失能老人，进行家庭的无障碍改造，我们在上海这方面进行了了一些探索，我们到上海的黄埔区和长岭区他们政府是拿出一部分资金对那些有困难的老年人家庭进行无障碍化的改造，我觉得他们这个做法很好。就是说我们要对老年人要提供相应的服务补贴和养老津贴，特是我们现在有独生子女的父母亲的家庭奖励制度，农村有计划生育的服务政策，另外，我们现在有8个省份在做高龄老年人的养老津贴制度，我想这些都应该归入到我们十二五规划当中的重要归重的一个方向，另外，需要重视孝亲敬老的传统美德的建设。

社会养老服务，我们想，还是要以居家养老为基础，居家养老说白了就是把社区的照顾和家庭的居住结合在一起，给老人提供上门包户的服务，因些我们要在城市的街道和社区的两个层面，在农村的乡镇和居委会的层面，加强养老服务设施的建设，所以我们提了一个指标，80%以上的乡镇，50%以上的农村社区要建立养老服务设施，在十二五期间，咱们就根据自己能力都建才好呢，但现在我们还做不到，另外城市街道、居委会两个层面要达到全覆盖，特别要实现居家养老服务机构日间照料中心卫生服务站速餐网点的基本覆盖，还有要加快养老机构的建设，民政部、发改委和我们老龄办三家正在研究制度我们全国的十二五期间养老服务体系的建设规划，提出了一个指标，1000位老人30张床位的指标，这是机构建设的指标。不过我看在解释的时候也好像存在一些问题，比方说，1000名老人30张床位，我们现在才16张，还要增长1倍，但是从床位的增长量还看就不是1倍了，你现在才是1.7亿老年人，按这个数量算是每1000名老人是16张，到2015年就2.16亿了，按这数量来算的话1000名老人30张床位就是差不多700万张床位，我们现在仅有300万张，还要增加将近400万张，所以绝对不是翻一

番，是翻一番还要多。另外，县级以上城市至少要建立一所养老机构，优先发展失能老人长期护理和康复服务，养老护理的床位要在高龄和失能老人的10%，这是我们根据要重点优先发展的护理机构提出来的，并且，在新建、改建、扩建的养老机构的床位当中的护理床位要达到60%以上，30‰张床位其中要有60%以上的是护理型的机构床位，说白了要突出护理机构建设，这跟国外通情是法制问题，人家国外国家资助或国家办的不允许你收健康老人的，说健康老人你进入占用失能老人应该享受的资源，因为资源有限，这样失能老人就进不来。如果资源丰富的话，那谁想进都可以，但我们现在做不到这样，所以只能优先照顾失能高龄老人，从这个角度呢，我们把失能型的护理机构列为重点，这是非常非常重要的。再有就是要加强养老机构服务队伍的建设，持证上岗率真要达到85%以上，现在我们养老服务持证上岗率非常低，可能不到10%，因此我们要加强这方面的检查监督，特别要加强培训教育，使我们的养老服务队伍专业化水准有一个大的提升。

老年人生活的环境叫人居环境建设，要加强老龄基础设施建设，特别现在很多地方提出了老年人10分钟、15分钟生活圈，那么老年人需要的服务在10分钟的范围内步行可以找到，如放宽点，15分钟要找到，那么在社会要建设许多的便民利民的、方便老年人的服务设施和网点，要推进无障碍建设，那么很多的建筑设施包括公共服务设施都要有便老年人的无障碍设施、无障碍通道。要开展老年友好型城市，老年宜居的社区创建和活动，这个是世界卫生组织提出来的，我们也正在推进，而且把它作为十二五期间推动老年事业发展的一项重要工作。它有一系列的创建标准和指南。

要加快发展老龄产业，要完善产业政策，要促进老年用品、产品的开发，要引导老年产业健康的发展，我们的老龄产业应该说落后太多，所以优先发展老龄事业和产业，这是十七届五中全会对十二五规划建议提出来的，那么很多事情我们可以靠市场解决的，我们也可以通过老龄产业市场的发展和开辟去满足老年人的需求，有一些公益性的福利性的服务需要政府的投入和政府的支持来发展，但是政府在某种程度上不能完全代替市场的立场，要丰富老年人的精神文化生活，加强老年大学的建设，加强老年人文化工作，社区的文化活动场所要普及，要开展老年人体育健身活动，老年人健身的比例要达到老年人总数的50%以上，另外，十二五期间，我们要继续办好“第二届老年人运动会”，扩大老年人的社会参与，推进银龄行动，探索实现我们老有所医的新形势，要加强老年人社会管理，推进基层老龄工作机构和老年群众组织建设，老年协会的城镇、社区工达到95%，农村的村一级要达到80%以上，要做好退休人员管理服务工作，社区管理的离退休人员要达到80%，要加强老年人的思想政治工作，引导老年人参与民主政治建设和社会活动。

老年人权益保障，完善老年人法律法规体制建设，特别是《老年法》的修订，在十二五期间，除了修订、完善、颁布之后，还要加大宣传和贯彻，做好老年法律服务，加强老年人维权法律援助和社会监督。

要推进老龄科研和国际合作，加强老年科学研究，加强老年事业的资讯网路建设，加强国际交流和合作。资讯建设我在这里说几句，我们从今年开始，要加强居家养老服务的资讯网路建设，要进行试点，民政部和发改委也要拿出一部分资金做试点。我也希望你们各地要进行一些探索，刚才我们张局长谈到说：得给老年人有个呼救系统，呼救系统只是说事的，其实真正呼救的老年人并不是很多，比如说发生脑血管破裂了，按个急救键，这个确实能够及时发现在哪，因为有GPS定位很准确，马上就能知道你在哪了，那怕你跑到国外去，人都知道你在哪个国家、哪个城市、哪个街道都能及时找到你给你提供一个医疗的支援和紧急的救助，便那毕竟是少数，老年人真正需要的是日常的各种各样的服务，那么你这个服务平台的打造，我这个老年人打个电话说：我今天想去医院，给我来一个陪护看病的人，你得有人上门去提供陪护。你跟人说我没人提供，你自己去吧，你说要你干啥？还要多花一毛钱打这个电话呢？所以从这个意义上你得有可行的或者说服务的平台，你这样搭建好，老年人需要什么服务，一按键，一指路你就能及时准确的给他提供，并且提供了之后还有追踪有监测，你说我派个人跟老人谈心聊天去，老人不满意，一追踪老人说：他什么谈心聊天啊？他净家常里短的扯老婆扯丈夫，根本不需要，结果他还要赚我的钱，在这种情况下，你就要把他废掉，你就不能再用他。老人的需要是多方面的，从生活辅助，到精神文化的辅助到心里的疏导等等，这个都需要我们服务平台的打建各种服务的供给，才能够真正做到。

那么十二五期间呢我们现提出了5个方面保障措施，还是强调政府辅导作用，政府的辅导作用非常重要，但是我们要改变政府职能，不能像过去那么辅导，唉呀，我们要发展老龄事业什么都政府投，政府办、政府管，结果呢，社会力量办不闻不问，或者说为了表明政府，我还资助社会力量办，撒点胡椒面，结果大钱自己用，小钱放出去还给自己脸上贴金，这是不对的，过去我一直给大家灌输说市场经济条件下，政府的职能是什么，政府的职能是掌控，而不是化权，市场经济条件下，公共服务领域有三种力量在起作用，第一种是市场，第二种是企业，有钱赚企业就愿意干，政府千万别去发愁，第二种力量是第三部门，就是社会中间服务机构、服务组织、社会团体。那么他不是追求利润的，但是他追求自身价值的实现，追求社会功德，他能干的政府也不要马上去接手干，让社会力量去干，只有企业觉得没钱赚不愿意干，第三部门想干但是又太耗钱，我又没这个实力干不了，没办法才兜着，我们说这是一个选择。也得进行一个不断的比较，这才是政府的职能，所以我们现在做不到这个，大家可能想想，我们这里也有公办的，也有民办的，也有政府的领导，我们是不是在转变政府职能的过程当中，真正按照这个方式去做？没有，现在我们做得很不够，这是第一。第二，建立多元的长效投入机制，就是说我们政府的投入虽然的逐渐增长，但是跟国民经济快速发展的增长是不相匹配的，是滞后的，我们现在经济发展一年增长10%，那我们老龄事业社会事业发展每年增长10%吗？可能没有，特别是老人这块是绝对没有，并且在动员社会力量投入方面你总得有一些政策啊，有一些优待，有一些扶持啊，另外有一些资金啊作引导性的资助，有没有？有的地方有，有些地方没有，更多的地方，我们的政策是形同虚设的。第三、加强老龄宣传，宣传不要认为就是天天在家喊，他也是润物细无声啊，是潜移默化的对社会产生影响，我们记得06年我们做老龄人口发展趋势预测的时候，讲了之后，成篇的组织报导，对社会的影响很大，现在一说老龄化，大家都知道老龄化很严重，怎么知道的呢？就是宣传造成的，所以，宣传攻势很重要，你看企业为什么舍得花那么多的大价钱去争那个票房花多少亿做广告，大家说那广告谁看啊，一看电视广告来了赶紧换台，尽管这样，对你的影响还是十分深刻的，比如说你要去买牙膏的时候，不知道什么品牌的牙膏好，你可能马上就会想到什么高露洁啊，这就对你产生影响了，所以从这个角度宣传很重要。

第四、加强老龄工作机构建设，就是我们这种老龄工作机构，从目前看还是一个配角，还是附属的，因为他只是一个综合协调、检查监督、参公附属的作用，没有真正的行政职能，真正做项目的时候只能民政部去做，但是民政部一做呢就给亲儿子喂奶，自己民政部门办的养老机构大量输血，管你办好办坏，我每年给你多少事业费，不够的我再给你追加，社会力量办的想着要一点资助，说我现在就差几万块钱给老人买一个洗衣机、烘干器，现在拿不出来能不能给点资助？说不行，你怎么能用公家的钱给你自己花呢？是不是？所以从这个角度，我觉得就没想到人家花你这个钱也是在做养老，你自己花也在养老，并且比你养得还多还好，你为什么非要自己去养呢？你交给社会力量办不行吗？你当裁判员，你别当这个运动员行不行啊？你又是裁判员，又是运动员，你跑到后面你也得想想办法把跑前面的这个拉下去，是不是？还是你第一，这就不对了。最后就是建立检查监督评估的体制，这个也很重要，我们现在有一些政策、一些标准、一些规范已经制定出来了，昨天我们郭院长说有没有？我说有，但是有了之后不通行，因为没有人去检查监督，没有人去强制性的实施和贯彻，如果我们建立起这样的检查监督机制之后，能使我们现有的政策很好的落实，我觉得也比我们再给他不断制定出台新的政策，到下面还是不落实，还是一纸空文，我觉得比那个强，最后还是我原来说

的，这个马克思说，马克思当时不是说明搞这个批判，当时不是讲得非常清楚吗？一打纲领没有一步实际行动的，你这么做对不对？我们制定了一打的优惠政策和标准规范，还不如实实在在抓落实去呢。

有几个亮点实际我刚刚已经说了，养老保障制度，我们推出了新农保全覆盖，城镇居民的基本养老保险制度投买，护理保险制度的探索，高龄困难老人的津贴制度的推行，这是从保障的角度。从服务的角度我们突出了社区养老服务设施的建设，为城乡社区分别确定了具体的指标，突出了养老机构和护理床位的建设，规定了平均的比例，根据老龄化发展要求养老机构明确了1000名老人30张床位的指标，这是一个要经过努力才能达到的指标，并且加强了养老机构检查监督的法制化建设的要求，我们明确提出了推动三个创建活动的要求，老年友好型城市，老年宜居社区和老年婚新家庭的建设。

第四，我们提出了发展老龄产业的要求和措施，阐明了完善老龄产业政策，这种产业化的规划国家扶持部研究、制订、落实、引导、扶持老龄产业的发展优惠政策，引导老年人消费，培育繁华老年品市场，促进老年产品、用品的开发等方面的措施办法。第五，提出了加强老年社会的管理的理念和措施，分别确立了城乡基层老年群众组织的指标和要求，城镇95%以上，农村80%以上，践行了国际社会践行健康老龄化，积极老龄化的理念，突出了老年社会参与的力量，同时，把加强老龄工作体系建设也在规划当中进行了了明确。这5个方面应该是我们的亮点。

十二五规划的特点我只能点点题了，时间到了。一是建设以人为本的理念，全面、科学可持续发展的科学发展观。第二是事融合了积极老龄化、健康老龄化的理念。第三是注重社会在养老服务中的作用。第四，突出引导尊老敬老的氛围老年宜居的环境。第五、提出了老龄工作机构和老龄群众组织建设的新要求。

最后我想做一个结束吧，十二五规划是我们在调查研究，广泛听取各地区，各部门基层干部意见的基础上形成的。2009年9月，我们老龄办成立了规划编制组，开始规划前期的准备和起草，2010年4月到11月，我们邀请人大政协及25个有关的部门组成11个检查组，对十一五规划进行了全面的检查监督，同时，对十二五规划听取了地方的意见和建意，同时我们编制规划组先后召开5次座谈会，广泛听取各地各方面的意见，先后2次在成员单位和各部门（28个部门）征求相关的意见进行修改，2月11日，我们将规划草案提交，全国老龄工作委员会十三次全体成员会议审议并获得全体通过，所以我们有理由相信，经过全社会的努力，规划确定了各项任务一定能够得到全面的贯彻落实。我们现在说了很多，但是，真正规划我们将来公布之后还是以公布的规划为准，我只是给大家介绍一个基本的定义，希望大家和我们共同努力吧，把我们十二五期间老龄事业的发展向前推进一步，我也希望在座的各位院长在你们的实际工作岗位上能为我们老年人提供更全面、更周到、更人性化的关怀和服务，从而使我们老年人真正能够享受到他们所需要的各种服务，真正能够安度晚年，使们的社会更加和谐。

另外大家以后还有什么问题可以经常的联系和交流，也希望大家把你们工作中的酸甜苦辣包括你们创造的成功的经验和作法及时提供给我们，我们向全国推广。谢谢大家。

「马德里国际老龄问题国际行动计划地域性分析」

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摘要

全球人口急速老化，世界各国是否已为人口结构转变而来的挑战做好应对的准备？2002年是历史性的一年，全球159个国家于第二次老龄问题世界大会签订《马德里老龄问题国际行动计划》（下称《行动计划》），承诺以政策及服务建构全龄社会。《行动计划》勾划了国家应对人口老化的政策目标与服务方略，为政策制定者及服务提供者提供指导性原则。从2002年起转眼十年，世界各国进展如何？距离2002年订定的目标还有多远？本论文将就亚太地区30个国家就《行动计划》的三大优先方向：（1）老年人与发展、（2）增进老年人的健康和福祉及（3）确保老年人有利的支助性环境所实施的老龄政策与项目探讨《行动计划》的落实情况。

全球两个人口最稠密国家中国及印度位于亚洲，随着战后婴儿潮出生人士逐渐步入60岁高龄，亚太地区人口将高速老化。2010年亚太地区60岁人士有438,000,000位，2050年老年人口数目将飚升三倍，达1,260,000,000之多，成为全球拥有最多老年人口的地区。亚太地区各国在经济、社会、文化及政治方面发展程度不一，人口结构改变所带来的挑战相信会更益复杂。

2002年，全球159个国家于第二次老龄问题世界大会上签署了《马德里老龄问题国际行动计划》，承诺透过政策及服务应对人口老化所带来的机遇挑战，大力推动建构全龄社会。《行动计划》则为各国政府处理多项重点老龄事项提供了纲领。

为评估各国自2002年起的进度以及策划《行动计划》未来的五年执行计划，不同地区都对《行动计划》的落实状况启动了第二次的全球评检，预计于2013年完成。亚太老年学研究中心受《联合国亚太经社委员会》委托，对亚太区国家为长者及老年化而设的机制、法例、政策及服务进行分析。

亚太老年学研究中心透过自填式问卷调查，收集与长者及人口老化相关的国家机制、法例、政策、项目及服务的资料及数据。问卷以《行动计划》内容为骨干，并派发到《联合国亚太经社委员会》 所属的成员国及附属成员。及至2012年7月，共有30个国家和地区提供资料，包括亚米尼亚、澳洲、阿塞拜疆、孟加拉、中国、北韩、斐济、格鲁吉亚、香港、印度、印尼、日本、南韩、老挝、澳门、马来西亚、马尔代夫、蒙古、缅甸、尼泊尔、纽西兰、巴布亚新畿内亚、菲律宾、俄罗斯、萨摩亚、斯里兰卡、泰国、土耳其、乌兹别克和越南。问卷由四部份组成：(1) 处理及协调老龄事务的机制及行政安排；以及《行动计划》中三大优先工作方向 (2) 老年人与发展、(3) 增进老年人的健康和福祉及 (4) 确保老年人有利的支助性环境。

处理及协调老龄事务的机制及行政安排

大部份受访国家都有设立专责部门或联络机关，以汇统及协调老龄事务至政府行政，亦监察老年人与人口老化的相关事宜（表1）。上至常设的司局级组织，下至单一的工作局、跨部门的老龄事务委员会，又或执行部门内的分支或其中一项职能。各国采用的一系列联络机制，阐述了特定国家和地区在应对长者需要的不同策略。

澳洲和纽西兰均有专属的行政安排，设立专门处理长者及老龄事务的司局级部门。纽西兰的长者事务署有独立的预算，而长者事务署署长职能旨在领导和统筹跨部门协作的方略、人力和资源，处理老年事务。资料显示，多个国家和地区均采用跨部门、跨局和跨署的行政方式，以便适切到位地应对老年化所带来的挑战。接近三份之一的受访国家和地区，主要属于发展中经济体，处理老年事务的权责并没有委托于专责的联络机关，而是分散于不同的政府部门，如医疗、社会福利以及劳工事务等。有好几个国家地区如孟加拉、香港和印尼均设有议会、委员会或督导会，作为政府在制定和发展老年政策或服务的咨询组织。

优先方向1：老年人与发展

长者参与老龄事务决策，可确保所提出的方案在设计和执行上均能照顾长者的需要。多个国家和地区不但有特别的政策确保当局能听取长者的意见，亦容许长者在政策制定又或决策时有不同程度的参与。透过参与高层咨询组织及至社区层面的委员会，长者可以影响政策拟订及执行，亦可评检服务的提供。纽西兰政府开展了一项全国的社区义务联络人计划，现有44名联络人。他们主要负责咨询所在地区的长者，透过他们的网络和长者组织收集情报，并供予长者事务署，让政府在方案策划及服务评估上聆听长者的声音。

《行动计划》认同设立社会保障制度和全民保障的重要性，各国以不同的形式和手段，如退休金、医疗保险、残疾保险、无收入长者最低保障等，为市民提供保障。退休金是老年人重要收入来源，在已发展经济体退休金制度较成熟。为长者而设的全民退休保障，指给予所有付合资格（如年龄及居留年期等）的退休人士划一金额的准贴，则只有少部份国家和地区提供。

社会保障机制对于亚太地区很多国家和地区而言，尤其是发展中的，仍在起步阶段，致使大部份劳动人口步入老年时并没有退休金，又或需要在常规经济以外工作。但除缅甸以外，区来各国都致力为所有人提供最低的社会保障，不论在工作年期是否有参与退休供款计划，均给予基本收入。纵使先进经济体如日本、纽西兰及澳洲的退休保障系统发展成熟，但近期都需要进行改革，应付增长的长者人口及不断转变的需要，以紧贴世界银行所提出对保障系统 (1)水平充足、(2)可负担、(3)可持续，以及(4)稳健的四大要求。只有少数国家和地区为民众提供长期护理保障，但值得注意的是各国因应其社会、经济以及文化等因素，都有着独特的社会保障系统。

在增加长者就业机会方面，大部份国家和地区主要为长者提供培训课程又或更改法定退休年龄，而澳洲、中国、南韩、菲律宾、越南、澳门、蒙古、印尼以及萨摩亚则给予长者实质支持以助他们继续就业或创业。

优先方向2：增进老年人的健康和福祉

提倡健康和福祉是「健康老龄化的基石」，推广健康不但可以益寿延年，更为生活倍添姿采。为此，《行动计划》呼吁国家：第一，减少「增加患病及其后老龄依赖性的因素累积的影响」（译文；原文见联合国《马德里政治宣言及马德里老龄问题国际行动计划》，2003，页23）；第二，发展「政策，避免长者健康转差」（同上，页29-30）；第三，为提供「足够及可取得的食物及营养予长者」（同上）。因此，研究分析主要从两边探究政策

及项目：预防非传染病及推广长者摄取足够营养。

数据显示，有三份之一的受访国家和地区设有推广长者健康及积极老龄化的政策和项目，有24个国家和地区则政策和项目以提供可负担的保健服务。只有亚米尼亚、老挝、北韩、孟加拉、斐济、巴布亚新几内亚和乌兹别克没有提供任何此方面的资料以供分析。资料亦显示，在该24个受访国家和地区，主要有两种政策：一是由政府全资或部份准贴的综合健康护理保障和包含长者在内的医疗计划；二是采用甄别制度为附合年龄及其他条件的长者提供免费的医疗福利。越南需要80岁或以上，亚米尼亚、澳门、尼泊尔由65岁开始，而马来西亚及格鲁吉亚则由60岁开始。亚太区内只有少数国家包括日本、蒙古、南韩和泰国设有综合医疗系统免费为全体国民提供服务。

在服务提供者的老年病学及老年学培训方面，大多数受访国家和地区都倾向采用，由高等教育机构提供文凭或学位程度的课程，较为理论和学术导向；或者由本地机构提供量身订造的在职服务培训，则较为短期、技巧主导和目标为本。中国、纽西兰以及澳洲则采纳终身学习的导向，透过职业训练传授老年病学及老年学，技能亦可经由资历架构内建的晋升阶梯得到认证。而澳洲的长者护理劳动力基金则是例证，设有一系列由基础到进阶程度的培训和教育，在每职级都有详细的工作定义，以鼓励人们进入护老行业。

在提升长者自理和增强长者在社会护理项目发展的参与上，大多数受访国家和地区都知悉鼓励长者自理的重要性，并有采取相关行动。纽西兰就率先试行一项无缝护理服务模式（综合服务提供模式）以协助长者留在家中生活。为推广在家复健，政府与社区疗法服务提供者和老年病学专业的医护人员为病人、照顾者以及家庭成员提供教育和培训。澳洲政府在《国家医疗改革协议》下，大力提升健康护理服务消费者的参与和话语权，在健康知识、社区参与和消费者权益尤其是知情权方面，积极改善。这些行动都鲜有在其他国家观察得到。

优先方向3：确保有利的支助性环境

「原区安老」的概念旨在鼓励政府引入措施，容许长者继续在家安老。只有少数受访国家和地区有专门政策协助长者居家安老，如香港、泰国、纽西兰和澳门。我们亦观察到有三分之一受访国家和地区努力为长者提供住宿，包括公营房屋及安老院等。在南韩、菲律宾和日本，就有法律规管长者的房屋供应。发展中国家如亚米尼亚和乌兹别克由于经济仍在转型，人口老化在城市化的进程下同步发生，大部份人仍在乡郊环境老化，在缺乏交通及支援的情况下被遗留及隔离。

有19个受访国家和地区通过车费津贴或宽免和在公共交通工具上设立优先座位，给予长者可负担及可使用的交通系统。澳洲和纽西兰就在入息审查的前提下，向长者提供旅游津贴或折扣。计划下受惠长者除了交通上有折扣，还可以获得一系列的商品服务优惠，以便移除长者在使用公共交通及设施时的负担及阻碍，藉此鼓励他们参与消闲及娱乐活动。南韩、日本、菲律宾、泰国、越南、斯里兰卡和日本都有立法规管及要求建设无障碍设施予长者。

协调好专业和一般护理，加上给予照顾者充足培训，确保了长者连续的照顾。在不少受访国家和地区，我们都观察到他们都有发展为专业和一般照顾者而设的培训课程。资料显示培训主要由专门的院校或大学提供，对象多为专业照顾者，反而在一般照顾者方面则缺乏关注。而在能力认证方面，只有中国大陆和香港有设立，但两地的认证系统均没有容许当地符合资格的学员在其他亚太地区国家或地区工作。菲律宾则有通过教育系统发展出类似模式。

《行动计划》特别关注疏忽照顾、虐待又或暴力的潜在危险，并呼吁计划签订国要建立支援服务，以行动消除任何形式的虐老行为。我们注意到人口及经济的挑战导致虐老事件的增多，事件多在家庭发生，受害者多为年长妇女。只有4个受访国家和地区有专门立法保护长者免受任何形式的虐待。香港、南韩、萨摩亚、澳门、俄罗斯、印尼、纽西兰和澳洲就有透过公民教育、前线人员培训、研究、对受害人提供辅导、庇护及经济支持等以应对问题。

结论和建议

自《行动计划》于第二次老龄问题世界大会签定至今十年，令人欣慰的是得番亚太地区大多数的国家和地区都紧贴老龄化的状况，并推出和推动一系列不同强度的政策以回应逐渐浮现的挑战。顾及亚太地区独有的老龄化状况及特色，我们要特别注意下列几方面。

(1) 顾及性别差异的老龄政策及项目

年长女性将会占60岁以上长者人口的60%和最年长的一群的70%，女性生命历程中发生的不同生命事件会增加其随年龄增长的脆弱性。尤其当她们都生活在在男性主导的亚洲社会，对女性的歧视将会导致粮食和保健的不平等，接受任何程度的教育都受到限制，生育缺乏适当的医疗护理和支援。在劳动市场的性别歧视则导致女性收入低及不能从事较优厚的工作。当持家和照顾配偶和年长双亲的责任定型并落在女性身上时，都窒碍了她们挣取收入和收取退休金。家庭暴力可以从小发生在女性身上，一直延续至结婚后，是虐老的惯常模式。守寡则令女性失去收入来源，进而孤立于社会。文化传统和观念会令女性得不到需要的医疗护理，并威胁她们的健康和福祉。因此，政策和项目需要更关注女性，特别是贫困和教育程度不高的一群。

(2) 重建家庭观念及照顾功能以提供更好的长者护理

亚洲家庭虽有传统（亦即大家族同住，家庭成员之间共享资源，以满足心理、社交和生理需要），但随着城市化、核心家庭的兴起和女性接受更多教育并投身劳动市场，家庭照顾长者的功能正日渐消减。在华人社会进行的多项调查都一贯地显示，无论是年轻人或长者，他们在「家庭照顾长者」的传统观念上都变弱了。非正式的人际网络的角色变得更重要。家庭在非正式的照顾网络如朋友和邻居的帮助下，能够为满足长者的需要提供所需的协助。因此在紧接的时间重振传统家庭价值观念尤关重要，要透过正规及非正式的教育年轻人适当的行为和观念。

(3) 为正式和非正式长者照顾者建构能力

大多数国家都认为老龄化的一大挑战是培训护理员和专才。亚太区需要为护理培训设立能力认证系统，不但可以容许合资格的本地学员能够在其他亚太地区国家工作，亦可以透过承认非正式照顾者（如家庭成员和社区照顾者）的照顾能力，以吸引、招聘、保护和奖励他们去照顾长者。

(4) 在《行动计划》的基础上更进一步

《行动计划》没有约束力，缺乏独立监察和问责的机制以监督计划的实行。这亦是解释国家和地区之间在某些领域进展缓慢又或事情处理优次缓急出现差异的其中一个原因。澳门特别行政区政府于2008年发展出一套「老龄政策综合评估系统（APIAS）」，将《行动计划》的精髓化为具体项目，以助政策制定者、服务提供者和服务使用者从下而上去监察、评估和审视老龄政策。此系统有两大主要部件：第一，设有全面的政策实行指标；第二，设有有效的工具以供长者检视老龄服务及政策实施后的生活质素。老龄政策综合评估系统从本地的「提供者」和「用者」的两方面出发，论设计及规模，是亚太地区第一项采用和跟进《行动计划》方略的评估工具。此工具功能广泛，适用于全地区/全国又或特定功能区域，有效改善和加强区域合作，并就《行动计划》在老龄议题上向前迈进。

表 1：亚洲及太平洋地区选定国家的全国性老龄事务联络机关/委员会/部门概览

种类	名称	成立年份	国家/地区	量	%
老龄事务司局级机关	1. 澳洲长者事务部 2. 老龄事务署	1986 1990	澳洲 纽西兰	2	6.67
老龄事务跨局或部门委员会	3. 全国老龄工作委员会 4. 老龄事务跨部门工作委员会 5. 高龄社会对策会议 6. 卫生福利部低生育及老龄化总统委员会 7. 长者事务全国委员会 8. 长者福利中央委员会 9. 全国协调及监察委员会 10. 全国长者委员会 11. 越南老龄化全国委员会 12. 全国长者会议	1999 2009 1995 2005 1999 2006 2004 2004 2004 -—	中国 斐济 日本 韩国 老挝 尼泊尔 菲律宾 泰国 越南 斯里兰卡	10	33.33
老龄化或长者事务全国性委员会	13. 孟加拉老龄化全国委员会 14. 北韩联合安老事务中央委员会 15. 安老事务委员会 16. 长者全国委员会	2002 2003 1997 2004	孟加拉 北韩 香港 印尼	4	13.33
社会福利/社会公义/劳工事务司、局、署、处等各级机关	17. 劳工及社会事务局长者事务处 18. 社会公义及展能部 19. 家庭及社会政策部社会服务及儿童保护局 20. 健康及社会发展部 21. 社会工作局长者服务处 22. 妇女家庭及社区发展部社会福利署 23. 社会福利署家居照顾计划顾问委员会[1] 24. 社区发展局伤健人士及长者处[2]	— 1999 2011 — 1999 2001 2004 2010	亚米尼亚 印尼 土耳其 俄罗斯 澳门 马来西亚 缅甸 巴布亚新几内亚	8	26.67
没有资料/没有设立任何机关			格鲁吉亚 马尔代夫 蒙古 萨摩亚 乌兹别克 阿塞拜疆	6	20
				30	100

[1] 此委员会于 2011 年 8 月改组为全国老龄化委员会。
[2] 2002 年成立国家长者协调委员会但及后废除。伤健人士及长者处于 2011 年 7 月与服务受惠对象举行会议并设立内部委员会。

「多元文化及语言背景长者的健康及护理：澳洲的政策与实践」

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导言

在不断全球化的社会中，应付来自多元文化及语言（CALD）背景长者的健康及社会需要成为一大挑战，其重要性也越来越高。世界卫生组织指出要成为老龄友好型社会，首要条件是要设计多元化顾及不同需要（世界卫生组织［WHO］，2007）。澳洲政府上下一致认同满足多元文化及语言背景长者的需要之重要性，更把其作为现时所提议的长者护理改革中其中一个重点（肯诺恩斯，全，高夫与伯克，2006；澳洲联邦，2012；拉德马赫尔，卡鲁纳拉特纳，葛瑞丝与费尔德曼，2011）。此论文以较早前的老龄化与多元文化的概括研究为基础（芭特莉特，拉奥与沃伯顿，2006），探讨多元文化及语言背景人口老龄化所带来的挑战和机遇，同时包括全面的文献综述（拉奥，沃伯顿与芭特莉特，2006）和分析政策与实践的意涵（沃伯顿，芭特莉特与拉奥，2009）。除了涉及多元群组的健康和社会需要，此论文还包括一系列影响多元文化及语言背景长者的健康福祉的因素，概述当中的创新意念和优良的实践方法，并讨论日后研究、政策与实践的路向。

多元文化及语言背景之人口趋势

由于出生率下降，预期寿命上升，以及移民模式等因素影响，澳洲现正处于人口老化阶段。估计在2050年，澳洲65至84岁的人口数目会比现时多出一倍多（从2010年的260万人增加至2050年的630万人）；当中85岁以上的人口更是上升3倍（从2010年的40万人增加至2050年的180万人）（澳洲联邦，2010）。澳洲的人口多元化，外来人口占了总体人口的26.8%（澳洲统计局，2011），使其成为经济合作与发展组织（OECD，2011）中人口最多元化的成员国之一。因为移民潮的关系，多元文化及语言背景的人口老化速度比普遍的群组快，在海外出生的人口当中17.9%的人超过65岁，但总体人口中，65岁或以上人士只占11.8%（澳洲统计局，2011）。在移民群组中，长者主要是二次大战时期的欧洲移民（例：有56%的意裔澳洲人年龄超过65岁），而来自次一浪移民潮的欧洲和次撒哈拉地区移民则较为年轻。这些移民潮乃是受到移民政策所影响，包括1970年代废除的「白澳政策」（沃伯顿与其他研究员，2009）。近期的报告强调在制定服务供给时，必须考虑到老一代多元文化及语言背景群组的多样性（澳洲高龄人士老有所为中心，2011）。

现时政策方向

根据《1997年养老服务法》（2010），来自非英语背景的人士被列为在居住和社区护理方面有特殊需要的群组。再加上，多元文化及语言背景人士和原住民与托利斯海峡岛民在2007年家庭及社区护理国家计划指南（澳洲联邦，2007）也同被列为有特殊需要的群组。现时澳洲有两个政府计划是关于提供文化适合性护理－－就是社区伙伴计划（CPP）和文化适合性照顾服务伙伴计划（PICAC）（澳洲卫生和老龄部，2009）。

社区伙伴计划于2005年成立，提供资金予不同组织支持多元文化及语言社区，使长者服务更便捷和得到更好的支持。首轮的社区伙伴计划基金注资240万到全国各省共40家的机构（比绍普，2005）。随着多元文化及语言背景长者护理服务需求显著上升，在2009年起基金分三年注资1560万到77个社区伙伴计划中（伊利特，2009b）。

文化适合性照顾服务伙伴计划是为了提升长者护理服务的容量，以应付多元文化及语言社区长者的不同需求（澳洲卫生和老龄部，2009）。透过文化适合性照顾服务伙伴计划，一家机构在澳洲全国各省都受到资助，为长者护理供应商、社区伙伴计划和多元文化及语言社区提供支持；其中包括为长者护理业界提供具素质的文化适合性护理培训。一如社区伙伴计划，受文化适合性照顾服务伙伴计划所赞助的机构数目不断上升，从2009年（伊利特，2009a）开始两年间赞助270万到2011年起（巴特勒，2011）三年间赞助金升至660万。社区伙伴计划和文化适合性照顾服务伙伴计划扮演了桥梁的角色，连系了社区组织、服务供应商和政府；尽管这两个计划并不资助员工薪金等间接成本和不可追溯过往的资助，但仍然补助了培训费用等直接成本（澳洲老龄与社区服务，2007）。

现时不少人对澳洲现行的长者护理体制是否可应付未来预计增加的长者数目和需求存在不少忧虑，澳洲政府要求生产力委员会进行大规模的长者护理业界检讨（生产力委员会，2011）委员会的其中一个重要建议是引入单一的途径去简化获取护理服务的程序。委员会承认改变长者护理业界的其中一股动力就是老龄人口多样化，其中包括来自多元文化及语言背景人士和原住民与托利斯海峡岛民，建议如下：

建议的途径应照顾多元需要，成立接待多元文化及语言背景长者的综合中心，提供口译服务，并确保诊断工具符合文化适合性，可切实评估护理需要。同时为来自多元背景的长者在长者护理标准的人权和需要方面加强认可。（生产力委员会，2011，第LXXXVII页）

为响应生产力委员会的检讨，澳洲政府公布了长者护理改革建议书－－长寿更好计划（澳洲联邦，2012），措施包括增加对多元文化及语言背景人士（244万）和原住民与托利斯海峡岛民（431万）的服务资助金，并同时提供更多支持予退休老兵、不同性向的长者和无家可归的长者。此改革建议书已得到长者护理业界的一定支持，但仍等待国会通过。

多元文化及语言背景长者的健康与社会需要

健康需要

澳洲移民比起土生土长的澳洲人明显较为健康（澳洲健康与福利研究中心，2010；德雷帕，特瑞尔与澳登堡，2004）。这个「健康移民效应」是由于移民政策中筛选的机制，倾向挑选健康人士，有些情况是挑选较高社会经济地位的人。

然而，移民的际遇也会为移民人士的健康老龄化带来影响。有证据指出因为战争、政治经济动荡，或宗教冲突等原因移民到澳洲的人士，发现自己难以适应新国家的环境，导致影响了健康（拉奥与其他研究员，2006）。此外，根据移民原因而签发的签证种类（难民、家庭团聚，或技术人员）也与移民人士的心理压力有关连（周，2007）。移民澳洲后居住的时间长短也对健康和社会构成正面和负面影响。当泰利，阿里和李（2011）的研究指出移民人士需要两到三年时间适应新的医护系统，而阿里扎德－柯仪、马修和候赛因（2011）则在其研究表示移民人士的心理压力是与文化适应有关（以在家中是否以英语沟通作指标），而非在澳洲居住的时间长度。一些小型移民群组和来自较早期的移民潮的移民，由于人口数没有再增加，会有更大机会成为被孤立的群体（沃伯顿与其他研究员，2009）。

尽管普遍移民人士健康状况较好，但社会经济、文化和基因等因素依然导致他们要面对一些健康问题。例如：最近的研究指出来自北欧和亚洲的移民有较大机会患上糖尿病（澳洲卫生福利

局，2010）；年长的伊朗移民承受较大的心理压力，对健康福祉的满足度较低，并且具较大的功能性限制，在日常生活中需要帮忙和协助。（阿里扎德 - 柯仪与其他研究员，2011）；意裔的长者比澳洲长者更常受背痛的困扰，背痛程度更剧烈，更使人衰弱（史坦拿威与其他研究员，2011）。有关背痛一项的研究，其研究员指出背痛程度的差异，可以社会经济因素如教育程度和职业背景来解释。

一般而言，多元文化及语言背景长者在临终前数年都需要住院，并有较高比例的人有精神问题，尤其是心理压力问题，也会因患上晚期痴呆症而需要医护服务（拉奥与其他研究员，2006）。一个在1999年至2001年间以年龄超过五十岁或以上的移民人士为对象的纵向研究证实移民人士的心理压力比以往更大，同时指出随着时间的增长，压力会越来越大；压力增加的原因与移民人士来自那些国家（可分为西方发展国家、亚洲国家和其他种类）和持有的签证种类有密切关连（周，2007）。

社会需要

很多人认为多元文化及语言背景长者会与家人同住，但沃伯顿以及其他研究员（2009）指这不过是一个迷思。尤其是新近移民家庭会忙于确立自己的新生活，无暇照顾家中的老人。在越来越都市化的社会，传统的孝道被瓦解，过去的多代大家庭也逐渐被核心小家庭所取代（芭特莉特与廖，2009）。除此之外，多元文化及语言背景家庭较常与家中的老人接触，因此在某些情况下削减了这些长者接触所需的护理和支持的机会，因为保守的家人不欲寻求外界的帮助或是不知道有可用的资源（佰活与其他研究员，2011；沃伯顿与其他研究员，2009；肖，哈拉兰布斯，安格斯与希尔，2008）。

来自非英语国家的多元文化及语言背景长者由于语言障碍和丧失以往的社交网络的关系，会有较大机会与社会隔绝（拉奥与其他研究员，2006）。而被隔绝的程度更会因为长者重使自己的母语而越来越大（沃伯顿与其他研究员，2009）。另一个导致与社会隔绝的因素是来自小型移民群组和过往移民潮的移民人口日渐年长，但其所属的群组中再无新人加入，减少了他们接触具同样文化背景的人口之机会。语言障碍也同时阻碍了多元文化及语言背景长者参与主流的义工活动（沃伯顿与麦克劳林，2007）。

医护与社区服务的使用

现时有充足的证据证明多元文化及语言背景长者没有得到足够的医护与社区服务（约翰史东与卡力沙其，2008；米力恰普与加耶戈斯，2011；拉奥与其他研究员，2006）。尽管普遍的多元文化及语言背景长者较少使用医护与社区服务，但他们使用服务时，却偏好选择社区服务多于居家护理服务（拉奥与其他研究员，2006）。多元文化及语言背景长者也较少获得养老评估小组（ACAT）的转介，也许可能是因为家人没有注意到或不想使用，然而一般要获得居家护理服务都需要小组的转介。不同的移民群组也有些差异性，例如：相对于普遍人口，伊朗长者被阿里扎德 - 柯仪等研究员指出有更多的医护和心理服务需要，但他们却很少使用服务。研究报告更表示，英语水平较低的长者健康问题较多，更为需要服务，但这些长者使用服务的比率却不高，这大概与伊朗社区对可用服务的关注不大，或是本身的文化倾向于家庭护理照顾有关。

证据显示地理位置也对服务使用有影响，特别是在乡郊和偏远地区较少提供文化适合性护理（拉奥与其他研究员，2006）。由泰利以及其他研究员（2011）的研究报告中，检讨了年长亚洲移民在塔斯曼尼亚所享用的服务，一些研究对象指塔斯曼尼亚的医护系统比澳洲大陆的逊色，多元文化及语言背景专用护理服务也较少，以至一些长者要出行到澳洲大陆，甚至回乡以获得更好和更多的文化适合性护理。报告亦指一些英语水平较低的长者在使用复杂的医护系统时感到吃力和困难（泰利以及其他研究员，2011）。另一个关于亚洲移民的研究（肖，2008）也表示来自中国的移民对医护服务关注较少，尤其是综合保健服务，也许是因为这些服务在中国并不常见。

提供文化适合性护理

如上文所述，澳洲政府上下一致同提供文化适合性长者护理服务的重要性。因此必先好好考虑不同的因素，包括下列因素：

老龄的观念

不同文化中对老龄观念的差异也会影响到多元文化及语言背景长者对日渐年老和接受医护与社区服务的反应。一个关于澳洲中国籍移民的研究指中国籍长者视年老为无可避免的人生过程，并确立了一套信念系统，促使了自我隔离和变得更为内向，包括不愿参与体力活动（古，2011）。西方国家的「成功老龄化」概念在其他文化中意义不大。这论点也被陈、沃特和齐艾恩（2010）的英籍澳洲人和中国籍澳洲人的比较研究中提到。研究表示英籍澳洲人重视如何安然迈向老年，相反中国籍澳洲人则更着重财政稳健，保持活力和有意义的生活方式。由于「积极老龄化」概念使一些非主流文化包括原住民老人被边缘化，因此朗真（2010）建议应把「优质老龄化」和「真实老龄化」列成重点。

性别差异

性别在健康老龄化方面也扮演了重要角色。例如，女性多元文化及语言背景长者一般较依赖丈夫处理财政收支或是交通接送，并且较少上英语班学习；若她们因丈夫去世或病重，或是与丈夫离婚后失去配偶的支持，便会产生相当多的障碍（沃伯顿与其他研究员，2009）。相反，一个与公共健康讯息翻译有关的研究指亚洲男性会倚靠妻子来获得健康相关讯息（郑瑞，史提芬逊与沃伊道，2011）。而来自不同文化背景的女性在参与体育运动方面也有不同的自觉障碍；越南出生的女性太重视自己的外表，而意大利出生的女性则不健康、太累和不喜欢运动（波导与其他研究员，2009）。另一个与性别有关的老龄化范畴是多元文化及语言背景女性需要负起更多的护理职责（佰活与其他研究员，2011）。

获取文化适合性食物

相关的研究虽然不多，但仍指出在社区和居家护理中提供文化不适合的食物造成了差别待遇，因此应具备更大的灵活性（沃伯顿与其他研究员，2009）。无法得到合适食物是导致多元文化及语言背景长者粮食不足和营养不良的原因（米力恰普与加耶戈斯，2011；拉德马赫尔，费尔德曼与波导，2010）。这情况同时也会被经济压力、身体不好和行动力低，以及缺乏社会支持等其他因素加剧（拉德马赫尔与其他研究员，2010）。多元文化及语言背景长者可能需要长途跋涉去找寻文化适合性食物，而且会担心入住护理院舍后无法获得合适的食物。最近有关多元文化及语言背景人士粮食需要的研究（米力恰普与加耶戈斯，2011）表示，尽管澳洲一些省份透过家庭及社区护理计划（HACC）提供食物，但仍需投入更多努力以求改善，包括发展提供文化适合性食物的服务，及进行更多的研究去找出这些服务的影响和寻找日后服务的路向。

澳洲原住民的需要

提供文化适合性护理给原住民与托利斯海峡岛民是澳洲的一大挑战，特别是为居住在偏远地区的社区群组提供服务是当前的急务。但出现在家庭及社区护理计划、服务、社区与服务对象之间的价值观不一致，成为了破坏文化和谐的根本问题。在北部省份发现，家庭及社区护理计划服务供应商使用不一的评估程序并依靠最少量的证据进行临床服务（林德曼与佩德勒，2008）。为应对这些文化不和谐，公众提议在北部延杜穆的沃匹利人社区建立「家庭模式」的长者护理（史密斯，格兰特与尼尔森，2010）。前线护理服务一般由能操沃匹利语并认识服务对象的本地社区成员负责。这种紧密的连系使服务人员能了解本地人的需要，如性别角色和回避关系（即：有亲属关系或基于礼仪原因某些社区成员不可直接碰面）。为解决以上复杂的问题，可采取「常识」对策，如分开男士和女士专用地方，在每个房间都设有两道门和观景窗以避免有回避关系的成员同时进入房间。

语言障碍

语言障碍早已被确立为阻碍多元文化及语言背景长者使用医护服务和接受合适护理的一大障碍。沟通屏障影响了护理的所有范畴，包括：获得护理、诊断、评估、治疗和最终提供的护理服务水平（韦殊·盖瑞，福罗拿，格兰特·迪克逊与克林肯·韦伦，2008）。现在有必要为多元文化及语言背景长者提供更多翻译文本、提供翻译员，以及加推更多英语学习班（沃伯顿与其他研究员，2009）；然而提供专业翻译协助加剧了医护保健互动的复杂性（韦殊·盖瑞与其他研究员，2008）。

除了提供专业翻译员，现时的首要工作是在社区和居家护理中安排更多双语医护人员（佰活与其他研究员，2011；豪，2009；米力恰普与加耶戈斯，2011；沃伯顿与其他研究员，2009）。从事医护业的人口中约有25%至33%是在海外出生，经较早期欧洲移民潮移居至澳洲的欧洲人多数从事社区护理业，反观近期的亚洲移民则较多从事居家护理。其他国家有大量非技术性移民劳工从事护理业，但在澳洲则没有这种情况，在澳洲土生土长和海外出生的医护保健人员在技术和培训方面并无差别（豪，2009）。更有学者指出应更好地运用现有的双语职员，包括让他们把护理程序和文化偏好更紧密结合（肯诺恩斯与其他研究员，2006；沃伯顿与其他研究员，2009）。

种族特设服务与主流服务之争

提供种族特设服务还是提供主流服务这争论带出了澳洲医护保健人员和他们的服务对象价值观的不同（肯诺恩斯与其他研究员，2006）。例如：西方着重提供以服务对象为主导的护理，而其他文化中以家庭和社区为主导，并偏好自我决断，因此则成为了冲突的源头。

虽然大部份多元文化及语言背景长者继续接受主流的护理服务（豪，2009），但事实上种族特设服务和主流服务依然各有支持（拉德马赫尔，费尔德曼与布朗宁，2009）。澳洲的多元文化及语言背景人口多样化，包含了许多不同的文化群组，为每个群组提供个别服务去满足其需要实在难以实行（拉德马赫尔，费尔德曼与布朗宁，2009）。然而不论是资助种族特设服务还是主流服务都惹起不少争论，如资助种族特设服务会造成边缘化，加剧种族主义；而资助主流服务则会边缘化多元文化及语言背景群组，忽视其独特的需要（拉德马赫尔与其他研究员，2009；伯顿与其他研究员，2009）。近期有建议应平衡主流、多文化和种族特设服务来为日后的长者护理对象提供最佳的服务。

优良的实践方法和创新意念

发展多元文化及语言背景人口专用的检测工具

越来越多人承认一般大众合用的量度工具未必适用于多元文化及语言背景人口身上（安德逊，萨契戴夫，布罗德提，塞勒与安祖斯，2007；罗尔与其他研究员，2009）。在澳洲不论是普遍人口或是多元文化及语言背景人口，患上痴呆症的人数不断上升（进入经济学，2009），因此有意发展专为多元文化及语言背景人口而设计的检测工具，其中有两个不同的方法。一是把多元文化及语言背景人口的身份、年龄、社会经济地位等列入考虑因素，加入现行的简易精神状态测试以改善成效（安德逊与其他研究员，2007）。另一方面，卢坚的斯（2011）的研究强调为居住在偏远乡郊地区的原住民发展有效的文化适合性检测工具，即金伯利原住民认知评估量度表。另一个创新的检测工具是由韦殊·盖瑞与其他研究员发展的种族与健康沟通复杂度计分表，用以帮助临床医生评估多元文化及语言背景病人是否需要翻译的协助。

新南韦尔斯多元文化及语言背景人士未雨绸缪策略性模型

新南韦尔斯高龄、残障与家庭照顾部门（DADHC）认为多元文化及语言背景长者在计划面对健康衰退和死亡时遇上许多重大障碍（例如：遗产分配、持久授权书、医护事前指示），因而成立了未雨绸缪多元文化及语言背景社区计划（澳洲文化与原住民研究中心，2008年）。此计划包括文献综述，发展策略性模型，以及为三个目标群组（意大利人、阿拉伯人和克罗地亚人）发展沟通框架及相关资源。这些数据和其他跟原住民与托利斯海峡岛民相关的资料，以及与一般相关信息都可以在高龄、残障与家庭照顾部门的网站中取得（http://www.adhc.nsw.gov.au/individuals/ageing_well/planning_for_the_future），另外也有不同计划帮助其他有需要的群组。

促进多元文化及语言背景群组的健康

有鉴于多元文化及语言背景长者因语言和知识障碍而发生较多的不良医疗事故，所以澳洲开展了以操意大利语、国语和广东话群组为对象的电台宣传（郑瑞与其他研究员，2011）。在悉尼、墨尔本和全国性的民族语言电台广播中加插了广告和访问。为了解宣传成效，在电台宣传进行前后皆向悉尼和墨尔本当地来自三个目标群组的家庭进行了调查，发现在意大利语和广东话社区中对使用药品质量的认知有所提升（郑瑞与其他研究员，2011）。研究员同时指出在这些群组中人口分布多样化，因此应为年长人士（70岁或以上）特别设计不同的宣传讯息。

为服务多元文化及语言背景人士的人员制定工作指引

如上文所述，澳洲尝试为长者护理业界各个范畴制定工作指引，以避免发生文化定型。其中一个方法是着眼于清晰的信息交换，并且为员工应向服务对象和其家人提供的信息制定有用的指南；此外列明员工应为服务对象提供那些信息，强调使用可用资源，包括经培训的外籍员工（肯诺恩斯与其他研究员，2006）。根据沃伯顿与其他研究员的与服务供应商和政策制定人的商讨，以下为提供文化适合性措施的重要因素：

- 承认多元群组的存在 - - 多元化可以是优势同时也是挑战；
- 运用现有优势 - - 包括善用现时服务中的专才，各社区的拥护者和长者们，因为很多时候他们可以帮忙照顾他人；
- 发展文化财产 - - 包括善用双语员工；
- 培养包容性和反歧视 - - 但不代表我们认为种族主义不存在；
- 提供信息和加强沟通 - - 包括提供英语课程，翻译文本和翻译员；
- 建立合作伙伴 - - 在较早前的概括研究（芭特莉特与其他研究员，2006），确立了为多元文化及语言背景长者提供服务的主要持份者（图1）。

图1）为多元文化及语言背景长者提供服务的主要参与者（芭特莉特与其他研究员，2006，第51页）

这些通用的原则已收录于为社区长者护理业界制定的工作指引简报中（社会政策研究中心与慈善团体，2010）。

结论

此文章清楚展示了多元文化及语言背景澳洲长者在现在和未来所要面对的挑战。文化种族主义被认定为导致多元文化及语言背景澳洲长者所得到的医护保健服务与主流大众不同的主因，并成为需要有系统地解决的结构性问题（约翰史东与卡力沙其，2008；沃伯顿与其他研究员，2009）。要解决这些问题，需要政府、研究员、护理提供者、社区组织，以及多元文化及语言背景长者和其家人的共同努力。澳洲政府体会到老龄人口的多样化，并致力改革长者护理体制。最先要面对的挑战是如何打破多元文化及语言背景长者所面对的沟通障碍。解决方法包括提供更多翻译文本（澳洲文化与原住民研究中心，2008；郑瑞与其他研究员，2011）和提供专业的翻译服务，以及开设英语课程。

现时有关多元文化及语言背景人士健康和社会服务的研究为数甚少，很多论据是从灰色文献中引述而来，因此有欠科学严谨（拉德马赫尔与其他研究员，2008）。要解决我们知识上的不足，特别是在处理社区护理（拉德马赫尔与其他研究员，2009）和痴呆症病患（佰活与其他研究员，2011；罗尔与其他研究员，2009）的问题方面，必须进行研究项目作政策和实践的咨询，了解多元文化及语言背景社区的需要。

一如前文强调合作伙伴是发展多元文化及语言背景长者服务不可或缺的重要原素（拉德马赫尔与其他研究员，2011；沃伯顿与其他研究员，2009），因此稳健的合作伙伴关系可确保政策与实践的成果能满足各持份者的需要。方法包括制定策略加强多元文化及语言背景社区与研究员之间的连系（正如消费者网络一样），透过设立情报交换所来增加获取数据的途径。

尽管文中所述的问题和对策是以多元文化及语言背景澳洲长者为主，但仍然可作为其他国家的借镜。文中很多议题是其他地方也可能要面对的，因为人口老龄化为全球的养老政策、计划和服务提供都带来了相似的问题和挑战。

参考书目：

（请参照原文）

「中国老年照护需求的增长与养老护理人员能力建设」

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摘要

中国大陆60岁及以上老年人口已经接近1.9亿人，伴随着人口老龄化的迅速发展，老年人需要生活照料的比便和人数也在提高，根据测算其中生活不能自理的老年人超过1000万人，对社会和家庭养老护理人员的能力提出了新的挑战。国家十二五规划明确提出了到2015年的发展目标，增强机构养老和社区照顾为老服务的能力，转变政府职能，扩大基本公共服务的提供，政府部门也日益重视家庭的发展。在上述背景下，本文分析了目前需要存在的主要问题和相关政策建议，提出符合资质的养老护理人员需要加大培养力度，形成学校、机构、社区多层次培养教育体系。在体制机制上创新医护和养老护理人员之间的流动体制，提高养老护理人员的队伍稳定性和业务水平。在积极老龄化政策框架下，认识到老年人有家庭照料中发挥的重要作用，并在社区服务中增加对家庭护理人员的支持内容。养老护理人员的能力建设的长远发展，需要政府和社会在老龄社会应对战略、政策法规和具体服务措施三方面得到支撑。

「中国基本养老形势与『十二五』规划——中国养老服务体系解析」

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摘要

1. 中國公益慈善事業進入快速發展新階段
2. 新階段的五大特徵
3. 公益慈善事業當前面臨的最基本矛盾
4. 發展現代公益慈善事業的基本政策選擇趨向
5. 在專業化、聯盟化、巨型化的宏觀格局中實現公益組織的重新定位

一、当前全国养老服务基本形势

2011年6月16日，民政部发布《2010年社会服务发展统计报告》。截至2010年底，全国各类老年福利机构39904个，比上年增加233个，床位314.9万张，比上年增长9.0%，年末收养老年人242.6万人，比上年增长6.6%；

报告显示，2010年继续推进基本养老服务体系建设试点工作，试点范围从5个省份扩大到12个省份,中央下达试点资金3亿元，支持建设126个试点项目。继续推动建立高龄老人补贴制度，高龄补贴制度在7个省份全面建立。（民政部）

老年人的基本生活照料形势

2011年7月5日，根据民政部最新公布的结果，目前我国已有14个省份，全面建立起了对高龄老人发放津贴、补贴的制度，总共惠及800万老人。（中国广播网）

2011年7月11日，新疆自治区党委举行常委（扩大）会议，研究建立80岁以上老年人基本生活津贴制度和免费体检制度、建立社会救助和保障标准与物价上涨挂钩联动机制。会议决定，为全区80岁以上高龄老年人按年龄段每人每月发放50元—200元的基本生活津贴，每人每年免费体检一次。会议决定，按照低标准、广覆盖、保基本、可持续的原则，从今年7月1日起，对自治区行政区域内农业、非农业户籍80周岁（含）以上的老年人发放基本生活津贴。（搜狐）

中国老龄化的严峻形势：过去！

郑秉文教授观点：2000年第五次人口普查时，60岁及以上人口为1.331亿人，而此次“六普”为1.776亿人，10年来净增了4450万人，这个资料恰恰是总人口净增的数量（总人口净增数量为4440万）；换言之，10年来，中国净增的4440万人口都是60岁以上的老人。

中国老龄化严峻形势：未来五年

预计2015年老年形势（据新华社）：60岁以上老年人口：2.16亿，约占总人口16.7%，年均净增800万，超过新增人口数量；80岁以上高龄老人2400万，约占老年人口11.1%，年均净增100万，增速超过人口老龄化速度；65岁以上空巢老人逾5100万，约占老年人口近25%；“十二五”时期：将是人口老龄化加速发展期，呈现老龄化、高龄化、空巢化加速发展的新特征。

未来：全国老龄办的预测

第一阶段

从2001年到2020年是快速老龄化阶段。这一阶段，中国将平均每年新增596万老年人口，年均增长速度达到3.28%，到2020年，老年人口将达到2.48亿，老龄化水准将达到17.17%，其中，80岁及以上老年人口将达到3067万人，占老年人口的12.37%。

第二阶段

从2021年到2050年是加速老龄化阶段。伴随着20世纪60年代到70年代中期第二次生育高峰人群进入老年，中国老年人口数量开始加速增长，平均每年增加620万人。到2023年，老年人口数量将增加到2.7亿，与0-14岁少儿人口数量相等。到2050年，老年人口总量将超过4亿，老龄化水准推进到30%以上，其中，80岁及以上老年人口将达到9448万，占老年人口的21.78%。

二、中国政府养老行政行为转型

第一个养老服务体系的国家行政规划

2011年，中国养老服务体系进入行政管理规划，意味着中国社会的养老服务将要得到较大推动。

政府行为的重大调整

从过去制定《中国老龄事业发展“十一五”规划》以及以前的几个五年规划，到2011年2月11日民政部发布《社会养老服务体系建设“十二五”规划》（征求意见稿），其实是政策结构的重大转型；因为只有进入国家的行政规划，才可以组织实施，才能进入行政程式，配置行政资源；社会养老服务体系建设正式拉开序幕。“起步十年，依然起步”的阶段开始结束！

三、如何定位

社会养老？

- 指导思想和基本原则的重大变化
- 从家庭赡养到社会养老
- 政府承担社会责任
- 指导思想的重大变化

意见稿提出：基本建立起与人口老龄化进程相适应、与经济社会发展水准相协调，以居家为基础、社区为依托、机构为支撑的社会养老服务体系；相适应、相协调是过去不敢想的事情，这是一个高难度的要求！机构不再提“补充”而是提“支撑”！强调了机构建设的重要性！

基本原则的确立

以长期照料、护理康复和社区日间照料为重点，分类完善不同养老服务设施的功能，优先解决好需求最迫切的孤老优抚对象、“三无”老人、“五保”及失能、半失能老年人的照料和护理问题。基本原则就是从最为需要的人群和领域开始，重点是护理和照料！

四、300万张床位：

意味着什么？

- 平均每张床位投入10万元就是3000亿元！
- 平均5万元则是1500亿元！
- 每张床位需要近2个人建设目标：
- 总体需要500万人！

建设目标：

到2015年，基本形成制度完善、组织健全、规模适度、运营良好、服务优良、监管到位、可持续发展的社会养老服务体系；每千名老年人拥有养老床位数达到30张，直接新增养老服务就业岗位500万个。居家养老和社区养老服务网路基本健全。

建设任务：

以社区日间照料中心和专业化养老机构为重点，通过新建、改扩建和购置，改善社会养老服务体系的基础设施条件；充分考虑经济社会发展水准和人口老龄化发展程度，“十二五”期间，增加日间照料床位和机构养老床位300万张，实现养老床位总数翻一番；改造30%的现有床位，使之达到建设标准。

五、中央、地方、社会三大责任的划分

重在西部，成为一个新的政策重点。中央政府的投入战略与西部地区发展产生较为积极的影响。

资金筹措：

社会养老服务体系建设投资以地方投入为主，鼓励社会捐资，中央予以适度补助，做到“保基本、广覆盖、可持续”。中央补助投资涵盖不同层次、不同功能的养老服务专案，主要用于社区居家养老设施建设和养老机构建设，发挥带动和示范作用。中央补助投资根据年度投资预算和建设需求情况安排。

西部重点支持的原则：

原则上，在中央支持的项目中，中央补助东部地区不超过总投资的30%、中部地区不超过总投资的50%、西部地区不超过总投资的70%；对于财政困难的老少边穷地区、人口老龄化问题比较突出地区和国家有特殊政策的地区，中央视情况采取包建的办法安排补助；中央归集的彩票公益金要积极支援发展社会养老服务。

六、政策的开放与机遇

政策向社会开放：中央提出“发展多层次的社会化养老服务，加大对公益性养老服务设施建设与经营的支持，引导社会资金投入养老服务领域。加强养老护理职业教育，发展面向老年人的家政、护理康复等服务”要求

资金机遇：

规划指出：加大资金投入，建立长效机制。对公办养老机构保障所需经费，列入财政预算并建立动态保障机制；对社会组织兴办或者运营的养老机构通过政府购买服务或政府补贴等多种方式予以支援。中央和地方的投入将会达到多少亿元？会多于1千亿元吗？

管理提升机遇：

规划指出：建立制度标准，确保规范运营。建立、健全养老服务相关法规和准入、退出、监管制度，规范养老服务市场行为；加快出台和完善养老服务的相关服务标准、设施标准和管理规范；抓紧制定养老机构建设标准，建立等级评定制度，完善老年人社会福利机构基本规范和建筑设计规范；建立养老服务评估制度；健全标准管理体系，大力推动各级各类标准在养老服务行业中贯彻落实。创新体制机制，强化专业管理：建立公开、平等、规范的养老服务准入制度。

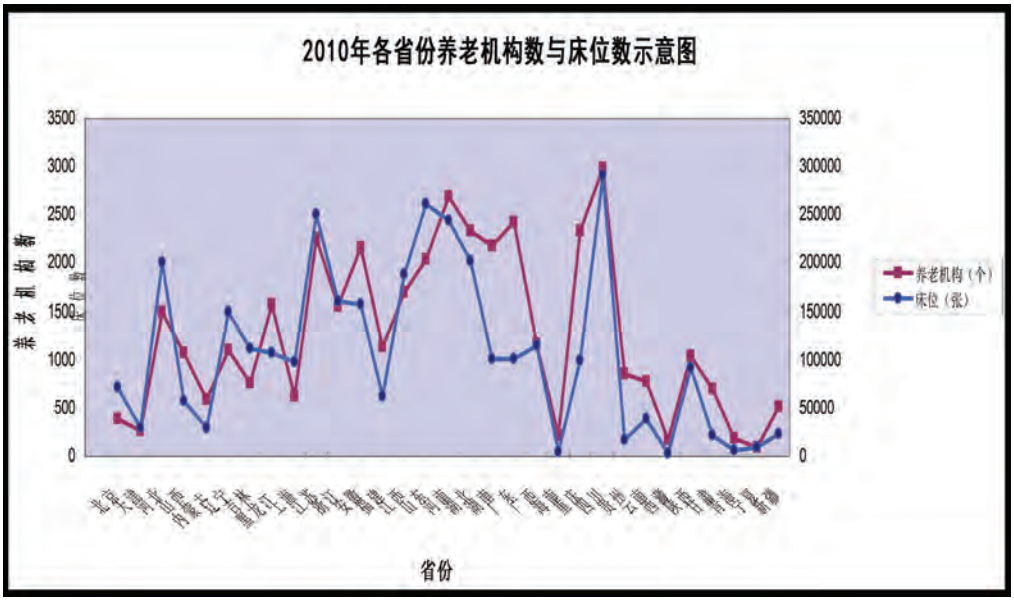
土地、税费优惠机遇：

规划指出：完善扶持政策，推动健康发展。按照当前的土地划拨目录，保障对社会养老服务体系建设的土地供应。有针对性地进一步研究制定土地供应、税费优惠、财政补助、社会保险等相关扶持政策；有条件的地方，可以探索实施老年护理保险，增强老年人对护理照料的支付能力；建立科学合理的价格形成机制，规范服务收费专案和标准。

人力资源机遇：

规划指出：加快人才培养，提升服务品质。加强养老护理职业教育，有计划地在高等院校和中等职业学校增设养老服务相关专业和课程，开辟养老服务培训基地，加快培养老年医学、护理、营养和心理等方面的专业人才，提高养老服务从业人员的职业道德、业务技能和服务水准；

将养老机构纳入护理类专业实习基地范围，鼓励大专院校学生到各类养老机构实习；制定从业人员职业技术等级评定制度，实行各类养老机构从业人员的职业资格认证和持证上岗制度；探索建立在养老服务中引入专业社会工作人才的机制，开展社会工作的学历教育和资格认证；增设社区养老服务公益性岗位，支援养



老机构吸纳就业困难群体就业；有条件的地区，可探索实行养老服务岗位政府补贴制。加快培育从事养老服务的志愿者队伍，实行志愿者注册制度，形成专业人员引领志愿者的联动工作机制。

科技服务机遇：

规划指出：运用现代科技进步成果，提高科学管理水准。以社区老年人服务需求为导向，以社区日间照料中心为依托，按照统筹规划、实用高效的原则，采取便民资讯网、热线电话、爱心门铃、健康档案、服务手册、社区呼叫系统、有线电视网路等多种形式，构建社区养老服务资讯网路和服务平台，为社区居家老年人提供便捷高效的服务。

七、社会养老服务体系建设的基本挑战

需求与供应的差距有多大？

有多大的政策选择空间？

主要矛盾是什么？供不应求！

目前是1899万80岁以上的高龄老年人的基本生活保障与护理的问题。但到2015年，如果80岁以上高龄老人2400万，约占老年人口11.1%，年均净增100万；有多少人需要长期照料护理？未来的600万张床位可以满足要求吗？500万养老护理人员从哪里来？每年需要100万的增长趋势！而中国2010年的普通本专科毕业生为575万，成人本专科毕业生197万。

政府规划的挑战！

两个大的挑战：一是规划的内部结构问题，社区与机构如何划分比例？区域布局如何确定？社会如何进入？哪些机构最为缺乏？养老服务仅仅是床位和人员护理吗？还有很多中间环节，就是一个养老产业的系列，如老年玩具、康复器具、心理咨询服务等。规划的具体化是一个大的挑战！

社会养老如何进行市场规划？

- 社会与政府之间形成积极互动模式？
- 哪些方面供不应求？
- 每个机构和公司能够供应哪种需求？
- 如何加工养老产品的供应？
- 有没有系统发达的咨询机构以及利用咨询机构的公司？

八、实操型养老机构的前途

行业化、网路化、专业化建设的挑战

养老地产的形势

2011年7月13日，来自相关管道的消息称,新华保险也频频动作,加紧对养老产业的投入,成为继泰康、国寿、合众之后的第四家真正涉足养老社区投资的保险机构；据了解,新华保险已成立一个“战略推进办公室”,这个机构全面负责新华保险“以全方位寿险业务为核心的金融服务集团”的五年新战略在全国各地分支机构的推进；作为五年新战略转型的重要内容,其正在酝酿建立养老社区,并在广州等多地选址,积极谋划将业务延伸至养老、健康等产业。（和讯网）

重大的挑战：高端养老机构空置率高

2011年7月13日，高端养老机构空置率高，补贴错位引发争议。天津市“全龄化绿色生态宜老社区”上河苑整个社区共有17栋6到11层的公寓，户型从60平方米到120平方米不等。上河苑是天津市12个老年宜居社区之一。未来十年内，天津将建设1.8万亩这样的社区，每个社区的规模都将在300亩以上，供10万余名老人集中入住。社区的建设和运作，拟交给市场化机构。学者杨团认为，根据有关调研，有着较高支付能力的低龄老人，并没有购买社会养老服务的需求。真正需要机构养老服务的高龄老人，其有限的支付能力不仅限制了企业的定价空间，护理服务的高人力、管理成本更抑制了企业的利润。高端养老机构空置率高，已成普遍现象。（搜房网）

我国整个社会的养老服务咨询机构还太少、太少，老年服务业的知识还严重缺乏力量。

养老服务支援系统：美国既有老年协会，会员达5000万之多，同时又建立人老年住宅服务协会，美国建筑协会老年住宅设计中心，还有美国老年公寓及护理业项目投资中心等。

养老护理行业化的潜能

实现组织化，建立固定的联系管道，增强行业的力量，提高行业的管理水准。

有无行业的标准？行业的模范？

网路化的效用

- 资讯与网路平台的构建
- 经验的及时交流
- 危机的及时应对
- 行业系统学习能力的提升

专业化的力量

- 进一步分工：行业内部的分工
- 地区的分工
- 专业的细化
- 咨询机构的应用
- 社会养老服务业发展需要理性选择！

「日本的银发市场：从银发到黑发的优质生活消费」

日本关西学院大学政策研究学院教授
黎安国　教授

1. 日本社会（银发市场？）：社会经济的例外主义？

你所见的并不是真实的日本！这是我提出这问题时，我的日本同事跟消息提供者对我的反驳，而我完成这篇概论后也认同他们的理据……也许这篇概论能帮助我们意识到自己对另一个亚洲社会的认知是如此有限（即使我们经常到日本旅游，而且又身处这信息交流发达的年代），特别是自1868年起，深嵌于社会经济发展超现代化进程中的日本传统主义，对我们来说真的有如谜一样。

相比起欧元区的危机（由希腊国家财政问题引起，再加上同为欧猪四国的西班牙财务问题），中国自1970年代后期起采取门户开放政策，经济发展成功（+9%国内生产总值）；香港则拥有惊人的良好公共财政状况（至少有几十亿的外汇储备和间或的公共财政盈余）；日本在新自由经济学的角度来看，并不算是功能经济体。日本自1990年代泡沫经济爆破后一直处于一浪接一浪的低潮，过去三十年仅有些微的经济增长（国内生产总值1-2%）。也许更严重的问题是来自日本国家（在改为34个地区超过千个町市后更差）政府的公共财政方面：在2012年，国债为国内生产总值的200%！在2012-2013年度政府财政预算中，30%的支出是用于支付国债的利息，有超过30%的收入要用作债务融资。

香港是新自由经济的天堂！香港男性（预期寿命为80岁）比日本男性（79.5岁）更长寿，寿命长度冠绝全球！香港女性的寿命长度排第二位（85岁），仅次于日本女性（85.6岁）！香港绝佳的经济力量和动力，不但为诺贝尔奖得奖者米尔顿．傅利曼所称颂，更在瑞士洛桑管理学院的全球竞争力排名（2011-2012）中名列前茅，反观日本只在25名以后的位置。再者，香港这个文明社会每日都充斥着大小的异议，以人均计算非公营（或非牟利）机构或新兴的社会企业的活跃度也比日本优胜……那么香港是否比日本这老龄化的社会更好？而问题是：既然日本在新自由经济和公共财政方面皆处于弱势（以香港和中国的成功作为衡量的标准），我们为什么要研究这个有国债融资问题之老龄化社会的市场活动？或者我们作为外人，可从这个表面上看来具高生活水平的谜般岛国社会学习到什么？是什么促使很多香港中产阶层选择日本作为理想的海外旅游点？

这篇短文（比演讲更具分析性，讲述更多关于老人生活方式）尝试以「社会化」（部份去商品化）市场的条件中相互矛盾的动力，和特定的长者年龄层去解构部份的谜思。根据我们的观察，日本本身的「银发市场」相比起新自由经济和企业融资角度所描绘的更为社会化。尤其是日本语的「经济」包含公众的社会经济利益，即经世济民这含义。历史上「经济」一词来自希腊文oikonomia，意为管理家庭；而中文「经济」一词则是在19世纪末从日语汉字「经世济民」而来，但只词乃源自千前传入日本的中国经典古藉（约出自公元317年）。我们对银发族的消费研究（在老年时间的金钱、时间及其他资源的花费）为否成为跨文化学习的重点？

在此必须强调日本老龄化社会经济的社会文化基础，与新自由经济所形容的市场中供应、需求和价钱形成动态平衡的本质甚有差异，甚至乎相对立。自明治维新（1868年以后）和二次世界大战后，日本独特的发展进程（例外主义）成为了为老龄化社会勾划社会经济和制订政策的助力。以下罗列了部份为具指针性的独有特征：

进化的社会保障系统（局内人与局外人的分别）：

- 在职业福利模式中扩阔框架（家庭收入），设有全民退休保障计划，全民健康保险，长期护理保险。
- 二次世界大战后有新的性别分工模式，区分成职场支薪族和家庭主妇。
- 与其他东亚国家超级现代化所驱使的老龄化相比，日本的封闭式人口以计划好的政策演化和改变在过去四十年的延缓老龄化过程。
- 进化成仔细和精密的供应方式去应付由公民、大众及市场推动的铰接式银发族（缝隙）消费。
- 设有公共和机构赞助体制，根据老人的需要和必要性去采购健康护理产品和服务。
- 银发族消费是个与特定一代的老人（1950年代的幸存者）有有关的现象，未来的一代（1970年代）并不确定是否会有同样现象。
- 到底是谁的天堂（局内人vs.局外人的职业福利）是「用家的天堂」还是「卖家的地狱」。

个人与家庭对老龄化的适应：

- 在仔细的家庭财政预算（家庭账目）和社会家庭互惠（交换登记）系统中蕴含发展完善、经验丰富的精明消费概念——这是主妇的基本持家知识！
- 日本人生活成本高昂，生活艰难：男人勤奋工作，女人刻苦持家；但只有成功受聘才能获得安全感——职业性福利模式影响（局内人vs.局外人；永久的职员 vs.临时合约雇员）
- 对于没有工作（啃老族 / 尼特族）或是没有家庭（不是主妇或子女）保护的人，生活就更为艰难。
- 生活方式改变：银发族消费是由老人的需要和生活必需性所推动。
- 经过悉心策划计算预算后才作高端消费（功能 + 外在美 + 时间性）。
- 大学生（永远！）和新近退休人士会因应社会家庭时间作出娱乐花费。
- 为所有事作预算，但会在某一时间放松下来；经过一至五年良好的退休生活，预算工作就会成为「俭朴」的手段。
- 生活成本高昂的高生活水平社会中不同阶层有差别待遇，在特定的社会经济阶层，某一地域或网络中导致缺乏选择。
- 中产阶层所推动的消费：低价或低质量（或是二手）的货品或服务消失。
- 老龄人口生活成本高昂，货品供应过剩但服务短缺。
- 垂死阶段或善终服务需要的传统仪式全面商业化和工业化；殓葬和宗教仪式费用昂贵。（例：TEARS网页）

与顾客的结构性关系及营商的社会文化：

- 从地区性的中小企经营理念而来，商业关系比财政关系更为社会化。
- 产品和（用户）服务大部份被供货商作结构性包装和周期性

推出。

- 有预防措施去达致零投诉或零瑕疵；和弥补错误的大量措施。
- 根深柢固的高强度顾客关系（不单只是顾客关系管理）
- 不管经济好坏，商对商（B2B）和商对客（B2C）关系都是结构性链接，并长期关系密切。
- 劳动过程一直以社团主义为主，近年逐渐倾向「利伯维尔场」模式；但职业良好依旧是胜于一切的衡量标准（工资 [价格] 是最后的考虑因素）。
- 银发族消费是差异很大（有时甚至是零散），市场规模狭小（供货商与顾客的关系差不多是一对一或是一对几），难以为局外人所理解。

急速都市化地区因老龄化而导致的社会问题仍未解决：

- 长期（二十年）的经济衰退仍然持续，到底还会衰退多久（另一个十年）？
- 都市中年长的独居失业工人失去社会家庭联系。
- 失去（永久）工作就等于失去一切：城市中因失业而无家可归的人。
- 一些失业和无家可归的的长者因生活成本高昂而百上加斤。
- 在退休前（五十几至六十几岁）自杀并非罕见（全国每年总数超过三万宗）。
- 独居死亡（非自然死亡）数字在近年明显上升。
- 所有问题都在测试由市政府行政的社会保障监测的极限。

明显地从外间（比局内人多）的角度来看，日本的银发市场依然是可喜，并以商业主导的世界观来看待这活力充沛的日本「银发市场」——从灰发（老龄化中）、银发、金发（富裕的年长消费者），以至黑发（殓葬和与家庭相关的宗教仪式）市场都无容置疑地（并不是太多兴趣）抓紧营商机会。例如一本台湾商业杂志（引用日经的数据）指出，全赖长者的财富累积和拥有更多的空余时间，现在以及未来的银发市场会持续蓬勃……这到底是讽刺、玩笑，还是另一个经济泡沫？我的日本同事（专业上班族同时又是主妇）当我向她展示这新闻剪报时反问……

同样乐观的还有日本的旅客，他们惊叹日本拥有多样化、大规模和大量的长者护理产品和服务，在市场中更有仔细精致、专门度身制定的服务。这些全是日本生活方式结合了功能、外在美和时限性所造成的社会文化差异之代表——这些差异基本上在另一年龄层或是地区性的货品和服务都可见。

超过150页的长者护理产品和服务目录甚为常见，当中包括简介护理政策、健康保险、长期护理保险和消费者权益的章节……不论购买任何物品，通常也会详尽咨询使用者、使用者的家人和长期护理保险经理人。这些准备充足又花巧的资料，蒙蔽了我们一部份的视野，阻止了我们去发掘潜藏在65岁或以上人口占了总人口23%的日本老龄（持续老龄化）社会之动力和暗涌——这只是迈向超级老龄化社会的开始；银发族消费仍然会长期盛行，但社会经济状况也正在改变……

2. 家庭生活历程中延展型（非主流）生活方式之银发族消费

日本不是一个新自由经济的天堂，只有少于2000名外籍佣工从事护理行业！日本的海外劳工无法像香港（约280,000人）、台湾（约180,000人）和新加坡（约170,000人）的海外劳工一样自由地从事家庭佣工或护理工作；因此日本的银发市场以劳动市场的灵活性来说是完全失败的（以新自由经济概念作衡量标准）。日本这老龄社会的人力资源是依靠其数量不足的劳动人口，中年、老龄化和年长（大部份为兼职工作的女性）的地区性劳动力。引进外来人口去应付人口老化的试验性计划只能解决问题的皮毛：通过与印度尼西亚、泰国和菲律宾的自由贸易协议，有不少于1500个外籍护理员接受为期四年的在职培训，希望能通过日本国家考评成为合资格的人员。但今年第一批的毕业生当中，只有30%的人能通过日本国家考评（专业资格试和日本文化及语言试）；这计划可说是在设计时间已经失败，以这规模引进外籍护理员和家庭佣工根本在现时或是未来十年都无法弥补总体人力资源的不足（外籍护理员估计约需200,000人，家庭佣工估计约需500,000人）！因此，香港和其他引进外籍护理员的国家应感激这批外来工人全天候二十四小时工作，去解决都市化及现代化所造成的长者护理需要（大部份来自女性）！

没有外籍佣工从事护理和家庭照顾工作，日本的长者护理就如普遍的（传统）社会一样，由女性成员，通常是媳妇去照顾长者、小孩，以及负担生计的人；这对在六十多岁退休亦并留守家中的前职场人产生强烈的影响。如何处理婴儿潮退休人士成为关键性问题（如因退休引起的婚姻 / 家庭压力，最后导致离婚）。如无法好好解决这问题，家庭制度则无法完整地衔接老龄化社会。

诚然，我们必须继续研究在老龄化社会中的生存之道……日本这老龄化社会中，银发族消费与社会和政策差异有关，长者专注在其社会经济活动，当中有四个互相连结而又有明显分野的范畴（可作为了解银发族消费的分类系统）：

- 在退休早期（或是退休准备阶段），以新增的闲暇时间和可用的退休金尝试新式，试验性的生活方式。
- 产品和服务的供给，是按实际需要衡量，并由政策所推动。
- 赚钱养家的人重投家庭生活，退休夫妇参与社区活动。
- 在老年或善终时进行社会文化所规范的仪式。

按照我们的观察，独居人士或夫妇在适应退休生活是皆分成三个时期：强调已退休，接着重新学习如何花费在娱乐消闲方面，以及最后家庭团圆（或是按法律分居或离婚）并参与社区活动。

2.1 以新增的闲暇时间和余钱体验新生活方式（一阵子！）

对于大部份支薪族而言，退休金和新增的闲暇时间就彷如一份大礼。而那些在过去三十多年一直默默累积财富（尽管一大部份已用作养育子女和子女教育费）的富裕退休人士，现在更可说是过着天堂般的生活——他们现在可尽情花费在娱乐消闲了。

退休人士和其配偶等待了三十多年，终于可以响应那些享乐的诉求；而各商家也瞄准了这些闲暇时间和退休金，推出各式各样的新颖刺激的消费体验，或是新产品和服务去把握每个商机。但这些娱乐消费某程度上是基于与配偶因长期性别分工而导致的危机解除，并重投家庭生活有关。

事实上大部份可见的银发市场是新一浪消费主义和其诱惑的产物，目标客群是一群为了成就优越社会，被日本式严谨的工作和家庭理念所束缚的支薪族（和其妻子）。例如：50岁以上、55岁以上、60岁以上、65岁以上和70岁以上人士购买各种货品和服务时可享受林林总总的折扣和优惠——这明显是过于乐观地认为这群老龄人口可以带动日本衰退的经济。到底他们有多大帮助到现在还不能下定论，因为不同的实证研究有不同的结果。

不再受到工作和家庭限制的退休人士和其配偶成为了社区中带动非主流生活方式，兴办绿色环保活动的推动力：可持续发展理念成为银发市场的一部份。绿色消费和相关的采购成为乐活族日后拯救地球的世界性行动——或者从大众消费主义中退下来会成为新一代或现代退休人士的新主流。假若节约和减少原料 + 重新利用 + 物品回收成为现代和新一代老龄人口的新规范，那么新古典经济学中由娱乐消闲花费来带动市场需求的如意算盘恐怕很快会打不响。

日本的老龄化社会除了走向智能型的绿色消费外，还有推动了非市场组织（政府组织和非政府组织、公共组织、社会和社区组织、公民组织）发展，带动社会互惠式消费，如发起活化邻里关系，增设保障学童安全的社区巡访员等一些促进本地交流的试验性计划……

2.2 按实际需要衡量，并由政策所推动的产品和服务供给

健康护理服务转移目标至老龄人口是明显不过：越来越多的私营诊所和医院改装成为长期护理康复中心——这已成为社区护理的长期护理保险中永久的固定发展框架。但在此必须强调新发展方向依然是在国家赞助的全民健康保险和长期护理保险的范围内，使得长者能够在保障（2+5）范围内使用服务，购买货品和服务，或支付简单小型的房屋翻新费。但这些服务可提供的支持并不太，只可维持一定的现有生活水平。

长久以来日本的公营和私营机构都抱着积极参与的态度来看待老龄化社会（例如：在经济衰退期，仍有私人营运的项目培训健康和社会福利专才）。企业、政府组织和公共组织欣然接纳这群老龄人口，主动推出照顾长者实际生活需要的新产品和服务——如铁路公司从单一的客运服务扩展至长期护理的物流服务（日间护理接载服务）。

在特别成立或是新兴的供应链网络中，也出现由政策带动的社会化银发族市场，主要围绕传统和日常生活消费（如铺迭榻榻米用的辅助工具和可移动的风吕浴设备）。而一些无客群年龄之分的企业，像是阪急和阪神铁路公司也利用自己在铁路（和百货公司）网络上和物流支持上的优势，根据已有客群发展长期护理的看护服务。因为有了正面、稳定而且支持充足的政策环境，明显地越来越多的供货商应运而生。

「银发采购」对于维持银发市场极为重要：公共和私人空间升级（或是日本所谓的改革）成为通用设计，营造无障碍环境。这些提议经整合，正式成为政策（规例、法律和服务守则）和实际措施（由货品和服务供货商实行）；而素质提升则成为执行政策体制的必然有机产物。

换句话说，在银发采购制度下，扩展护理服务和产品是提供更佳消费选择的手段。全靠在长期护理保险中复兴公共和社会护理，新的法规体制促进了供应方面的动力。因此在老龄化或老化社会中，扩大供给的两个最主要因素是对于提供新产品和服务的长期的政策方针和社会共识（因为通常在营运初期和中期都会有财政亏损）。就成熟的市场运作而言，专为长者而设的产品和服务其演化过程是会按照新构思和市场对创新意念的反应来作稳定发展。

2.3 重投家庭和社区生活

相比起其他银发消费范畴，这部份是最具争议和最不明确的，特别是关于赚钱养家的人与配偶（主妇）重聚共度时光，成为真正的永久家庭成员！

由于几十年来一直在家庭时间和空间中缺席，支薪族的回归成为了很多忙于处理家庭事务之主妇的头痛根源。在退休早期因琐碎杂事引致误会和冲突时有发生，以下是很多主妇的写照：

> 「我的支薪族老公除了认识他的工作外，对生活根本一无所知……甚至连自己衣服鞋物的大小也不知道……我要教导他（他年纪已经大得难以学习新的家庭生活）关于如何在这个家生活的所有事情！我已经花了二十多年去教育子女同样的事情，现在我又要重复以往的工作，去教育我那位年迈的支薪族……这使我筋疲力竭！……如果可以我希望能花多点时间去看看外面的世界，享受生活［旅游和观光］，至少我不用再教导他所有事情……只需要跟着别人［导游］的指引……」（摘自个案专访）

基于在退休初期难以融入新的正常家庭生活和进入愉快的退休生活，所以外出的娱乐消费在调适过程中并不罕见。

相对而言，前支薪族在外会比在家中轻松，而且在家庭以外会较容易找到可干的活儿，一如他们以往受雇时在外工作一样。一些男士更会参与活动小组，重投自己所属的圈子——配合或是继续他们三十多年来的工作习惯（钱财已经不是他们的主要考虑因素），继续远离已经缺席几十年的家庭（睡觉的地方）。

退休是生命历程中的新职业，在典型的日本社会中代表有更多时间去参与不同的社交或社区活动——某程度上是（不在劳动市场）女性特别「自由时间」的延长：作为公共和私人服务的经验使用者，她们为退休配偶提供帮助，让他们重投个人（兴趣）或是社区的团体活动。

刺激社区活动参与率是社会共识：日本其中一个活化老龄人口的政策建议就是促进长者积极参与社区活动，即「银发人力资源运动」（シルバー人材センター；http://www.zsjc.or.jp/），目的是帮助一百万名会员投入社区的劳动市场，同时推动社区发展。为此日本的市政府踊跃为重投社区的人（退休人士）提供公共空间，促使他们以现有技能或经再培训所得的技能担当兼职工作。

有多余时间和资源是重投社区生活的基本条件。在日本，团体活动（特别是自助式和互助式）几乎都是自资和自负盈亏的，市政府（地区）的支持主要是提供空间（场地）和方法（在大型节庆中宣传和活动推广）。1995年1月17日阪神淡路大震后，非政府组织（日本称为非牟利组织）持续蓬勃发展。从那时开始，非牟利组织的运动更有势头，得到更多的认可和更具影响力——非牟利组织与一众社区组织成为日本人重投社会的试验计划的主办地点；女性和退休人士（男性）则成为解放公共领域的行动者。

总括来说，退休人士着重非牟利，不追求最大利润，只重视参与社区和商务活动；原因是他们的健康和护理需要已经有了退休金和全民保险的保障。全因为有了这批老龄的新血，使得在自助式和互助式的社区运动中，一些非主流的社区生活试验计划蓬勃起来，如时间银行和社区交换交易系统，促进了两代人之间的互动。这些老龄人口参与社区活动具象征性意义，在多方面巩固了社会的基础，令民众对退休金制度和全民健康（包括长期护理）保险体制感到安心认同。也许这些银发族消费带来的社会经济好处——着眼追求更大的公众利益，是被主流的新自由经济论所低估。

2.4 发达资本主义下善终的社会、文化、经济差异

社会礼仪大体来说是人类社会的功能性延续，尤其是在社会家庭系统中注入生命力和加强适应力。在所有礼仪中，殓葬和祭祀祖先的仪式最具效用，因为这些仪式不论是在认知和实体上都提供了寄托和连系了两代间的传承：过去、现在与未来！与日本其他的仪式相比，善终仪式是最为重要和最被重视的（以社会价值和金钱的角度来看），因此值得我们特别留意。这些仪式显示出从银发市场至黑发市场当中的复杂程度。

长者业务最重要的市场就是所谓的「黑发市场」（目标并不是银发族或金发族），即殡仪及善终业务（因佛教徒对寿命长短和永生的理念，在死后仍需悼念服务）……这些全部与殓葬行业和与死后信仰有关的宗教业务相关。殡仪业工业化由来已久，最近随着运输服务商成立更多殡仪馆，殡仪服务供应也越来越多。例如：有更多的殡仪馆是靠近铁路站和交通运输系统，如TEARS殡仪会馆其中一所殡仪馆就是在南海钱的岸和田站旁边。显然，殡仪业界的商业运筹概念，满足了善终服务的需要，比一般的业务提供更多。

在日本，尊重和重视死者是社会的规范，伴随着很多仪式，发展成为工业化的殡仪业和相关的信仰活动。基于其超越实体存在的需求（亚洲人相信生命可以不同形式出现，换言之一个人死后仍会有另一种形式的生命），日本人一般较偏好以佛教仪式超渡和祭拜死者。尽管在日本市场竞争激烈，举行这些仪式仍然费用高昂，每项仪式都经计算和订价，更包括了下葬后的祭礼，和往后数十年的祭祀香火……

基督徒会为新生婴儿取教名，而在日本为了区别生者和死

者，则会按死者所属的佛教分支，由寺院僧侣为死者更改名讳。例如，在昭和时期（1925-1989）十分有名的演歌女皇美空云雀死后由佛家僧侣为立法号 / 法名为慈唱院美空日和清大姊，正式皈依佛门，这需要付上昂贵的费用（估计需要布施超过500,000日元），才能在死后于佛门中获得自己的新身份……

为取得法号 / 法名而进行布施（由200,000至1,000,000日元不等）变成争议性的话题（通常不在公众场合谈论），到底法号 / 法名是否应该免费赠与死者？《朝日新闻》（2011年7月21日）访问了几位灾区佛寺的主持法师，发现虽然一些法师免费赠予法号 / 法名给死者，但也有部份人收取布施来确保寺庙财务运作：

「这两个月来，我所赚取的相等于我过去三至四年收入。」一个法师说道。

但对收取法号 / 法名的费用，仍有不同或者是相反意见：

「在灾区中，是有需要去降低取立法号 / 法名的收费……但寺庙是由信徒的布施所支持。若免费赠予法号 / 法名给死者的行动继续蔓延，一些寺庙会因此而无法维持。最重要的是与信徒建立互信关系，传扬法号 / 法名的意义，给他们体面的葬礼。」

葬礼（就如婚礼一样）在日本有参与人数的限制，除非当事人富有得可接待未有受邀的宾客。葬礼费用取决于参与的人数，一般是按人数来作预算，就像平常的业务预算一样。但善终安排比一般业务要求更多，因为生者需要考虑到户藉问题来决定谁会在受邀之列。

近年来对于葬礼费用统一化，和一些可持续数十年的宗教祭祀仪式的服务收费存在不少争议。其中一个冲突源于永旺信用卡公司在2010年5月与六百间来自八大佛教支派的寺庙达成协议，为旗下会员提供统一的葬礼收费。此举惹来了很多反对的声音，特别是不在协议列表中的宗教团体，声言此协议是商业利益对宗教活动的入侵。由于多次谈判失败，协议在同年九月被取消。现在殡仪市场是可以自由定价！

善终过程显示了日本整体银发消费与黑发消费当中的关连。当中有两股互相竞争的力量，去塑造银发市场（以商界的认知）的发展路向。一股是来自社会经济动力及其所衍生的社会安全动力，另一股是保障商业和财政收益的地位争夺势力。

在此向与会者提出最后一个问题：殡仪费用是否由逻辑和财务驱动之银发市场的一部份？若果是的话，又该怎样为其定价？因此我们所面对的挑战显而易见，就是如何克服社会文化道德、习惯和风俗等社会经济差异，让老龄中和老龄人口，以及逝者都能享受更好的生活。这就是在发达资本主义中，难以与利润为本的商业运作模式（受财务收益影响的社会）衔接的银发至黑发消费。

***此简介为长篇分析文稿节录，如欲索取详细资料，请电邮至：*

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「马来西亚的银发市场：消费模式、休闲活动与消费偏好」

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摘要

本论文透过论证消费过程令长者在生理上、社交上及情感上与积极老龄化的概念相配合，将消费行为带进积极老龄的领域。在马来西亚及其他亚洲国家，由于长者人口的增加，再加上新一批年长消费者有着较高的教育水平及收入，并过着与其上一辈不同的生活方式，我们将可预期长者市场板块的吸引力将逐渐增加。即便如此，商家大多忽略了此市场板块。

本文重心研究买菜的消费，因为长者支出大多在食物及饮品上。此研究探究长者在判断是否消费时的决定因素，包括商品或服务资讯及其来源。本论文也会聚焦在长者在消闲活动及媒体习惯的消费行为。

研究进行了涵盖整个马来西亚半岛城市及乡村地区的家庭住户调查，访问了537户；68.3%居于城市，31%居于乡郊；受访者平均年龄为64岁（SD=7.3）；男性受访者占57%，而女性则占43%；马来人占56%，华人占29%，而印度占12.1%；56%的受访者为已退休或非受雇，另外22%虽已退休但仍以全职或兼职的方式工作；约38%月入少于1500马币，只有仅多于四份一的受访住户的月入界符1500至2499马币。

研究结果显示，长者通常于杂货店、菜市场、超市及周末/夜市场消费。消费时他们多独自或偕同配偶前往。有83%的受访住户表示，令他们选择到某家商店消费的最主要因素是「容易寻找商品」。而决定是否购买某商品的最主要决定因素是该货品的质量，其次是耐用性、安全特点、舒适度和价钱，品牌则是最不重要。接近100%的受访者有参与至少一项消闲活动，而普遍的消闲活动包括：看电视、阅读、园艺和运动。在商品及服务的资讯来源，结果显示他们都依靠子女。研究结果亦明显显示长者在人际关系和沟通上有信心，并多无视广告资讯。

从研究结果我们可以为营商者带来多重的启示：长者并非被动的顾客；他们主动和精明，亦会表达他们的偏好。由于此研究提出两步的沟通流程，亦即：因为长者依靠子女提供资讯，商家宜重新制定他们的销售沟通方式以接触该消费群。营商者不单要考虑此消费群的基本需要的潜在可盈的市场，由于长者活跃于参与消闲活动，商家亦需要注重其他与消闲有关的商品和服务。理解长者消费群能带来转变，使市场提供的商品和服务更适切到位。

简介

人在变老过程中其中一个期望是能在老年享受高质生活。要达到这目标，必需为老年人提供机会，实现他们在身体、社交、精神层面上都健康的可能性（世界卫生组织，2002）。这就是积极老年化，是指一个优化在健康、参与、安全方面的机会的过程，提升生活质素（世界卫生组织　2002，12页）。消费以及作出关于消费活动方面的决定的能力属日常事务，必需视为积极老年化的一个部份，因为消费活动会从身体、社交以及情绪方面——如对喜欢的产品或最爱的电视节目有情意结——接触老人。从涉及考虑财务因素及购买决定之消费谋划时所展现出的良好认知功能，证明年长人士投入消费行为。因此，虽然撤离理论指出老年人从工作及社会关系逐渐抽离是无可避免且自然的过程（Powell, 2001），但老年人即使在退休甚久后，仍继续是消费者。老年人，如处较低年龄组别内的人一样，都是经济的一份子。他们是商品和服务的一个细分市场，同时也是专门产品的细分市场。这些老年人组成所谓的”银发市场”。

但是，在许多亚洲文化中，老人似乎被市场营销人士设想为「隐形顾客」（Ong及Phillip, 2007），其消费需要及选择常被认定是理所当然，并认为在传统亚洲家庭价值规范下，这些需要由其家人负责。忽视「银发市场」及老人是消费者，从在二十一世纪消费者文化为消费带来无孔不入的影响的角度看，可会令市场营销人士大受损失。许多现今的老顾客曾经是后二次大战时期的年轻顾客，当时被视为是购买、享用产品方面的创新者（Higgs et al. 2009）。随时间过去，有些已由「市场地方」转战「市场空间」，参与最为新潮的零售途径。这群较为年长的顾客对科技熟悉、热衷，我们经常观察到他们使用手提电话和iPad，并使用社交媒体。因此，有证据显示消费、具消费能力及能作出有关消费的选择，能对生命后期时的身份产生重要影响（Gilleard, 1996）。Kontos（2005, 33页）亦简洁地总结一个配合的观点，指出「资讯社会」、「后工业社会」及”「后现代社会文化」的精神在一个冒起的消费者文化论述内结合，使「老年时期被重构成一个具营销可能性、与已商品化的少年价值观联系的生活方式。」

马来西亚的银发市场

马来西亚跟许多亚太区国家一样，一直历经国民健康改善、有较长平均寿命、较少夭折率及伴随的不断下降的出生率，因而出现了人口老化现象。根据政府统计部门（2010）所指，2,251,216马来西亚人被划分为年长人士。在2020年，马来西亚将成老人化社会，人口中将有9.9%的人是六十岁或以上。虽然数量从比率上看是小，但必需注意年长人士的绝对数量正在增加。到2030年时，五十五岁以上人士的细分市场将成主流，因为随着在婴儿潮出生的人士退休（及再较早前出生的人士已入暮年），会出现一个显著的增幅。这个市场的吸引力预计将随时间而增加，因为新一批年长消费者具高学历及高收入，且生活方式与父母辈有异。他们将会有可观的可使用、及可自由决定如何使用的收入。将年长消费者视为一个正在发展的细分市场、是重要消费者，是一个过往有时被忽略的要点（Ong及Phillips, 2007）。举例说，在美国，五十五岁以上人士的细分市场购买了30%的在家享用食物、年长消费者有较高品牌忠诚度（Moschis et al. 2004）。银发市场提供丰富生意机会——前提是市场营销人士了解老年人的需要及需求、他们的媒体选择及能让他们作出知情决定的资讯来源。有关年长消费者是何许人及他们的所需方面的知识，将有助各公司推出更能吸引这个细分市场的通讯及市场营销计划。

在马来西亚，对年长消费者的注意程度维持在一个偏低水平（Ong, Kitchen及 Jami 2008）。市场营销的入门文章一般均假设年长人士的消费模式及生活习惯在生命周期内大致不变，忽

略了由生物意义上的衰老和生命中发生重大事件而为了应对而改变的消费习惯、什或更简单的生活习惯上的改变，而使消费喜好改变的可能性。不单老年消费者可能与年轻消费群有别，就算老年消费者当中，也各自相异（Silvers 1997; Dychtwald 1997）。事实上，生命阶段后期的消费并非无差别（Higgs et al. 2009:103）。这篇文章正是在这个大前提下打算对马来西亚的银发市场提出见解。

这篇文章的主要目的是检视年长人士的家庭开支、日用品方面的购买行为及在作出购买决定时的考量准则。与积极老年化的观念相配，我们尝试找出马来西亚年长人士是否积极追求闲娱活动，以及他们的媒体选择及观看的电视节目。因为资讯对于作出日常生活中的消费决定的根本性影响，了解老年人如何取得资讯极为重要。此外，这篇文章亦探讨年长人士是否开心的消费者及希望测试消费上的满足与生活上的满足的关系。

研究

这篇文章引用的数据来自一个以马来西亚年长人士为对象的大型研究[1]。研究收集的数据来目西马来西亚的北部、中部、南部及东部，这些地方有大量的商品及服务，其选择亦十分丰富。数据收集方法采用封闭式提问法的问卷调查，收集与年长人士相关的事项的数据。住户统计调查根据由政府统计部门发出、以随机方式产生的统计块清单进行，面对面的调查访问则由一队受过训练的统计员进行。问卷调查以回译翻译法使内容译成马来语及普通话，共收集了537份来自五十五岁或以上的年长人士的回复。

样本

列表一显示了回复者人口统计上的特征。在城镇居住的回复者占整体样本68.3%，其余 31%回复者来自乡区。这与马来西亚的城市化率接近。回复者的年龄平均值为64（标准偏差=7.3）。男性回复者占样本57%，女性则占43%。与在婴儿潮中出生的他们的所属年龄组相称，大部份回复者教育程度低，约75%完成了小学或中学，只有8.6%接受过文凭或大学教育。马来人在回复者样本中占56%，中国人29%，印度人则12.1%，大约反映了整个马来西亚人口的组成部份，因为样本中城镇居住者占了较大比率。从宗教角度看，回教徒占了56%，佛教徒占了24%，基督教徒占10%，印度教徒则占8%。大约四份三回复者已婚并有子女，而与他们现处的生命周期相称 ，58%与配偶同住，17%只与子女同住——可能因为回复者当中丧偶比率为 18%。 一小部份的回复者，占整体的16%，只与配偶同住，因为成年子女不与父母同住并非罕见。大约56%回复者已退休或不受雇，而大约225名回复者则仍然从事有酬的全职或兼职工作。另外22%回复者则已退休，但仍然从事全职或兼职工作。与回复者已退休的景况相符，约38%回复者月入少于1500马币[2]。稍多于四份一回复者月入介乎1500马币至2499马币，而有小部份（11.5%）月入等于或多于4500马币。

开支模式及日用品的购买

调查中的项目与在马来西亚住户开支调查中出现的项目相似。列表二显示了结果。每月开支的平均值为1327.4马币（标准偏差为850.8）。在各项开支当中，食物占了最大比重（34.9%），其次是总租金、燃料及电力支出（12.4%）及运输与通讯（10.2%）。若考量饮品开支，并与食物开支相加，两种类别合共占了总支出的40.7%。 食物及饮品方面占总开支大比率属意料中事，因这些皆是退休家庭的常需项目。马来西亚为燃料包括石油、柴油及煮食煤气提供普及津贴，因而这个类别的支出颇低。在家外进食的食物的支出是其之后的主要支出项目，因为外出用膳是马来西亚的一个普及生活模式。结果亦显示医疗及保健支出是马来西亚年长人士消费模式的第五大项目。

虽然马来西亚的年长人士可能共享同一个宏观环境，如经济、文化及社会带来的影响，检视来自城镇及乡村的回复者是有意思的，因为在城镇及乡村地区提供的产品及服务在产品种类、品牌及服务类别方面有异。以t检验来比较在城镇及乡村地区生活的年长人士的消费模式，可以看到两个组别在多项支出类别有明显差异：食物、家俬及家俱、医疗、交通及通讯、娱乐、在家外进食的食物及杂项支出（列表2）。在城镇居住的年长人士相比在乡村地区的年长人士大多明显在这些项目中花更多钱。这些分别，部份可解释为在城镇居住的人的生活方式有别于乡村人士：在乡村生活的人普遍过着比较简单的生活方式及拥有生活上的基本需要已感到满足。

有见于食物及饮品在住户开支中占了主要比重，这个研究检视了回复的年长人士的日用品购买模式、零售店的偏好及其原因。回复者被要求从一个有八类他们可能会从内购买日用品的商店的清单中剔选三个他们偏爱的商店种类。他们大多在以下地方购物：杂货店、街市、超级市场及周末市集/夜市（列表3）。约58%在杂货店（亦即便利店或街坊店）购物，38%在街市购物，而36%在超级市场购物。比较城镇及乡村的成年人，结果显示虽然杂货店同时是城镇及乡村回复者的偏好商店种类，在p值<.001下，78%的乡村回复者偏好杂货店，相比城镇的49%。因为超级市场及超级广场皆是现代化的零售商店，主要出现在城镇，故此城镇的年长人士，相比在乡村的，有更大比率在这两处购物。至于街市及周末市集/夜市，这些开放式的市集在乡村年长人士当中（46%）更受欢迎，他们继续倚靠这些市集来满足他们日用品的需要。只有36%的城镇回复者表示街市是他们在购买日用品时至爱光顾的商店。

回复者亦表达了他们的商店偏好的原因。如83%回复者（列表3）所指，最重要的因素是容易找到物品及商品。容易找到物品皆是城镇及乡村回复者选择零售商店种类的最主要原因。这显示他们偏向在熟稔的商店购物，因为可以将找东西的麻烦减至最小。「容易找到物品」的因素可以促进有效的决策过程，亦可示为是属功利主义者的顾客的特征。价钱是回复者光顾的其次原因，再其次是产品类别及舒适的环境，以上皆是城镇及乡村回复者共有的原因。两组回复者当中并没显示出明显差异。忠诚卡是两组回复者最少提及的光顾原因。

城镇回复者最多提及的原因是：容易找到物品及商品、价钱、产品类别及特别优惠。首三个原因亦是乡村回复者提及的原因。乡村回复者与城镇回复者的差异是因为特别优惠从不是杂货店的经营策略，杂货店多注重它们送货上门的个人化服务。乡村回复者第四个最多提及的原因是舒适，他们喜爱在令他们感到舒适的商店购物。

对比城镇与乡村的回复者，在p值<.01下，乡村的回复者（91%）提及容易找到物品及商品是他们选择在那一间商店购买日用品的理由，比率显著多于只有80%如是说的城镇的回复者。有趣的是，对比乡村回复者，有显著较多的城镇回复者指出特别优惠是他们选择某商店的原因（p值<.05）。特别优惠大抵是是多数在城镇地区出现的超级市场/超级广场的特色，它们为吸引人流而往往采用每日低价策略。对比城镇回复者，较多的乡村回复者提及服务，如外卖服务及送货上门服务，是他们选择惠顾某商店的原因。零售业态如邻里杂货店，直至现在仍提供个人化的服务。

与产品相关的衡量准则

Curasi（1995）发现年长消费者在惠顾零售商店时十分注重其顾客服务及价钱。在一项有关购买日用品的研究中，Hare, Kirk和Lang（1999）指出主要因素一是与产品有关：大小、价

1 研究收集了来自马来西亚东部及西部的1356人士的数据，由马来西亚政府资助

2 兑换率为一美元约等于三马币

钱、优惠和质素，和/或是与商店有关：布置及结算系统。Lipke（2001）瞩目的发现了品牌在银发市场并不重要，因为这顾客群原来对品牌没有有特定喜好。在一个针对六十岁或以上的消费者的研究，Duizer et al.（2009）找到购买食物产品时的重要因素是价钱、安全、包装尺寸及可回收性，而最不重要的因素则是包装的颜色、形状及物料。虽然以往的研究结果明显同意与产品相关的衡量准则之重要性，我们探讨消费者是否偏向用共同的一套标准来作出与产品相关的购买决定。与测试在城镇及乡村出现的日用品购买行为时一般，预期两者中购买决定的衡量准则亦会有异。

这个研究包含了一系列在作出购买决定时的衡量准则（列表4），回复者被要求以李克特量表由1至5标示每项准则的重要性，当中「1=毫不重要」至「5=十分重要」。结果显示最重要的准则是质素（平均值=4.39，标准偏差=0.72），接着的是耐用性（平均值=4.38，标准偏差=0.77）、安全特性（平均值=4.35，标准偏差=0.77）、舒适（平均值=4.32，标准偏差=0.71）及价钱（平均值=4.24，标准偏差=0.84）。是次研究的结果支持Lipke（2001）的研究结果，显示品牌最不重要。这亦暗示着发达与发展中国家内的年长人士的消费行为有共通点的可能性。

在对购买决定有重要影响的因素方面，城镇回复者的回复与总样本一致。不过，在乡村的年长人士则以价钱为单一最重要因素，由4.94平均值（标准偏差=0.25）可以看出。其次最为重要的因素是质素，接着是耐用性、安全特性及舒适（列表4）。比较在城镇与在乡村的回复者，他们对大部份因素的重视程度都各异：安全特性、耐用性、消晰标示、售后服务、质素、环保友善及舒适。对设计、便利使用者、品牌及价钱方面的重视程度，两者则没有显著分别。在城镇与乡村回复者之间发现了显著的不同，表示市场营销策略需要对齐这些消费者的不同喜好。

被问及他们在购买日用品时的同伴，回复显示年老回复者通常都独自一人购物或有配偶同行。少于20%回复者说他们在购买日用品时会与子女或其他家庭成员一起。这并不奇怪，因为70%的回复者在早上购买日用品 ，只有约20%在傍晚购物。下午并不是回复者偏好的购物时间。接近60%回复者在平日购买日用品，其余则指他们偏好在周末购物。城镇与乡村回复者之间在购买日用品时偏好那些日子、时间以及他们的购物同伴的事项上没有明显差异。

闲娱活动的参与

与积极老年化的概念相呼应，这个研究尝试检视年长人士有否参与闲娱活动，以量度他们对社会的参与程度。结果显示至少531位回复者（或99%的回复者）至少有参加一项闲娱活动（列表5）。这些年长人士参与的闲娱活动数量的平均值是1.8（标准偏差=1.1）。看电视是最多回复者参加的活动，接着是阅读、园艺以及运动。约四份一人提及其他活动，如参加宗教活动、手作、与朋友联谊及进行探访。这些结果提供了证据，指出年长人士显然是积极的。比较在城镇居住与在乡村居住的年长人士，研究结果显示城镇回复者显然较为积极（p<.001）——他们闲娱活动数量的平均值是1.92（标准偏差=1.20），而乡村回复者的平均堉则为1.57（标准偏差=0.86）。因为有较多的土地，乡村回复者与城镇回复者相比，有较大部份进行园艺活动——一项传统上乡村人士会进行的活动，因为马来西亚历史上是一个农业社会。至于其他在城镇与乡村回复者之间参与程度有明显不同的活动，居住城镇人士相比乡村人士都较为积极参与。

因为看电视是回复内最热门的闲娱活动，故此研究检视了一些受年长人士欢迎的电视台和城镇与乡村回复者的观看习惯。TV3是最多人观看的电视台，其次是RTM2和 RTM1（列表6）。NTV7则再次之。惟一需付费并播放电影及剧集的电视台Astro则在城镇回复者中受欢迎。因为相比乡村回复者，有明显较多城镇回复者看电视，故此发现有明显较多年长人士在电视上观看除了NTV7外大部份的电视台并不令人感意外。除了新闻 —— 有三份一回复者表示会观看 —— 外，回复者亦喜欢观看具娱乐性的节目，如电影及剧集。一小部份（7%）喜欢看纪录片。这些关于电视观看行为的结果对于从事营销传播（尤其是与针对大众市场的日常用品相关的）市场营销人士有重大意义。

在报章读者方面，结果显示约五份一回复者没有阅读任何报章（列表6）。马来语的日报在回复者样本中最受欢迎。更深入的分析没有显示城镇与乡村回复者在观阅马来语日报方面有明显差异。至于英语日报，研究则显示城镇与乡村回复者的读者数目在p<.001下明显有异，城镇回复者中明显有较多读者。至于中文日报，虽然《星洲日报》读者数目在城镇与乡村回复者之间没有明显分别，但《南洋商报》的则明显有异，相比城镇回复者，在乡村地区的人士当中只有细比率是读者。这结果对聚焦中国人市场的市场营销人士的宣传工作有启示作用。

产品及服务资讯的来源

作为消费者，年长人士需要倚靠特定资讯来源作出在知情下的购买决定。是次研究收集了可能是资讯来源的其相关数据，这些资讯来源是年长人士在购买选择以下常用的产品及服务时会倚靠的：旅游、财经事项、日用品、时装、电器家俬、医疗及保健和购物。列表七显示了结果。儿女（儿子和女儿）是这些年长人士在选购所有在研究内出现的产品及服务项目时的主要资讯来源。其次是朋友。结果清晰指出对亲自认识的人作为资讯来源的倚赖。以上可见，虽然这些年长人士通常独自或与配偶一起购买日常用品，但有关这些日用品的资讯是从儿子或女儿传向这些年长人士。

大众媒体、收音机和电视及报章均没有成为除购物外各项产品及服务的热门资讯来源，显示年长人士倚靠这些大众媒体来取得有关购物的资讯。

由于研究的焦点是日用品的购买行为，故探讨了在城镇及乡村中间如何使用资讯来源的差异。分析显示除配偶外，所有资讯来源的使用方式都没有明显分别。比较大比率的乡村回复者（N=99或58.2%）对比城镇的回复者（N=180或49%）是从配偶处获得资讯。

他们是快乐的消费者吗?

为了量度年长人士的购物满意度，回复者被要求以「五点」李克特量表，「1=不满意」至”「5=满意」的方式下，在一系列项目上作出表示：购物设施、消费者保障、便利年长人士的产品、顾客服务、投诉渠道、结算系统、休憩地方、楼梯及保安。回复结果可以是由9至45。从结果的平均值25.56（标准偏差=7.1）可以反映整体上回复者并不特别满意。回复者除了对获得大于3的平均值的休憩地方和顾客服务感到满意外，对研究内其余所有项目均感到不满意。这些结果对希望针对老人的市场细分的市场营销人士是有力的启示。在这个研究内，对生活的满意程度由生活满意度量表（SWLS）（Diener et al. 1985）来量度。回复者被要求以李克特量表作表示，「1=强烈不同意」至「7=强烈同意」。结果，平均值是25.13（标准偏差=5.7）。以皮尔森相关系数表示，显示作为消费者感到满意与满意于生活的两者间有显著正数的关系，r值= .173（p<. 001）。乡村和城镇的年老回复者之间对消费的满意程度和生活满意程度的比较结果则显示没有任何显著不同。

讨论及结论

这文章提供了关于马来西亚的年长人士之支出模式的见解。显然，马来西亚的年长人士的大部份支出用在了食物和饮品，因而鼓励了对这些年长人士在购买日用品方面作更详细的研究。如这份文章所证明，对马来西亚的年长人士推广日用品，需要先了解他们在何处及何时购物，并明白他们所用的衡量准则及他们在作出购买决定时用上的资料的来源。研究结果显示马来西亚的年长人士是活跃的；他们了解自己想要什么，也能在购买时明智地判断什么事项是重要的。他们对于购物决定的取态跟来自较发达国家的年长人士没有分别（例Biren 1994；Duizer et al. 2009）。显然，他们在购买日用品时是独立的，因为多独自或与配偶一起购买。少于20%会跟自己的儿女一起买日用品，尽管他们倚赖儿女提供各项产品及服务的相关资讯。除了当他们要获得有关购物的消息时，他们对市场营销者的推广差不多视而不见，这显示当针对年长人士时，获得他们的信任十分重要。在闲娱活动的参与方面，他们可以被形容是积极的。

市场营销者应避免对他们作出狭隘及不准确的定性（如他们只是较老的消费者及不再活跃）。随着因为人口老化而较老消费者市场逐渐扩大，市场营销者应具智慧的考虑一些具潜力及有利润的市场细分，如不单满足较年老消费者的基本需要，而是跟闲娱相關的产品及服务。在英国就发现由属于相较年轻一代的年长人士作主的家庭，在闲娱上花费较多，但在食物及燃料的支出则下降（Higgs et al. 2009）。根据在较发达国家发现的这个趋势，可以预期随着时间，马来西亚也会经历类似的趋势。事实上，趋势已经出现了。我们观察到有较多的住城镇年长人士会花费在闲娱活动及能提供自我满足的产品。

至于传播策略方面，市场营销人士必须认定年长人士使用的资讯来源。广告信息内的呼吁必须含有能同时吸引成年人士(年长人士儿女)及年长人士的元素，以创造一个强烈的信息，因为年长人士倚靠他们的儿女提供资讯。年长人士的儿女扮演的角色大抵是资讯收集者及影响者。他们是年长人士家庭的守门人及意见领袖。市场营销人士在决定以电视台及报章作为传播广告信息的媒介时必须考虑年长人士多看那些电视台、多读那些报章。特别是当针对华裔市场时，市场营销人士必须明白报章阅读习惯在城镇及乡村地区有别。

在这个研究中，缺少一个明显的控制组可能被看作是一种局限。在将来，我们会建议将研究扩大，加入一个控制组或至低限度一个由在较年轻人士组成的对比组，使我们能够就年长人士的消费者态度及购买行为，以及两者在各年龄组别内及组别之间的不同，作出更强力的论说。购买行为亦可能因应个别产品而有所不同。因此未来的研究应该检验不同产品类别，包含针对年长人士的产品以及适合所有年龄人士的产品。

图表

（请参照原文）

Symposium A Articles

论文（论坛A）

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「中国医学在养老护老中的作用」

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孙启新

上海嘉定康福敬养院是一家民办非企社会投资兴建的，采取的经营与投资分离的管理模式。康福敬养院总投资2500万，占地28亩，共有200张床位。成为了集宾馆、医疗、护理、娱乐为一体，「老有所医、老有所养、老有所乐」的老人们的新家。成立9年多来，我院树立了以中医经络养生、中医养老、寓医于食、医食同源的养老特色品牌，采用「三疗」（食疗、茶疗、乐疗）加精神慰藉对院内老人进行健康调理。现在院内老人平均寿命85岁，最高寿者104岁，均过着安居乐陶陶的生活。九年多来康福敬养院同时也取得了良好的社会效益和平整运行的经济效益。

一、医疗

上海嘉定康福敬养院与上海同济医院中医老年病及抗衰老研究中心协作并聘请教授及专家到上海嘉定康福敬养院指导工作和开展科研，根据每个人身体的特殊性个体差异，采取以中医养生为特色的「医疗、食疗、乐疗、精神疗法（喜怒哀乐悲恐惊）、运动疗法（做操、行走、散步）」各种疗法对老人进行适合自己身体的治疗方法。同济大学陈百先教授多年采用中医中药治疗老年认知障碍、中风后遗症等。中医学认为人的的衰老与五脏（心肝脾肺肾）中脾和肾两大脏器功能好坏关系最为有关，其中肾为先天关系更为密切，脾为后天补充关系必不可少。中医讲「老者多肾虚、老者都气虚、老者都阳虚」，「老年人气血两亏」，补气养血、活血化瘀、提高正气阳气，提高老年人的免疫功能，对肾衰竭、抗肿瘤、抑制疾病等都可取得良好的效果，对于提高老年的身体状况、延缓衰老有明显的疗效。

二、食疗「安身之本，必资于食」

医食同源，老年人的营养不足和营养不平衡是导致多种疾病的主要原因。人类和动物都必须借助于食物才能生存，康福敬养院根据四季特点特制定四季养生粥。

1. 春季饮食养生。春季饮食调摄是根据人体所需要的营养结合气候变化的特点，从防病健身两方面采取有效的方法进行的。春季饮食宜辛甘、清淡为主，这是因为春季多雨、多风、多寒、多湿，医学认为，辛能放风、温能祛寒、淡能渗湿，这样人体就能抗御外邪侵袭，健脾益气。遵循春季养生三原则：（1）高热量优质蛋白原则；（2）增强免疫原则；（3）清肝护脾原则。

2. 夏季饮食养生。夏季因天气炎热，汗出较多，消耗人体大量体液及营养物质；同时，天热影响脾胃消化吸收功能，减少食欲，造成入不敷出。因此饮食方面要化湿祛暑的同时，要健脾益胃。既要补充损耗的物质，又要供给肌体维持正常生理的需要。夏季以清淡芳香为主，清淡利消化，芳香促食欲，并食用一些冷饮，以防暑降温。

3. 秋季饮食养生。秋季天高气爽，万物荣华。根据《黄帝内经》的观点，肺属金，通气于秋，肺气盛于秋，而五行相克，金克木，肺气太盛，很容易损伤肝的功能，而肺主辛味，肝主酸味，辛味能胜酸，所以秋季应该本着「少辛多酸」的原则来养生。秋季饮食方面以润燥宜气为主，以健脾补肝清肺为主。

4. 冬季饮食养生。冬季气候寒冷，自然界阳气闭塞，阴气盛。进食以温补为主，以抑阴护阳，贻养精气为要，必须多吃含糖、脂肪、蛋白质和维生素的食物，同时多食蔬菜，以均衡营养，防止脂肪堆积。

根据老人的生理身体状况补充维生素和微量元素，老人的饮食加工方面除了色、香、味、型，还要加上酥、烂、淡。以适应身体需求。

根据中老年人的饮食需求专门设计了养生粥、养生膳食、养生茶，用于中老年人的抗衰老及慢性病的防治，营养不足和营养不平衡是导致多种疾病的重要诱因，营养是生命的物质基础，营养的改善能延缓衰老，搭配合理的优质蛋白质、丰富的维生素和微量元素在人体抗衰老过程尤为重要，营养与健康和衰老之间有着显著的直接关系。长期坚持用传统中医及食疗的方法，就可以达到营养平衡，控制慢性病的发展延缓衰老的功效，使更多的人带病延年益寿。

三、茶疗

同济大学专家陈百先教授根据老年人的身体生理机能常见的疾病专门制定保健养生系列：降压茶、降糖茶、通便茶、降脂茶、活血化瘀抗衰老茶。老人们根据自己的需求而饮之以达到健康延年。

四、乐疗

老人肺部生理功能下降，肺的通气功能下降。我院特创独特的「乐疗」，每天让老人们放声歌唱。「乐疗」的医学机理：一是增加肺活量，二是增加膈肌运动，减少肺部感染，尤其是对脑中风、老年认知障碍的老人来说可以起到启动脑组织、恢复记忆的特殊调理功能。

五、中医经络养生操

经络养生操，经络降压操。通过经络穴位操可刺激穴位，调节功能增强分泌活动，改善血液回圈，促进新陈代谢。如梳头，头是「诸阳之首」是督脉「百会」穴位，是指挥和调节人体各种活动的中枢神经系统。举例：梳头是脑部运动最理想的项目，它可以刺激穴位，调节功能，增强分泌活动，改善血液回圈，促进新陈代谢。多梳头，可以醒脑增寿，还能使面容红润精神焕发，梳头还是治疗失眠、眩晕、心悸、中风后遗症和青少年白发的辅助手段。平时可每天梳头3~5次，每次不少于3~5分钟。

六、艾灸

艾灸又名艾疗。是指应用高温（艾叶或其他物质燃烧后产生的温热）或低温，对皮肤有刺激作用的其他物质，直接或间接接触皮肤表面后产生的刺激，作用人体的穴位或特定部位。经烧灼、温熨、借灸的温和热力以及药物的作用，通过经络传导，起到温通气血，扶正祛邪，从而达到预防或治疗病症的一种外治方法。

《黄帝内经》指出「外所不为，灸之所宜」，灸法是以经络、阴阳脏腑理论为指导，具有温散寒邪、行气活血、温通经络、活血逐痹、回阳固脱、消肿散结以及强体保健的作用。古云「阳精若壮千年寿，阴气加强必毙伤。」故为医者要知扶阳气为本，强调阳气在人生命活动中的重大作用。现代研究表明：灸法可调节机体各系统脏器的活动机能，增强特异性，非特性免疫，从而提高机体的免疫功能。《医学入门》则有「凡病药之不及、针之不到、必须灸之」之说。故灸法是针灸学中重要的组成部分，也是中医学的一重要的治疗方法。

根据老年人生理特点。老者阳虚，功能衰退，如何提高老者阳气是当前世界医学一大难点。

我院采用艾灸疗法康福灸道对老人进行无创伤、无痛苦、无损伤又安全的调理方法，使老人恢复阳气提高老人的免疫功能，尽量少得病，不得病，提高生活品质，既健康又延年。

「养老护理员队伍紧缺的思考」

广东省广州市越秀区东山福利院院长
汪世灏

养老护理员队伍的稳定,关系着养老服务品质保障,影响着养老福利事业的健康发展。全国各地养老机构，包括社区居家养老服务承办机构，普遍面临着人员流失，缺员及招聘困难。这种现象的日益显著，给整个行业乃至当今整个社会提出了一个严峻的警示，作为养老服务机构管理者必须认真对待。政府部门同样也应有因应对策，积极主动地迎接当代银发浪潮的到来。

一、养老护理队伍的现状

护理员紧缺已成不争的事实，国内已进入老龄化的多个城市分别报导了有关资讯。北京需要护理老人约60万，养老护理员缺口大（京华时报，2011年11月30日）；天津市有养老机构318所总床数3363张，但养老护理员的人数不足6000人；上海是全国第一个老龄化的城市，近几年每到春节长假，上海的保姆缺口都在10万以上（东方网、作者王诺）。广州「养老护理员缺口巨大」（广州日报，2012-05-09）。哈尔滨、南宁、郑州、宁波等市媒体都报导了养老护理员紧缺的现象。连中原人口大省，河南省的养老护理员缺口也在二十万以上。养老护理人员奇缺，具有专业技术的人员缺乏，招工难，成为老年护理服务发展的一大瓶颈，已经引起各地政府的重视。老年护理服务时常成为各级人大、政协会议的议题。

从护理员来源看，绝大部分来自中西部欠发达的地区的城市及偏僻的农村，较为集中在甘肃、河北、四川、河南、湖北、广西等省、区。一个较为奇特的现象是东北三省和珠江三角洲地区很少从事该业。一些民族地区的外来务工人员也不愿意进入养老护理员队伍。笔者所在机构护理员共60名，广东籍护理员仅5名，占比例8.3%，尚无一名少数民族护理员。

从年龄结构看，很多机构从业者多是四、五十岁、即「4050」人员居多，有些机构护理员五十多以上较普遍，甚至有个别护理员超过60岁，其本身就进入了老年行列。我院护理员平均年龄38.88岁。这个年龄层次在行业内算比较年轻，但与我们五年前的员工平均年龄有明显增高。当时我院招聘新护理员年龄不能超过35岁。招工难，年龄不得不一再放宽限制。护理员由于年龄大、体力下降，适应工作环境能力差、往往不能尽快进入工作状态。

从文化程度看，外来务工人员，下岗再就业的「4050」人员，学历偏低，多数是小学或初中文化。尽管已经有养老护理专业大、中专和职业技术学院，但毕业生进养老机构很少。甚至经过养老护理职业培训的失业人员很少愿意就业。我院护理员大专2名（3.3%），中专、高中10名（10.6%），其余均为初中及以下文化水准。

从流动性看,机构养老护理员流动性大，流失率高,新入职率低.与五年前相比较工作3年以上明显减少,大多数在一年以内就离职。有些新聘人员刚上岗，培训完就辞职了。我院仅2011年全年护理员流动43名。占护理员总数的71.6%。有19名人员工作不满30天。

从福利利待遇看，绝大部分养老机构都为护理员落实社会保险；经过入职前技术培养和职业道德、规章制度教育；免费食宿；拿到手的工资及奖金在1600~1800元 / 月。本院给护理员有带薪年假5~10天，探亲假15天。实行8小时工作制。普通加班工资按150%计，法定假日加班工资按300%计。每年度组织一次外出旅游。综合薪金、保险、福利性开支，广州市养老护理员普遍保持在3000~3500元 / 月左右。

二、护理员紧缺产生原因

目前，养老护理员紧缺产生的原因，或者说影响外来务工人员选择护理员岗位的因素是多方面的。既有现今社会性人口宏利宿减，外出务工人口减少；新生代外来务工择业倾向改变的宏观影响，又有养老机构用人机制和政策性层面缺失的制约。社会普遍认为：养老行业待遇低；工作时间长；需要很强道德和专业性；社会存在偏见，是造成这一行业从业人员流失、缺乏的主因。实际上这些还不是产生这种现象的深层次的原因。

随着城市化步阀加快，农业人口在减少，已失去土地耕作的人口应该存在重新就业的选择。但是这些剩余出来的劳动力有政府经济补偿，生活无忧，不到万不得已，不会从事养老护理工作。

新生代外来务工人员，与上一代打工者相比，不再单纯是为养家糊口而打拼。现在年轻人，特别是独生子女，连自己父母都没照顾过，怎么能考虑去做养老护理工作？当本地人都不愿意从事的工作，外来务工者因为方言的差异、地城性情差别、老年人性格特征等诸方面限制。都很难把护理员工作作为正常的选择。更为严重的问题，有些老人家属，甚至老人本身就不尊重护理员的人格，动不动出口伤人。把养老服务视作纯粹的经济关系，有钱就能买到一切。这种不自觉的伤害，对养老护理员队伍的心理造成极大负面影响，直接引起队伍的不稳定。

护理员队伍组成模式的无序化，也是护理员缺乏的痼疾。据了解，各个养老机构的人员来源相对集聚，一个员工可能介绍或带一群人。当其中一个员工动摇后又影响一批同乡。既可能一会形成人员相对过剩下，又可能突然出现绝对不足。使机构管理造成难度，又引起护理品质的上下波动。外来务人员季节性变化是困扰着护理队伍稳定性的另一难题。农忙季节、传统节日、节假日对外来务工者是避不开的实际困难。如果机构动员、劝说或者不准假，护理员就会直接辞职不干。发生该现象在各养老机构应该不是个别情况，令机构管理者进退两难。此外，由于夫妻两地分居，异地务工的现象在护理员中相当普遍，因为夫妻情感生活，子女教育抚养，自身长辈赡养问题，某一个环节出现异常，直接影响护理员的工作情绪和队伍稳定。

作为养老护理员来说，工作8小时，体力消耗并不比在工厂流水线作业时候大。但是日复一日，面对着固定不变的老年人，无疑会使护理员心情沮丧，精神压力是巨大的。而当护理失能的老人，需要料理老人的大小便，帮助老人洗澡，尤其是男性老人，护理员心理上难以跨过这道坎。很多护理员就因此打退堂鼓，立即逃之夭夭。往往借口是闻不得老人的气味，或者干脆说工资低不愿干。可事实上，养老福利事业属于微利，甚至无利润的服务行业。护理员薪酬待遇尽管有各地规定的最低工资标准保障，并且逐年在提升，但是相对于精神道德、责任要求较高的行业来说，从业人员始终感觉到劳动报酬与付出不相匹配，自然而然这项工作就没有什么吸引力。而作为养老机构由于收费标准的限制，运营成本不断上升，公共财政支持力度不够，仅靠不停加薪来留住员工，招徕员工根本不实际，也不可能。机构管理者往往无计可施，捉襟见肘。

尊老爱老是中华传统的美德，但是落实到行动上实属不易。在有相当一部分人心态浮躁，急功近利的时候，不可能有大学毕业生从事护理工作，哪怕是在家待业。偶而有个别青年学生来，也只是达眼烟云。没有新生力量的事业是没有生机的事业，没有青年人进入的养老行业机构不会有前途。在正确引导青年人，特别是青年学生择业观，尊老养老问题上，社会舆论的提倡、媒体的宣传作用都存在很大缺失。硕士研究生摆档卖肉，可以有大量媒体围观，但是大学毕业生做护理员则少有问津。这种现象可以看作传统歧视之上的社会性歧视。

我国人口老龄化特点是未富先老。社会发展进程中经济资源有限，但老年问题是当今面临的重要社会问题。在有限的财力支持下，相应政策扶持仍显不够，养老护理员几乎没有任何政策性照顾和鼓励。住房问题，户籍制度，子女教育，社会保险等都是她们的后顾之忧。对护理员从业过程中舒缓心理压力，情绪疏导往往被社会和用人机构所忽视。

三、解决护理员紧缺的对策

《中国老龄事业发展十二五规划》提出，积极应对人口老龄化，注重发挥家庭和社区功能，优先发展社会养老服务，培养壮大老龄服务事业和产业。短期内，社会不可能一蹴而就能解决目前养老护理员紧缺的困境。需要政府、全社会、养老机构联合行动，采取有效的措施，把解决护理员缺乏的矛盾当作一项关注民生问题的大事。与之有关的各个方面，下大力气解决实际困难，以期促进养老服务事业健康发展。

政府加大政策扶持,提升养老护理员社会地位.将养老服务作为社会公益性岗位，鼓励城市下岗人员、无业人员及城郊村转居人口从事护理员工作。对愿意安心养老的本地籍人员从社会保障，保障性住房、子女就学就业给予特惠照顾。逐步扩大护理员来源的本地化，防止过度依赖外来务工人员。城市义工为老服务应该常态化、制度化。实行规范化管理，防止流于形式化和走过场。

目前，可能仍然主要依靠外来务工人员从事养老服务行业。但政策性倾斜照顾，是提高护理员社会地位，增加归属感，提升行业社会认同度的主要措施。例如外地护理员入户籍政策，外来工子女就学，购房或租房优惠条件，社会福利保障等特殊照顾措施。最终消除本地工与外地工，正式工与临时工的差别，给予外来工以人性化关怀，增强城市养老事业的从业人员坚实的社会保障。

养老服务的发展前途在于专业化，单纯生活照顾的养老机构已经不能适应市场的需求。政府要创建本科、专科层次的养老相关专业教育，纳入普通高校招生计画。大力推广中专、职业技术教育中开设护理员培养方式，扩大养老服务需要的专业人才队伍。招聘大学生服务养老的鼓励参照支援西部建设的办法。

科学技术就是生力，养老服务事业离不开科学技术的进步。积极扶持养老产业，自主创新更适合国情，适用于养老服务的设施，用品。逐步增加技术化，智慧养老，减轻护理员体能负担。能省出时间和精力，让护理员更多时间与老人交流，增加对老人心理需求服务。

整个社会应转变思想观念，传播先进理念，提供社会的公正认识，争取社会的理解与支援。养老服务是一项社会很需要的新兴职业，应摒弃职业贵贱之分的观念，使普通大众认识到养老护理是一项集知识与技能的技术工种。同时，养老机构也要反复强化对护理员的传统美德教育。

随着经济的发展，我国完全可以考虑把养老护理员作为公益性岗位，从公共财政中给予经济适当补贴。参照许多国家、地区的财政补贴政策。法国政府为在公共部门和非营利性部门工作的人支付80%的最低工资，其余部分由雇主支付，以吸引从业者长期坚守岗位。英国养老护理员年薪在1万英镑以上，同时还给予劳动补贴，免费医疗方面的待遇。美国养老护理员是可以入籍后参加公务员行列，还给予家属购买养老保险。

作为养老机构，更应该根据经济能力为护理员创造工作和生活条件。实行奖优罚劣的合理考核制度，兑现与劳动人力市场机制匹配的薪酬待遇，依据服务年限调整晋级幅度，根据个人能力提供职务晋升机遇。提供养老事业者心理咨询服务，缓解精神压力。多开展形式新颖的文娱体育活动，丰富员工业余文化生活，缓解体力疲劳。组织定期旅游，短暂脱离工作环境，放松心情，增添生活情趣。同时要关心员工个人、家庭困难。积极创造条件便利护理员跟家庭联系；邀请配偶和子女假日、假期来访探视，家庭团聚，实行人性化管理，用事业留人，用感情留人。增加护理员对事业的认同感，对单位的归属感。总之，全社会必须重视护理员紧缺的问题，积极应对，采取行之有效的办法，切实保障从业人员社会福利，维护个人权利。保持护理队伍稳定，促进护理员素质提升，开创养老服务事业新局面。

「对社会养老模式的思考与探索」

福建省福州市金秋老人院院长
顾志萍

摘要

根据我国社会老龄化进程加快，社会养老服务需求迅速增长的趋势，提出构建社会养老模式，类比以人为中心的社会养老服务支援系统；结合养老服务的实践，探索社会养老服务支援系统的作用，方法和路子，为高龄病残老人提供优质服务，对提高老年人幸福指数，推动积极老龄化，健康老龄化进程，加快老龄事业科学发展，实现有中国特色的积极老龄化战略思想，具有重要现实意义。

「十二五」时期，我国将出现第一个老年人口增长高峰，60岁以上老年人将由目前的1.85亿增至2.21亿，老年人口比重由13.7%升至16%；80岁以上老人2400万，65岁以上空巢老人将超过5100万。在老龄化进程加快老年人生命过程（寿命期）逐渐延长，今后谁来养老，怎样养老的问题，已成为民众热切关注的焦点。在「政府主导，社会参与，全民关怀」的国家老龄工作方针的引领下，构建「以人为中心的社会养老模式」，运用集体力量营造一个积极老龄化，健康老龄化的社会人文环境，创建适合我国国情，具有中国特色的社会养老服务体系；为维护老年人的合法权益；提高老年人的生活、生命品质，提供政策和法律保障。在帮助老人分享社会经济发展成果的同时，支持老年人享有「独立、参与、照顾、自我实现、尊严」的晚年生活，对我国老龄事业科学发展，提高老年人的幸福指数，具有深远的战略意义。

一、以人为中心的社会养老模式与内涵

（一）以人为中心的社会养老模式示意图：

（二）社会养老模式的内涵与意义：

1. 老年人是具有生物属性的人，是心理的人，社会的人。社会是老年人安生立命的根基。老年群体是社会群体的重要组成部分，老年人既是积极老龄化，健康老龄化的参与者，也是社会经济发展的资源，他（她）是人类文明，民族繁衍昌盛的创造者，传承者。在社会养老服务系统的支援下，调动老年人的主观能动性，是实现积极老龄化，健康老龄化战略思想的根本保障。

2. 现实社会养老目标的载体是社会养老服务支援系统。这一系统要素包括：人力支援要素；财政，公共资源保障要素；政策、法律支持要素；社会、医疗保障要素；老年文化教育要素；老龄社会管理等要素之间，相互支持密切合作，形成合力发挥作用之时，就是社会养老目标实现之日。

3. 以人为中心的社会养老模式的目标是在于科学养生，优质养老的条件下，提高老年人的生活、生命品质和幸福指数，实现老年人的人生价值。

4. 以人为中心的社会养老模式的实质。人与自然环境，社会环境是统一体，每个人都应有整体的生理、心理状态，和社会适应能力，人生活在内、外两个相互作用，又相互制约的环境之中。老人内环境，是一个在一定条件下具有动能平衡的自律系统。然而，内环境能否平衡运转，受老人的遗传性，意志力，个性特征，行为方式，健康状态以及复杂多变的自然、社会环境的制约，当老人受到矛盾刺激和压力因素影响时，必须调整自己的心态或环境，提高社会适应能力，力求以最佳生理，心理状态，颐养天年。

5. 社会老养模式是在整体、综合效应作用下，产生周而复始的动态养生过程。由于有机体不停地在与外界进行着物质的、能量的、资讯的交换，老年人对社会养老服务支援的需求也在不断发展变化之中。就健康老龄化而言，老人健康时需要卫生保健预防疾病，解决潜在健康问题；生病了需要规范化的有效医疗护理，以减轻痛苦治愈疾病；康复中要为其提供康复条件，以求恢复功能，重建健康。总之，老人总是在社会老养服务系统的支援下求得不生病，少生病或病而不残，残而不废。事实证明，老龄人在走完人生最后一步之前，都离不开社会养老服务系统的支援和关爱。因此，充分发挥养老服务支援系统的作用，对加速社会养老服务体系建设，推动我国社会养老服务业进入科学化、人性化、精细化的良性回圈，对落实“政府主导，社会参与，全民关怀”的国家老龄工作方针，实现积极老龄化、健康老龄化目标具有深远战略意义。

二、结合金秋老人护理院的运营实践，建构养老服务支援系统，探索发挥支援系统功能的方法和途径

福州市金秋老人护理院（以下简称「金秋」）创建于2000年12月，她是一所集养老，老年慢性病防治，康复护理，临终关怀为一体的民办老人养护院。在11年运作过程中，「金秋」视自己是社会养老服务体统里的一个分支系统，用系统概念指导运作过程，尽心尽力为老人提供优质服务，得到社会的肯定和赞誉，主要做法和收获是：

（一）确定市场定位：

从我国老年人口基数世界第一；「四一二」家庭养老功能弱化；社会老龄化进程加快；高龄病残老人对长期专业护理的需求急增的实际情况，结合「金秋」专业护理特长为出发点确定：专收高龄病残，智慧缺失，家庭无力照料的老人作为我们的服务物件。这一定位，有利于积极主动应对社会养老服务的客观需求；从解决养老服务工作中的重点，难点问题入手，研究现代老年护理学内涵和规律；为提高老人养护老院的资质，拓宽可持续发展的空间奠定基础。

（二）拟定服务宗旨：

「金秋」坚持「以人为本，珍爱生命，尊重老人，奉献爱心，竭诚服务」的宗旨理念，营造诚信做人，爱岗敬业，情暖人心的宜居人文环境，让老人能安心养老，子女能放心托付，打造一个夕阳无限好，金秋情更浓的老人之家。

（三）组建、培养一个具有奉献精神，团结协作，艰苦奋斗、训练有素，技能良好，管理规范的工作团队：

为践行「金秋」服务宗旨，我们认为提高员工总体素质，是第一要素。为此，我们创办了「金秋护理职业培训学校」，积极宣导从业者将养老服务工作当「仁爱事业」来做，提高自我认知水准，用人生观，价值观，护理职业道德原则，考量自己的职业行为，做到敬畏生命，尊老、爱老、护老，用心尽责为老人服务，这是「金秋」养老文化的核心内容。

（四）了解高龄病残老人的身心疾苦，积极应对他们的真切需求：

1. 病残老人的共性疾苦：

（1）一身多病。常见老年病多发病，盘根错节地聚集于老人一身，高血压引发的心脑血管病占48.6%；中风导致瘫痪占28.8%；痴呆症占21.3%；糖尿病占12.6%；骨折占8.6%，帕金森综合症6%；大面积深度褥疮4.2%。每位老人的诊断至少是三、四个，多则七、八个，真可谓病魔缠身、苦不堪言。

（2）并发症严重，致残率高。进入高龄（75岁以上）的老年病人，病而不残者少见。主要原因：一是老年人生病后，未得及时有效的规范化治疗，多般是小病扛着，用点药了事；二是卫生保健措施不完善，医疗保险尚未全覆盖，老人怕花大钱看病，子女怕费时费事，通常得过且过，顺气自然消极应对，老人的生活品质难以保障，自然是小病拖成大病，重病导致先失能，后失智，到智能缺失之时也就难有回天之力了。

（3）智能丧失的老人受失忆、失明、失语、失听的困扰；机体代谢和免疫功能低下；他们无时间、空间、定向概念，自我表达、自我保护意识缺失，他们的安全隐患丛生，让人忧心护理难度大风险责任重，是老人养护院面临的大难题，值得深入研究，汇聚社会共识，提出应对良策。

2. 高龄病残老人的共性心理特点：

（1）老年人在社会角色，家庭角色转换期，郁结于心的不适应心理，对进入高龄期老人的健康影响较大，加之老年人的思维，个性行为方式各异，他们饱受焦虑，孤独，猜疑，沮丧，心绪不宁，精神抑郁等负面心理影响，受害非浅，且难自拔。

（2）有些病残老人常因家庭人际关系不和；子女不孝；兄弟姐妹间为家产分割问题久战不休；或老人遭遇丧偶悲情等精神刺激，极易引发精神障碍疾患。对老人的身心健康极为不利。

（3）老年人心理需求具有潜在性特点。从精神、心理层面看，老人、特别是高龄病残老人，他（她）们所求的安慰和保障，不只是有食饱腹，有衣暖身就可以了，更重要、更深层的需求是：受人尊重、被人爱。期盼活得有尊严，有指望。所以对老人的精神、心理关爱就像空气和水一样，是时刻不可或缺的。

（五）建构具有可操作性的老人整体护理流程，使科学专业护理能更好地为老年人造福：

据我们统计当老人进入病残期至逝世，一般需要三、四年的专业护理，长则八、九年时间在我院住三至四年（含第四年）的老人，占44%；住5年以上，占27%；至今仍有15位常住「金秋」7~11年的老人，平静地生活在「金秋」。11年中，我们共托收677位病残老人，他们平均年龄85.5岁，全护理占91%，介护占7%，「金秋」靠什么运营这样一个人生驿站的：

1. 建立老人整体护理流程：

满足老人生理需求，精心料理吃、和、拉、撒、睡 ⇄ 监护生命体征、及时发现人老呼吸、回圈、消化、排泄系统动态病情变化，及时采取有效应对之策，维护机体内回圈常态运转 ⇄ 注重精神，心理关爱，保护老人的精气神，促进身心健康 ⇄ 营造卫生、整洁、和谐的宜居环境，提高老人对机构集体养老的适应能力 ⇄ 以自然之气，养自然之身的科学护理知识、技能、经验和合理营养，辅以适当有效的医疗、药物救治措施，提高机体免疫力，调动自我修复能力，稳定病情，促进康复，再回归家庭养老者占29%。

2. 整体护理流程的意义和作用：

（1）整体护理是在尊重老人需要和保护老人权益的基础上；运用护理科学原理，技术方法和经验，帮助老人改善、维持、调节，恢复完整的生理、心理状态和社会适应能力。整体护理是一个多层面的护理措施，相互联系，相互作用的动态护理过程。她伴随老人生命的全过程，周而复始地维护老人体内外环境的平衡和应适，达到提高老人生活、生命品质的目的。

（2）整体护理，体现了普遍性和特殊性相结合的特点，在处理好病残老人普遍性需求的基础上，要根据他们不同的生理需求和个性心理特征，人文环境和病情的发展变化，用一把钥匙，开一把锁的方法，提供人性化与个性化相结合的优质服务。

（3）整体护理流程体现了护理的科学性，和她对人类健康的贡献。「护理」是人类的爱抚事业。「护术」是「仁术」，仁者爱人，这是护理的本质。人的生、老、病、死都离不开护理，那里有人，那里就需要护理，护理为人类的繁衍昌盛，做出贡献；她为不同年龄段，不同生活、职业、背景，不同性格和需求各异的人提供服务，护理也是一门精细艺术。

三、坚持救死扶伤原则，全心全意为病残老人服务

（一）坚持少花钱办好事：

在院老人中，无医疗保险的老人占三分之一，他们出不起高额医疗费，难以走通求医之路。带着病痛熬日子的陈奶奶，中年得三叉神经痛的病，吃了半辈子止痛片，没有解除她的疾苦。入住“金秋”后，我们为其求医问药，终于请到一位三甲医院的止痛专家，上门为她会诊，只花了几块钱，用三叉神经封闭术，解决了她多年的疾苦。王奶奶得了很难缠、很痛苦的带状疱疹，我们用中草药土法上马，花小钱，治大病。

（二）坚持精心调理：

郑奶奶心动过缓，脉搏每分钟40次左右，家人担心她会在睡梦中走掉。94岁时送入「金秋」，她耳背、性子急，爱干净，对饮食等生活习惯有自己的特殊要求，稍不顺心就耍性子。我们服务人员对老人家耐心、精心照料，医生、护士认真负责摸清她的病情，积极寻求有效治法，最后用中西医结合，以小剂量西药配合长期服用中药，用滋补心气的方法，脉搏逐步提升到60~70次/分，健康状态得到有效改善，她住金秋8年从未回过家，102岁逝世。她的八位儿女从不同角度感慨地说：老娘送入金秋，就像「进了保险箱」，她在你们的「娇惯」中养老，是享有「特殊待遇」、福寿双全的幸福老人。

（三）坚持人道原则：

我们宣导员工要敬畏生命，维护老人的尊严和他们的治疗权、生存权。工作中大家深切感受到，高龄残疾老人活到听不到、看不见、吃不下、走不动，睡不安；思维断裂，精神痴滞状态时，再说提高生活品质，就会沦为老人无法享用的空话和奢谈，我们深切感受到每位老人都是「一本书」，从业者首先要读懂这本书，弄懂老人心，及时行孝才是真孝；一切为老人，为了老人的一切，子孙后代要舍得一切，才是真爱、大爱。从这一认识出发，我们坚持用心对待高龄病残老人的疾苦，坚持能治要治、要早治；能救必救的原则，不应付了事，不随意放弃。林宝进老人因鼻咽癌气管切开，手术后放疗、化疗全用过，身体极度衰弱；手术部位严重感染，并引发气管、食道连通瘘，由鼻饲管给食，从漏口喷出，随之发生流质饮食进入气管引起呛咳，实难维系生命。家属请二位护工（每天每人500元）也不能解决问题，医院

无对策，要求家属接老人出院。家属在无可奈何的情况下找到「金秋」，请求帮助老人度过临终期。我们并没有这方面的护理经验，但老人的疾苦告诉我们：「金秋」只有救死扶伤的责任，没有拒收生命垂危者的权利，主动上门接老人入院，通过积极对症处理病情，和手术部位的创面，精心护理病人，感染被控制，手术部位的水肿，淤血逐步消退；瘘道噎食现象逐渐减轻，老人终于撑过了2011年，至今仍生活在整体护理照料之中。事实证明，我们并无回天之术，但只要我们坚守信念，用爱心支撑生命的事业是有光明前景的事业，是光荣的事业。

（四）攻坚克难提高治疗率：

长期卧床大小便失禁，自己不会翻身的高龄重症老人，褥疮是他们的天敌，尤其是深度、大面积褥疮，直接威胁到老人的生命安危。我们经过多年探索，不断改进护理、换药、保护受压部位的方法，本院的褥疮发生率为0。近两年从院外带进的褥疮越来越多，除个别低蛋白血症患者外，基本都能治。

黄亨花奶奶是高血压心脏病，中风瘫痪，哮喘患者，89岁突发「天疱疮」，我们没有见过这种皮肤病。老人从头到脚，包括鼻、口腔黏膜，全身密布大小不等的水疱，大疱破溃，跟着出现大片疮面。起始我们找皮肤科医生会诊，联系转院治疗。然而，专科医院以老人有老年病不便收治为理由拒收；另一方面家属以付不起医院的高价医疗消费，拒绝转院；面对如此局面，「金秋」选择留其在我院治疗尽全力服务。为求得到中医皮肤病专家萧治安祖传秘方配成的药膏，我们由专人排队等候四小时。每天由2位护士花4~5个小时为老人全身换药、涂药，她高烧不退不能进食，全靠静脉补充营养，历时40多天，患者转危为安，全部医药费只花7000多元。

（五）坚持「以人为本」理念，以人性关怀伴随老人有尊严地走完人生旅程：

11年里我们为152位老人送终，「金秋」有规范的临终关怀程式，它包括：临终期监护；善终服务等一系列规则程式，如遗体料理，除常规遗体料理外，我们要为老人化淡妆，行告别礼，送花圈等“金秋”养老文化为老人送行。老人亲属、好友参与、目睹全程，无不为之感动。

四、借助社会力量，搭建对高龄病残老人的心理关爱平台

（一）积极组织动员集体力量关注老人的精神生活，参与心理关爱行动：

我们用请进现场走进课堂的方法，组织社会志愿者包括政府部门事业单位，如省妇联，红十字会，慈善总会，老年服务协会等机构；大专院校学生，医院，超市，以及享有盛名的大集团、大公司员工。仅2011年，上述单位派出1600余名志愿者，以长流水不断线的方式：定期（学校学生）与不定期（社会志愿者）上门为老人送温暖，诸如：物质慰问满足老人的生活需求；歌舞表演激发老人情趣和心智；话聊交流情感给老人以精神安慰，送医送药促进老人健康等内容丰富，形式多样的敬老活动，给老人们带来安慰和生活乐趣，滋润着老人们的精神生活。

（二）金秋老人护理院不只是我们从业者尊老、爱老、护老的场所，我们把她看成是一个小社会，是传承现代孝文化的一个生动课堂：

无论来访者身份高低，学问深浅，只要走进老人护理院，就能生动地感受到人生的酸甜苦辣和悲欢离合的精彩和沉重；就能感悟、体验到，作为社会人，「感恩」「回报」意识是人们必备的高尚品德，也是每位公民应尽的义务和责任。我们根据不同的志愿者和来访物件；尤其是青少年学子，向他们宣传我国社会老龄化发展趋势和惠老、养老方针政策；宣传传统孝道和现代孝文化的内涵，引导年轻人深思自己肩上的责任，激发他们爱国、爱家、爱父母、尊师重孝的热情和共识；励志培养自己成为合格的接班人。

我们尚需凝心聚力，不断提高认知水准和行动能力，不断创造条件，开拓为老服务的新局面，取得为老服务的新成果，用我们的拳拳赤子之心，更多更好地为积极老龄化，健康老龄化做出新奉献。

「中国养老院长的思考」

中国国际养老院院长协会副会长兼秘书长
刘蕴华

2007年11月，我从我的祖国首都北京率团赴柏林出席霍夫曼先生发起的在德国首都柏林的柏林大酒店召开的第一届世界养老院院长领导大会，不仅见识了现代大都市，还解释了各国养老院长朋友，认识了喀麦隆王子和联合国主管养老的官员，我作为中国的代表被安排在会议的第一天上午发言。与会院长对我国的4万多家养老机构产生了浓厚的兴趣，院长们告诉我「从我的发言他们看到了世界养老的新视觉，并接受到我的祖国来共同切磋养老护老技艺」的邀请。

今天院长们来到了我的祖国香港，我愿趁此次机会把我当院长以来的体会说出来，供大家参考。

一、养老院长是个四面玲珑的角色

我是机关干部，1992年到国外参观考察时，曾在一份杂志上看到世界人口老龄化的趋势，回国后开办了北京金梦圆养老院。办起来以后，可不像自己想的那么简单，因为一个院长一要接受民政部门的管理，二要和家属搞好关系，三也要注意老人的沟通。而事情又巧妙的钩织在一起，让人很难琢磨，不好处理，所以必须出处兼顾，酸甜苦辣都有。

二、身不由己的养老院长

养老院长的管理应列入社会科学，一个院长一走上岗位，他的身上就会套上一种无穷的责任，大事、小事、人事，时时处处都有，在您刚刚要下班，有位爷爷或奶奶病重、突发病，都会使你情不自禁的留下来，关注老人身体的变化，尽管各级管理人员都在，但就是放心不下，还有时候，老人临终前一定见院长，我记得广州市老人院院长洪佩贤、南京院长韩品嵋、杭州院院长李咏、无锡社会福利中心主任陈影和上海陆美玲、湖北吴九菊院长等等老一辈院长都有此体会。老人的一声呼叫就是命令，老人临终前攥着院长的手流着泪难以割舍这个世界，多么希望院长继续让他（她）生命延长的眼神让每一位院长撕心裂肺。每一位院长都挖空心思让老人在离开这个世界前减少痛苦，有时候依偎在老人耳边，说着安慰的话，有时脸贴脸老人才闭上眼，院长唯独怕老人临终前留下遗憾，还要叮嘱服务员，还要为老人擦身穿衣，每送走一位老人，院长将有多日心情处于无限低沉中、想念中……

当然，这时如遇上家属和老人意见不一致的，又必见院长的，院长在其中将麻烦多多。

三、养老院长需要稳定

当今随着全球老龄化，住养老院已成为一种养老文化，现在我国养老院有4万多个，如再加上这两年新开发的社区服务这一块，约有5万多家了，一正两副，那么中国将有15万个院长。浩浩荡荡的队伍，大家都在争相出养老护理的书，写养老方面的文章，但统观全球，目前，尚拿不出切合实际的一整套院长管理手册，为什么呢？不好写，院长的工作太杂，非常繁琐。比如，上边提到有的老人临终前呼喊着找院长，而机构对外的一些工作，如消防、卫生防疫、各种会议都提出必须院长去参加，若院长不去，则会被责怪、被扣分、被罚款。特别现在走关系，要求降低收费标准的事宜不断产生，不给他降就拿专业压你，有的被折腾的过不去，就只好破产，小的养老机构，如30~60人，就时常被这种困惑而压倒。在这里我特别提到的香港社会福利署，是我从事养老机构工作以来，极为崇敬的一个部门，特区政府通过社会福利署有力的推动着16条和35条，使香港养老院舍的大踏步的向前进。如在内地中小富裕城市也能参照，无疑对内地养老事业也是一个推动。但院长时不时的调动，对养老院无疑也是一种损失。我是想说，养老院长实在应该稳定。

四、养老院长需要德才兼备

以上提到香港当养老院长好当些，因为香港社会福利署政策好，但同样香港的养老院长大都是护士出身，我熟悉的几十位香港老院长，他们大都是护士出身，都是从医院摸爬滚打而来，并且受过较好的护理基础教育，聪明而伶俐的护士，一旦演变成院长，可就「飞黄腾达了」，能力强的，她们一个人可以掌握17~18家养老院。她们在用自己学识和经验为特区政府分忧，但目前养老机构面临的是一个接班人问题，大陆的目前独生子女政策，青年一代吃不了苦，不愿干养老院，他们认为又脏又累的工作，其实他们的父辈的能力性和才能才是他们最应该继承的。而且可能一辈子也学不到的。社会鄙视养老院这个行业，看不起院长，其实养老院长一是必须有德并有才的人才能胜任，因为这是一个高尚而任何人也离不开的岗位。

五、养老院长的忧虑

养老院长的忧虑有六个，一是养老院的青年人不好搞对象；二是待遇低；三是护工没文化；四是养老院是个大社会；五是养老院长生活的不容易；六是政府对养老机构的各项政策还跟不上。

我这里指的是由于养老院长面对的是生命，每个青年人入职很难，一旦入了职就需要有一种废寝忘食的精神才能在老人需要的时候，任劳任怨的服务，但面临我们有的地区还比较穷困，养老院待遇上不去，而作息时间不宜固定的情况下，青年人难以搞上物件，院长为此而张罗，但还是留不住一些年轻有活力的年轻人。三是护工没文化，护工看不懂中文也看不懂英文，技能上不去，所以，院长一着急就自己动手干，现在培训护工的很多，但大都是走马观花，为了收费，时间3~5天，实在不能解决问题，建议社会把对护工的培训放到真正的议事议程上来，方法上，行政管理上也应增加投资，改进护工培训环境，本次会议专门为此安排了一个特别专案，那就是28日上午将专门为6名优秀护理员颁奖，同时设立《护工基金》，这次工作我们想还只是初次，第一次，也就是说，有6位护理员将在本次会上将为他的祖国，他的养老院捧回一个世界杯。随着国家政策的不断落实，院长对护工的管理工作也一天比一天好做。

下面我还要提到的养老院是个大社会，她如同一面镜子，把人的本来面目照的透透彻彻。大部分老人住进养老院，儿女都经常来看，还带上父母平日喜欢的食品，但我确实在香港看到一对青年夫妇大骂父母为「老不死的」，还在柏林郊区的一家养老院里，104岁的阿婆自住进养老院后，其养女一次也没来看过她。在我们大陆的养老院里1位儿媳说：「我一见到我婆婆就想吐。」

还有的为给父母交费，几个儿女分着交，谁也不想多交一分等等，我在想，父母的养育之恩。血缘都是相通的，儿女怎么不能像父母待他那样偿还父母呢？五、养老院长生活的不容易。在与院长相处的时刻里，逐步了解到，大家由于工作时间不定，为工作花的心思太多，而影响回家和家人团聚而被丈夫或妻子抛弃，这些院长常年处于不被理解和误会之中。当院长们把爱献给天下儿女时，但反过来却不被自己的家人所理解而甚至于被丈夫或妻子抛弃，感情生活十分淡薄，但当倍受亲情折磨的院长们谈及此事时，几乎异口同声的说：「没办法，不理解就不理解吧！工作还是得做呀」，由此可见院长们的胸怀如此宽大，趁此机会，我也呼吁社会上，特别院长们的亲人们一定要支援院长的工作，因为他（她）们为了让大家安宁替大家尽孝，在呕心沥血。六、政府各项政策应跟上。当养老院长时间长了，碰到的问题自然很多，但归根结底，总感到养老政策应根据各国养老事业的脚步而跟上，当机构发展了但政策跟不上，院长干起来就很吃力。因为院长的工作和直接责任就是人。

我很希望通过这次大会，政府部门能够较多的关注养老院长的今天和明天。

「香港私人营办安老院的发展趋势」

香港安老服务协会主席及紫云间沁怡护养院行政总监
陳志育

八十年代初随着香港的经济起飞，劳动力市场需要大量人手，而一批来自内地的医务工作者，配合当时经济发展的需要，看准时机创办了私营安老院，为有需要幫助的家庭释放劳动力。私营安老院经过三十年的发展，供应量随着市场的需求而快速增长，直至目前为止，香港763间安老院当中，有579间属于私营机构营办的院舍，私院数目占全港安老院总数的75.9%，合共提供53,310个宿位。

踏入廿一世纪，香港逐步迈向老龄化社会，医疗科技的进步和完善的公共医疗服务，令香港的长者平均寿命位居世界第二位，长者的寿命延长的同时，对长期护理服务的需求亦相应与日俱增。目前，香港65岁或以上人口有941,312人，长者人数占人口总数的13.3%，而安老院宿位的供应量亦增至75,716个，占长者人口约8%。近年，政府提出多项支援长者社区照顾的措施，未来社会对长者护理服务的需求会更加多元化，而对院舍服务的期望和要求亦会越来越高。

近几年来，大部份入住私院的长者都需要高度护理照顾服务，因此，私院的角色和功能亦随着服务使用者的需要而转变。根据资料显示，入住私院的长者平均年龄为83歲，平均入住的时间约30个月，反映大部份入住院舍的长者都是需要高度护理照顾服务，院舍很可能是入住长者人生最后的一处居所。因此，院舍服务专业化是大势所趋，专业的介入是提高安老院服务质素和使用者信心一个不可或缺的重要元素。院舍除了提供护理照顾服务外，亦更重视长者在复康、精神和社交方面的需要。

直至2012年4月30日，政府中央轮候册内登记轮候资助宿位的长者人数有28,165个，平均轮候时间约三年，长者长期护理服务属公帑大量资助的服务，每个资助宿位平均成本约20万元/年，惟现时申请资助宿位的长者毋须接受经济审查，只须通过评估，确认有长期护理需要便合资格轮候资助宿位。按照香港人口老化的数字推算，政府如不采取果断的措施，轮候资助宿位的长者人数只会持续增加，轮候时间亦会越来越长。而缩短轮候时间最有效的方法，便是政府向合资格(通过长期护理需要评估及经济审查)的长者派发院舍服务券，让长者根据自己的需要向合规格(符合特定院舍服务标准的服务提供者)的院舍购买服务，落实『钱跟人走』的概念。

当长者可以根据自己的需要灵活地选择服务单位，不但能促进安老服务的发展，更会推动业界提升服务水平。院舍服务亦会朝着专业化方面发展，市场上会有越来越多的安老院，为长者提供专业的复康照顾服务、失智症照顾服务，护养及善终照顾服务。

国家十二五规划，内地养老宿位与长者人口约比例是3%，以目前1.9%的比例，预计于2015年前全国需新增一万间养老机构及二百万个宿位。民政部将大力推动养老产业的发展，积极推动公办民营、民办公助的养老产业运行机制，并致力培训养老服务人才，提高养老机构管理人员的专业化、职业化发展。

香港是亚太地区华人长期护理服务发展较为成熟及领先的一个城市，安老院的营运管理模式，不但可内地供养老机构作为借鉴，同时，亦可作为内地养老机构交流经验和培训人才理想的地区。未来几年，中港两地在养老产业方面的交往会日趋频繁，香港安老服务业界在营运管理及人才培训方面具有一定的优势，可协助推动内地养老产业的发展。

「香港安老院如何成为一条龙服务的平台」

香港晓光护老服务有限公司执行董事
谢伟鸿

每一位本能够自我照顾的长者，经过多年来身体出现变化和衰退，总有一天连基本日常生活也需依赖他人照顾。政府近年致力推广「居家安老为本　院舍照顾为后援」，长者慢慢由家庭走到社区，作为社区的后盾，院舍当中尤其担当一个非常重要之角色。

院舍既要在有限资源下提供照顾服务，又要平衡政府、院友及家属和院舍职员之需求，它应何如在市场上定位，继而建立一个完善之一条龙照顾服务平台？入住安老院舍之院友主要来自家庭或独居需要照顾的长者，及社区中心、各医疗部门需要照顾的长者，以下为安老院提供一条龙服务的配套措施：

(一) 有效善用社区资源，保持区内专业组织之紧密沟通：

i. 政府为入住安老院的长者提供外展医疗服务

ii. 社区义工为入住安老院长者提供各式各样娱乐活动

iii. 各宗教部门为长者提供宗教自由服务

(二) 安老院管理政策及制度亦以「优质服务」作指标：

i. 根据国际标准建立完善管理系统

ii. 订立服务使命，使每一位职员能够了解并实践院舍服务使命、宗旨及目标

iii. 院舍定期提供服务质素改善机制或计划

iv. 人力资源之职员培训及进修，从而配合工作上的需求

v. 持续监察，使服务使用者参与改善行动

vi. 订立目标或相关成效指标，并利用成效指标作为将来改善服务依据

(三) 安老院照顾及护理之服务标准：

i. 院舍为来自不同背景的长者提供安全舒适可靠的环境

ii. 为入住安老院舍的长者提供优质服务

iii. 为需要心理照顾的长者提供支缓

iv. 透过不同活动及辅导使每一位长者的身、心、灵都得到健康

v. 长者从入住到照顾，院舍专业护士为长者定期提供一系例的个人护理照顾计划，使每一位长者真正得到优质服务

vi. 专业职业治疗师或物理治疗师为康复中的长者提供治疗同康复计划评估

vii. 院舍与政府医疗部门保持紧密联系，使每一位长者得到及时的治疗

viii. 尽心尽力对待长者、以礼待人、尽力在合理情况下做到有问必答、有求必帮。主动的精神更使每一位长者住得安心放心

ix. 对专业团队有严格要求，尤其药物管理、治疗管理均须达到一定水准，使每一位长者真正得到关心和照顾

(四) 临终照顾服务：

i. 透过此服务希望长者在晚年阶段能够积极生活，为自己的人生预早作妥善的安排，达到「老而善终」致力为入住安老院舍的长者服务

ii. 提供教育、辅导、舒缓、善终等作出支援

iii. 为长者安排转介，提供院友及家属之心理辅导等

iv. 为有困难的长者提供适当支援

事实上，院舍需要依赖各相关部门和社区服务中心，以及来自家庭成员等的合作，制定院舍政策及守则，为长者提供一个舒适安全的环境。而在护理方面，院舍亦要确保为长者提供一个真正达到护理水准的优质服务平台，在院友年迈时提供临终照顾服务，令所有入住院舍的长者都可以无忧无虑安享晚年。

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"The Implications of Active Participation among Elderly to Care Giveing"

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Abstract

The aging population in the Philippines has grown to over six million in 2011. This increase translates to an increase in family expenditures, with care of old adults being regarded more of a family rather than a state responsibility in the country. Transitions occurring within the Filipino family, such as increased local and foreign migration, or the growth of single-person households, will likewise result in changes in care giving arrangements for the Filipino elderly. Research studies have found that active participation addresses caregiving costs and concerns currently being faced by Filipino families. By engaging actively, old adults are able to achieve successful cognitive functioning. Improved cognitive functioning, in turn, contributes to the reduction of negative emotions, which usually occur with the decline in cognitive abilities in the late adulthood stage. Researches on the antecedents of, and consequences to active participation among old adults points to two major frameworks to care giving for the elderly. The first approach involves the adoption of a positive adult developmental approach to care. This approach focuses on a redefinition of health in terms of resources, and the adoption of a systems viewpoint to health care for old adults within the community. A second approach emphasizes a geropsychological approach to health care, which integrates mental health care with general medical care for the elderly. Implications to care giving for Filipino elderly are seen in more pronounced efforts at managing and harnessing personal, social and community resources for aging.

Global population trends are alerting policy makers on the needs and demands of support for the elderly. The demands seem to be daunting because of the increasing unavailability of previous forms of support for this group. For example, greater mobility among members of the family due to a wider reach of work placements and opportunities is anticipated to contribute to lower levels of support (Gibson, Carter, Helmes & Edberg, 2010). The decreasing family size, as well as the increase in single-person households, may also bring about a diminishing support for the elderly (Gibson et al., 2010). Concerns about support are highlighted in the present times as a large number of older adults is anticipated with the baby boomer generation turning 65 years old within 2011 (Karel, Gatz & Smyer, 2012). With the escalated number of person who will reach and pass the age of 65 years will come more cases of dementia, and with this comes changes in the demands for services for older adults (Yap, Thang & Traphagan, 2005).

Yap et al. (2005) document the nature of aging in Asia. According to these authors, the elderly in this part of the world are likely to live longer and are generally of stable health after retirement. Like in all parts of the world, the population of elderly in Asia has increased considerably. According to Yap et al., the population has tripled from 95 million in 1950 to 32.2 million in 2000. This rate is expected to grow to 1.2 billion by 2050. There will be contextual changes that will accompany aging in the region. Traditional roles, such as grandparenting, will not be as common as these were in the past years. More importantly, traditional support for the elderly will also be negatively affected by the forces of globalization.

Yap et al. detail the consequences of the growing number of old people in this part of the world. A rise in the demand for activities and programs is likely to occur with the decrease in traditional roles to play and less activities to keep them occupied. Other concerns include the so-called "dependency burden," which pertains to the load on younger members of the population who will now have to provide support for an increasing number of older people. Added to this are issues about the sustainability of informal support systems, such as the family, when trends in family mobility and changing roles of women put a strain on the provision of adequate support for older adults (Yap et al., 2006; Ofstedal, Knodel & Chayovan, 1999; See McNay, 2003, for a discussion on how changing women's roles influence care giving practices for the elderly).

A similar trend is evident in the Philippines. As of 2012, a recorded 6.8 million of the 90 million country population are 60 years old and above, growing at a rate of 4.39 percent from 1995 to 2000 (Uplifting the Welfare, 2012). The same global demographic trends are seen to be influencing the lives of the elderly. Abejo (2004) reported that the increase in the number of elderly has posed problems for care giving. Domingo (1994) claimed that aging is a low priority issue for the Philippine government. Because of this, there is greater reliance on the family, especially female members, for support. Children are expected to fulfill a debt of gratitude, or utang na loob, to their parents as they grow older. Domingo's study revealed that changes in the family, such as later marriage among females, and the resulting lower fertility, have implications to care giving for the elderly in the country. The rapid migration of the youth can also result in the physical separation of older family members from the younger ones, who are usually tasked with the care of the elderly (Abejo, 2004).

The living arrangements of the elderly, as reported by Abejo (2004), reveal their desire to live independently. For example, the 2000 census data reveal that old parents prefer to live in their own homes, separate from the children. According to Domingo and her associates (1993, as cited by Abejo, 2004), this signifies a desire for autonomy and a strong attachment to their own homes. Abejo further observed that they eventually live with their children when their deteriorating health no longer permits them to live alone. In these cases, the children are expected to fulfill their obligation to care and support their parents. Health care expenses are usually shouldered by members of the family (Cruz, 1999). Thus, poor health among the elderly translates to economic burden, especially for families with inadequate financial resources. Cruz's (1999) study

revealed that the Filipino elderly are likely to obtain support from their co-resident children than from their non co-resident children. Moreover, the female elderly, more than the males, are more likely to receive both monetary and non-monetary support from their children.

The Filipino elderly have been given various roles in the community (Carlos, 1999). They are tapped as resource persons in conferences and seminars, and are also requested to take the role of story tellers to children at day care centers. The elderly have also been involved in volunteer work in activities relevant to environmental protection and the promotion of health. They are also recruited to provide care to institutionalized and handicapped children, and to give assistance to children whose parents are temporarily not in their homes. Both male and female elderly are very often found to contribute their services in church-related activities. Senior citizens are also trained to provide support and informal counseling services to their peers by organizing visits to the old members of the community who are lonely or bed-ridden. However, Carlos commented that the number of older people who avail of these opportunities to remain active in their community remain to be small. Lower levels of awareness, improper program implementation, and the small number of communities implementing these programs are the usual reasons for low levels of participation by the elderly.

Active Aging and Mental Health

In 2002, twenty years after introducing the concept of "aging in place" to promote an approach to health care delivery to older persons outside of institutional settings, the World Health Organization launched the notion of "active aging" to promote active engagement of elders in their communities through appropriate transportation, housing and other services (Hou, 2011). Active engagement in leisure activities is often associated with better levels of cognitive functioning among the elderly (Tesky, Banzer & Pantell, 2011). However, in their review, Bielak, Anstey, Christensen & Windsor (2012) discovered a lack of evidence of a positive relationship between activity engagement among the elderly and cognitive functioning. Indeed in their research, these authors found that enhanced activity level was not associated with an increase in cognitive change. Although the association between activity and cognition was not strong, they were able to establish that those who were higher in activity levels also exhibited higher cognitive performance. Their research revealed a trend which showed that the association between cognitive ability and active participation was already evident in all stages of adulthood. This means that the active elderly should have gained cognitively largely as a result of high activity engagement before old age. Thus, Bielak and his associates suggested that if there were to be any cognitive gains, enhanced activity levels should already be introduced before later adulthood.

Similar conclusions were reached by Gow, Corely, Starr & Deary (2011). Their study established that old persons who are likely to engage in social and intellectual activities also have higher cognitive abilities. However, the authors found that enhanced cognitive ability is not likely to result from activity and engagement. Rather, physical activity is often introduced to prevent further cognitive decline. Cognitive ability is likely to be influenced by activity and engagement throughout adulthood, while physical activity continues to influence cognitive ability in old age.

There seems to be a missing element in the investigations looking at active engagement and cognitive functioning among the elderly. While the two previous studies cited underscored a continuing engagement from early adulthood to obtain desirable levels of cognitive functioning during old age, these studies failed to take into consideration other elements or factors that may have played a role in maintaining cognitive functioning among the actively engaged elderly. The study of Tesky, Banzer & Pantell (2011) may be providing that additional element by looking into the interactions of the older adults in their engagement. In their study, the authors looked into the role of emotions and relations with others in cognitive functioning in old age.

Tesky and her associates tested the effects of peer-mediated cognitive training on the old persons' assessment of their memory functions. There was an improvement in assessment as a result of the training. The authors explained that contact with peer groups during training made the participants realize that their cognitive performance was appropriate for their age. This realization among the participants brought about more positive emotions about the cognitive performances. They became less worried about their cognitive performances, and with it came lessened anxiety, shame and depression. The authors claim that a reduction of these negative emotions is likely to also reduce risk factors for dementia or long term cognitive decline. The authors further contend that the activity protocols, such as participation in social interactions, reading more, engaging in more walks, helped in the adoption of a more active lifestyle.

The study of Tesky and her associates demonstrate the call for models of care that explicitly take into account features of the older person's life environment to determine the effects of active engagement on the well-being and optimal functioning of the old person. These models therefore need to be more integrated, incorporating social, emotional, interpersonal levels in the design of care giving interventions for the elderly.

Towards an Integrated Model for Care

Karel, Gatz and Smyer (2012) contend that interdisciplinary models of care have become more effective in providing mental health services to old adults. More integrated models of health care involve the assimilation of mental health care to primary and community health care. Trends in the utilization of mental health services among the aged point to a shortage in the health workforce. These authors argue for an enhanced awareness of geropsychology-related competencies. These competencies involve the provision of mental health and behavioral interventions to alleviate the health problems of older adults (Karel, Gatz & Smyer, 2012). According to these authors,

> "… there will continue to be older individuals needing mental and behavioral health care who get none; primary health care will continue to be the first setting of care for most older individuals with mental disorder; and, in the coming decade, psychological services for individuals with dementia and their caregivers will become a more prominent need across care settings." (p. 187)

The integration of primary/medical and community mental health approaches in the design of services for the elderly is consistent with the human development perspective which

has combined both these two approaches in explaining positive changes in the life of a developing person. This perspective, called the developmental systems perspective, adopts an integrated view to human development by examining the interdependency of systems – the individual, families, communities and societies – influencing the life of a developing person.

Adopting the Developmental Systems approach to active aging

Taking off from the seminal ideas of Urie Bronfenbrenner of the bioecological perspective to development, one prominent proponent of the developmental systems perspective, Richard Lerner, put forward the view that individual change is influenced by changes among systems of development, namely, the individual, families, communities, and societies. These changes are interdependent and transform over time (Lerner, 1996). The integration of these levels of organization constituting human experience forms ecologies of development. According to Lerner (1996), ".. the concept of development is a relational one: Development is a concept denoting systemic changes—that is, organized, successive, multilevel, and integrated changes—across the course of life of an individual ..." (p. 781).

In this perspective, the essential property of development is plasticity, which reinforces the belief in the potential for change across the life span. Change will be shaped and be influenced by past development and contextual conditions. This potential for change provides a positive view to development – that there can be person and context characteristics that will promote well-being and that promise a more optimistic development for the person. Development can therefore be designed to be positive. How are we to design development towards positive change? As mentioned, Lerner explained that the basis of change lies in the interaction between the different levels of organization constituting human life, i.e., the biological, individual psychological, social relational, sociocultural and the physical. Embedded in historical change, these levels of organization dynamically interact to produce development.

Development towards positive change will therefore entail determining the characteristics of the individual and of the context that promote the capacity of the individual to deal with the challenges that come with age-related change. In the case of the elderly, an entire range of support systems involving constructive individual-context interactions can therefore be identified and can be used to clear the path to positive development among the elderly.

Towards a Positive Developmental Approach to Active Aging: Implications to Care Giving

Care giving for the elderly, viewed in terms of geropsychological competencies, as well as from a developmental systems perspective, allows an integrated approach for support which will include a consideration of how different components and levels of human life are dynamically interacting to produce desirable outcomes for the old person. A more integrated view is inconsistent with the study of human development that has developed from either psychological or biological principles. Providing care for the elderly will then be in line with the study of human development that conceptualizes and studies "the life span to a multidisciplinary approach that seeks to integrate variables from biological through cultural and historical levels of organization into a synthetic, coactional system" (Lerner, Weiner, Arbeit, Chase, Agans, Schmid & Warren, 2012, p. 277). Care giving should then take into consideration what Brandtstadter (1998 in Lerner et al., 2012) called the "adaptive developmental regulations" occurring within the reciprocal individual-context interactions. The focus should therefore be on determining the nature of interactions that bring about capacity to cope with the challenges of old age and that will allow for continued experiences of personal growth for the elderly. In the words of Lerner and his associates (2012), the "diversity [in individual and contextual characteristics – MSM] may be approached with the expectation that positive changes can be promoted across all instances of variation, as a consequence of health-supportive alignments between people and settings" (p. 278).

Caregiving for actively participating elderly can be geared towards the promotion of resilient relations between the old person and the context within which he or she is actively engaged. Lerner and his associates explain how resilient individual-context relations can be achieved:

"They must ascertain what fundamental attributes of individuals (e.g., what features of cognition, motivation, emotion, ability, physiology, or temperament); among individuals of what status attributes (e.g., people at what portions of the life span, and of what sex, race, ethnic, religious, geographic location) characteristics; in relation to what characteristics of the context (e.g., under what conditions of the family, the neighborhood, social policy, the economy, or history); are likely to be associated with what facets of adaptive functioning (e.g., maintenance of health and of active, positive contributions to family, community, and civil society)?" (Lerner et al., 2012, p.281)

The goal is therefore to promote exchanges between the old adult and his or her contexts that will result in positive development. The goal for caregiving is to promote resilience. Lerner and his associates have identified how old and very old adults can exhibit resilience. Baltes and his colleagues in the area life span development in human development theory have provided some insight using the Selection-Optimization-Compensation paradigm on the resilience of old adults in the following manner:

> "When orchestrating the optimization of development by processes such as selection and compensation, the appraisal of resources is of central importance. Questions such as how to evolve a goal structure and the associated goal-relevant means and motivational investment strategies, how to deal with selection related disengagements from other possible goals, when to accept a loss and re-orient one's life, and when to still strive harder because current behavior is not yet employed to its fullest capability become crucial in composing life development." (Baltes, Lindenberger & Staudinger, 2006, p. 643 as quoted in Lerner et al, 2012)

Older adults in conditions of resilience are aware of the resources available to them to achieve their goals. The means to towards these goals involves a goal structure in which the old person adopts means and strategies to select behaviors, to optimize available internal and external resources, and to compensate for loss.

Recent studies have adopted the developmental systems approach, affording a more integrated, holistic view to active aging. According to Sargent-Cox, Anstet & Luszcz (2012):

> "One of the benefits of this approach is that psychological and social mechanisms are amenable to intervention and subsequently may be helpful in reducing poor physical functioning outcomes. Furthermore, a holistic approach to health—that is, one that views health as a multidimensional and dynamic interplay between biological, sociological, and psychological influences—allows researchers and practitioners to employ a variety of methods to increase the health and well-being across the life span and also as problems surface." (p.1)

In their research, Sargent-Cox and associates looked into how the older person's interpretation of the aging experience can influence physical functioning. The findings show more positive expectations of aging can influence more favorable health outcomes. Those who have good expectations about aging are less likely to engage in non-healthy behaviors and are likely to undertake activities that promote good health outcomes. The authors attribute this to the beliefs that older adults have about their control over the aging process. On the other hand, those who believe that they cannot control processes of aging, also are likely to have negative interpretations of aging and then have the tendency to indulge in poor health behavior practices. The authors suggest that interventions focus on altering perceptions and expectations of aging, which are usually negative. The stereotypes of aging as the onset of dependence and disability will have to be altered. According to Sargent-Cox, Anstet & Luszcz (2012), "intervention programs that combat and challenge misconceptions or exaggerated aging myths may be an important mechanism to counteract negative age expectations and self-fulfilling prophecies." (p.8-9)

In another study, Sartori, Wadley, Clay, Parisi, Rebok & Crow (2011) looked into how restrictions of life space can lead into decreased sense of autonomy, which, in turn, can lead to experienced difficulties in the conduct of daily life activities. The authors reason that restrictions in spatial mobility, which define life space, can lead to more dependence on other. Greater dependence can then lead to a decline in the quality of life and an increased risk for depression and mortality. The study results showed a positive relationship between cognitive function and life space. These findings are supported by previous work showing that reduced life space influenced cognitive decline, which, in turn, is accompanied by other risks, such as depression and dependency. The study also demonstrated that a belief in the control of others is associated with reduced life space, or spatial mobility. The authors contend that this belief is partly due to the implicit expectations from others, which are influenced by the negative stereotypes on aging.

The study of Lachman, Neupert & Agrigoroaeil (2011) also demonstrated that older adults with a high sense of control possess better health and well-being. According to the authors contend that this sense of control observed among the old adults is related conceptually to Bandura' concept of self-efficacy. Self-efficacy consists of self-regulatory beliefs that influence perceptions about situations. Moreover, these beliefs provide motivation to undertake tasks. Bandura (1990) stated that

> "People's beliefs that they can motivate themselves and regulate their own behavior play a crucial role in whether they even consider altering habits detrimental to health. They see little point to even trying if they believe they cannot exercise control over their own behaviour and that of others. Even people who believe their detrimental habits may be harming their health achieve little success in curtailing their behavior unless they judge themselves as having some efficacy to resist the instigators to it." (p. 11)

The studies mentioned above document a crucial mechanism operating in the individual-context interactions among the elderly. This has to do with the self-regulatory abilities as influenced by control beliefs (Lachman, Neupert & Agrigoroaeil, 2011), the old person's ability to manipulate the breadth of his or her life space (Sartori, Wadley, Clay, Parisi, Rebok & Crow, 2011), and beliefs that influence perceptions of control of the aging process (Sargent-Cox, Anstet & Luszcz, 2012). These processes contributing to self-regulation has been identified by Lerner and his associates to be the main ingredient to resilience, and thus to positive development in aging.

Approaches to care giving, adopting a developmental systems perspective, which then allows us to view aging in terms of positive developmental processes, will then entail ensuring resilient relations. We may be guided by the following recommendations from Lerner and his colleagues:

> "... practitioners may explore the developmental history or current circumstances of individuals in order to identify such successful relations and seek to replicate them when the person is not showing resilience. In addition, because resilience is not just a person-level characteristic, practitioners should seek to identify the resources in the environment that can enhance the probability that past successes will be reenacted or that will create new, innovative, and healthier individual ←→ context interactions." (p. 293-294)

In the Philippines, where caregiving practices have focused on community involvement by the elderly, more attention should be given not only to enhancing participation by the elderly, but to the identification of interactions that bring positive outcomes for older Filipinos. There is therefore an urgent need for research to go hand in hand with practice to achieve this end.

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"Types of Support Received by Co-resident and Non Co-resident Older Malayasians"

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Abstract

Dependency in old age is commonly linked to declining health and financial resources and thus, older persons have to rely on family members for support. Nonetheless, family support has been found to vary widely by coresidence status. The purpose of this study is to determine the contribution of co-residence status and selected demographic variables in predicting the likelihood of older persons receiving financial and/or non-financial support from children. A sub-sample of 1,273 older persons aged 60 years and above was obtained from a nationwide survey in Malaysia in 2010. Respondents' response on the types of support received from children were collapsed into financial (monetary assistance and payment for: treatment cost, place to stay, in-home care services, and assistive devices) and non-financial support (household chores, care when sick and others). Multinomial logistic regression was performed to assess the contribution of factors on the likelihood that respondents would receive support (0 = No support, 1 = Either financial or non-financial support, 2 = Both types of support). The model contained eight dichotomous independent variables including sex, education level, marital status, employment status, co-resident status, health problems, monthly personal income and household size. Descriptive results showed that 78.9% of older persons co-reside with their children. Majority of older persons received both financial and non-financial support (64%), compared to financial only (11%), non-financial only (9%), or no support at all (16%). Chi-square test of independence found that there was significant relationship between co-residential status and types of assistance received. Multinomial regression showed that co-residence with children was the most influential determinant of support type, followed by employment and education of older persons. The full model containing all predictors was statistically significant (X2 = 196.512, df = 16, p = 0.001) and correctly classified 66% of cases, which was more robust proportional by chance accuracy rate, in distinguishing respondents with different types of support received. Reference group for the model are those who received no support. If an elderly were to co-reside with adult children, they are 3 times more likely to receive both support than not getting any. Differences in the respondent's gender and health were significant determinants of partial or full support. While co-residential status affects the overall support for the elderly in Malaysia, the relative influence of other predictors must be given due consideration. The disadvantaged elderly or older persons at-risk should be provided with assistance so that they do not face unmet needs in terms of support in old age.

Introduction

As people grow older, the ability to sustain independent living is impaired which, in turn, exacerbate individual's need for support. Dependency in old age is primarily linked to deterioration in health and physical functioning, along with shrinking socio-economic resources, that reduce the ability of older persons to cope effectively with environmental stress (Baltes, 1996; Van Der Meer, Fortuijn, & Thissen, 2008). Accordingly, older persons would have to fall back on their informal social networks for subsistence. The family provides unpaid informal support (Hansen, Cartwright, & Craig, 2012), distinguished into tangible or intangible mechanisms (Beets, Cardinal, & Alderman, 2010) and rendered in the forms of material (cash or goods), space, and time spent interacting, providing emotional support, care and assistance with housework (Glaser et al., 2006). It has been argued that families remain as the basis of informal support and constitute the main caregivers for older people (Croissant, 2004); however, changes in demographic, social and economic circumstances, as well as shifting social norms impinge on the functioning of family support system.

The vital role of families in providing support for older family members, particularly in the Asian region, is affected by a number of important trends in the population, namely, demographic transition towards lower fertility and mortality, as well as increasing longevity. This transition is concomitant with changing social norms including postponement of marriages and childbearing; higher participation of females in education and employment; and increase in divorce and dissolution of families (Chongsuvivatwong et al., 2011; Frejka, Jones, & Sardon, 2010; Jones, 2007; Jones & Ramdas, 2004; Mammen & Paxson, 2000; Quah, 2008). The literature on intergenerational support has demonstrate dynamic flow of support, upward and downward, between parents and children over the life course (Fingerman et al., 2011; Saraceno, 2008; Schröder-Butterfill, 2004), but this discussion is limited to the support from children to parents.

It is important to note that norms of parental support are being modified and altered as a result of transitions in marriage and family life. For instance, the changing status of Chinese women and higher living standards transform contract of care across generations as married daughters withdraw from traditional role as primary caregivers to work in the city (Luo, 2012). Additionally, negative effects of divorce are particularly deleterious for older men, in which diminished kinship obligations, estrangement, family conflict and intergenerational ambivalence can result in unmet support needs (Grundy & Sloggett, 2003; Hans, Ganong, & Coleman, 2009; Settersten & Angel, 2011; Shapiro & Cooney, 2007). It was argued that that parents' marital dissolution can undermine support provision as a result of less obligatory and more voluntary ties between parent and children following the divorce (Connidis, 2009). Therefore, support becomes contingent upon age-related need of the parents and intimacy of parent-child relationship in the context of smaller and detached family network, diminishing role of caregivers, and resilience of families in coping with life course transitions.

Next, social mobility, accompanied by spatial movement, diminish potential support as younger generations move away from their place of origin in the pursuit of education, marriage, and better livelihood through intranational relocation to urban areas or transnational migration to more developed nations (Hoang, Yeoh, & Wattie, 2012; Jones, 2009; Kaur, 2007; Kelly, 2011). Underlying this social trend are rapid urbanization and the change from agriculture-based to manufacturing and service-based industries (Song, Li, & Feldman, 2012). The shrinking kinship network and increasing mobility of families imply that a section of the older population has to subsist without support from family or that the support obtained does not completely meet the needs.

In sum, shifts in the population age structure, rapid socio-economic development, and changing social mores limit old-age support by reducing the capacity of families to stay together and attend to the needs of older parents. Given the limited coverage of social security and services to facilitate independent living in the region, inadequate access to family help can seriously undermine the well being of older persons. Thus, the purpose of this study is to determine the contribution of coresidence status and selected demographic variables in predicting the likelihood of older persons receiving financial and non-financial support from children in Malaysia.

Population ageing and the demand for old-age support in Malaysia

The rapid change in the population age structure among developing countries, including Malaysia, has profound implications as these countries cope with population ageing at lower levels of development (Mason, Lee, Tung, Lai, & Miller, 2006), while simultaneously being confronted with issues of healthcare, poverty and social security (Rowland, 2012). A consistent and central theme in this demographic transition is the "feminization of ageing" (Davidson, Digiacomo, & McGrath, 2011). Due to a large number of surviving females who will face age-related changes in later life at a great socio-economic disadvantage from lower levels of health, education, work participation, and income security (Heslop & Gorman, 2002; Krueger & Burgard, 2011), the availability of old-age support from the family is crucial, primarily for older women. Nevertheless, older men should not be excluded from gendered notions of ageing because cumulative disadvantage in later life from increasing illness and disability levels the risk of mortality associated with socio-economic inequalities (Hoffmann, 2011) .

A brief snapshot of population ageing in Malaysia demonstrates convergence with international trends with some unique local experience due to ethnic diversity. Very low mortality, distinctly high life expectancy and earlier decline of fertility rate to replacement level among the Chinese highlights that ageing is more evident in this ethnic group in comparison to others (Ong, 2002). To exemplify, a study by Hamid, Momtaz and Ibrahim (2012) reported that successful ageing, defined as good health and physical functioning, are higher among the Chinese compared to other ethnic groups. Previous studies also cite higher education and better access to healthcare in urban areas among the Chinese, contributing to lower prevalence of chronic diseases, including dementia (Hamid, Krishnaswamy, Abdullah, & Momtaz, 2010; Krishnaswamy et al., 2009; Momtaz, Hamid, Yahaya, & Ibrahim, 2010). Local studies on ethnic differences in living arrangement found that coresidence depends on parents' health, children's marital status and housing cost (Chan & Davanzo, 1996; DaVanzo & Chan, 1994), suggesting that there is a tradeoff between autonomy/privacy and the need for support. Thus, ethnic differences, to a certain extent, explain some variations in health and social attributes of older population which characterize the need for support.

The next trend is the ageing of the older population. Ong (2002) reported that between the years 1980 to 2020, the young old (65+) is projected to have a steeper growth compared to old-old (75+) but this trend would soon change as these age cohorts survived to more advanced age. Increasing longevity and improved health status of older people ultimately suggest that the young olds would become the main care provider for family members of similar or older cohort groups (i.e. spouse, siblings and parents) when support from offspring is nonexistent or lacking. It is also important to note that future older adults in the population are going to be better educated, more resourceful (Hamid & Yahaya, 2008) and with presumably different expectations of support from the family.

Population ageing and the changing family context

The rapid progress of population ageing in this country, with significant underlying trends of reduction in fertility and increasing longevity marks an important transition affecting families. First, lower fertility rates shrinks family size from one generation to the next, reducing potential support from children (McDonald, 2006; Morgan, 2003). Second, longevity affects the chain and arrangement in generational care due to increased coexistence among multiple family generations and competing demands for care (Allen, Blieszner, & Roberto, 2000; Bengtson, 2001; Luo, 2012).

The lack of formal support Malaysian social and welfare policies perpetuate the role of family as the main source of support for the elderly and the young (Hamid & Yahaya, 2008; Omar, 2005). In the country's welfare system, the role of the state still rather limited to the poor and vulnerable groups and thus, leaves out a large proportion of older people who may need support but do not qualify for assistance.

Support from coresident and non-coresident child

While it has been found that the support provided by adult children operates on the basis of parental needs (Fingerman, et al., 2011; Guo, Chi, & Silverstein, 2009; Silverstein, 1995; Zimmer & Kwong, 2003), filial piety (Silverstein, Parrott, & Bengtson, 1995), traditional gender role (Cong & Silverstein, 2008; Silverstein, Gans, & Yang, 2006), social exchange (Shi, 1993) and parent-child affinity (Stuifbergen, Van Delden, & Dykstra, 2008), the availability and proximity of family members also confine the types and level of support relayed (Glaser, et al., 2006; Ng, Phillips, & Lee, 2002). Some of these frameworks are based on traditional and normative expectations, while others offer more practical explanation for support given. For instance, filial piety denotes altruistic values that obliges male offspring to honour the duty of looking after parents, in repayment for their sacrifice (Sung & Kim, 2003). In contrast, contingency theory posits that children would only render their services when an older parent's condition has worsened to a point that requires their intervention due to competing demands (Fingerman, et al., 2011; Settersten & Angel, 2011). Nonetheless, these frameworks point to the fact that elderly support is ideally provided in living situations where there is harmony and regular contact.

Coresident adult children are able offer more substantial level of material and instrumental help and supply the required support as the need arises (Ng, et al., 2002). Furthermore, widowhood, declining health and increasing disability prompt the need for intensive support that can be exclusively met by adult children who are coresident or in close proximity (Korinek, Zimmer, & Gu, 2011; Silverstein,

1995; Zimmer & Korinek, 2010). In addition, coresidence along male lineage is a family ideal in Asian societies but children's personal resources enabled them to move away from patrilocal coresidence (Chu, Xie, & Yu, 2011). Moreover, parents were also found to report higher actual and perceived support from children when they are living in the same household (Yi & Lin, 2009).

Non-coresident children, in contrast, tend to provide less comprehensive and less regular support (Eggebeen & Hogan, 1990) usually in terms of financial or material support (Luo, 2012; Yi & Lin, 2009). More recent research has shown that shifts in traditional norms and circumstances in living arrangement do not preclude children from observing their filial responsibilities. In such situations, non-coresident adult children, specifically those who have migrated to urban areas or overseas to work, fulfill their obligation by remitting money to their family back home (Luo, 2012; Rindfuss, Piotrowski, Entwisle, Edmeades, & Faust, 2012) to compensate for their lack of filial cohabitation (Kim, 2011). Likewise, in the case of Singapore, Thailand and Malaysia, the resource rich but time poor families subcontract filial piety, that is the labor-intensive care of older parents, to migrant domestic helpers and private nursing services (Boontinand, 2010; Choo et al., 2003; Huang, Yeoh, & Toyota, 2012).

To recapitulate, the interaction between living arrangement and support provided by children to older parents are shaped by traditional and practical notions of support. The preceding discussion illustrates the advantages of coresident living that enables more direct, wide-ranging and immediate supply of support. However, changes in living arrangement and social roles compel children to replace direct help with more material support, implying that family support is an enduring element in the society in spite of pervasive demographic and socio-economic transitions.

Method

A sub sample of 1277 community-dwelling older persons age 60 years and above was obtained from a nationwide study in Malaysia entitled "Review on the National Policy and Plan of Action for the Elderly" in 2010. Multistage random sampling was used to obtain a nationwide sample based on the proportion of older persons in each state. The sampling size was obtained from the Department of Statistics based on 95% confidence level with 3% margin of error and accounting for 80% response rate. The total sample size was then divided into four equal age groups. Older persons (aged 60+) comprise the fourth age group and were recruited based on the inclusion criteria of having Malaysian citizenship, living in the community, good mental status and voluntary participation.

Respondents were interviewed in their homes by trained enumerators using standardized questionnaire. Respondents' reports on the types of support received from children were collapsed into financial (payment for: treatment cost, place to stay, in-home care services, and assistive devices) and non-financial support (household chores and care when sick). Multinomial logistic regression was performed to assess the contribution of factors on the likelihood that respondents would receive support (0=no support, 1=either financial or non-financial support, 2=both types of support).

Results

The socio-demographic characteristics of the respondents (n = 1,273) is shown in Table 1. The mean age of the respondents is 67.4 years and a majority of the respondents are Malay and Bumiputra, married, living with children, received little formal education and are not working. The average household size is 5.4 persons, with 23.1% of the respondents living below the official household poverty line in Peninsular Malaysia (RM720 per month).

Nearly all the older persons (86%) reported being "taken care of" by their children and the most common types of support cited are care when sick and financial assistance (Table 2). On average, each respondent received about 2.5 (SD = 1.621) items of support.

By computing and collapsing the 8-item responses into financial and non-financial sub-categories, it was found that 64% of the elderly received both types of support, while 11% receiving only financial support, 9% receiving only non-financial support, and 16% reported receiving no support at all from their children (Figure 1).

Chi-square test of independence found that there was significant relationship between co-residential status and types of assistance received. Older persons who co-reside with their children are more likely to receive monetary and non-monetary assistance ($X2 = 83.94$, $p = 0.001$). Older men, non-Malays, the more educated, married and working older persons, as well as the elderly with no health problems, are less likely to receive support from their children (Table 3).

Analysis of variance showed that respondents who received both types of support also have more children or adult children, larger household size and lower monthly personal income (Table 4).

A multinomial logistic regression was performed to analyze relationships between types of support received and eight (8) dichotomous independent variables. The MLR compared the multiple groups through a combination of binary logistic regressions, with the reference group being "None" or the no support received group. The statistical test for the final model chi-square showed that there is a significant relationship between the dependent variable and the combination of the independent variables (Chi-square = 196.512, df = 16, $p = 0.001$). The proportional by chance accuracy rate was computed (59.77%) and the model accuracy rate of 66.0% exceeded this standard. Based on the requirement that model accuracy has to be 25% better than the chance criteria, the criteria for classification accuracy was satisfied (see Table 5).

From Table 6, there were significant relationship between the respondents' sex, education, marital status, employment status, co-residential status, household size and health problems and the different types of support received from children. Coresidence with children was the most influential determinant ($X2 = 39.86$, $p = 0.001$), followed by employment ($X2 = 24.64$, $p = 0.001$) and education ($X2 = 15.04$, $p = 0.001$) of older persons.

Coresidence with children plays a significant role in differentiating the "Either or" and "Both" groups from the "None" group (Table 7). Respondents who were not co-residing with their children were 75.3% less likely to be in the group receiving either non-financial or financial support, and were 67.1% less likely to be in the group receiving both non-financial and financial support than the group of respondents who received no support at all.

Discussion

The following section discusses current findings in relations to the research literature on the due importance of coresidence in support provided to older persons. First, the study affirms the fact that coresidence and family support remain stable even though there are claims that extended kinship ties diminish in favor of nuclear family forms that are more

mobile and adaptable to the current social context (OECD International Futures Programme, 2008). Nonetheless, given the common practice in Malaysia and in neighboring countries (Boontinand, 2010; Choo, et al., 2003; Huang, et al., 2012), the receipt of non-financial support such as "care when parents are sick" may also be provided by a live-in domestic worker (signifying coresidence) under the supervision of the children (as a symbol of children's involvement).

Next, the study reveals that coresidence is the strongest predictor for old age support, over and beyond, employment and educational status. The strong ability of coresidence status in differentiating between receiving both financial and non-financial support with the group that does not receive any support also imply that parents and children mutually benefit from coresidence, for example, through the sharing of housework, care, and household expenditures (DaVanzo & Chan, 1994; Grundy & Harrop, 1992). The results are also in line with the findings of previous studies that shared living arrangement promotes higher family support and that parents report more assistance from their children due to increased interaction (Grundy & Harrop, 1992; Yi & Lin, 2009).

Third, differences in the respondent's gender and health were significant determinants of partial or full support. Past studies have shown that mothers have the advantage of getting support over fathers due to their role in maintaining affective ties and close relationships with children. Fathers may also receive less financial support and more assistance with housework due to their former breadwinner status (Lin et al., 2003; Settersten & Angel, 2011). The fact that fathers are less likely to receive assistance may be the reason why there is a higher prevalence of unmet needs, or the lack of physical support, among older men with physical disability in Malaysia (Momtaz, Hamid, & Ibrahim, 2012). In addition, the significance of health is in line with the contingency hypothesis (Fingerman, et al., 2011; Settersten & Angel, 2011), in which children are more likely to respond to the crisis or needs by providing financial and non-financial support to their ailing parents (Choi, 2003).

Conclusion

In conclusion, while co-residential status affects the support for the elderly in Malaysia, the relative influence of gender, marital status, health status and household income must be given due consideration. The disadvantaged elderly or older persons at-risk should be provided with assistance so that they do not face unmet needs in terms of financial and/or instrumental support.

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Table 1: Descriptive Statistics

Variable	N	%	M	SD
Sex				
Male	638	50.1		
Female	635	49.9		
Age	1723	100.0	67.42	6.744
Young-old (60 - 74)	1096	86.1	65.36	4.256
Old-old (75 - 84)	151	11.9	78.59	3.003
Oldest-old (85+)	26	2.0	89.35	5.268
Ethnicity				
Malay	725	57.0		
Other Bumiputra (Indigenous Peoples)	292	22.9		
Chinese	179	14.1		
Indian	70	5.5		
Others	7	0.5		
Stratum				
Urban	599	47.1		
Rural	674	52.9		
Education				
No Formal Education	518	40.7		
Primary Education	525	41.2		
Secondary Education	195	15.3		
Tertiary Education	35	2.7		
Marital Status				
Divorced / Separated	22	1.7		
Widowed	409	32.1		
Now Married	842	66.1		
Number of Children	1273	100.0	5.49	2.605
1 - 3 Children	309	24.3	2.40	0.725
4 - 6 Children	548	43.0	4.97	0.795
7 or More Children	416	32.7	8.48	1.760
Number of Adult Children Aged 21+	1273	100.0	5.17	2.536
Living Arrangement				
Living Alone	52	4.1		
Living with Spouse Only	146	11.5		
Living with Children / Children-in-law	1004	78.9		
Other Living Arrangements	71	5.6		
Household Size	1273	100.0	5.41	3.278
Self Rated Health				
Very Poor	16	1.3		
Poor	380	29.9		
Good	814	63.9		
Very Good	63	4.9		
Number of Health Problems	1273	100.0	1.60	1.400
No Health Problems	322	25.3	0.00	0.000
At Least One Health Problem or More	951	74.7	2.14	1.209
Employment Status				
Never Worked	367	28.8		
Stopped Working / Retired	514	40.4		
Now Working	392	30.8		

Table 1: Descriptive Statistics (Cont'd)

Variable	N	%	M	SD
Monthly Income	1273	100.0	665.11	1059.040
RM665 or Lower	864	67.9	224.30	199.323
RM666 or Higher	409	32.1	1596.29	1460.105
Monthly Income (Excluding from Children)	1273	100.0	454.82	996.754
RM455 or Lower	887	69.7	62.17	121.231
RM456 or Higher	386	30.3	1357.10	1441.262
Household Members with Income	1273	100.0	2.02	1.016
Percent of Household Members w. Income	1273	100.0	45.41	23.860
Less than 25%	171	13.4	15.61	5.919
25% - 49%	550	43.2	33.23	5.639
50% - 74%	404	31.7	55.74	7.525
75% or More	148	11.6	96.86	8.062
Monthly Household Income	1273	100.0	2141.23	2774.774
RM720 or Lower	294	23.1	401.52	199.062
RM721 or More	979	76.9	2663.68	2969.676

Table 2: Item Response for Types of Support Received from Children

Item	Support Received from Children	Yes	%
1.	Payment of Treatment Cost	599	47.1
2.	Pay Cost for a Place for Parents to Stay	89	7.0
3.	Pay for Caregiving Services at Home	49	3.8
4.	Perform Household Chores for Parents	564	44.3
5.	Purchase of Assistive Devices	179	14.1
6.	Taking Care of Parents when They are Sick	833	65.4
7.	Financial Support	825	64.8
8.	Other Forms of Support (i.e. Transportation etc.)	48	3.8

Number of Support Received: M = 2.50, SD = 1.621

Note: Items 1, 2, 3, 5 and 7 were summed and collapsed into a dichotomous variable indicating recipient of financial support while items 4, 6 and 8 indicating non-financial support.

Figure 1: Financial and Non-financial Support Received from Children

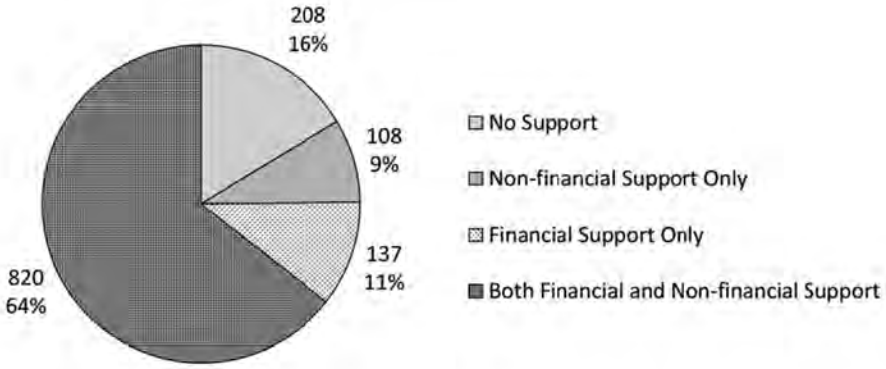

Figure 2: Financial and Non-financial Support Received from Children by Co-residential Status

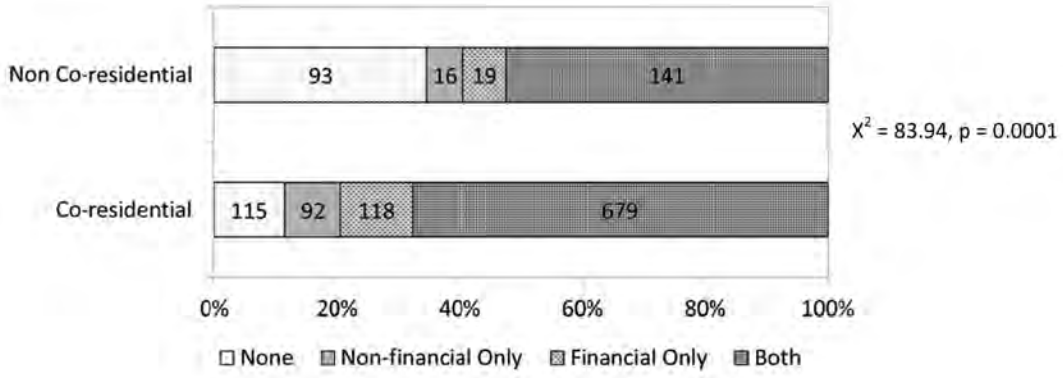

Table 3: Cross-tabulation of Categorical Independent Variables and Types of Support Received

Independent Variables	Types of Social Support Received (Row %)				X^2	p
	None	Non-financial Only	Financial Only	Both		
Sex						
Male (1)	21.3	10.0	13.0	55.6	44.284	0.001
Female	11.3	6.9	8.5	73.2		
Age Group						
67 years old or younger (≤67)	18.3	9.9	11.4	60.4	13.666	0.003
68 years or older (68+)	13.5	6.5	9.9	70.1		
Ethnicity						
Malay & Bumiputra	16.0	8.9	9.5	65.5	9.528	0.023
Non-Malay	17.6	6.6	15.6	60.2		
Education						
No Formal Education	12.5	6.2	7.1	74.1	63.466	0.001
Primary Education	15.4	10.5	12.8	61.3		
Secondary Education (1)	24.6	8.7	16.4	50.3		
Tertiary Education (1)	40.0	11.4	2.9	45.7		
Marital Status						
Now Married (1)	20.4	9.4	11.2	59.0	39.389	0.001
Not Married	8.4	6.7	10.0	74.9		
Children Aged 21 Years or More						
5 Children or Less (≤5)	18.2	9.6	11.3	61.0	10.302	0.016
6 Children or More (6+)	13.7	6.9	10.0	69.4		
Health Problems						
None (1)	19.3	11.5	12.4	56.8	11.786	0.008
One or More	15.4	7.5	10.2	67.0		
Employment Status						
Now Working (1)	27.3	14.5	7.4	50.8	88.447	0.001
Not Working	11.5	5.8	12.3	70.5		
Co-residential Status						
Living with Children (1)	11.5	9.2	11.8	67.6	83.940	0.001
Other Living Arrangement	34.6	5.9	7.1	52.4		
Household Size						
5 Persons or Less (≤5)	21.3	9.3	9.2	60.2	35.307	0.001
6 Persons or More (6+) (1)	9.7	7.4	12.9	70.0		
Monthly Personal Income (Excluding from Children)						
RM455 or Lower	13.0	5.5	11.6	69.9	66.209	0.001
RM456 or Higher (1)	24.1	15.3	8.8	51.8		

Note: With the exception of Ethnicity, all the Independent variables above remained statistically significant when the ependent variable categories were reduced from 4 to 3 (by merging 'Non-financial Only' and 'Financial Only' categories into 'Either Non- Financial or Financial Support' category).

(1) denotes the reference groups used for the Multinomial Logistic Regression Analysis

Table 4: Mean Comparison for Continuous Independent Variables by Types of Support Received

Independent Variables	Types of Social Support Received Mean (SD)				F	p
	None (n = 208)	Non-financial Only (n = 108)	Financial Only (n = 137)	Both (n = 820)		
Age	66.29 (6.150)	66.35 (7.268)	66.50 (5.934)	68.00 (6.744)	5.832	0.001
Number of Children	5.18 (2.756)	5.18 (2.699)	5.28 (2.623)	5.65 (2.540)	2.836	0.037
Children Aged 21+ Years	4.61 (2.608)	4.60 (2.594)	5.02 (2.614)	5.41 (2.464)	8.070	0.001
Household Size	4.26 (3.063)	5.09 (2.767)	6.11 (3.568)	5.63 (3.275)	12.406	0.001
Monthly Personal Income	1035.02 (1399.818)	856.20 (1322.996)	568.52 (653.861)	562.24 (946.189)	12.944	0.001
Monthly Personal Income (Excluding Money from Children)	844.59 (1395.672)	822.87 (1338.487)	306.11 (533.287)	332.32 (833.227)	21.662	0.001

Note: All the Independent variables above remained statistically significant when the Dependent variable categories were reduced from 4 to 3.

Table 5: Multinomial Logistic Regression: Classification Table

Observed	Predicted			
	None	Non-financial or Financial Only	Both	Percent Correct
None	64	0	144	30.8%
Non-financial or Financial Only	18	0	227	0.0%
Both	44	0	776	94.6%
Overall Percentage	9.9%	0.0%	90.1%	66.0%

Table 6: Multinomial Logistic Regression: Likelihood Ratio Tests

Effect	Model Fitting Criteria	Likelihood Ratio Tests		
	-2 Log Likelihood of Reduced Model	Chi-square	df	Sig.
Intercept	612.397	0.000	0	
Sex	620.040	7.643	2	0.022
Education	627.435	15.038	2	0.001
Marital Status	620.487	8.090	2	0.018
Employment Status	637.037	24.641	2	0.001
Co-residential Status	652.261	39.864	2	0.001
Household Size	620.571	8.174	2	0.017
Health Problems	618.458	6.061	2	0.048
Monthly Personal Income (Excluding from Children)	613.337	0.940	2	0.625

Table 7: Multinomial Logistic Regression: Parameter Estimates

Types of Support from Children	B	SE	Wald	Sig.	Exp(B)	95% Confidence Interval	
						Lower Bound	Upper Bound
Either Non-financial or Financial							
Intercept	0.116	0.288	0.163	0.686			
Female	-0.185	0.235	0.622	0.430	0.831	0.524	1.317
Primary Education or Lower	0.477	0.245	3.779	0.052	**1.611**	0.996	2.605
Not Married	0.524	0.263	3.965	0.042	**1.689**	1.008	2.831
Not Working	0.750	0.237	10.032	0.002	**2.118**	1.331	3.370
Does Not Co-reside with Children	-1.398	0.256	29.716	0.000	**0.247**	0.149	0.408
5 Persons or Less in Household	-0.365	0.233	2.455	0.117	0.694	0.439	1.096
Has Health Problems	-0.107	0.215	0.249	0.618	0.898	0.589	1.369
RM455 or Less Monthly Personal Income (Exclude Children)	-0.145	0.253	0.328	0.567	0.865	0.527	1.420
Both							
Intercept	0.269	0.255	1.115	0.291			
Female	0.266	0.199	1.780	0.182	1.304	0.883	1.928
Primary Education or Lower	0.822	0.213	14.944	0.000	**2.274**	1.499	3.449
Not Married	0.630	0.227	7.719	0.005	**1.877**	1.204	2.926
Not Working	0.992	0.200	24.576	0.000	**2.695**	1.821	3.989
Does Not Co-reside with Children	-1.112	0.201	30.485	0.000	**0.329**	0.222	0.488
5 Persons or Less in Household	-0.571	0.208	7.583	0.006	**0.565**	0.376	0.848
Has Health Problems	0.274	0.188	2.116	0.146	1.315	0.909	1.901
RM455 or Less Monthly Personal Income (Exclude Children)	0.050	0.214	0.055	0.815	1.052	0.691	1.601

Note: The reference category is "None".

"Informal Caregiving Patterns in Korea and European Countries: A Cross-National Comparison"

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Abstract

Purpose: This ecological study examined demographic and institutional differences in informal caregiving. We conducted a cross-national study about the characteristics of informal caregivers in 12 European countries and Korea.

Methods: Data were collected from individuals aged 50 years and older participating in the 2004/2005 Survey of Health, Ageing and Retirement in Europe (SHARE) and the 2006 Korean Longitudinal Study of Ageing (KLoSA). We examined the associations between informal caregiving and macro-level characteristics (GDP, total fertility rates, labour force participation rates, level of women's empowerment, long-term care resources).

Results: Korea and some southern European countries (notably Spain and Italy) had high percentages of women, homemakers, co-residents, and spouses in informal care giving roles. In contrast, Northern European countries (Denmark and Sweden) had high proportions of employed informal caregivers. Lower female labour force participation was associated with higher proportions of women caregivers. A higher proportion of women caregivers in the population were also associated with a lower national GDP per capita.

Conclusions: Our findings suggest that several contextual and institutional variables are associated with the proportion of women participating in caregiving.

Introduction

Informal caregivers, i.e., family or friends providing unpaid care, represent a major source of care for disabled persons in almost all countries. Despite the substantial physical and psychological burdens associated with this role, it remains the most common form of long-term care even in developed countries. Most societies are characterized by rapidly ageing populations, increased prevalence of nuclear family structures, and higher rates of women participating in the labour force, yielding diminishing resources available for care-giving. Few studies have examined the prevalence of informal care and the characteristics of caregivers in different countries. Due to large cross-national variations, a comparison of informal care patterns across countries is useful in order to disentangle the impact of policies and institutions that may influence formal and informal care behaviour. It has been established that most informal caregivers are female family members, especially spouses or adult children, including daughters-in-law (Sundström, 1994). Aging parents in East Asia live with their sons if possible, and care-giving for them is traditionally the responsibility of daughters-in-law (Campbell & Ikegami, 2000; Yoon & Ryu, 2005). Major determinants of state reliance on female informal care include: a) traditional culture (e.g. Confucian system of elder care in East Asia), including systems of patriarchy and strict division of gender roles where women stay home and are assigned to domestic roles including the care-giver role, and b) women's empowerment and economic autonomy, which predicts that as more women enter the labour force, the less likely they are to be involved in informal care-giving. Consequently, per capita GDP could be expected to be lower in countries where there is a higher proportion of women involved in informal care, because they are at home looking after dependent elders instead of being in the paid workforce (Indeed, this situation gives rise to the feminist adage that when a man marries his parent's care-giver, the national GDP goes down). Because of family obligations, competition with males, and sexual discrimination, women have difficulty finding employment in the industrial sector of the economy. In advanced industrial nations, there is a positive relationship between economic development and female labor force participation. Continued economic growth and expansion of the tertiary sector of industrialized economies, where female labeled jobs are concentrated, increases the demand for female workers (Pampel & Tanaka, 1986). Economic growth is likely to be lower in countries with a higher proportion of women involved in informal care because they are at home looking after dependent elders instead of being in the paid workforce.

We sought to examine macro-level societal characteristics associated with higher national reliance on informal care-giving. At the micro level, informal caregivers may adopt their care-giving role for many different reasons, including tradition, lack of family resources to pay for nursing home care, and dearth of formal long-term care resources (Wiener & Cuellar, 1999). We note that the proportion of elderly in the country does not necessarily correlate with the size of the informal care sector, but different societies have different ways of coping with that need. A low fertility rate -- such as occurs in Korea-- is often pointed out as a factor that worsens the aged dependency ratio (i.e. the ratio of people over age 65 vs. those in the working age group) over the long term. However, in the short term, we hypothesize that fertility rate is one of the index for national policy for family and women. Therefore, countries with low fertility are mirrored in many fertility related human behaviours such as women's labour force participation, women's burden of gender role and other dimensions. This appears to be the pattern in countries such as Korea and Japan, where fertility rates are below population replacement levels, notwithstanding the fact that women's labour force participation is not as high as in most other highly industrialized countries. If the norm of informal care-giving burden by women results in lower fertility, it could lead to a vicious cycle further worsening the dependency ratio in the future, implying even greater care-giving burden.

By its very nature, culture and traditions are slow to change, so that societies must turn to state sector policies to address the challenges of population aging and the rising demand for care of dependent elders. Public policies have attempted to maintain networks of informal care, but few countries offer programs that provide adequate support for informal caregivers. In their report for WHO, Brodsky et al. (2003) categorized extant support programs into five types: 1) emo-

tional counselling/training programs, 2) respite care to provide temporary relief (Australia, Germany, the UK, the US, and Germany), 3) paid or unpaid leave for employees to take care of a family member (Sweden, the US, and the UK), 4) tax benefits for the caregivers and direct or indirect payments for caregiving (Austria, France, Germany, the US, and the Netherlands), and 5) pension credits (Germany and the UK). Debates about the form and content of support programs for informal caregivers have focused on balancing familial with social responsibility, horizontal equity, and the possible discouragement of women from participating in the labour force.

In this study, we sought to provide a cross-national comparative perspective on informal care-giving in 13 countries, using both micro-level data and ecological data. Our study has four objectives. First, we provide a descriptive, cross-national comparative profile of the prevalence and characteristics of informal caregivers in twelve European countries (Austria, Germany, Sweden, Netherlands, Spain, Italy, France, Denmark, Greece, Switzerland, Belgium and Israel), and Korea, based on micro-level data from the European SHARE survey and the Korean Longitudinal Study of Ageing (KLoSA).

Our second objective was to conduct an individual-level analysis of the demographic characteristics of informal care-givers in each country. In every country women are more likely to be involved in informal care-giving than males. However, we hypothesized that this gender difference in the allocation of the informal care-giver role will be strongest in traditional Confucian societies (such as Korea); followed by Mediterranean societies with strong familial orientation (Greece, Spain, Italy); followed by Western European countries with a Christian Democratic tradition (Germany, Austria); and weakest in Nordic countries with a strong welfare state, and strong state provision of formal care-giving support (e.g. Denmark, Sweden).

Our third objective was to turn to ecological level analyses of macro-level societal characteristics in relation to the size of the female informal care-giving sector. We hypothesized that: 1) total fertility rate will be inversely correlated with informal care, 2) women's labour force participation is inversely correlated with informal care, 3) as a result of 2), per capita GDP is inversely correlated with informal care, and 4) there are no relationship between % aged individuals, % of the elderly in long term care facilities, and the size of informal care sector.

Our fourth and final objective was to develop a typology of societies based on a 2 x 2 matrix, with the axes corresponding to the prevalence of female-provided informal care and the total fertility rate (Figure 1). A high percentage of female informal caregivers in society implies a high level of demand for care-giving (e.g. due to population aging), and/or a low level of state support for the formal care-giving sector. We hypothesize that there is an inverse correlation between women's involvement in informal care and women's reproductive decisions (i.e. the total fertility rate, on the vertical axis). In other words, the greater the demand for informal care-giving by women, the lower their fertility rate. Using data from our 13 countries, we sought to test whether the countries in our sample fit the pattern we describe.

Methods

1. Data

The data used in this study were collected from the 2006 Korean Longitudinal Study of Ageing (KLoSA) (http://www.klosa.re.kr) and the 2004/2005 Survey of Health, Ageing and Retirement in Europe (SHARE) (http://www.share-project.org). These data were derived from each study website. In this study, we sought to provide a cross-national comparative perspective on informal care-giving in 13 countries, using both micro-level data and ecological data. Nationwide data about detailed informal caregiving are not yet available from other countries. SHARE baseline data also provides an excellent opportunity to explore our hypotheses because it includes caregiving questionnaires in 12 different European countries, which would represent sufficiently wide range of Western social contexts.

Korean Longitudinal Study of Ageing (KLoSA) has been launched with its baseline survey in 2006. One of the purposes of KLoSA was to gather data to be used for international comparative research. The 12 EU nations have been conducting panel surveys of those aged over 50 since 2004 named SHARE. KLoSA data was initially designed with benchmarking SHARE. The baseline surveys of KLoSA and SHARE (for European countries) are the best dataset to investigate our study purpose, because they are all nationwide representative, and their questionnaires on informal caregiving are quite similar in the baseline surveys.

KLoSA focused on Koreans aged 45 years and older living in households selected according to multistage stratified probability sampling (based on geographical area) and was designed to produce a sample that was representative of the nation. With the list of households in the main sampling units and relevant tools, interviewers visit the households and identify compatibility of each. Interviewers conduct the interviews all eligible family members (aged 45+) in the sampled household. A total of 10,254 individuals completed interviews conducted by trained interviewers. The household response rate was 70.7%, and the individual response rate within households was 75.4%. Detailed information about the survey has been reported elsewhere (Jang et al., 2009a; Jang et al., 2009b).

The Survey of Health, Ageing and Retirement in Europe (SHARE) is a multidisciplinary and cross-national panel database of micro data on health, socio-economic status and social and family networks of more than 45,000 individuals aged 50 or over. As such, it responds to a Communication by the European Commission calling to examine the possibility of establishing, in co-operation with Member States, a European Longitudinal Ageing Survey. By now SHARE has become a major pillar of the European Research Area and in 2008 was selected as one of the projects to be implemented in the European Strategy Forum on Research Infrastructures (ESFRI). The original sample in the SHARE study included households with at least one person aged 50 years or older. The weighted average response rate among the 12 countries participating in the SHARE in 2004/2005 was 61.8%, and the within-household response rate was 86.0%. The un-weighted total of eligible individuals was 22,777 persons in 15,537 households (Börsch-Supan and Jürges., 2005). At times, other household members acted as proxies and reported the pertinent information about eligible but unavailable household members. We limited our analysis to the population of informal caregivers aged 50 years or older (N = 8,528) when assessing the distribution of caregivers. We used data from the total population aged 50 years or older in 13 countries (total of 35,799 persons) when assessing the factors for acting as familial informal caregivers.

2. Measurements and analysis

Informal caregivers

The KLoSA asked, "Are there any members of your household who are unable to carry out activities of daily living, such as eating, washing, dressing, etc.?" "Have you provided any help to household members with activities of daily living during the past 12 months? If so, who was helped?" and "Did you help anyone not living with you with the instrumental activities of daily living (IADL), such as household chores, transportation, grocery shopping, financial management, etc.? If so, who was helped?" If respondents answered affirmatively to these questions, interviewers then asked them about their relationships with care recipients. The SHARE questions inquired about care provided to persons outside and inside households: "Is there someone living in this household whom you have helped regularly during the last 12 months with personal care, such as washing, getting out of bed, or dressing?" "Did you give help to others outside the household?" "Which family member from outside the household, friends or neighbours, have you helped in the last 12 months?" If respondents answered affirmatively to these questions, interviewers then asked them about each person cared for. For both SHARE and KLoSA, individuals who helped family members, friends, or neighbours with ADL or IADL during last 12 months were classified as caregivers.

With regard to the characteristics of caregivers within each country dataset, we analysed the descriptive characteristics (frequencies and percentages) of caregivers including sex, age, marital status,

co-residence with care recipient, employment status, and relationship with care recipient. We stratified the caregiver samples into two age groups: 50–64 years, and 65 years and older. Respondents' marital status was categorised as "married and living with a partner" vs. "other". Living arrangement was dichotomised into living with the care recipient (1) or other (0). The employment status of respondents was divided into three groups: employed (1), unemployed (2), and housewife or out of the labour market (3). With regard to relationship to care recipients, respondents helping their parents were categorised as "children", those helping their spouses were categorised as "spouses", and those helping others were categorised as "others". Using logit model, we checked the main characteristics of informal caregivers in each country. Outcome variable was informal caregiver or not (1=caregiver, 0=non caregiver), and age, gender, marital status, educational level, employment status, and self-rated health were included in the model as the independents.

National data

In our ecological analyses, we examined the relationships by Pearson correlation between the percentage of female informal caregivers and older caregivers in each society and other aggregated characteristics, including proportion of elderly people in long-term care facilities, women's participation rate in the labour force, proportions of female legislative or managerial level workers, total fertility rate in 2006, life expectancy for men and women in 2006, proportion of elderly people in the total population in 2006, and GDP per capita in 2006. All data were collected from OECD statistics. To develop a typology of societies based on a 2 × 2 matrix, axes were set to correspond to the prevalence of female-provided informal care and the total fertility rate and other national ecological data.

Results

Table 1 presents the descriptive characteristics of informal caregivers from the micro-data in 12 European countries and Korea. The proportion of women caregivers was largest in Spain (66.7%), followed by Korea (64.8%), Italy (60.9%), and Greece (60.2%). About 36.9% of Danish women, 35.1% of Belgium women, and 35.0% of Swedish women responded that they were informal caregivers, among the highest proportions in the countries in our sample. In Korea, only 7.1% of men and 8.0% of women responded that they were informal familial caregivers. More than half of the informal caregivers in Korea were older adults aged 65 years old or older, whereas middle-aged caregivers were more common in European countries. Informal caregivers in most countries were not in the paid workforce; however, more than 50% of Swedish (53.5%) and Danish (52.1%) caregivers were employed. Most informal caregivers across countries in our sample were married. Korean informal caregivers were much more likely to live with care recipients (88.1%) than were those in other countries. As expected, Korean caregivers were also more likely to be married to care recipients (47.4%), whereas less than 25% of the caregivers in European countries were spouses.

Figure 1A illustrates our 2 × 2 matrix: the vertical axis represents the percentage of women engaged in informal care, and the horizontal axis represents the total fertility rate. We created corresponding figures for the percentage of caregivers who are elderly (Fig. 1B), labour force participation of women (Fig. 1C), and per capita GDP (Fig. 1D). Countries with low total fertility rates, such as Spain, Korea, Italy, and Greece, were characterised by high proportions of women and elderly caregivers. However, France, Sweden, Denmark, and Netherlands were characterised by both relatively high total fertility rates and low proportions of female caregivers (Fig. 1A). This correlation matrix appears to be similar to the association between the proportion of older informal caregivers and the total fertility rate (Fig. 1B). Germany exhibited low rates of female informal caregivers as well as a low total fertility rate. Spain, Korea, and Italy (in descending order of high proportions of female caregivers) were also characterised by lower rates of female participation in the labour force (Fig. 1C) and accompanying lower GDP per capita. The trends of correlation have found between proportion of female informal caregivers and women's labor force participation rate, and per capital GDP. This correlation seems to come from two groups which are in the second quadrant (Korea, Spain, Italy) and in the fourth quadrant (Denmark, Sweden, and Netherlands). We used macro-comparative analysis with correlation, and scatter-plot trend to focus on explaining enduring cross-national differences. However, general linear reality assumes that social world consists of fixed entities with variables attributes (Abbott, 1988). Thus it is hard to show that every nation of a phenomenon follows essentially the same rule. But the value of this work might be to contrast specific instance (nation's case) of a given phenomenon as a means of grasping the peculiarities of case (Tilly, 1984).

Correlation coefficients from ecological analyses of aggregated country characteristics revealed that total fertility rates were negatively correlated with the proportions of women caregivers (correlation coefficient: -0.58). Countries with lower total fertility rates were more likely to have elderly women caregivers. As hypothesised, lower rates of female participation in the labour force were associated with higher proportions of female caregivers. GDP per capita was negatively associated with the proportion of women caregivers; that is, countries with low GDPs were characterised by more women caregivers (Table 2).

Table 3 presents the logistic coefficients of being in the caregiver role, based on logistic regression models. For each country in our sample, we examined the associations between caregiver role and the following individual characteristics: sex, age, marital status, educational level, employment status, and self-rated health. With the exception of Spain, Italy, Greece, Switzerland, and Korea, men aged 65 years old or older were less likely to be informal caregivers than were middle-aged men. Middle-aged women were more likely to be caregivers than men in the Netherlands, Italy, Denmark, Greece, and Korea. Unlike their European counterparts, Korean older women were more likely to be informal caregivers (beta = 1.09) than were Korean middle-aged men. Those who were married and living with their spouse were more likely to be informal caregivers than were those with any other marital status, and this association was found in all countries. Employment status was not associated with being in a caregiver role except Netherlands. Respondents rating their own health as poor are less likely to help someone else because of their own health problems; this hypothesis was supported in Germany, Sweden, the Netherlands, and Denmark, but not in other countries. Italy and Korea showed positive coefficients, indicating that the role of caregiver might have been adopted out of necessity and irrespective of self-rated health status.

Discussion

This descriptive study examined the distributions of informal caregivers in Korea and 12 European countries using baseline micro-data from the KLoSA and SHARE. As expected, most caregivers in our sample countries were married women. Most of the caregivers in all European countries, with the exception of Spain, were 50–64 years of age and lived apart from care recipients. Korean caregivers were more likely than caregivers in other countries to be older and to be married to care recipients. About 88% of the Korean informal caregivers were living with care recipients compared with less than a quarter in most European countries.

Korean culture has traditionally emphasised caregiving by daughters-in-law (particularly the wife of the oldest son), but this is changing rapidly (Yoon & Ryu, 2005). Our results indicate that the main source of care has recently become the older adult in the household, primarily the spouse. Given that married women are now much more likely to work outside the home than they once were, a severe shortage of long-term social support for disabled members of the household often results in the caregiving role being transferred to older women in the household (Chae & Jeon, 2004; Jeon et al., 2007). Denmark and Sweden are characterised by higher proportions of younger adult and employed informal caregivers. It is likely that caregivers from younger generations are more involved in paid work and more likely to be responsible for young children and a household separate from that of the patient (Grande et al., 2006; Harding et al., 2003; Higginson

& Priest, 1996; Payne et al., 1999).

Some researchers have stressed the need to pay attention to gender differences in caregiving (Dahlberg et al., 2007). In our study, three countries with relatively high percentages of women caregivers (Spain, Korea, and Italy) were characterised by low rates of female participation in the labour force and low GDP per capita. SHARE data revealed that intensive caregiving negatively affected labour force participation among middle-aged women in both northern and southern European countries. The data revealed high rates of co-resident care in Korea and Spain, likely reflecting more intensive care in these countries because co-residence may reflect a greater need among care recipients (Carmichael & Charles, 2003; Ettner, 1995) and, consequently, a greater time commitment by caregivers. Given that the adoption of a caregiving role was associated with non-participation in the labour market in these countries, the GDP per capita may also be affected by this depletion of the labour force. Crespo (2006) argued that a sustainable ageing society needs caregivers to be engaged in both caregiving and in the paid workforce, even if the correlation between the proportion of caregivers who are female and female workforce participation rates is not causal but reflects other factors about the society, including salary levels for women.

We found an inverse correlation between women's involvement in informal care and women's reproductive decisions (i.e., the total fertility rate on the vertical axis). In other words, the greater demand for informal caregiving by older women is associated with a lower fertility rate among young women. Our 2 × 2 matrix results in a typology of four different types of society, characterised by varying combinations of informal care and fertility rates: a) societies with a high female informal care burden and low fertility (e.g., Korea); b) societies with high levels of state support for caregiving (i.e., low informal care sector) and high fertility (Nordic countries); and two off-diagonal types, c) states with a high informal care burden and high fertility, and d) states with high levels of state support for caregiving but low fertility. Type (c) states would be associated with a division of roles, i.e., the women who are involved in informal care are not the same ones as those having children. Type (d) societies may be those that are in transition from type (a) to type (b), i.e., where a welfare state has made efforts to provide support for caregivers, but where fertility rates remain stuck below replacement levels. Some countries, especially those following family-centred conservative ideologies, consider informal care to be a family or moral issue rather than a social and policy issue (Chee, 2000; Sung, 1990). The Asian tradition of filial duty based on Confucianism (Sung, 1990) and the European tradition of Christian democracies may produce a double burden of young women caring for children for and working people engaging in elder care. Similar characteristics were associated with these two forms of caregiving, despite age differences between informal caregivers (older age) and women in childbearing (younger age), such as low fertility rates among the younger generation and a high percentage of informal caregiving role among the older generation. It is likely a phenotype of gender role burden for each age cohort among Korean women.

In contrast, Denmark, Netherlands, Sweden, and Germany had relatively more integrated long-term care systems than did other countries. Despite the differences among these four countries, they appear to share a similar long-term-care-policy orientation (Brodsky et al., 2003). The main common features of long-term care in these countries included administratively integrated and comprehensive services along with effective care networks and case management. We found the smallest gender differences in the allocation of informal caregiver roles in Nordic countries (with a strong welfare state and strong state provision of formal long-term care support). Germany was an interesting case, providing high levels state support for caregivers and family-friendly policies (for example, women may take up to three years off work after having a baby and be guaranteed their job when they return to work (Brodsky et al., 2003). However, this is a recent phenomenon and represents an explicit attempt by the German government to motivate couples to have more children. Fertility rates have not changed to date but might in the future and Germany may eventually end up in the upper-left quadrant. Germany may set an example for traditional Confucian societies (such as Korea) and other societies working to balance an ageing population with the need to maintain replacement fertility levels.

Another notable finding of our ecologic analysis was the lack of relationship between the proportion of the elderly population admitted to long-term-care facilities and gender differences in the allocation of the informal caregiver role. Focusing on institution-based long-term care may not solve women's informal care burdens or encourage women's labour-force participation. Additionally, we found no relationship between the percentage of aged individuals and the proportion of women engaging in informal care.

Providing care for disabled older adults has been described as a stressful experience that may erode the physical and psychological health of the caregiver. Most research on the health of caregivers has focused on depressive symptoms and the burdens of caregiving. These studies have usually included two kinds of predictor variables: (1) factors that are unique to the caregiving context (patient characteristics, duration and amount of caregiving), and (2) factors associated with general risks for impaired psychological health, such as financial stress and being female (Pinquart & Sörensen, 2003; Ory, Hoffman, Yee, Tennstedt, & Schulz, 1999). Caregivers do not choose to become caregivers; indeed, in the present study, adopting this role was not a planned event (Brodsky et al., 2003). Our analyses showed that adoption of the care-giving role in Italy and Korea seemed to result from the limited choices available, irrespective of the health status of caregivers, in that being a caregiver in these countries was associated with self-rated poor health. We found the opposite trend in several other countries, such as Germany, Sweden, the Netherlands, and Denmark, where those with poor self-rated health were less likely to be caregivers.

Our findings are limited in several respects. Because our data were drawn from different countries, we cannot rule out cultural variations in the meaning of "help with activities of daily living". People with certain cultural backgrounds may tend to report differently about the same conditions. Because few consensually-accepted definitions of informal caregivers have been developed (i.e., those including operational definitions of time spent or duration of care), we defined informal caregivers as those who reported helping family members with ADLs or IADLs. Additionally, no detailed data about the intensity of care (e.g., the frequency of care) were available for our analyses. The SHARE and KLoSA included information about the average frequency of care-giving, but the questionnaires used in these datasets were not comparable. Therefore, we could not interpret the different proportions of family caregivers among total populations across countries. Our macro-level analysis is also subject to the usual caveats about ecological inference. Several possible associations may not have been observable due to the time lags that characterise national characteristics. Additional studies including longitudinal trends with large-n regression analysis are needed to examine causality and to elucidate how such variables might explain national statistics.

Conclusions

Korea, Spain, Italy, and Greece exhibited similarly high percentages of women, homemakers, co-residents, and spouses among informal caregivers. Denmark and Sweden were characterised by high proportions of employed informal caregivers. Relieving women of their informal care-giving roles and enabling them to share these roles with formal care providers and other resources might increase the participation of women in the labour force and thereby enhance the economic development of societies.

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Table 1. Characteristics[a] of familial informal caregivers in 12 European countries and Korea according to data from SHARE (2004) and KLoSA (2006) baseline surveys.

	Austria	Germany	Sweden	Netherlands	Spain	Italy	France	Denmark	Greece	Switzerland	Belgium	Israel	Korea
Number of family informal caregivers (Unweighted)	403	810	1033	972	457	580	729	610	540	247	1349	571	227
Sex (%)													
Men	43.7	46.3	46.7	47.5	33.3	39.1	41.9	47.2	39.8	42.5	49.1	40.8	35.2
(% of survey respondents)	(22.7)	(27.6)	(34.9)	(34.6)	(15.6)	(20.3)	(24.0)	(38.5)	(17.4	(24.0)	(38.8)	(20.8)	(7.1)
Women	56.3	53.7	53.3	52.5	66.7	60.9	57.1	52.8	60.2	57.5	50.9	59.2	64.8
(% of survey respondents)	(21.2)	(27.7)	(35.0)	(33.9)	(22.4)	(25.5)	(25.4)	(36.9)	(22.2)	(28.7)	(35.1)	(25.5)	(8.0)
Age groups (%)													
50–64	59.6	62.2	64.6	71.8	53.7	61.7	64.9	72.9	66.5	59.9	65.2	68.5	48.0
65+	40.4	37.8	35.4	28.2	47.3	38.3	35.1	27.1	33.5	40.1	34.8	31.5	52.0
Job status (%)													
Employed	22.3	38.6	53.5	40.4	20.6	23.8	57.3	52.1	33.5	44.1	31.8	46.8	27.8
Unemployed	2.0	6.5	2.8	2.1	4.8	1.6	4.8	6.3	1.7	1.2	6.1	4.4	41.9
Homemakers and others	75.7	54.9	43.7	57.5	74.6	75.6	37.9	41.6	64.8	54.7	62.1	48.8	30.4
Marital status (%)													
Unmarried	29.5	17.3	25.5	14.3	23.2	16.4	25.4	29.2	23.7	29.2	20.7	16.6	14.1
Married	70.5	82.7	74.5	85.7	76.8	83.6	74.6	70.8	76.3	70.8	79.3	83.4	85.9
Living with recipient (%)													
No	76.2	81.6	90.9	87.8	49.2	65.9	81.6	93.3	80.0	82.6	84.7	74.3	11.0
Yes	20.8	18.4	9.1	12.2	50.8	34.1	18.4	6.7	20.0	17.4	15.3	25.7	88.1
Relationship with recipients (%)													
Spouse	17.6	13.3	8.2	11.4	23.9	18.9	12.8	7.6	16.1	14.5	12.8	21.4	47.4
Children[b]	33.9	46.7	46.6	46.7	46.8	43.7	48.4	42.4	44.5	44.4	40.1	42.6	36.3
Other relatives	48.5	40.0	45.2	41.9	29.3	37.4	38.8	50.0	39.4	41.1	47.1	36.0	16.3

[a] Weighted percentage of each characteristics among total informal caregivers, [b] Including sons, daughters, sons-in-law, daughters-in-law.

Table 2. Correlation coefficients between countries' characteristics and proportion of female and aged informal caregivers in 12 European countries and Korea.

	Proportion of older caregivers (aged 65 years old or older) among total caregivers	Proportion of women caregivers among total caregivers
	Coefficients (*P*-value)	Coefficients (*P*-value)
Total Fertility Rate (2006)	-0.62 (.039)	-0.59 (.052)
GDP per capita (2006)	-0.58 (.057)	-0.68 (.018)
Life expectancy in men	-0.24 (.469)	-0.11 (.727)
Life expectancy in women	0.41 (.203)	0.48 (.131)
Proportion of the elderly in LTC facilities	-0.41 (.263)	-0.57 (.100)
Empowerment of women (% of female legislative, managerial workers)	-0.28 (.398)	-0.41 (.206)
Labour force participation by women	-0.40 (.212)	-0.75 (.008)
Percentage of older population among total population.	-0.47 (.139)	-0.13 (.688)
Proportion of women caregivers among total caregivers	0.75 (.007)	1

Note: LTC = long term care.

Table 3. Logistic regression coefficients(β) for being familial informal caregivers in 12 European countries and Korea according to data from SHARE (2004/2005) and KLoSA (2006) baseline surveys

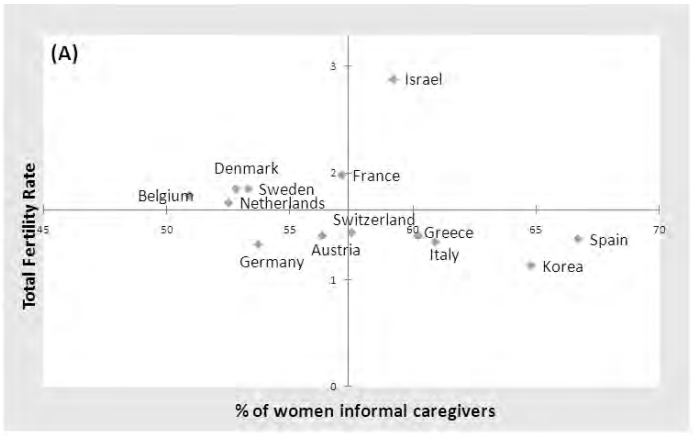
	Austria	German	Sweden	Netherlands	Spain	Italy	France	Denmark	Greece	Switzerland	Belgium	Israel	Korea
Sex and age													
Men aged 50–64	Reference												
Men aged 65+	-0.64*	-0.58**	-0.70**	-0.52*	-0.18	-0.48*	-0.47*	-0.86**	-0.45	-0.60	-0.45**	-0.21	0.53*
Women aged 50–64	0.14	0.11	0.04	0.19*	0.32	0.39*	0.40	0.31	0.47*	0.02	0.05	0.41*	0.77**
Women aged 65+	-0.30	-0.53**	-0.69**	-0.69*	-0.08	-0.08	-0.43	-0.79**	-0.15	0.01	-0.67**	0.01	1.09**
Marital status													
Single [a]	Reference												
Married and living together	0.68**	0.42**	0.34**	0.69**	0.002	0.63**	0.56**	0.51**	0.65**	0.30	0.61**	0.60**	0.92**
Education [b]	0.18**	0.02	0.02	0.09*	0.09	0.22**	0.11**	0.12*	0.13**	0.15	0.07*	0.19**	0.15*
Job status													
Unemployed or others	Reference												
Employed	-0.33	-0.08	-0.02	0.32*	-0.12	0.13	0.01	0.04	-0.02	-0.04	0.14	0.14	-0.11
Self rated health (1: very good-5: very poor)	0.06	-0.36**	-0.23**	-0.17*	-0.07	0.20*	-0.10	-0.17*	-0.009	-0.17	-0.04	-0.21**	0.10
N	1,847	2,929	2,957	2,837	2,336	2,502	2,945	1,620	2,705	933	3,663	2,445	6,080

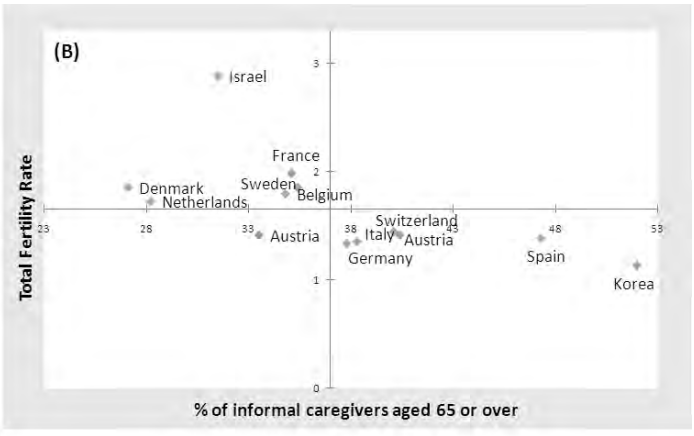
[a] Including divorced/widowed/separated/never married; [b] Educational level categorized as eight (0-7) for 12 European countries (SHARE), and as six (0-4) for Korea (KLoSA).

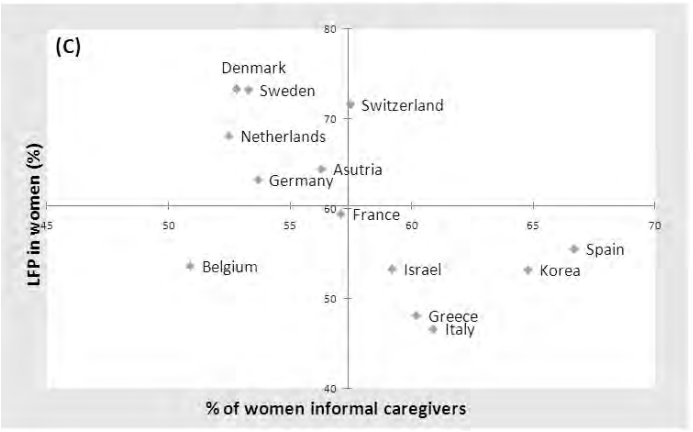
*$p < .05$; **$p < .01$

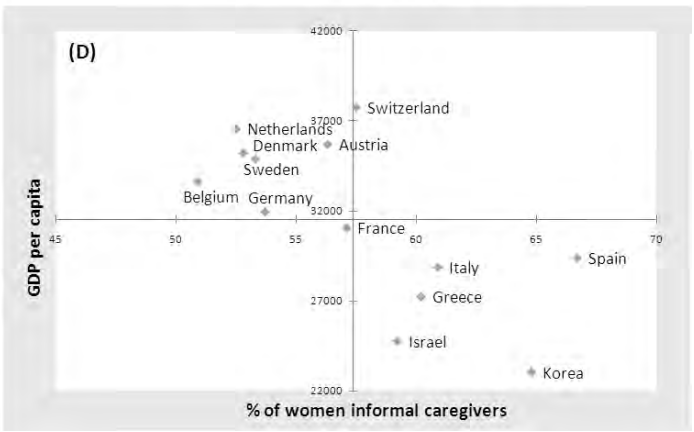
Figure legends

Figure 1. Percentages of women informal caregivers and total fertility rates (A), percentages of informal caregivers who are aged 65 years old or older and total fertility rates (B), percentages of women informal caregivers and the rates of women's participation in the labour force in 2006 (C), and percentages of women informal caregivers and the GDP per capita in 2006 (D) in 12 European countries and Korea.









"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

of total expenditures to be relatively low.

Informal care provided by the family is the main form of old-age care in Singapore. Kin members are the primary care providers. In addition, there is the practice of hiring foreign domestic workers (FDW) as live-in maids. To hire a FDW, the family has to apply for a work permit from the state. The FDW salary is regulated and a state levy has to be paid (Singapore Ministry of Manpower). The main type of household structure in Singapore is a one family nucleus with a majority of two generations living together. Of the one family nucleus, 16% are one generation households; 75.5% consist of two generations; and 8.5% have three or more generations living together (Singapore Census of Population, 2010). Older adults who have suffered from spousal loss tend to co-reside with their children and extended family. Among men aged 65+, 8.3% were widowers and among women of the same age group, a staggering 72.2% were widows (Singapore Census of Population, 2010). In terms of household size, 23% of all households have four members; 20% have three members; and 19% have two member households (Singapore Census of Population, 2010).

Because of declining household size which will affect the availability of family care-givers, it is expected that in the future there will be growing demand for formal care services provided by state subsidized HCBC or by the private sector. These care services include day center based care and home care. For easy accessibility, day centers and senior activity centers are mostly located in public residential blocks in the densely populated city state. Institutional care is available for older adults who do not have caregivers or have caregivers who do not have long term care nursing skills. The rate of institutionalization among older adults 65+ was 3% in 2010 (Singapore Ministry of Community Development, Youth and Sports).

2.2. China

In 2008, the population of China was 1.3 billion of which there were 108 million individuals aged 65 and over. China has the highest ranking in the world for the largest absolute number of older adults. The GDP per capita of the country was US$3,414 in real US dollar terms in 2008 (World Bank). Health expenditure as a percentage of GDP was 4.63% in 2008 which was higher than Singapore and Indonesia (National Bureau Statistics of China). Public expenditure on health as a percentage of total health expenditures was 49.9% in 2008 (World Bank). By gender the life expectancy for men is 71.4 years while for women it is 74.8 years (World Bank, 2009). The TFR is below replacement rate but at a relatively higher rate than Singapore at 1.63 in 2008 (World Bank, 2009).

Traditionally, most Chinese live in multigenerational families and the adult children or extended family is the primary care provider. For higher income households, the housekeeper (bao-mu) is also a care provider. While this tradition was weakened during the 1950s – 1970s, it was revitalized following economic reforms in the late 1970s (Chen, 1996) and was legalized in the 1990s (Ministry of Civil Affairs, 1996). But given the country's family planning policy, the "4 – 2 – 1" household structure is now the norm and there is a higher risk of older adults living alone (China Research Center on Aging, 2012). This risk of living alone is exacerbated by widowhood. While 23.3% of Chinese men aged 65+ were widowed, over 50.5% of Chinese women aged 65+ were widowed in 2000 (Kinsella and Wan, 2009). Prior to the establishment of the People's Republic of China (PRC) in 1949, elderly institutional care did not exist. In the 1950s as a part of the socialist welfare system, elderly homes were established to accommodate the "Three-No" elders – those who had no living children / relatives; little or no income; and no physical ability to work. The elderly homes were primarily built in each urban residential block with funding from different levels of government (Chen, 1996). From the late 1990s until the mid 2000s, institutional care consisting of a network of nursing homes and multi-functional care institutions has emerged throughout China particularly in urban areas (Ministry of Civil Affairs, 2005; Zhan, Liu and Bai, 2005). Approximately 4% of these institutions are privately operated and located in urban areas. Publicly operated institutions provide better services than the private sector (Zhan, Liu and Bai, 2005). The percentage of older adults 65+ in institutional care was less than 2% in 2003 (China National Statistical Bureau). Unlike most developed countries – where the predominant reason for institutionalization is disability – the rate of institutionalization among Chinese older adults remains low due to cultural norms and a limited institutional care system (D. Gu et 2007).

With smaller household size, China is confronted with similar policy challenges as Singapore. Social welfare investments are being made to increase the availability of community day care services as well as to expand the limited institutional care system (China Research Center on Aging, 2012).

2.3. Indonesia

In 2008, the population of Indonesia was 234 million of which there were 13.9 million individuals aged 65 and over. Indonesia is ranked the seventh country in the world in terms of the largest absolute number of older adults. In percentage terms, 5.9% of the total population is aged 65 and over. However the proportion of older adults in Indonesia could be considered to be larger if the cut-off age for an older person in a developing country is age 60 instead of age 65. The Indonesia National Socio-Economic Survey in 2004 showed variation in the proportion of older people across the provinces in the Indonesian archipelago ranging from 2% in Papua to 12.8% in Yogyakarta. The proportion of older people in Central Java was about 9.5%.

The GDP per capita of the country was US$2,172 in real US dollar terms in 2008 (World Bank). In comparative terms, the GDP per capita of Singapore is the highest followed by China. Also relative to Singapore and China, Indonesia has the lowest health expenditure as a percentage of GDP which was 2.5% in 2008 (World Bank). However, public expenditure on health as a percentage of total health expenditures was 45.5% in 2008 which was comparable to China but higher than Singapore (World Bank). By gender the life expectancy for men is 67 years while for women it is 70 years. Compared to Singapore and China, Indonesia has a TFR that is at replacement rate in terms of developing countries with high child mortality. In 2008, the TFR was 2.3.

Informal care in the form of self-care coupled with support by children is the norm in Indonesia (Kreager, 2006). In traditional Javanese society (not all of Indonesian society), older parents typically co-reside with one of their youngest children, usually a daughter in the extended family, who accepts responsibility to take care of them until they die. High income older persons provide key intergenerational support for families have high social status and are respected in their communities (Schröder-Butterfill, 2004). However,

intergenerational relationships have become an emerging issue, particularly for those who live in urban areas, as societal values change from extended family to nuclear family structures, and younger generations become more mobile in search of better career opportunities (Ng et al, 2010).

Compared to Singapore and China, older Indonesians are arguably more self-reliant and this can be seen from estimates that nearly 25% of women and almost 50% of men aged 65 and over remain in the labor force (United Nations, 2002). However, such estimates invariably under-report the extent of work in the informal sector, particularly among women. No public old-age pension exists and mandatory formal sector schemes only cover approximately 15% of the labor force (Asian Development Bank, 2000). Similar to China, only urban dwellers who have worked in government sectors, the military or industries receive pensions. Pensions are not paid to the urban poor or traditional agricultural workers (Phillips, 2005).

The availability and quality of HCBC and institutional care vary across the provinces in Indonesia (Wada et al, 2005; Kreager, 2006; Van Eeuwijk, 2006). The major sources of public and private outpatient health care for the elderly are government health centers (puskesmas) and subcenters (puskesmas pembantu); private clinics; community health posts for the elderly with volunteer staff (posyandu lancia); and traditional health practitioners. Institutional care is in the form of old people homes. However, the use of formal care appears to be minimal compared to Singapore and China. Possible explanations for this include the preference for self-care and support from children; and low demand for formal care given fewer functional limitations (Wada et al, 2005).

3. Methods

3.1. Data

To carry out this cross-country comparison using ordinary least squares (OLS) regressions, I use three datasets. For Singapore, I use the cross-sectional Singapore Ministry of Community Development, Youth and Sports' Informal Caregiver Survey 2010 which consists of 1,190 non-institutionalized respondents aged 75+. This survey dataset only captures households that consist of older adults with informal care-givers. For China I use the fifth wave of the Chinese Longitudinal Healthy Longevity Survey (CLHLS) 2008 - 2009. This wave contains 16,540 respondents who are either non-institutionalized or are institutionalized. The CLHLS covers 22 out of 31 provinces in China. Unlike other national surveys focusing on the elderly in China, which exclude institutionalized respondents, the design of the CLHLS oversampled this group. Also, the CLHLS is the first national longitudinal survey with the largest sample of oldest-old individuals conducted in a developing country. For Indonesia, I use the fourth wave of the Indonesia Family Life Survey (IFLS) 2007 which contains separate books on non-institutionalized older adult socio-economic status, household structure and health status. In this wave, new health questions were asked and they are comparable to the US Health and Retirement Surveys. The IFLS covers 13 out of 26 provinces in Indonesia. For the fourth wave, 13,535 households and 44,103 individuals were interviewed.

For this paper, I restrict the samples for Singapore and China to only urban dwelling respondents aged 75+ with at least one self-reported ADL limitation. The size of the restricted sample for Singapore is 988 observations. The size of the restricted sample for China is then 1,077 observations. I choose a lower cutoff age for the Indonesia sample. As such the restricted sample for Indonesia consists of only urban dwelling respondents aged 60+ with at least one self-reported ADL limitation. The restricted sample size for Indonesia is 237 observations, which is noticeably smaller than for Singapore and China. This is because a large proportion of Indonesians aged 60+ in the unrestricted sample does not have any self-reported functional limitation.

3.2. Variables

Older adults living alone or with family in all three countries are classified as receiving informal care. The extent of informal care received is measured as an outcome variable, in terms of the amount of time the care recipient receives for assistance with functional limitations. For Singapore and China, the amount of care received is measured in terms of hours of care per week. However for Indonesia, the amount of care received is based on the number of days in the month when the respondent is unable to carry out his / her primary activity and as such receives assistance for those days. Within each of those days, the respondent is then asked to estimate the number of hours of care received.

The main explanatory variables for how much informal care received are the care recipient's family network, socio-economic characteristics, functional limitations and SRH; and health and social care utilization. Most of the explanatory variables used in the linear regressions are categorical variables or binary variables. I use only comparable explanatory variables available in the three country datasets. This may then limit the extent of analysis for a given dataset that may have fewer comparable variables. In particular, there are fewer variables available for Indonesia compared to Singapore and China. All study variables have minimal missing values.

The variables for the family network consist of the care recipient's marital status, household structure (household size, co-residence status and whether there is a secondary caregiver); and relationship type with each extended family member. Socio-economic characteristics covered are the care recipient's annual household income (or level) or monthly individual earned income; and whether the older adult receives a pension or some form of old-age benefit. Functional limitations are measured using the older adult's self reported inability carry out at least one ADL. The ADL measure is based on the Katz index scale (Katz et al., 1983) consisting of six items, including bathing, dressing, indoor transferring, toileting, eating, and continence. The individual is classified as ''ADL disabled'' if the individual needs help in at one or more activities. Given the different country datasets, SRH is measured using five categories for Singapore and China; and using four categories for Indonesia. For Singapore, the highest SRH rank represents "excellent" health while it is the inverse for China where the lowest SRH rank represents "very good" health. Indonesia is similar to China where the lowest SRH rank represents "very healthy". In terms of the variables for health and social care utilization, such as HCBC, there is variation across countries given the types of services available. Also there is variation in terms of whether there is a distinction between medical care and social care.

4. Results

4.1. Descriptive Statistics

Table 1 provides the percentage distributions and means for the study variables by country. Given the samples for the three countries, the average amount of time received for care is highest for China; 60.21 hours per week. This is most likely related to the average age for the China sample which is 96.36 years. In contrast, the average age for the Singapore sample is 83.10 years and for the Indonesia sample, it is 71.97 years. More than 60% of all three country samples consist of older women. While the majority of older adults for Singapore (64.98%) and China (87.93%) are widowed, the exception is Indonesia where 58.65% of older adults are still married. Unexpectedly average household size for Singapore is larger than for China and Indonesia. On average an older adult household has 4.37 members; 45.34% of all households include a FDW. The mean household size for China is 2.46 and for Indonesia it is 2.10. For Indonesia smaller than expected older adult household size may perhaps be related to the adult children's outmigration for employment. Given the structure of CLHLS and data availability, 5.58% of older adults in the observed data are institutionalized. There is no information on institutionalization for Singapore and Indonesia.

There is considerable variation across the countries in terms of the relationship between the care recipient and the primary caregiver. For Singapore, the majority primary caregiver for an older woman is the daughter and the majority primary caregiver for an older man is either the daughter or the son. For China, the majority primary caregiver for an older woman is the daughter and the majority primary caregiver for an older man is the son. For Indonesia, the majority primary caregiver for an older woman is the biological child and this distinction is made as Indonesian families tend to have non-biological children e.g. children adopted from another family. For older Indonesian men, the majority primary caregiver is the wife.

Upon further examination of the family network size for care-giving, for Singapore, 53.14% of older adults have a secondary caregiver. For individuals with a secondary caregiver, 7.80% are siblings and 45.34% are the FDW. For China, no survey questions were asked concerning secondary caregivers. The family network is treated as one unit for care-giving without a distinction made between primary and secondary caregivers. For Indonesia, 71.31% of secondary caregivers are biological children, 12.24% are grandchildren and 5.91% are non-biological children among all relationship types. With the exception of Singapore where aged parents tend to have their adult children providing care, older adults China and Indonesia tend to receive multi-generational care, albeit primary care or secondary care.

From Table 1, a majority of older adult households with caregivers in Singapore have a monthly household income of less than SGD$4,000. Only 15.79% are high income households, earning SGD$5,000 or more. To finance healthcare, 75.81% of care recipients in the observed data have individual MSA. However a substantially higher 92.31% of caregivers in the observed data have individual MSA. As the MSA is tied to the individual's provident fund, a relatively lower percentage of older adults with a MSA suggest that during their working years, they worked in the informal sector and could not qualify for membership in the provident fund. As a relatively higher proportion of caregivers have a MSA, this suggests that caregivers are able to provide financial support for healthcare expenditures.

Table 1 presents further information on income and old-age benefits in urban China. On average the log of annual household income is 10.12 log points with a standard deviation of 1.12 log points. 36.30% of all older adults in the sample receive a pension; 14.11% have old-age insurance; 13.28% receive free public medical services; and 12.63% receive collective medical services. Older adults who receive medical care from the collective healthcare system are retirees of state and collective enterprises. There is no further information on the extent of healthcare coverage received and how much it is supplemented by individual or family out-of-pocket spending.

In contrast to Singapore and China, there is little data on older adult household incomes in IFLS for Indonesia; there are substantial missing values on income. As a proxy for income, I use the older adult's level of educational attainment. Among all older Indonesians in the observed data, 42.87% do not have any formal education only 2.22% have a college degree. Health insurance coverage is minimal among older Indonesians in the observed data. Only 9.2% have of those observed have health insurance.

From Table 1, the majority of older adults in the observed data for the three countries have either one or two ADL limitations. Also the three countries share similarity in terms of how older adults perceive their health status. The majority across the three datasets rate their health as either in the lowest rank or second lowest rank meaning the poorest health or second to poorest health. In relation to their subjective health, Table 1 proceeds to provide statistics on objective healthcare and / or social care utilization. 22.27% of older Singaporeans in the observed data were hospitalized in the previous six months. Throughout their lifetimes, the older Chinese were hospitalized on an average of 3.11 times with a standard deviation of 12.62 times. Only 6.22% of all older Indonesians in the observed data visited the posyandu in the previous month. Social care utilization or the use of HCBC remains minimal for all three datasets.

4.2. Output

Table 2 presents the OLS regression output describing the characteristics that influence the amount of care an older adult receives in Singapore, China and Indonesia. For Singapore, the main characteristics for receiving care are the household income level, functional limitations and the presence of a FDW in the household. When the household income level falls from one level to the next level, the older adult receives 0.76th of an hour more of care per week from the primary caregiver and this is statistically significant at the 1% level. Also when the older Singaporean has one additional ADL limitation, s/he receives 0.86th of an hour more of care per week from the primary caregiver and this is statistically significant at the 5% level. The amount of care received from the primary caregiver is ameliorated by the presence of a FDW within the household. Acting as the secondary caregiver, the presence of a FDW decreases the amount of care from the primary caregiver by 2.75 hours per week and this is statistically significant at the 5% level. As such the FDW complements in the primary family caregiver in the amount of care provided. Household size has no effect which suggests that the number of family members co-residing does not matter for care-giving. The use of home help services and home medical services reduce the amount of care provided by the primary caregiver by

3.37 hours per week and 0.77 hours per week respectively. But these two results are not statistically significant. In contrast the older adult's participation in a day health center increases the amount of care from the primary caregiver by 1.73 hours per week. But this result is also not statistically significant. Taken together, these findings imply that in a low income household in Singapore, the older adult will receive more care from the primary caregiver, particularly the adult child. High income households can compensate for care with a secondary caregiver such a FDW. The availability of HCBC has very weak effects on the extent of the provision of care.

For China, the main characteristics influencing how much care is received are the older adult's functional limitations, age, whether s/he receives medical services from a collective and the presence of a bao-mu. For an additional ADL failure, the older adult receives 9.67 hours more care each week from the family and this is statistically significant at the 1% level. For each year of aging, the older Chinese receives 0.86th of an hour more informal care from the family unit and this is statistically significant at the 5% level. Like Singapore, the size and composition of the family household does not affect the extent of care received. Despite increasing disability and age, the additional amount of care needed is vastly decreased when the older Chinese is able to receive medical services from the collective and has the bao-mu as a secondary caregiver. The use of collective medical services reduces the amount of informal family care by 11.45 hours per week, statistically significant at the 10% level; and the presence of the bao-mu reduces family care by 17.65 hours per week, statistically significant at the 5% level. While there is strong similarity between Singapore and China in the use of maids as secondary caregivers, unexpectedly these findings show the strength of the collective and the medical services it provides to the Chinese elders. In contrast, social care utilization, not unlike Singapore is weak.

In sharp contrast to Singapore and China, the family network in the Indonesian household plays a substantial role in the amount of informal care received. When household size increases by an additional family member, the older adult receives 4.36 more days of assistance with primary activities that s/he is unable to perform. This result is statistically significant at the 5% level. When there is a designated secondary caregiver such as an adult child supporting the spouse who is the primary caregiver, amount of assistance with primary activities falls by 4.17 days and this is statistically significant at the 5% level. This may imply that the designated secondary caregiver assumes full responsibility for completing the primary activity instead of merely assisting. Bearing some similarity to China, public health insurance coverage and the use of the public posyandu do strongly influence informal care. Having health insurance coverage such as akses for retired / working public sector employees increases the amount of assistance with primary activities by 6 days and this is statistically significant at the 5% level. Using the posyandu for medical care reduces the amount of assistance needed by 11.44 days and this is statistically significant at the 5% level.

5. Preliminary Conclusions

This empirical paper has focused on examining the characteristics of older urban care recipients from an Asian perspective. A cross country comparison of Singapore, China and Indonesia was carried out using survey data at the individual and household level. I focused on the older adult's family network, household income and old-age benefits available from existing public institutions in the one developed country and two developing countries. For Singapore the main predictors for receiving care were the household income level, functional limitations and the employment of a FDW as a secondary caregiver. It appears that high income households in Singapore are in the position to purchase more care for the elder from the private market. Such a choice may then help the family continue to be the cornerstone of eldercare within Singaporean society. However the use of HCBC has minimal effect on the amount of care received. This is despite the availability of HCBC subsidized by the state. This may mean that for both high income and low income households, there may be a low preference for going outside of the family for social care. For China the main predictors for receiving care were functional limitations, age, whether s/he receives care from collective medicine and the presence of a bao-mu. Urban China shares much similarity with Singapore where the employment of a bao-mu as a secondary caregiver strongly complements the primary family caregiver in the amount of care provided.

Household size and composition in terms of multi-generational co-residence have minimal effect on the amount of care the older adult receives in Singapore and urban China. This is in sharp contrast to Indonesia. When the urban Indonesian household size grows, the older adult tends to receive more care. Also Indonesian grandchildren play a larger role in providing care to elder compared to China. The grandchildren do not play a role in eldercare in Singapore.

There is a stark difference in eldercare between the three countries in terms of the existing public institutions providing old-age benefits. As a part of the socialist welfare system in urban China, this paper has found that the collective medical is one of the main predictors for reducing the amount of informal family care needed. This suggests that the public provision of healthcare for retirees of state and collective enterprises can help to minimize the amount of social care the family needs to provide. Similar to China, public health insurance coverage (akses) in Indonesia for urban dwellers in the public sector and the use of the public elderly health post (posyandu). No such public institution effects were found for Singapore. However, such public health coverage for urban Indonesians and urban Chinese appears to be limited. Only public sector retirees are able to receive such benefits while individuals in the informal sector are not eligible for such old-age benefits.

While all three countries in this analysis are Asian, there is variation in the characteristics of the care recipients. While the Asian values of filial piety can drive informal care, existing public institutions in each country will influence the extent of health and social care received. Based on available data, the Singaporean family chooses to keep informal care within the family while the state does play a role in elder healthcare and social welfare in urban China and Indonesia.

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This is a preliminary version.

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Table 1

Singapore

		Means (SD)
Hours of Care Received Per Week		14.13
		(13.77)
Age		83.10
		(5.34)
		Percentage Distribution
Female		68.52%
Marital Status		
	Married	32.39%
	Widowed	64.98%
	Separated / Divorced	1.61%
	Never Married	1.01%
Household Size		4.37
		(1.85)
Co-Residence Status of Care Recipient		
	With household member(s)	99.99%
	Alone	0.01%
	Institutionalized	0%
Primary Caregiver for Female Care Recipient		
	Husband	5.76%
	Daughter	72.23%
	Daughter / Son – in - Law	13.88%
	Sister	1.18%
	Sister – in - Law	0.15%
	Friend	0.44%
	Other Family Relatives	6.36%
Primary Caregiver for Male Care Recipient		
	Wife	38.26%
	Daughter or Son	49.84%
	Daughter / Son – in - Law	8.68%
	Brother	0.32%
	Other Family Relatives	2.90%
Secondary Caregiver		
	Sibling	7.80%
	Foreign Domestic Worker	45.34%
	None	46.86%
Monthly Household Income Level		
	Less than SGD$500	7.19%
	SGD$500 - SGD$999	12.85%
	SGD$1,000 - SGD$1,999	19.43%
	SGD$2,000 – SGD$2,999	16.90%
	SGD$3,000 – SGD$3,999	11.64%
	SGD$4,000 – SGD$4,999	7.49%
	SGD$5,000 and above	15.79%
	Refuses to respond	8.70%
Care Recipient has a MSA		75.81%
Care Giver has a MSA		92.31%
Functional Limitations		
	2 ADL Limitations	19.13%
	3 ADL Limitations	14.07%
	4 ADL Limitations	13.56%
	5 ADL Limitations	13.56%
	6 ADL Limitations	11.74%
SRH		
	Poor Health, 1	32.09%
	Fair Health, 2	48.58%
	Good Health, 3	19.23%
	Very Good Health, 4	0.00%
	Excellent Health, 5	0.10%
Health and Social Care Utilization		
	Hospitalized in the previous six months	22.27%
	Uses home medical services	2.2%
	Uses the elderly day center	1.62%
	Uses home help services	0.71%

China		
		Means (SD)
Hours of Care Received Per Week		60.21
		(62.95)
Age		96.36
		(7.47)
		Percentage Distribution
Female		65.83%
Marital Status		
	Married	10.86%
	Widowed	87.93
	Separated / Divorced	0.46%
	Never Married	0.75%
		Means (SD)
Household Size		2.46
		(1.27)
Co-Residence Status of Care Recipient		
	With household member(s)	90.06%
	Alone	4.46%
	Institutionalized	5.48%
Primary Caregiver for Female Care Recipient		
	Spouse	2.12%
	Son	17.91%
	Daughter-in-Law	19.04%
	Daughter	27.93%
	Son-in-Law	0.71%
	Son and Daughter	0.56%
	Grandchild(ren)	8.60%
	Other Kin Members	2.12%
	Neighbors	0.28%
	Social Services	5.36%
	Housekeeper *(bao-mu)*	13.82%
	No primary caregiver	1.55%
Primary Caregiver for Male Care Recipient		
	Spouse	14.40%
	Son	34.24%
	Daughter-in-Law	7.61%
	Daughter	17.66%
	Son-in-Law	2.99%
	Son and Daughter	1.63%
	Grandchild(ren)	5.71%
	Other Kin Members	1.09%
	Neighbors	0.27%
	Social Services	4.08%
	Housekeeper *(bao-mu)*	8.97%
	No primary caregiver	1.36%
		Means (SD)
Annual Household Income (ln)		10.12
		(1.12)
Care Recipient has a Pension		36.30%
Care Recipient has Old-Age Insurance		14.11%
Care Recipient receives free public medical services		13.28%
Care Recipient receives collective medical services		12.63%
		Percentage Distribution
Functional Limitations		
	1 ADL Limitation	38.72%
	2 ADL Limitations	15.97%
	3 ADL Limitations	9.56%
	4 ADL Limitations	10.40%
	5 ADL Limitations	10.58%
	6 ADL Limitations	14.76%
SRH		
	Very Good Health. 1	6.87%
	Good Health. 2	23.96%
	So So Health. 3	27.11%
	Bad Health. 4	11.23%
	Very Bad Health. 5	28.69%
	Unable to provide a response	28.69%
Health and Social Care Utilization		Means (SD)
	Number of times ever hospitalized	3.11
		(12.62)
		Percentage Distribution
	Uses social care services	4.9%

Indonesia		
		Means (SD)
Days Missed in Primary Activity, Last Month		10.74
		(12.66)
Number of Days of Care Received, Last Month		19.62
		(10.67)
Within Last Month, Number of Hours of Care Received in a Day		4.56
		(4.38)
Age		71.97
		(7.90)
		Percentage Distribution
Female		68.78%
Marital Status		
	Married	58.65%
	Widowed	33.76%
	Divorced	7.59%
		Means (SD)
Household Size		2.10
		(0.74)
Primary Caregiver for Female Care Recipient		
	Husband	16.55%
	Biological Child	35.97%
	Daughter / Son – in – Law	15.83%
	Grandchild	19.42%
	Niece / Nephew	1.44%
	Servant	5.04%
	Other Family Relatives	5.75%
Primary Caregiver for Male Care Recipient		
	Wife	70.42%
	Biological Child	22.54%
	Sister / Brother – in - Law	1.41%
	Niece / Nephew	5.63%
Secondary Caregiver		
	Biological Child	71.31%
	Non-Biological Child	5.91%
	Daughter / Son – in – Law	5.91%
	Sibling	1.69%
	Grandchild	12.24%
	Nephew	1.69%
	Servant	0.42%
	Other Family Relatives	0.83%
Highest Educational Level Attained		
	No Formal Schooling	42.87%
	Elementary School	17.58%
	Junior High	21.97%
	Senior High	15.38%
	College	2.2%
Care Recipient has Health Insurance		9.2%
Functional Limitations		
	1 ADL Limitation	15.61%
	2 ADL Limitations	21.10%
	3 ADL Limitations	8.86%
	4 ADL Limitations	10.13%
	5 ADL Limitations	6.33%
	6 ADL Limitations	37.97%
SRH		
	Very Healthy, 1	0.42%
	Somewhat Healthy, 2	41.77%
	Somewhat Unhealthy, 3	51.05%
	Unhealthy, 4	6.75%
Health and Social Care Utilization		
	Visited the Community Health Post for the Elderly *(posyandu)*, Last Month	6.33%

Table 2

Outcome Variable = Amount of Informal Family Care Received (time)
OLS
Standard Errors are in Parentheses

	Singapore	China	Indonesia
Outcome Measure	Hours Received from the Primary Caregiver for ADL Limitations, per Week	Hours Received from the Family Care-giving Unit for ADL Limitations, per Week	Days of Assistance Received with Primary Activities, Last Month
Age	0.1237	0.8623**	-0.0747
	(0.1300)	(0.3074)	(0.0946)
Care Recipient is Male	-1.3156	-8.1838	1.5915
	(1.073)	(5.1152)	(2.0922)
Married	1.5677	-3.7721	-1.9271
	(1.0757)	(7.0390)	(2.2711)
Household Size	-0.3336	-0.4365	4.3687**
	(0.174)	(1.6388)	(1.2732)
Has Secondary Caregiver	-0.8378		-4.1797**
	(0.5962)		(1.6642)
Has a FDW / *Bao-Mu*		-17.6553**	
		(6.4027)	
Household Income	-0.7630***	1.036 log points	
	(0.2148)	(2.7633)	
Institutionalized Benefits			
Care Recipient MSA	-1.5018		
	(1.0124)		
Care Giver MSA	-1.9062		
	(1.6536)		
Public Old-Age Insurance		4.1866	
		(5.9805)	
Public Free Medical		-7.9955	
		(6.4846)	
Collective Medical		-11.4563**	
		(6.0869)	
Public Health Insurance			6.4276**

			(2.4577)
Health Status			
ADL Limitations	0.8312**	9.6726***	0.2181
	(0.2442)	(1.1470)	(0.4168)
Self Rated Health	-0.8378	0.5781	1.4262
	(0.5962)	(0.8441)	(1.2262)
Health and Social Care Use			
Day Health Center	1.7354		
	(3.3118)		
Home Medical	-0.7742		
	(2.8522)		
Home Help	-3.3761		
	(4.9717)		
Social Services		6.9664	
		(21.6231)	
Posyandu			-11.4485**
			(3.7386)
Constant	5.5423	-53.6419	18.4797
	(7.3924)	(39.6714)	(8.3764)
R^2	0.11	0.12	0.17
Observations	988	939	204

Statistically significant at the *** 1% ** 5% and * 10% level

"Ethonographic Studies on the Role of Caregiver in Providing Care for Older Persons in Citengah Village, Sumedang, West Java and Its Implication of Care Giving Program"

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MS. VITA PRIANTINA DEWI

ABSTRACT

Many countries in the world will experience increasingly ageing populations in the 21st century. One of the countries that will have dramatic increase in the number of aged people in its populations is Indonesia. The increasing proportion of older persons in Indonesia also bring an impact on the issue of providing care for older persons especially for older persons who are no longer working. Most of study on elderly people are focused on social activities of the elderly. However, there are limited studies on the providing care for older persons in rural areas in Indonesia. Therefore, the decision to study providing care for Indonesian older persons was taken in order to broaden inquiry into the issues. Our study is a small scale study which is based on qualitative research in Citengah Village, Sumedang, West Java in 1999 – 2001..

The results showed that there is a flexibility in Citengah Village when older people were asked about who they wanted to care for them when ill or frail. For men, reliance on a wife or a daughter is clearly preferred, while women often state a preference for care by a daughter. Sometimes remarry will be done by older men in order to have wife to care for them. However, for both men and women care by a daughter-in-law, granddaughter, adopted child or even son or nephew is acceptable, especially if a daughter is not locally available or relations are not good. One rich elderly widower, who has six sons and one daughter, explained his decision to live with his only daughter after his wife's death with the comment: "With a daughter, I need not feel like a stranger (asing), nor reluctant (sungkan) to ask her to do my laundry or cook my favourite food."

For elderly men, where there is a wife (and often there is), she is by default the predominant carer. Indeed, in Citengah, a wife's role for ensuring men's domestic comfort and care in illness is recognised as so important that remarriage, even in old age, is not uncommon. Only if there is no wife do daughters emerge as caregivers. Care by a daughter is most common, but granddaughters, sons, and daughters-in-law also feature prominently. Caregiver played important roles in providing companionship, help and health care for elderly people. In relation to this, most caregivers were children or family of the elderly people.

From the study we concluded that further research is needed in order to increase capability of the caregiver. Hence, the implication of this research findings is the importance of care giving training to improve capability of caregiver (family and community) in caring the older persons, and developing support system to provide sustainability of this program.

Introduction

Many countries in the world will experience increasingly ageing populations in the 21st century. As the world experiences a demographic revolution towards a new era of ageing, comprehensive reforms to address social, fiscal, and health implications will be required. Yet while these impacts of ageing populations have largely focused on the developed world, the issue is also experienced by developing countries.

Literature has noted that the proportion of elderly people aged 60 years and above in the developing world will increase rapidly from 8 % in 2005 to approx. 20 % between 2015 - 2050 (Beard and Kunhariwibowo, 2001; United Nations, 2005). One of the developing countries that will experience these problems with its ageing population is Indonesia. This country has the third largest ageing population in the developing regions. Indonesia will have 13.2 % of elderly proportion in 2025: 7.8 % of elderly people population is on the island of Java and 5.4 % of older persons proportion is outside this island (Beard and Kunhariwibowo, 2001; United Nations, 2005).

This paper explores data from Ageing in Indonesia study of a rural West Javanese community. It employs qualitative methods. Ethnographis studies, analysis of elderly people's life histories, in-depth interviews, and focus group discussion were conducted in the village. In addition, repeated in-depth interviews also conducted with 28 or 29 participants.

The Location

The location, Citengah village, is about 11 km away from the Sumedang city. The village was chosen because there is a remarkably high proportion of elderly people who are above 60 years old in this community. Citengah is a typical traditional West Javanese (Sundanese) village. Its local economy is predominantly based on agricultural production, with the majority of households (90%) engaged in rice cultivation. Simple irrigated sawah (paddy fields) for the production of rice, cassava, beans and tea trees are developed. The main activities are subsistence farming and agricultural wage labourer. Some people grow additional cash crops, usually the same products as for consumption, and own fishponds, cattle and poultry. The sole secondary industry comprises one small timber factory. Services within the community consist of two schools, 4 mosques, 5 prayer houses (musholla), 20 small stores, 2 village nurses (one female nurse or bidan desa and one male nurse or mantri), and 1 polindes (village medical clinic). The total population is recorded as 1200 people, with 143 people are 60 years of age and above. All inhabitants are Muslim.

Religious Adherence

Islam is important in Citengah. It is a visible presence in the life of Citengah village. Informal religious instruction for children begins with the instruction in Koran recitation (pangaosan). Calls to the five daily prayers, often heard from mosques in the village. Every Friday men and boys join the prayer known as Juma'ahan. Militant Islam is also important to the village. Citengah was one of the areas in West Java where the DI/TII or militant Islamic movement built its headquarter in Citen-

gah's forest.

Islam is also integrated into the life of people in Citengah. Important aspects of Islamic faith and practice that has implications for care giving is the fact that Islam requires practices associated with care and positive views of life that stresses on respect and caring for older persons. The practices are part of everyday life.

The norms in Citengah emphasise on the importance of religious aspect in people's lives. One of participants was an honourable mullah and Islamic teacher in the village. He has been head of Citengah High mosque for approximately 18 years. Religion is one of the most important things in his life; he regularly attended religious events, and was anxious to keep Muslim laws (for example, he said it was necessary to take care of the older persons when they were getting older and older as it was a part of practicing Islamic values). Another participants received care from the village community in form of companionship. Village community also providing care for them inform of helping them with their activities of daily living such as dressing, feeding, washing, and toileting.

I would interpret these as symbolize of respect to older people. The caring that they receive do not automatically reduce their status in the village. Villagers still see them as old people to whom you should respect.

Care Preferences and Practices

There is a flexibility in Citengah when older people were asked about who they wanted to care for them when ill or frail. For men, reliance on a wife or a daughter is clearly preferred, while women often state a preference for care by a daughter. Sometimes remarry will be done by older men in order to have wife to care for them. However, for both men and women care by a daughter-in-law, granddaughter, adopted child or even son or nephew is acceptable, especially if a daughter is not locally available or relations are not good. One rich elderly widower, who has six sons and one daughter, explained his decision to live with his only daughter after his wife's death with the comment: "With a daughter, I need not feel like a stranger (asing), nor reluctant (sungkan) to ask her to do my laundry or cook my favourite food."

For elderly men, where there is a wife (and often there is), she is by default the predominant carer. Indeed, in Citengah, a wife's role for ensuring men's domestic comfort and care in illness is recognised as so important that remarriage, even in old age, is not uncommon. Only if there is no wife do daughters emerge as caregivers. Care by a daughter is most common, but granddaughters, sons, and daughters-in-law also feature prominently.

Conclusions

This paper has examined The Role of Caregiver in Providing Care for Older Persons in Citengah Village, Sumedang, West Java including the care preferences and practices of older men and women in two different rural communities in Indonesia. The aims were to analyse people's preferences concerning appropriate sources of care in the light of their own understandings of kinship, morality and personhood, to identify the range of acceptable care arrangements around the general norm of 'daughter preference', to examine the constraints operating on people's attainment of preferred practices. Further research is needed in order to increase capability of the caregiver.

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「老有所为对提供护理的启示」

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摘要

2011年菲律宾的老龄人口已增加至超过六百万人。由于照顾老人的责任被视为家庭责任多于政府的责任，老龄人口增长就引申出家庭开支上升的问题。随着本土和海外移民增加，或单人家庭数量不断上升，菲律宾的家庭结构发生转变，导致菲律宾的长者护理服务安排也有所改变。研究指出老有所为，即老人积极参与各项活动所引申出的护理费用和忧虑，是现今菲律宾家庭关注的重点。老人从积极参与各种各样的活动可以达致有效运用认知系统。而提升认知系统的运作，则可帮助减少在晚年时期因认知能力下降而产生的负面情绪。研究老有所为的前因和后果，点出了长者护理的两个主要框架。第一是采用正面的成人发展方式来照顾老人。此框架重点是要根据资源重新为健康下定义；采纳为小区长者保健护理设立制度系统的看法。第二是在保健护理时着重老年心理学，为老人提供护理时结合精神健康护理和一般的医疗护理。研究意味着要妥善照顾菲律宾长者，需要在老人的管控和运用、社会和小区资源方面投放更多的心力。

「为马来西亚独居和非独居长者提供的多种支援」

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摘要

老年时期的依赖性往往与健康状况转差和收入来源减少有关，因此老人需要依仗家人的照顾和支持。但即使同住，家庭支持的方式也是纷繁多样。此研究目的是尝试查明根据同住状况和特定的人口变量，看是否能有效预测老人可否从子女身上获得经济和工具性的支持。子样本的数据是从2010年在马来西亚全国进行的调查所得，共有1273位六十岁或以上的老人参与调查。调查对象的报告显示，从子女身上获得的支持可分为财政支持（金钱补贴及支付医疗费用、住宿费、家居护理服务费和辅助器材费）和非财政支持（打理家务杂事和患病时的照顾）。调查使用多项式逻辑回归分析来评估调查对象是否可获得子女支持的因素（0=没有任何支持，1=只有财政支持或只有非财政支持，2=两种支持皆有）。调查模型包括八个二分独立的可变因素，即性别、教育程度、婚姻、就业、同住、健康问题、个人月入以及家庭大小。描述性结果显示78.9%的老人与子女同住。大部份老人（64%）都获得财政支持和非财政支持；而只获得财政支持，或只有非财政支持的老人则各占11%和9%；甚么支持都没有的占16%。卡方独立性测定反映同住与获得的支持有重要关系。多项式回归分析显示与子女同住为最重要的影响，其次为老人的就业程况及教育水平。包含所有预测因子的完整模型从统计学上来说是具重要性的（X2=196.512，df=16，p=0.001），而且以机会准确值来说它有着充裕的比例，能准确地把66%的个案分类，反映模型能区分获得不同种类支持的调查对象。参照群组是由没有接受支持的老人。如老人与成年子女同住，他们获得财政支持和工具性支持的比率，比什么支持也得不到的比率高出3倍。受访对象的性别及健康亦是能否获得局部或全面的支持的决定因素。虽然同住状况影响了马来西亚长者得到的整体支持，但其他因素的相关影响亦需要注视。身体有残疾或高危长者需要获得支持，让他们不会老而无依。

「韩国与欧洲国家的非正式照顾模式：跨国比较」

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摘要

目的：此生态研究分析民间照顾服务的人口特征和制度的不同。研究在十二个欧洲国家和韩国进行了跨国调查。

方法：研究数据来自2004/2005年度欧洲健康、老化和退休调查和2006年韩国老龄化纵向调查。研究探讨民间照顾服务与国家的宏观特征（国内生产总值、总体生育率、劳动力参与率、女权的强弱程度、长期护理资源）之间有何关联性。

结果：韩国和南欧国家（特别是西班牙和意大利）的民间照顾者的角色，大多由女性、主妇、同居者和配偶所担任。相反，北欧国家（丹麦和瑞典）的民间照顾者大部份是受雇人士。低女性劳动力参与率与高比例女性护理照顾者之间互有关联。而人口当中有高比例的女性护理照顾者，人均国内生产总值也会较低。

结论：研究提出一些结构性和制度性的可变因素与女性在护理照顾中的参与比率有关连。

“新加坡、中国及印尼的长者护理服务使用者特色分析”

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摘要

此论文运用大量来自新加坡、中国和印度尼西亚的长者护理数据，去描绘和比较城市长者护理服务使用者的特色。文中使用的数据来自2011年新加坡民间护理提供者调查、2008年中国老人健康长寿影响因素研究调查，以及2007年印度尼西亚家庭寿命调查。在新加坡和中国的数据中，研究对象的最低年龄为75岁，并最少一项日常生活活动能力受限制。在印度尼西亚的数据中，研究对象的最低年龄为60岁，并最少一项日常生活活动能力受限制。文中会描述研究对象的人口特征、生活安排、生理健康、自测健康、社会医疗健保的使用，以及长者护理使用者和其护理提供者的社会经济状况。文中会根据各国经济增长的差异、制度的不同，及保健护理的适用范围，解释不同的长者护理服务模式。

「印尼西爪哇苏美当希丹格村长者照顾者角色的人种志研究」

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维达．布莉安堤娜．迪维女士

摘要

许多国家在二十一世纪都要面对老龄人口增加的问题，而印度尼西亚便是其中一个老龄人口急剧增加的国家。老龄人口比例增加，对提供长者护理服务产生了影响，特别是对退休长者的影响更为深远。大多数的研究都着重在长者的社交活动，以印度尼西亚乡村地区的长者护理作对象的研究为数不多。因此，此研究决定拓展此领域，深入探讨印度尼西亚长者护理服务的提供。此研究是以1990-2001年在印度尼西亚西爪哇苏美当希丹格村进行的定性研究为基础的小型研究。

研究结果显示希丹格村的老人在挑选他们病弱时的照顾者具有一定的灵活性。就男性而言，他们都明显地表示喜爱依赖妻子或女儿照顾；而女性方面则较常倾向让女儿照顾。有时候男性为了要有妻子照顾自己会选择再婚。但不论男女，尤其在女儿不在身边，或与女儿关系不佳的情况下，都会接受让媳妇、孙女、养子 / 女，或侄子、兒子照顾。一位有六个儿子和一个女儿的富有老鳏夫解释在太太去世后与女儿同住的原因：「跟女儿在一起，我不会觉得自己是陌生人，或者是在要求她为我洗衣服或做我喜欢的菜时觉得不自在。」

在老年男性的角度，当他有妻子（通常都会有），他的妻子就会自动成为最主要的照顾者。而在希丹格村，妻子的角色是要确保男性享有舒适的家庭环境，和在生病时有人照顾，正因为妻子如此重要，所以即使在老年，男性再婚的现象也甚为常见。如果男性没有妻子，女儿就接替成为照顾者。老人由女儿照顾是最为常见，但也有一定数目的老人由孙女、儿子和媳妇所照顾。照顾者在陪伴长者、帮助长者生活，以及在长者保健方面担当重要角色。因此许多照顾者是长者的子女或家人。

总括而言，研究显示有需要进一步探讨如何提升照顾者的能力。研究结果指出了为照顾者提供训练的重要性，提升家庭或小区长者照顾者照料老人的能力，发展出一套支持系统去持久有效地照顾长者。

Care Workers of Excellence

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只有原文语言版本

「优秀护理员」获奖者

毛喆鹏

杭州市第二社会福利院

我很荣幸当选“优秀护理员”，感谢单位领导这些年对我的培养，感谢大会组委会对我的认可。这是份荣誉、更是一份激励，这仅仅是进步的起点，这将是我今后工作的鞭策和动力。

大学毕业后我到杭州市第二社会福利院从事养老护理工作至今已有5年。现在，很多年轻人不愿做那么辛苦的工作，其实花多一些心思，认识一下你在做的事情，就一定会从里面获得更大的成功感。护理工作虽然很辛苦、很繁琐，夹杂着各种酸甜苦辣，但每当面对老人们依赖的眼神时，我觉得再辛苦都是值得的。作为一名养老护理工作者，我们的使命就是尽我们的努力让老人们“长寿而活得精彩”。老人行动不便时我双手帮助，老人有烦心事时我双耳聆听，老人寂寞无聊时我欢乐大家。

在今后的工作中我会继续对老人多一点尊重，多一点理解，多一点解释，多一点帮助，多换位思考，用老人的眼光去看问题，用老人的心感受问题，更细致、更专业的为老人解决问题。

马丽琼

广州市老人院

今天我有幸获得优秀护理员这一殊荣，并能在这么大型的会议上发表我的感言，我深表荣幸。首先衷心感谢中国国际养老院院长协会、香港岭南大学给予我获奖机会；衷心感谢广州市老人院对我的厚爱与信任，感谢领导们对我的关爱与培养，感谢同事们对我的支持与配合。

当选为优秀护理员，仅仅是进步的起点，这将是我今后工作的鞭策和动力。我并没有做出了不起的大贡献，也没取得特别值得炫耀可喜的成绩，我只是时刻向身边的劳动楷模——广州市老人院洪佩贤院长学习，努力做好属于自己岗位上的工作。能够获此殊荣，我觉得我是幸运的，这是汗水与努力结合的产物，是我对老年护理事业尽心尽力的表达，也是领导们对我工作的认可！我院有200多名护理人员，她们在平凡的为老服务岗位上辛勤工作、默默奉献，所以说这个奖应该是属于我们大家的。这次获此殊荣，也再次向每位护理员传达与说明了只要做好了属于你的那份工作，就会有回报的务实文化和平凡道理。

面对人口老龄化的严峻形势，我们身上的担子更重了，必须始终坚持“视老人如亲人、做老人好儿女”这一服务承诺，脚踏实地为老人提供更优质的服务，为构建幸福老人院再做新贡献！

林送代

北京金梦圆老年乐园

我是中国甘肃省礼县永坪人，我名叫林送代，本人干护理工作十三年。在十三年的护理工作中，我还品尝了人生、懂得了人生，学会了好多护理技能，在金梦圆老年乐园“让躺着的坐起来、让坐着的站起来、让站着的走起来”的护理理念下指导下，经我护理的老人重获了人生。

今后，我要更加严格要求自己，努力掌握更好的护理技能，不断增长护理的知识，总结一些经验，为我国护理事业尽心尽力。

在护理老人的过程中，无论其社会地位、文化背景、经济条件、家庭贫富、地位高低，均有同样的对待，使他们享受到社会的温暖，愉快的度过余生，幸福的度过他们的晚年。

徐志萍

上海嘉定康福敬养院

一个三峡移民的敬老情结

——记上海嘉定康福敬养院护理部主任助理徐志平（节录）

在上海嘉定康福敬养院，从持上岗证当护理员干起，一直干到护理小组长、专护组组长、护理部主任助理的徐志平，只要一提起他，人们无不伸出大拇指啧啧称赞：这个新上海人真的了不起。八年多来经过她的手护理获得康福的老人就有几十名，她不仅认真学习专业知识和技能，更重要的是具备热心、耐心、细心、真心和爱心，树立了做一个新上海人的信心。

重重困难何所惧，学好本领为老人

徐志平十分清楚，要干好一样工作，没有坚定的决心和信心肯定不行。首先是语言关，她从重庆三峡移民到上海，操着一口重庆口音，而她的同事和服务物件绝大多数都是上海人，她要表达的意思人家听不懂，别人讲的话她又完全不理解。尤其是老人，不仅语言表达不清楚、而且还有耳背。在这样的情况下，她不仅要改变自己的急性子，讲话的时候热别的慢声细语，而且有时甚至还要用上授予，她就是凭着自己的热心、耐心、细心、真心和爱心，一遍又一遍地与老人沟通，一遍又一遍地向同事请教。功夫不负有心人，通过一段时间的工作，她不仅攻克了语言关，而且护理业务也有了较大的提高，从上岗证到取得护理员初级证书，更大的收获是她和老人及其他工作的心开始融合在一起了。2008年徐志平被评为“上海市嘉定区十佳护理员”，2009年获得上海市第五届养老服务“双十佳服务明星”提名奖。

精益求精　与时俱进　追求人生最高目标

在上海嘉定康福敬养院，徐志平的好学上进是出了名的，不仅在参加培训的时候，她认真地记笔记，对于在日常护理工作中医生、护士和其他同志讲的每个关键问题，她都认真地记录在自己的笔记本上，在有空的时候就仔细琢磨。对于在护理工作中遇到的难题，她就自觉地收集有关的资料，并请教有关的医生、护士。

一方面是自己认真学习，不断积累经验，另一方面是她有崇高的理想，积极靠近组织，自愿加入中国共产党，现已成为一个预备党员。她将更好地全心全意为人民服务，为老年事业贡献自己的力量。

上海嘉定康福敬养院

張靜

杭州市第二社会福利院

我能够获得“优秀护理员”称号，要感谢单位领导和大会组委会对我的认可。我有这份殊荣，我感到很荣幸，心中除了喜悦但更多的是感动。

我是来自西北农村的一名普通护理人员，自2006年进入杭州市第二社会福利院工作至今，我最大的体会就是要时刻带着爱心来工作，并尽自己最大的努力去护理好每一位老人。老年护理工作表面看上去是很简单、繁琐和枯燥的体力劳动，但在我看来是其乐无穷的快乐劳动，每一位老人都有他们自己几十年的故事，真正用心去体会他们，每个人都是一本书，一部电影。希望通过我的努力能让他们每个人的故事有一个温馨的延续。

能够获得这个荣誉是对我以后工作的一种鞭策，在以后的工作当中，我更应该严格要求自己。我将不辜负领导的期望，老人的信任，更加尽心尽职，努力工作，并不断学习提升自己的护理知识和技能，用实际行动来照顾好老人的晚年生活。

王寧

香港廣安護老之家

各位領導，各位護老行業的同仁，大家好：

我叫王寧，我是97年由北京去到香港定居的，也是在同一年里我加入了護老者的行業。

回顧自己數年來在護理工作崗位上的點點滴滴，我感到心慰. 在院長的領導下，我在職業道德、服務態度、敬業精神等方面，一直受到院長、同事、長者及家人的一致好評. 同時也獲得了不少的榮譽.

護理工作看似簡單，很繁瑣。不只是為長者打針吃藥，正確執行醫囑，還要負責許多的生活護理、心理護理等內容，我是從生活護理做起的，記得剛到香港，我的廣東話聽說的都不好，長者經常因我不能聽或說發我的脾氣，暴噪的沖我大叫，百般刁難，也不記得多少次，長者將嘔吐物和大小便弄在我身上，但我始終牢記，我是一名護老者，他們是長者，是老人，是患者，站在他們的立場上想，我就心平氣和了，一如既往，一絲不苟的為他們服務。用真誠的笑容，溫柔的話語來安慰他們。我把老人視做自己的爺爺奶奶，在他們因嘔吐，大便弄污床單衣服時，我總是及時為他們擦洗乾淨，換上整潔的床單和衣服，是我這種不怕污，不怕累的精神打動了他們，使他們更加配合我的護理工作，也使我們建立了良好的關係。

護理學是向前發展的，知道更新的非常快，為了能更好的適應現代護理的發展，我也不斷的增值自己，堅持學習，提高自己的專業水平，先後在香港報讀了保健員課程、高級保健員課程及護理師課程，並通過考試拿到了畢業證書。

在做好護理工作的同時，我還積極參加香港政府醫院組織的各項護理分享活動，通過這些活動，不但豐富了我的精神生活，也養成了我積極樂觀的生活態度。

成績屬於過去，未來的路任重道遠，我已把它作為我今後工作的動力，決心在平凡的工作崗位更上一層樓。

謝謝大家！祝各位身心康健，工作順利！

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暨2012年
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