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Public–private mix for continuity of care for older persons:

study of select countries in the Asia Pacific regions

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Acronyms and abbreviations

AB-PMJAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
ADL	activities of daily living
AI	artificial intelligence
AYUSH	Ayurveda, Yoga, Unani, Siddha, Homeopathy
BCOCH	Board of Control for Orphanages and other Charitable Homes
BPL	below poverty line
CPC	Communist Party of China
Customized Care	Customized Care Service for Older Adults
CSSA	Comprehensive Social Security Assistance Scheme
DH	Department of Health
DHC	district health centre
DHS	Directorate of Health Services
DME	Directorate of Medical Education
e-Health	electronic health record-sharing system
GDP	gross domestic product
HA	hospital authority
HB	Health Bureau
HIRA	Health Insurance Review and Assessment Service
IPOP	Integrated Programme for Older Persons
ICT	information and communication technology
KSSM	Kerala Social Security Mission
LSGD	local self-government department
LSGI	local self-government institution
LTC	long-term care
LTCI	Long-term Care Insurance
LWB	Labor and Welfare Bureau
MCH	Trivandrum Medical College Hospital
MDS-HC	minimum dataset – home care

MoHW	Ministry of Health and Welfare
MOHFW	Ministry of Health and Family Welfare (India)
MOSJE	Ministry of Social Justice and Empowerment
NBCP	National Blindness Control Programme
NCD	noncommunicable disease
NGO	nongovernmental organization
NHI	National Health Insurance
NHIS	National Health Insurance Services
NHM	National Health Mission
NHS	National Health Service
NMHP	National Mental Health Programme
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease, and Stroke
NPHCE	National Programme for Health Care of the Elderly
OAH	old age home
OOP	out of pocket
PPP	public–private partnership
RGC	Regional Geriatric Centre
SHC	Seoul Health Companion
SHM	State Health Mission
SJD	Social Justice Department
SMG	Seoul Metropolitan Government
SOP	standard operating procedure
SWD	Social Welfare Department
THE	total health expenditure
TMC	Thiruvananthapuram Municipal Corporation
UNFPA	United Nations Population Fund
WHO	World Health Organization

Chapter 1: Introduction

Ageing populations are a growing global phenomenon, calling for closer integration of services for older persons, especially between the health- and social-care services[1] *(1–5).* In light of the rapid demographic transition in the region and the rising prevalence of multimorbidities among the older population, fault lines of the existing fragmented care regime have been exposed more than ever before. Integration has been advocated by scholars and international organizations for over a decade, but rather limited actions have been observed thus far. This has largely been a result of the restructuring of the welfare state across Asian countries influenced by the neoliberal health sector reforms in the 1990s and early 2000s. These reforms advocated for a cutback on public spending on health and expanded the role of markets in curative services. This resulted in the commercialization of health services that brought in market principles within public systems and policies that supported the for-profit sector in the financing and provisioning of services *(6–9).*

In several countries, social protection interventions were commercialized and this meant that the responsibility of care of older persons is assumed by the family and private institutions. A study by Baru et al. *(10)* revealed that in India, mainland China (henceforth China), Japan, Hong Kong SAR, Malaysia, Indonesia, Singapore and Sri Lanka, there exists a public–private mix in health services and social care for older persons. This mix involves multiple actors and agencies that include the public, for-profit and non-profit sectors in providing preventive, promotive, curative, rehabilitative, home-based and long-term care for older persons. Across countries, the role of private arrangements for care of older persons coexists with profit and non-profit initiatives at the individual, community and institutional levels. These may coordinate with public services but rarely integrate within and across the for-profit and non-profit sectors. The study also showed that there is considerable fragmentation in the role within and across the public and private sectors in health services and social care delivery. In countries where the proportion of older persons is high, there are efforts to better link and coordinate services for health and social care as compared to those that are at the lower end of the silver curve.

[1] Social care encompasses residential care, long-term care, community and home-based care.

This study goes one step further by including social care into the map, highlighting the need to move the scope of analysis beyond the medical setting to consider a wider spectrum of care needs of older persons. Broadly speaking, social care encompasses residential care, community care and home-based care. The definition of social care and support provided by WHO, as referenced by Gilton et al. *(11)*, emphasizes a holistic approach to an individual's well-being. This view extends beyond just medical or physical needs, considering multiple dimensions that contribute to a person's overall quality of life.

The fragmentation between health and social care for older persons is visible across countries and therefore poses a challenge to designing comprehensive strategies for continuity of care. The need for integration of services for older persons from the viewpoint of efficiency and quality has been exemplified by WHO, which states the need for services for older persons to be included in universal health care packages; for well-coordinated services between health and social care to provide optimal care when needed; to support healthy ageing with a person-centred and coordinated model of care *(12).* Furthermore, studies repeatedly emphasize the need for integrating health and social care to better address complex health needs and improve patient outcomes. As such, it is vital that policy-makers, practitioners and researchers alike prioritize bridging this divide and moving towards a more integrated care model.

Given the complex architecture of the public–private mix that operates in silos, it is bound to have consequences for access, cost and quality of health services, and social care for older persons. An earlier study of the supply side of health and social services revealed a fragmented landscape with multiple actors within the public sector. This resulted in the fragmentation of role, authority and power between the different actors in terms of financing, provisioning and governance of services. The study revealed that there was a public–private mix in financing and service provisioning in health and social services. Often the two sectors operated separately from one another, resulting in further fragmentation across the selected countries. It is in high-income economies that there were efforts to create partnerships for select services for older persons. This involved public financing through insurance schemes in partnership with private

provisioning. Based on our earlier findings, the study sought to document the public–private mix for continuity of care, which includes health services (including long-term) and social care across select societies in the Asian region. Based on a review of available studies we were able to provide an overview. To get greater depth and understanding into the processes we chose to focus on four urban sites – Hong Kong SAR, Seoul (Republic of Korea), Shanghai (China) and Thiruvananthapuram (India). The in-depth study covered the public and private actors who provide health and social services; the patterns of financing and the extent of coordination, cooperation and partnerships if any between the two.

Context and background

Nine countries and regions were initially reviewed. They represent diversity in terms of demographic profile, levels of socioeconomic development, approaches to welfarist interventions and the magnitude of the private sector's involvement in the health and social sectors. Most East Asian societies have comprehensive welfare provisioning that includes public health insurance, mixed provisioning of health services, education, unemployment benefits, pensions and support for older persons. The low-middle-income countries in South and South-East Asian societies have targeted public health insurance for the poor, weak public provisioning of health services, limited pension schemes and a few interventions for support and care of older persons. The diversity of sociopolitical contexts is reflected in the scope and depth of public financing and provisioning of health services (Table 1.1) *(13–17)*.

Table 1.1. Variations in sociodemographic profile and health expenditure of the original nine countries/regions

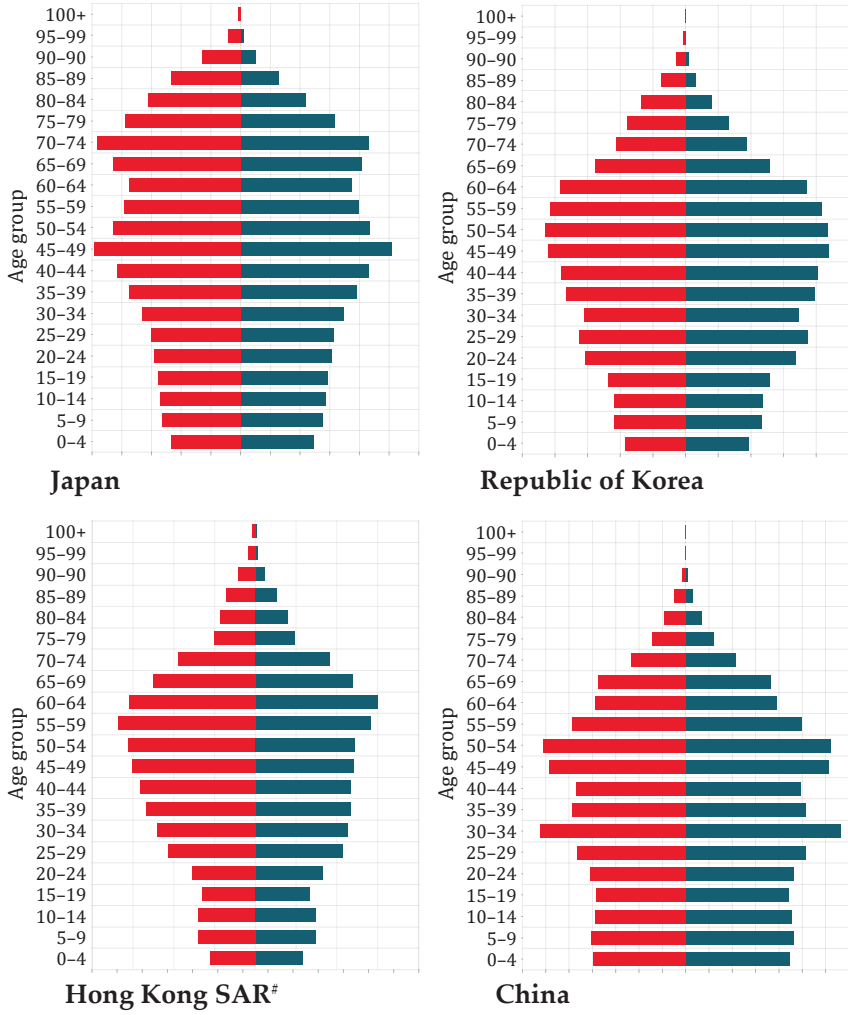
S. no.	Selected countries	Income level	Total population (in millions) UN Report 2023	Population aged 65 years and above (as % of total population) UN Report 2023	Current expenditure on health (% of GDP)	Government expenditure (% of current health expenditure)	OOP (% of total health exp.)	Public insurance coverage
I.	East Asia							
1.	China	Upper-middle	1425.7	14	5.6	54.7	34.8	Universal coverage through three insurance schemes subsidized by the government and contributions by formal sector employees
2.	Republic of Korea	High	51.8	18	8.36	63.08	32.50	Universal coverage through national insurance scheme – contribution and subsidies
3.	Hong Kong SAR, China	High	7.5	16	7.0	54.0	30.0	Partial insurance through private and employee insurance
4.	Japan	High	123.3	30	10.9	84.24	12.57	Universal coverage through insurance schemes – contributory and subsidies

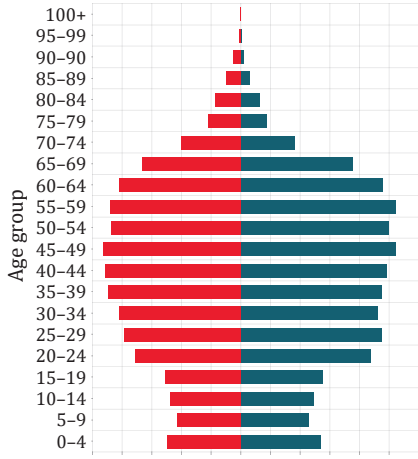
S. no.	Selected countries	Income level	Total population (in millions) UN Report 2023	Population aged 65 years and above (as % of total population) UN Report 2023	Current expenditure on health (% of GDP)	Government expenditure (% of current health expenditure)	OOP (% of total health exp.)	Public insurance coverage
II.	South-East Asia							
5.	Singapore	High	6.0	16	6.05	52.41	18.9	Universal insurance through public and private schemes
6.	Malaysia	Upper-middle	34.3	8	4.12	52.75	35.9	Partial coverage through voluntary private insurance
7.	Indonesia	Upper-middle	277.5	7	3.41	55.05	31.8	Introduced National Health Insurance in 2014 but has not reached universal coverage
III.	South Asia							
8.	India	Lower-middle	1428.6	7	2.96	36.65	50.6	Partial insurance coverage (public and voluntary private)
9.	Sri Lanka	Lower-middle	21.9	12	4.07	45.8	46.6	Partial coverage through voluntary private insurance schemes

Source: UNFPA (18); World Bank *(19,20)*

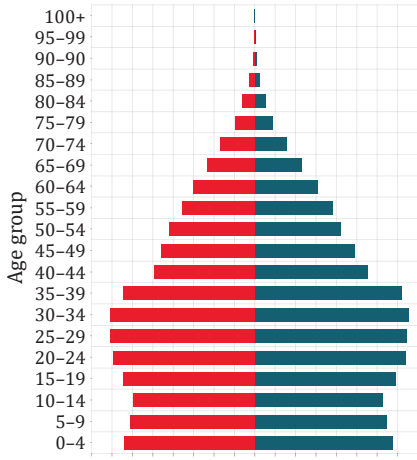
The demographic structure varies across the nine countries and regions, with Japan, Hong Kong SAR and Singapore representing the super ageing societies while Malaysia and Indonesia have a much younger population. Republic of Korea is well on its path to qualifying as a super ageing society and China has interregional variations, with the eastern region having already aged. Sri Lanka has a higher proportion of older persons, almost close to East Asian societies while India and Indonesia have only around 7% of older persons above 65 years *(18)*. Fig. 1.1 shows the current population pyramids for these nine societies.

Fig. 1.1. Population pyramids of the original nine study countries/regions (2020 data)

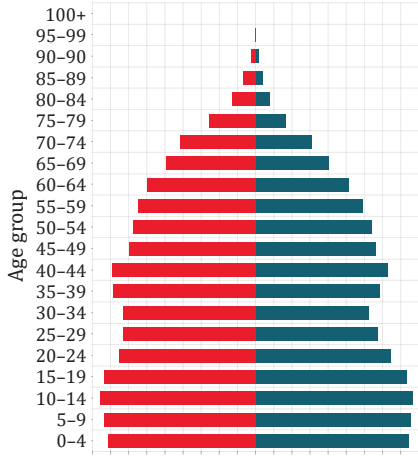




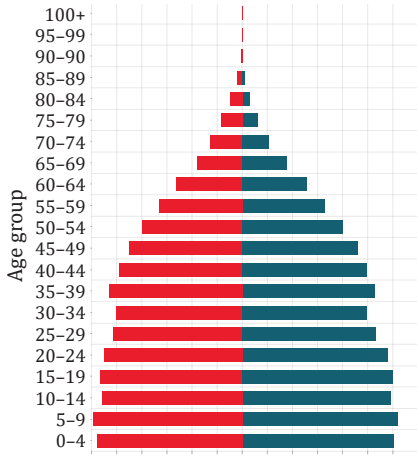
Singapore



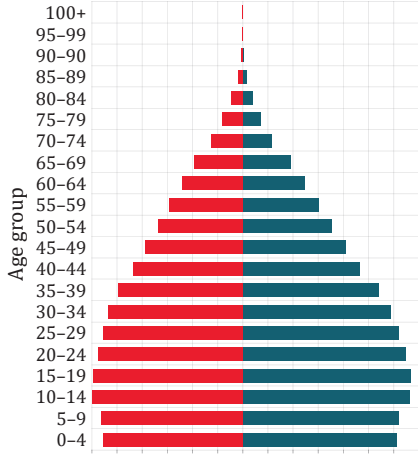
Malaysia



Sri Lanka



Indonesia



India

Source: UNFPA *(21)*; [#] Census and Statistical Department, Government of Hong Kong SAR (2021 data) *(22)*

Across all the nine countries and regions, welfare provisioning consists of the family, government and the private sector (including non-profit and for-profit). The mix of the three varies across countries and is determined by levels of public spending on health as a percentage of gross domestic product (GDP) and the nature and extent of private sector growth (Table 1.1). Given the variations in demographic and socioeconomic profiles, the introduction of welfare schemes for older persons is at various stages of maturity.

There is variation in the role of the State and the market in financing of and provisioning for health and social care for older persons. Welfare provisioning varies across them – families are still considered the primary caregivers but this role is clearly changing, followed by a mix of government and private sector (for-profit and non-profit) services. The proportion and mix of services is determined by the demographic profile, level of public spending on health and welfare schemes for older persons, and presence and scope of the private sector.

The patterns of financing determine the provisioning of health services and social care. In East Asian societies, there has been a shift towards integrating social care with health services, with its challenges. China, the Republic of Korea, Japan, Hong Kong SAR and Singapore represent a State-led model of near-universal health insurance coverage. These countries and region have rapidly aged and have introduced, or are building up, long-term care (LTC) for older persons. There is also an effort at greater coordination and integration of health and social services for older persons. In many instances, these reforms have included the private sector where the government purchases services from the private sector. Hence, there are more mature partnerships seen between the public and private sectors. In the case of the South Asian region, public insurance schemes are targeted for the poor and welfare, especially for older persons, is weak. Services for older persons in South Asian and South-East Asian countries are highly fragmented, given the low spending and a huge presence of an unregulated private sector. The role of the public sector in providing social services for older persons is primarily through government-funded institutions. The government provides financial support through grants-in-aid to nongovernmental organizations (NGOs) that deliver social care for older persons.

Health service systems across the world are fragmented along financing, provisioning and governance structures to varying degrees. This also gets exacerbated by the presence of public and private services that often compete with each other *(10)*. This mixture of public and private providers is also present in social care settings for older persons across the countries and regions that this paper analysed: China, Hong Kong SAR, India, Indonesia, Japan, Malaysia, Singapore and Sri Lanka. The study showed considerable fragmentation within and across public and private health and social care services. This was exemplified by the involvement of multiple actors and agencies that include the public, for-profit and non-profit sectors in providing preventive, promotive, curative, rehabilitative, home-based and LTC for older persons.

Countries that have already transitioned to an ageing society have attempted coordination and, in some instances, integration of services for older persons across sectors. Countries that are still transitioning need to proactively begin thinking of the role of a public and private mix along the lines of coordination as a step towards integration for continuity in care. There are lessons to be learnt from other countries in the East and South-East Asian region that have experimented and innovated along these lines.

The very nature of person-centred care for older persons demands coordinated and integrated care across health and social services. However, the fragmentation within and between health and social care for older persons is visible across countries and this poses a challenge for designing comprehensive strategies for complex health needs and hence, continuity of care. The architecture of service delivery gets further complicated, given the nature of the public–private mix of services that operate in silos. This has consequences for accessibility, affordability, governance and quality of services available to older persons and consequently on their life and quality-of-life outcomes.

Our review of nine countries and regions showed that there is a variety of public-private mix in health services and social care for older person in all these countries. This mix involves multiple actors and agencies that include the public, for-profit, and non-profit sectors in providing preventive, promotive, curative, rehabilitative, home-based and long-term care for

older persons. Across countries the role of private arrangements for care of older persons included profit and non-profit initiatives at the individual, community and institutional levels. On occasion there was coordination of activities with the public sector but rarely was there integration of activities within or across the for-profit and non-profit sectors. The study also showed that there is considerable fragmentation of roles within and across the public and private sectors in health services and social care delivery. In countries where the proportion of older persons is high, there are efforts to better link and co-ordinate services for health and social care as compared to those who are in the lower end of the silver curve.

This comparative paper relies on mapping the public–private mix for continuity of care that includes health services (including long-term) and social care across select countries and regions in the Asian region. The original overview of the nine countries and regions underlined the diversity in the demographic profile, financing of health services and social care in the Asian region. To get a deeper insight into the structure and processes of delivery of health services and social care of older persons, case studies of four urban sites from Hong Kong SAR, Republic of Korea, India and China were done. These case studies focused on the financing, policies, organization and provisioning of health services, social care, human resource requirement and extent of integration of services to meet the needs of older persons. It examined innovations for better integration and highlighted the challenges for financing, provisioning, human resources and regulation of health services and social care towards integrated care. It identified practical recommendations that policy-makers can use as they develop more person-centred health and social care services for their urban ageing populations.

Chapter 2: Methods

Based on the analysis of the nine countries and regions, the study delved into four urban contexts in order to get an indepth understanding of the actors, agencies and networks for health and social care for older persons. The choice of the four cities- Thiruvananthapuram (Kerala, India), Shanghai (Mainland China), Hong Kong (SAR) and Seoul (South Korea) was guided by the presence of a sizeable proportion of older persons, varied policy responses to the needs of older persons and innovations for integration of health services and social care. To address the objectives, all four sites undertook mapping of actors and agencies in the public and private sectors in health and social care through desk research, review of policy documents, interviews and expert policy consultations. For all four sites, a mapping of major actors and agencies was undertaken to delineate the architecture of the public–private mix in health and social care. The mapping exercise tried to capture collaborations or partnerships between the public and private sectors in health services and social care to illustrate the public–private mix. Based on the mapping exercise, key stakeholders were identified and typologies of institutions were derived. In-depth interviews with key persons in the policy arena, health services and social care institutions in the public and private sectors provided insight into the linkages and challenges in providing integrated care for older persons across diverse institutions. The specific focus was on financing, provisioning, human resources and regulations. The details of the interviews conducted for each site are given below.

Hong Kong SAR

The research team conducted a review of the literature and policy analysis. In addition, 10 in-depth interviews were conducted between 2020 and 2022 in Hong Kong. The interviewees included senior officials of the Food and Health Bureau (the "Ministry" formulating health policies) of the Hong Kong SAR Government and the Department of Health, hospital managers, frontline health professionals and social workers, elderly patients and caregivers. Due to social distancing rules that were still in force, some of the interviews were conducted via Zoom while others were conducted face-to-face.

Seoul

The research team conducted policy analysis and mapping of health and social service actors and agencies in Seoul and, where relevant, at the national (central) level. The analyses were based on a comprehensive review of central and city policies and programmes, as well as other relevant government and academic documents, including health and long-term care insurance statistical yearbooks, manuals and user guides for programmes and services for older adults, journal articles and websites. Our analysis and interpretation of the findings from the desk research also incorporated the insights and lessons learned from the policy discussion with six policy experts consisting of policy-makers and relevant administrators of health and social services in Seoul.

Thiruvananthapuram

A review of relevant government and policy documents provided the background and context for the study. In-depth qualitative interviews were conducted with key stakeholders across sectors and expert consultations with policy-makers from the government, representatives of the private for-profit and non-profit sectors. Six expert policy consultations were conducted between late 2020 to early 2023, which included senior bureaucrats and professionals of the health department, state planning board members, key persons of local self-government, including senior officials of the Kerala Institute of Local Administration, and a few elected representatives of local self-government institutions (LSGIs), professionals from the Kerala Health University of Health Science, palliative care professionals, representatives of private non-profit sector, members of the state orphanage control board (of the Social Justice Department [SJD]), Indian Medical Association representatives, NGO representatives, and state- and district-level officers of Kudumbasree[2] and the Mahila Samakhya programme[3]. The expert consultations covered a range of issues. These included the current status of services; main actors and agencies involved;

[2] Women's self-help group supported by the State, which also offers some care for older persons

[3] Centrally sponsored Women's Development Programme for empowerment and equality

extent of collaboration between the public and private sector; gaps and challenges faced and policy engagements for the future.

Shanghai

A review was undertaken of the available literature and analysis of policy documents to provide the context and working of schemes for older persons. During 2020 to 2023, 12 experts from government departments, academic institutions and nursing home/institutions were interviewed. The interviews covered details on modes of public–private partnerships in care services for older persons – cooperation content and cooperation mechanism, development status, existing challenges and suggestions of a public–private partnership model in the field of nursing care for older persons in Shanghai. The government departments included mainly the Civil Affairs Bureau, Health Commission, Working Committee on Aging Commission, Development and Reform Commission, Department of Finance and the Bureau of Planning and Natural Resources. The main academic institutions included the Institute of Urban and Population Development, Shanghai Academy of Social Sciences and Fudan University. The nursing home/institutions visited mainly included comprehensive service centres for older persons, day-care centres, elderly-care homes, welfare homes for older persons, nursing homes, and assisted meals in various districts. Due to the impact of COVID-19, the interviews were conducted through both online and offline methods.

The key elements of WHO's *(23)* approach to integrated health care for older persons was used for comparative analysis of the case studies. The key elements included financing, provisioning of services, human resources and regulation.

Chapter 3: Findings from the four case studies

Case study 1: Hong Kong SAR

Context

Hong Kong Special Administrative Region (henceforth Hong Kong) has a population of 7 million and is one of the most affluent societies in the world. Hong Kong is also one of the world's "super-ageing" societies with a remarkable record of population longevity and an extremely low fertility rate. Life expectancy at birth was 83.2 years for men and 87.9 years for women in 2021 *(24)*. Citizens aged 65 years or above numbered 1.45 million in 2021, accounting for 20.25% of the entire population, and this figure is projected to increase to 2.74 million (36% of the population) by 2046. The median age of the Hong Kong population has climbed from 35.1 in 2000 to 47.3 years in 2021 *(22)*. Such a gradual but significant demographic shift creates a tremendous demand for services for older persons, in both health- and social-care settings. Unfortunately, family support that used to be a major pillar of care for the older people in Chinese societies is no longer a reliable "safety net" in Hong Kong, due to the drastic change in family structure.

A remarkable characteristic of Hong Kong's older population is the rather high rate of poverty, largely due to the lack of universal retirement protection programmes. This explains the high demand for government-subsidized services and limited ability to pay for private services among the older people. Similar to the situation in other high-income economies, non-infectious degenerative diseases dominate Hong Kong's epidemiological profile, with cancer and cardiovascular diseases being the leading causes of death. It needs to be noted that refusal to vaccinate against COVID-19 among the older population in Hong Kong was high and the COVID-19 pandemic led to the death of more than 12 000 older adults in the territory.

Overview of welfare schemes for older persons

Traditionally described as a "residual welfare state", Hong Kong has not taken an expansionary approach to social policy. High poverty rates in the older population (around 45%) and the absence of universal retirement protection are among the top welfare woes in the territory. All funded

by taxation, three welfare schemes are of particular importance for older persons in Hong Kong.

- Old age allowance, colloquially known as fruit money, is a Hong Kong government programme introduced in 1973, which currently provides a monthly payment of HK$ 1620 to older residents. There is no means to test for the higher old age allowance given to recipients aged 70 years or above, making it a de facto universal programme.
- Old age living allowance, launched in 2013, seeks to provide a special monthly allowance to supplement the living expenses of older persons in Hong Kong aged 65 years or above who are in need of financial assistance. The current monthly payment is HK$ 4195. A means test (screening of assets and income) is required.
- Comprehensive Social Security Assistance Scheme (CSSA) is the last-resort social protection programme in Hong Kong. Serving as a safety net for those who cannot support themselves, this scheme provides cash benefits to eligible citizens and a means test is mandatory too. The CSSA was not designed for older persons per se, but they are the biggest group of recipients, largely due to prevalent poverty in the older people. Approximately 60% of CSSA recipients are 65 years of age or above.

Governance, financing, provisioning and human resources in health- and social-care settings

Governance and regulation

The Health Bureau (HB) sits at the apex of the health governance regime, assuming responsibility for policy formulation and monitoring. Health policies are enforced by the Department of Health (DH) and the Hospital Authority (HA). Founded as a public corporation, HA manages all public hospitals and government outpatient clinics in Hong Kong. The government provides recurrent fiscal subsidies to the HA via the HB in a fashion that largely resembles the British National Health Service. Starting from 2019, private health institutions are subject to government regulation on staffing, accommodation, and equipment. Yet, the private sector continues to enjoy a high level of operational autonomy.

Unlike in the Republic of Korea and Taiwan (China), health and welfare functions are not yet consolidated to one single ministry. The Labor and Welfare Bureau (LWB) oversees social welfare and elderly service affairs. As its executive arm, the Social Welfare Department (SWD) administers most social security programmes and regulates the service sector for older persons through licensing and registration.

The Elderly Commission was established in 1997 to advise the government on population ageing policies and foster interdepartmental coordination in policy formulation, but its role is more of an advisory and consultative one instead of execution. The division between the health portfolio and the welfare portfolio within the government structure is said to impede smooth coordination implement policies related to older people.

Financing

Health care in Hong Kong is financed from both public and private sources, each accounting for approximately half of the total funding. Government funding is mainly used in recurrent subsidies injected to public hospitals and clinics, as well as demand-side subsidies such as various forms of vouchers and benefits. Private funding includes individually purchased commercial health insurance, corporate health insurance (as a form of employment benefit), and out-of-pocket (OOP) payments that account for around one third of the total expenditure on health. There is no social insurance in the entire welfare system in Hong Kong. As a major effort to diversify Hong Kong's health financing, the government launched the Voluntary Health Insurance Scheme to encourage the subscription of government-regulated private health insurance plans, but this scheme is largely not relevant to this current study because the older population is not the key intended subscriber. Older patients who are CSSA recipients enjoy full fee waiver in public health-care facilities.

In the social care domain, the SWD's financial provision points to both non-profit subvented facilities and private for-profit ones. Providing the bulk of residential care services in Hong Kong, the large NGO sector receives government subvention and operates in high autonomy. The government also purchases a large quantity of residential care beds from the private sector that in turn provides services to eligible older persons at heavily

subsidized rates. For older persons suffering from moderate and severe disability but ineligible for government-subsidized services, purchasing residential services from the private sector is one of the common options, but the cost is significantly higher. There is limited presence of long-term care insurance (LTCI) in Hong Kong. OOP expenditures for private LTC services may create a financial burden for households.

A salient feature of financing in both the health and social care sectors in Hong Kong is the extensive use of demand-side interventions, particularly various forms of vouchers. Thanks to the government's fiscal strength, these voucher schemes give older persons and their families considerable financial relief as well as greater choice of services. The injection of funding through vouchers also fosters growth of the service industry for the older people.

- The *Elderly Healthcare Voucher Scheme* was launched in 2009 as a pilot. It gives eligible citizens aged 65 years or above earmarked vouchers to purchase private health services, including preventive care. This scheme also intends to reduce the long waiting time in public hospitals by diverting a substantial number of older patients to the private system. Currently, the annual provision is HK$ 2000, with an accumulation limit of HK$ 8000.
- The *Residential Care Service Voucher Scheme for the Elderly* enables older persons in need of residential care services but waitlisted in government-subsidized services to have additional choices during this waiting period. Currently carrying an annual value of HK$ 16 161, the vouchers can be used to purchase private residential care services.
- The *Pilot Scheme on Community Care Service Voucher for the Elderly* seeks to support "ageing in place" of older persons by offering them vouchers to choose community care services that suit their individual needs. Applicants need to pass the needs assessment and should be currently waitlisted for government-subsidized services. Depending on the actual service packages purchased, the current ceiling and floor values of the vouchers are HK$ 10 455 and HK$ 4372 per month, respectively.

Provisioning and human resources

Health-care provision in Hong Kong is characterized by a dual-track structure. While 70% of outpatient services are rendered by the private sector, public hospitals dominate inpatient services, providing 90% of hospital bed-days in the territory. The bulk of primary care is provided in private clinics where per-episode OOP payment is made. Public hospitals are the main providers of secondary and tertiary care. Patients pay nominal fees because of heavy subsidies from the government. The public hospital system operates on rigid referral mechanisms, but gatekeeping mechanisms are relatively weak in the private system. "Doctor shopping" is rather common in the private domain, potentially undermining continuity of care. Hong Kong's health system is dominated by Western medicine, while traditional Chinese medicine plays a supplementary role.

Following the establishment of the HA in 1991, multiple rounds of efforts have been made towards integration of the public health-care system. A pivotal move was the clustering of facilities. Seven public health-care clusters are in place based on geographical proximity. Each cluster has one to two central hospitals as the medical hub that is further supported by a couple of satellite hospitals providing acute secondary care and a dozen government clinics responsible for primary care. The most acute problem in Hong Kong's health system is the long waiting time in public hospitals. Inherited from the British NHS principle, the public hospital system in Hong Kong operates on universalism, providing heavily subsidized services to all citizens regardless of means. The overreliance on the public system, especially among lower-income households, coupled with population ageing, has created mounting demands. In addition, there is a severe shortage of doctors in Hong Kong as the number of physicians per 1000 persons is merely two, a level that is much lower than other high-income societies. The long waiting time is particularly severe for specialist care, with years of waiting being rather common. In recent years, there has been an accelerated brain drain in the health system, with many doctors and nurses emigrating overseas. Hong Kong currently has two medical schools that train doctors although a third one is planned. As a ratio of its population, the number of graduates remains low. Despite resistance

from vested interests, the government has been making efforts to relax the restrictive policies for overseas trained doctors to practise in Hong Kong.

Technically, services for older persons in non-medical settings – here referred to as "social care" – in Hong Kong encompass residential care, community care and support, and transitional care. Despite the wide recognition of the value of community care, the institutionalization rate in Hong Kong remains high as compared to many other high-income countries. In 2022, 36 375 subsidized residential care beds were distributed while merely 13 081 community care places were available. The annual government budget for residential care services was five times that for community care services. Predominantly operated by NGOs, community care services in Hong Kong include day-care centres, integrated home-care services, and enhanced home and community care services.

The cornerstone of Hong Kong's social care system for older persons is residential care facilities. NGOs, the dominant providers of such services, are subvented by the government. This de facto "public LTC system" charges nominal user fees but is overwhelmed by a long waitlist, as the gap between limited capacity and the vast unmet demand continues to widen. Subsidizing 90% of their operational costs through general revenues, the government is the biggest funder of this sector. Constrained by limited availability of beds in subvented facilities, the government launched the Bought Place Scheme and the Enhanced Bought Place Scheme in response to the soaring demand for subsidized LTC services. Operated by NGOs or private for-profit organizations, these "contract homes" provide subsidized services to elderly users at affordable rates.

The majority of local older persons in need of LTC prefer government-subsidized services not only for affordability reasons, but also because of the comparatively high quality of service. Unfortunately, supply-side expansion in this sector is gravely constrained by limited physical and human resource capacities, as well as the high demand for fiscal resources. Undersupply and rising demand combine to exacerbate the long waiting list problem. Eligible older citizens typically must wait for three to four years to move into government-subvented residential homes even after they have passed the needs assessment.

The large number of older persons with chronic disability have to make a hard decision: move into private homes (where the quality of service varies significantly) and pay much higher fees or stay at home but remain poorly attended. Market segregation occurs, given the varying level of ability to pay among the older population. High-end private homes do exist, but the charge exceeds what most older persons can afford. "Economical" private LTC beds cater to the middle-class and worse-off older persons, but the quality of service is controversial. As a result, it is unsurprising to observe a strong preference among older persons to wait for a government-subsidized place, despite the existence of a sizable private LTC network.

Like in other post-industrialized societies, family support in Hong Kong has become an increasingly unreliable source of support for older persons. This partially explains the high institutionalization rate. It needs to be underlined here that foreign domestic helpers – predominantly from the Philippines and Indonesia – are an important group of informal caregivers. There have been concerns regarding the qualification and training of informal caregivers, including both domestic helpers and family members. The SWD recently launched the Pilot Scheme on Training for Foreign Domestic Helpers in Elderly Care, which aims to strengthen their skills in taking care of frail elders. Given the rising demand for social care services for older people, the shortage of human resources in this sector has become increasingly critical. The government responds with new initiatives that seek to "import" caregivers from the neighbouring Guangdong Province, China, which shares a cultural and linguistic background with many of the older people in Hong Kong.

Another key human resources initiative is the Enrolled Nurse Training Programme for the welfare sector, which intends to equip graduates with the necessary competency in caring for the needy, especially older persons. Organized by the SWD, this two-year programme seeks to meet the growing demand for human resources in social-care services. While tuition fees can be fully reimbursed upon graduation, trainees are required to sign an undertaking to work in the welfare sector for at least two consecutive years. This initiative is expected to further mitigate the shortage of well-trained care professionals for older persons.

Underpinning the LTC system in Hong Kong is a rigorous needs assessment system called the "Standardized Care Need Assessment Mechanism for Elderly Services", which determines the allocation of subsidized LTC services. The mechanism incorporates an internationally recognized assessment tool called "Minimum Dataset – Home Care" (MDS-HC) to identify specific care requirements of older persons. In the needs assessment, assessors conduct comprehensive evaluation of the applicant's abilities in various domains, such as activities of daily living, cognition and communication, emotion and behaviour, health condition, social support, and living environment. Based on the assessment results, applicants may apply and be placed on the waitlist for appropriate government-subsidized LTC services. In case an older person on the waitlist suffers from major deterioration in health condition, a reassessment can be requested.

Fig. 3.1. Application process for standardized care need assessment mechanism in Hong Kong

STEP 1	**Raise a request**	An older person or his/her family raises a request for subsidized LTC services to a responsible/referring worker of a medical social services unit, an Integrated family service centre or an older person service unit in the district.
STEP 2	**Initial screening**	The responsible/referring worker conducts initial screening and refers the older person for arrangement of assessment as appropriate.
STEP 3	**Conduct assessment**	Assessor carries out the assessment through a home visit and face-to-face interview.
STEP 4	**Explain the assessment result**	The responsible/referring worker explains to the older person the assessment result and the service matched with the person.
STEP 5	**Formulate a care plan**	The responsible/referring worker draws up a care plan for the older person and assists him/her to apply for a suitable service.

Source: Social Welfare Department, Hong Kong SAR *(25)*

Public–private partnerships (PPP) in the health sector

Inspired by the idea of public–private partnership, the HA has identified several areas in which the private sector can draw off some portion of the heavy outpatient load from the crowded public system. The umbrella PPP programme run by the HA includes the following:

- General outpatient clinic public–private partnership programme: patients receive up to 10 subsidized visits per year in private hospitals/clinics through public hospital referral.
- Radi collaboration: cancer patients in public hospitals are referred to the private sector for radiological diagnostic examinations as part of their cancer care plan. This helps speed up the diagnostic process substantially.
- Cataract surgeries programme: patients on the waiting list of public hospitals' routine cataract surgery can be operated by a private ophthalmologist. This helps to reduce the waiting time significantly.
- Haemodialysis public–private partnership programme: patients receiving haemodialysis treatment in a stable condition can receive services by the private sector in the community setting.
- Colon assessment public–private partnership programme: patients on the waiting list for colonoscopy in public hospitals can choose a private specialist for colon assessment.
- Glaucoma public–private partnership programme: patients getting glaucoma treatment in public hospitals can receive private specialist services in the community.

Notwithstanding the minor variations in programme design, the operation of these specific schemes by and large follows the same principle. Private practitioners are invited to join a public–private partnership (PPP) and render services. The government heavily subsidizes private providers to maintain the same level of fees that patients pay in the public sector. Patients join the programmes on a voluntary basis and enjoy more choices when seeking care. This is intended to mitigate the burden on the overloaded public system by encouraging the utilization of private services. Zooming out of the HA premise, the DH also runs several flagship PPP

programmes, including the Elderly Healthcare Voucher Scheme. Other similar programmes relevant to elders include the Residential Care Home Vaccination Programme and the Colorectal Cancer Screening Programme.

PPP practices exist not only in the health service domain but also in social care. For example, the residential care voucher scheme and the community care voucher scheme mentioned earlier on also reflect similar principles. The Bought Place Scheme, too, is based on the same formula as the government purchases LTC beds from the private and non-profit sector to expand the capacity of government-subsidized services.

The wide use of PPP, including vouchers, in Hong Kong resonates with its long-time governance philosophy of positive non-interventionism and the macro structure of "small government, big market". Except the sizable public hospital sector, the government hardly runs its own welfare service network but predominantly uses subvention and other types of purchasing instruments as a financial lever to arrange service provision. The PPP modality in Hong Kong forges a contractual relationship between the government and the nongovernment service sector in which the former as funder enforces the contract and monitors the delivery of services and the latter is held accountable for the services it delivers. The wide use of PPP is, of course, supported by a range of factors in Hong Kong, such as strong public finance, a fledged market economy, and rule of law. In countries with poor governance oversight, such PPP initiatives may yield unsatisfactory outcomes due to corruption and poor capacity.

Efforts toward care integration

In light of the rising prevalence of multimorbidities among older persons, fault lines in the existing fragmented care regimes have been fully exposed. Hong Kong has embarked on a number of initiatives towards care integration, particularly between health services and social care domains. Some initiatives undertake organizational integration, while others are at the operational level.

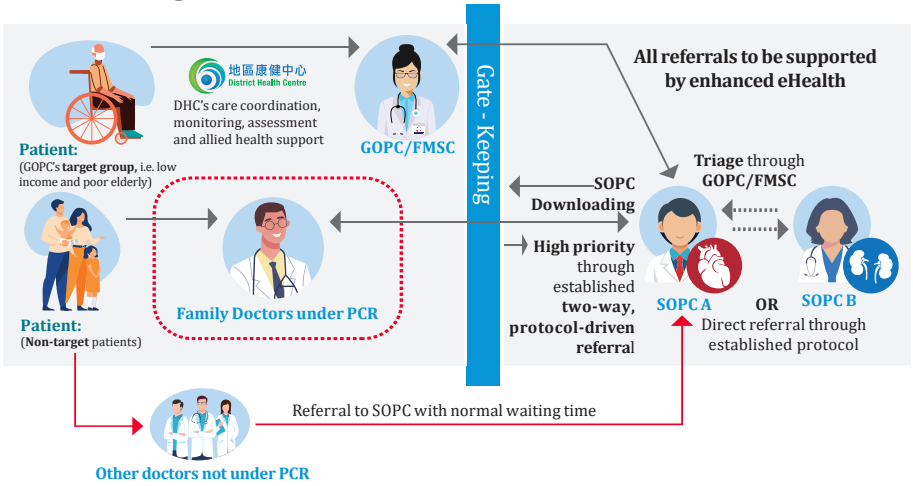
- Integrated home care services seek to enable ageing in place and a continuum of care within the community setting. Service providers offer enhanced support, care and rehabilitative services to community-dwelling elders.

- Enhanced home and community care services create a platform to provide integrated services for frail elders, allowing them to age at home or in a familiar environment.
- Integrated care and discharge support seeks to reduce unnecessary hospital admissions of elders through integrated care services. A multidisciplinary team provides care, support and training for patients and caregivers for 8 weeks after discharge from public hospitals.
- Community geriatric assessment team ensures older patients' smooth transition back to the community and maintaining a good quality of life. It also serves as a gatekeeper for hospital readmission and safe discharge.
- Integrated community centre for mental wellness provides one-stop district-based and accessible community support and social rehabilitation services ranging from early prevention to risk management for persons in mental recovery, persons with suspected mental health problems, their families/carers and residents living in the serving district through a single-entry point.

A paradigm shift in recent years is represented by the Hong Kong SAR government's release of its primary health care blueprint in December 2022. Striving to strengthen the primary care system as the foundation, the government is committed to putting abundant resources at district-based centres and the private sector to better manage the needs of a rapidly ageing population. A key feature of this blueprint is the plan to establish a strong regional health centre in each of Hong Kong's 18 districts. Residents with non-urgent medical needs will be encouraged to visit the local clinic and family doctor. The district health centres (DHCs) partner with the private sector to promote the concept of "family doctor for all" and collaborate with various health professionals to provide comprehensive services for persons, particularly older persons in the community. A three-year Chronic Disease Co-Care Pilot Scheme was recently launched, under which DHCs refer persons who are screened to be at high risk of hypertension or diabetes to the private sector for further examination. Those who are diagnosed with the diseases will receive treatment provided by family doctors and allied health professional teams – instead of hospitals – to help them better

manage their chronic diseases and prevent complications. As an incentive for enrolment, the government will subsidize half of the examination and treatment costs incurred (Fig. 3.2).

Fig. 3.2. Streamlined primary–secondary referral mechanism in Hong Kong



GOPC= General outpatient clinic, DHC= District health centre, FMSC= Family medicine specialist clinic, SOPC= Specialist outpatient clinic, PCR= Primary care register

Source: Derived from Health Bureau, Hong Kong SAR, Primary health care blueprint supplement *(26)*

Information and communication technologies (ICT)

Another salient feature in Hong Kong is the use of ICT to strengthen care integration. As a flagship platform to break down information silos, the electronic health record-sharing system (eHealth) enables registered public and private health-care providers to access patients' electronic health records. The eHealth platform is particularly useful in the ervice settings for the older people because health- and social-care professionals can easily view the health record of patients who may suffer from cognitive decline. The eHealth app was subsequently launched to allow personal health management at the fingertip. HA Go, a one-stop app integrating multiple HA services, was also launched. It allows users to manage their health records and that of their family members with ease. This user-friendly app also helps patients easily navigate their in-person visit at public hospitals.

Needless to say, strict data safety protocols have been set in place on all these ICT tools.

Case study 2: Seoul (Republic of Korea)

Context

The Republic of Korea, which occupies the southern part of the Korean Peninsula, is currently one of the fastest-ageing countries in the world. Persons aged 65 years and over accounted for 17.8% of the total Korean population of about 51.63 million in 2023 *(27).* The Republic of Korea officially became an aged society in 2017, with 14% of the population over the age of 65 years. The transition from an ageing society (7%) to an aged society (14%) took only 17 years for the East Asian country, compared with 24 years for Japan and 36 years for Germany. Moreover, by 2025, just 7 years after becoming an aged society, the Republic of Korea is expected to become a super-aged society, with 20% of the population over the age of 65 years *(28).* By 2050, older persons are expected to account for 40% of the Korean population, with 24.7% over the age of 75 years *(28).*

The life expectancy of Koreans was 83.6 years in 2023, and the country's avoidable mortality rate was 142.0 in 2020 *(29).* Over the past two decades, the Republic of Korea's total health expenditure (THE) as a percentage of GDP more than doubled from 3.9 in 2000 to 8.36 in 2020 *(30).* About 63.1% of THE is covered by government expenditure, and OOP costs account for about 26.7% of THE *(30).*

The Republic of Korea achieved universal health coverage in 1989 with a government-mandated social health insurance scheme. The National Health Insurance Services (NHIS), under the Ministry of Health and Welfare (MOHW), is the single public insurer in the country. While health and LTC are mainly financed by the public insurer, the provision of health care is dominated by the private sector and is uneven in urban areas, particularly in the Seoul metropolitan area. The Republic of Korea has the second highest ratio of hospital beds to population in OECD countries (12.4 beds per 1000 persons) *(31).* Several policy reforms have been implemented to improve the financial and service coverage of, and access to, health care for the older people in Korea *(32).*

As a major policy response to the rapidly ageing population, the Korean government also introduced public long-term care insurance (LTCI) for the older people as the country's fifth social insurance scheme in 2008. Korean LTCI provides comprehensive home, community and institutional (nursing home) benefits to persons aged 65 years and/or under 65 years with geriatric conditions listed in the LTCI Act. Eligibility for LTCI is based on the level of dependency, regardless of income level and the availability of informal/family care in Korea. Approximately 10.9% of the population aged 65 years and over were eligible for public LTCI in 2023.

As Central Government agencies under the MOHW, the NHIS and the Health Insurance Review and Assessment Service (HIRA), which is responsible for reviewing claims and assessing the quality of the NHI, have taken central roles in the management and operation of the health and long-term care systems financed by mandated social insurance schemes in Korea. As the complexity of older persons' service needs increases and the importance of coordination and continuity of care is emphasized, the role and responsibility of regional and local governments in developing community-based, integrated health and care systems for the rapidly ageing Korean society becomes critical.

Seoul, the capital of the Republic of Korea, is a densely populated megacity with a population of 9.4 million. Although it occupies only 0.6% of the country's land area, about 20% of the total Korean population lives in the capital, resulting in a population density of 15 650.1/km^2. The proportion of older persons in Seoul is expected to increase from 17% in 2023 to 40% in 2050 *(27).* In addition, the burden of care has increased as the proportion of older persons living alone increased from 4% of all older persons in 2010 to 7.5% in 2022 *(28).*

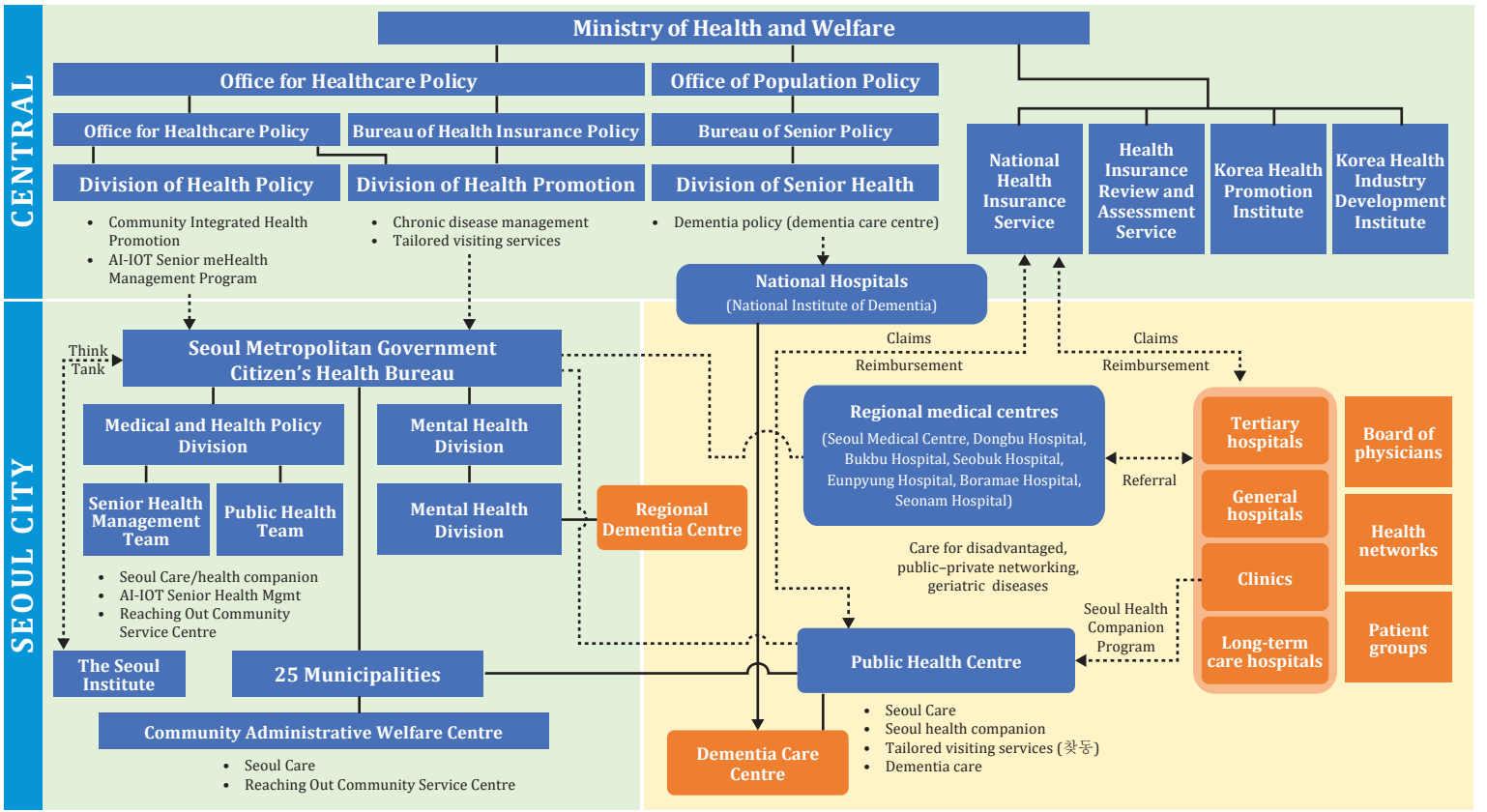
The Seoul Metropolitan Government (SMG) is responsible for the administrative affairs of the city, ranging from security, transportation and education, to sanitation, welfare and health. Despite the relatively centralized policy environment in the Republic of Korea, local governments are partially responsible for welfare services, especially for the disadvantaged *(33–35).* Older persons living in Seoul receive services through both central- and city-level policies and programmes.

The following sections summarize the public–private mix of care for older persons in Seoul, Korea, through mapping and policy analysis of health and social care for older persons.

Mapping actors, agencies and networks in health services for older persons

The mapping of health and social care for older persons identified multiple actors and agencies involved in the public–private mix of health and social care for older persons in Seoul, Republic of Korea. Actors and agencies were spread out across the Central Government and SMG levels, across the public and private sectors, and across different responsibilities for financing, organizing and delivery of care. Figs. 3.3 and 3.4 show the mapping of linkages between actors and agencies for the health- and social-care sectors, respectively.

Fig. 3.3. Mapping of actors and agencies for health services for older persons in Seoul



Boxes – Blue: public actors; Orange: private actors
Background – Green: Financing and administration; Yellow: Service delivery

Source: Author's representation

The following section presents the mapping results for the actors and agencies involved in the financing, administration and delivery of health care for older persons in Seoul (Fig. 3.3). The central-level administration of health services for older persons is overseen by the MoHW. Within the MoHW, the Office of Healthcare Policy and Office of Population Policy manage policies regarding health services directed towards older persons. Within the Office of Health Policy, the Bureau of Health Insurance Policy is responsible for managing policies and benefits for older persons under the NHI system, and the Bureau of Health Policy serves as the main administrative core for community-based health-care services for older persons. The Bureau of Health Policy oversees two divisions: the Division of Health Policy and the Division of Health Promotion. The two divisions are responsible for developing community-level health services and programmes for older persons such as integrated care programmes, chronic disease management programmes, and visiting services. On the other hand, the Office of Population Policy oversees the Division of Senior Health, which is responsible for managing the national dementia policies, including the management of regional dementia care centres in the community. Health-care programmes developed by the MoHW are transferred down to the SMG for administration at the city level and distribution of public funds at the municipality level.

At the city level, the SMG has its own governance and funding for the provision of health care to its older residents. Within the SMG, the Citizen's Health Bureau oversees health promotion and improvement policies. The development and management of care services for older persons are carried out by the Public Health Team and the Senior Health Promotion Team within the Division of Medical and Health Policy. Dementia care in the SMG is managed by the Dementia Management Team, under the Mental Health Division. Funding and management of most health-care services developed by Seoul City are often shared with the 25 municipalities ("gu") and direct service delivery for public programmes is often managed through public health centres. Governance teams under the SMG not only operate city-specific policies and functions, but also serve as channels to distribute central programmes and policies to the municipality level. The Seoul Institute and Seoul Health Foundation serve as a think tank for the SMG, providing research services to advance public health policy.

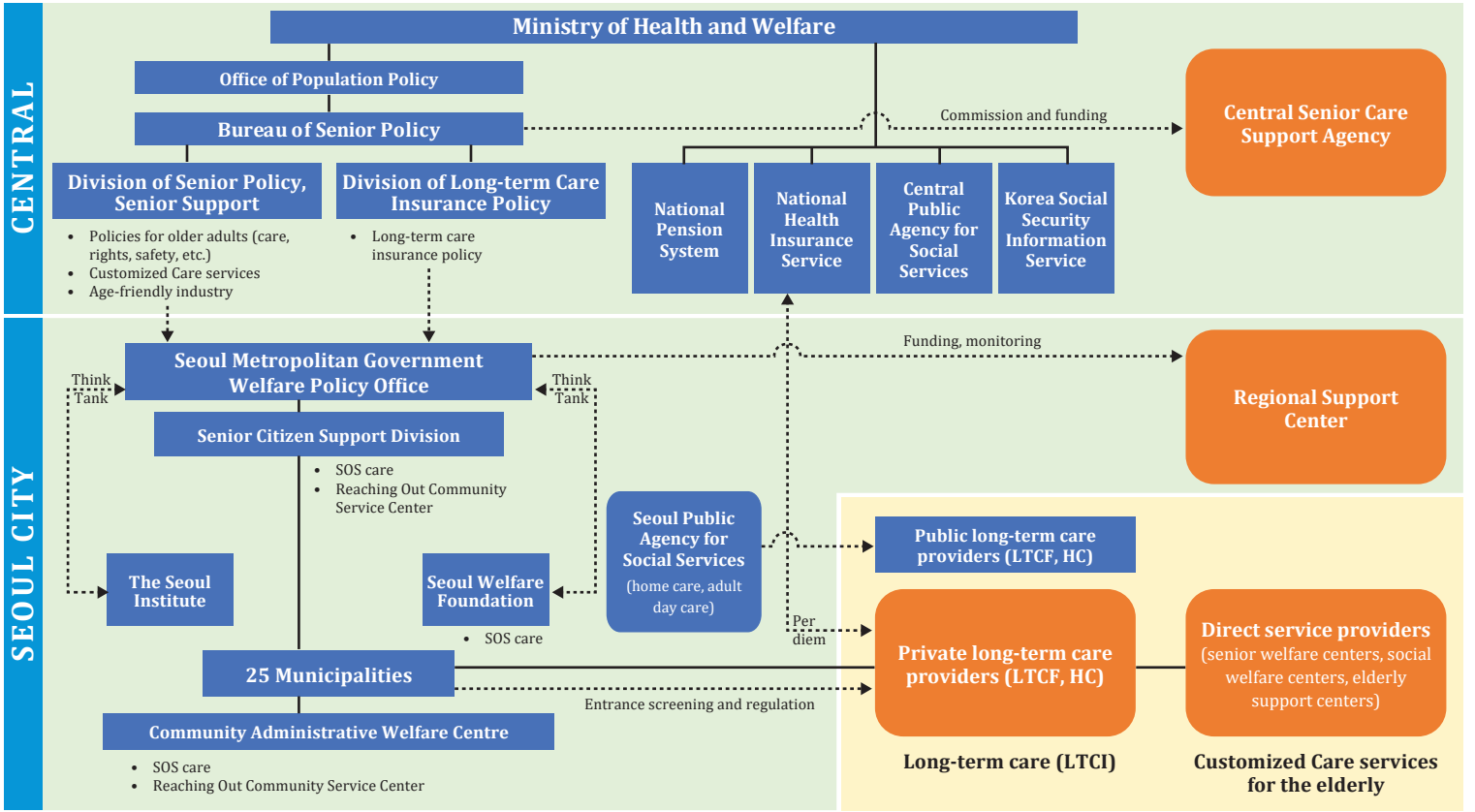
In Seoul, health services for older persons are provided by public and private health providers. Public service providers include the National Medical Center and the National Rehabilitation Center, regional medical centres and public health centres, which are located in each municipality. As the capital city of the Republic of Korea, Seoul has a number of national hospitals, including the National Medical Center, the National Rehabilitation Center and the National Center for Medical Health. The National Medical Center also serves as the National Institute of Dementia, the headquarters for central policy on dementia care. Furthermore, the city of Seoul is home to nine regional medical centres that serve the city's underserved populations, including low-income groups and older persons. In particular, the Bukbu hospital, Seobuk hospital and Seonam hospital specialize in providing public health services for geriatric conditions *(36).* There are 25 public health centres for each of the 25 municipalities in Seoul. The public health centres work closely with the municipal governments and dementia care centres to provide direct care and health management to older persons in the community. The remaining majority of health service providers are privately owned, ranging from primary care clinics to tertiary hospitals. In addition to acute care hospitals, LTC hospitals provide inpatient medical services for older persons with geriatric conditions under the NHI, and are separate from the LTCI *(37).* The board of physicians and health networks play important roles in representing private providers for participation in publicly managed services for older persons.

Mapping actors and agencies in social care for older persons

At the central level, social care services for older persons are governed by the Bureau of Senior Policy located within the Office of Population Policy at the MoHW. The Bureau of Senior Policy is divided into smaller divisions for the management of LTC and community-based social services.

Policy development and administration of LTC services is conducted by the Division of Long-Term Care Insurance Policy. The Division is responsible for the development of a comprehensive plan for LTC, the operation and evaluation of the policy, and the regulations for the designation and suspension of private service providers. The operation of LTC services is similar to that of the health services. The NHIS is responsible for financing and managing LTC through a mandatory national LTCI. The LTCI provides needs-based benefits to older persons who have difficulties in the activities of daily living.

Fig. 3.4. Mapping of actors and agencies for social services for older persons in Seoul



Boxes – Blue: public actors; Orange: private actors
Background – Green: Financing and administration; Yellow: Service delivery

Source: Author's representation

Community-level social welfare services, namely the Customized Care Service for Older Adults (노인맞춤돌봄서비스; *No-in machum dolbom service),* from hereafter referred to as Customized Care, are managed by the Division of Senior Policy and Senior Support. Customized Care, a tax-based social welfare programme, is the main preventive care service targeted towards those who are ineligible for LTCI and for those disadvantaged older persons residing in the community *(38).* The Division of Senior Policy and Senior Support develops annual operation plans and manuals for the welfare programme, and commissions administrative tasks to the private sector through consignment at each level – central, city and municipality *(39).* In addition to managing Customized Care, the Division oversees general policies for older persons, including care rights, safety and age-friendly industries.

At the city level, the Senior Citizen Support Division under the Welfare Policy Office of the SMG is the department responsible for social-care services for older persons. Funding and administration of social services follows a similar pattern to health services, with shared funding and administration between the SMG and 25 municipalities. Administrative tasks are shared between the city, 25 municipalities, and community administrative welfare centres located at each neighbourhood ("dong"). For Customized Care, the Welfare Policy Office collaborates with regional support centres within the city to monitor service delivery within the city *(39).* Finally, the Seoul Institute and the Seoul Welfare Foundation provide research and consulting services for the city's development and evaluation of key policies.

As for service delivery for social care, the private sector is dominant with a small proportion of publicly owned service providers. For LTC services, LTCIs (long-term care facilities, home-care facilities, adult day-care centres and so on) certified by municipal governments provide care services to beneficiaries. Customized Care services are provided by private providers, as mentioned in the section above. Direct service providers at the local level include senior welfare centres, social welfare centres, support centres for older persons, etc. While privately owned, these service providers are by law non-profit foundations in nature and are bound by strict financial accounting standards to ensure the public nature of welfare services *(39).*

City-level care services rely on both LTC providers and welfare centres. Municipal governments within Seoul contract with private service providers at the local level to provide on-call services to older persons *(40).*

Health services for older persons

The policy analysis of health services for older persons in Seoul focuses on medical care provided by hospitals and clinics under the National Health Insurance (NHI) policy, and tax-based health management programmes developed under the Citizen's Health Bureau at the SMG.

Financing

Health care is financed through a mandatory single-payer national health insurance system, the NHI, and medical aid, targeting a small proportion of the population under the poverty level, is financed through taxation. The NHI is responsible for reimbursement of service provision under a fee-for-service policy. OOP costs for copayment constitute a generous portion of health-care financing, including copayments for covered services and full payments for non-insured services under the NHI. Private sector involvement in health-care financing is limited to voluntary health insurance provided by private insurance companies. As of 2020, approximately 78% of all households were enrolled in private health insurance to complement the NHI *(41).*

At the city level, funding for health management programmes for older persons developed by the SMG are entirely tax-based with funding pooled between the city and district level ("gu") (i.e. 60:40). The SMG is responsible for preparing an annual budget for each fiscal year, allocating funds based on the goals and performance of the sectors. It is the responsibility of the division to work within the allocated budget to design and operate the care programmes. Programme funds are used for human resources, training, referral systems and building information systems.

Provisioning

In contrast to the predominantly public financing of health services, the Republic of Korea generally relies on private resources for service provision. Health services are provided primarily by private institutions

(primary clinics, secondary, tertiary and LTC hospitals), with the exception of a relatively small number of public health centres and public hospitals. By law, all health providers are non-profit entities, although providers may make a profit through provision of non-insured services. As of 2020, approximately 90% of all hospital beds were privately owned (Table 3.1). Despite efforts to increase the public share of providers, this has not been enough to keep pace with the rapid expansion of the private sector.

Table 3.1. Hospital beds by ownership type in the Republic of Korea and Seoul

	National		Seoul	
	2018	2020	2018	2020
Total	641 044 (100%)	656 068 (100%)	74 931 (100%)	79 031 (100%)
Public	63 924 (10.0%)	63 417 (9.7%)	8 333 (11.1%)	8 617 (10.9%)
Private (non-profit)	577 120 (90.0%)	592 651 (90.3%)	66 598 (88.9%)	70 414 (89.1%)

Source: MoHW Health and Welfare statistical yearbook *(42)*

Health facilities can be classified into clinics, small hospitals, general hospitals and specialized general hospitals based on the number of beds *(14).* However, gatekeeping for service utilization is weak because service users are free to choose from any level of provider as their first-contact provider, except for specialized general hospitals. Service users can access specialized care through referral from their first-contact provider, and the choice of provider is entirely of up to the user. Despite government efforts to strengthen the role of primary care through financial incentives at both user and provider levels, service users still prefer to use health services at higher levels of care, and providers focus on providing curative services rather than preventive services *(43,44).* In addition, the fee-for-service payment system tends to incentivize providers to provide higher-dose treatments and disincentivize preventive care. The lack of gatekeeping has distorted the health-care delivery system, as local clinics and tertiary hospitals compete for the same pool of patients.

Health services for older persons are provided at the city level through specific health management programmes developed by the SMG. For

example, health programmes for older persons in Seoul include the Health Care Network and the Seoul Health Companion Programme. The Health Care Network is a referral programme for disadvantaged groups in and out of the regional medical centres and/or public hospitals in Seoul. Specific target groups include recipients of National Livelihood Security Income, older persons living alone, the disabled and foreign workers, among others. Through the programme, regional medical centres provide medical care to low-income patients with unmet medical needs and also send out referrals to community-based services for discharged patients. The Health Care Network seeks to fill the unmet health-care needs of disadvantaged individuals generated by private-dominated providers and build a continuum of care from institution to community.

As for community-level health management for older persons, the SMG operates the Seoul Health Companion (SHC) Programme *(45).* The SHC Programme provides comprehensive, tailored community health services to promote ageing in place. Innovative public–private partnership is a key strategic strength of the programme. SHC actively involves private health providers in the service model. Taking advantage of the high utilization of health services at the clinic level among older persons, primary care clinics in the community serve as entry points to the Programme through financial incentives for referrals. By strengthening the role of local clinics, the SMG seeks to assign appropriate roles to both the public and private sectors for the sustainable provision of care to older persons (Box 1).

Box 1. Innovative public–private partnerships model in Seoul, Republic of Korea: the Health Companion Programme for Older Adults

The Seoul Health Companion (SHC) Programme is a newly developed programme, initiated in 2023 to provide health management support to older persons in the community (45). The goals of the SHC Programme are to provide health management for multimorbid older persons in the community to promote ageing in place. The Programme specifically targets multimorbid older persons living alone or with a spouse only.

The SHC differs from previous public health programmes in the city by shifting the role of patient identification and registration from the public sector to the private sector. Previous health management programmes in the city have relied on self-registration or referrals from partner programmes for patient recruitment and management. The need for self-registration has created blind spots in identifying older persons in need of services, particularly due to a lack of awareness of programmes provided through the public health centres. Through the SHC, primary care physicians who have built a rapport with community-dwelling older persons identify patients in need of community health management for their multimorbidity and refer them to the public health centre for enrolment in the SHC. In return, the SMG provides financial incentives to the participating clinics for referrals.

Upon enrolment, a multidisciplinary team at the public health centre, consisting of a physician, nurse, nutritionist and physical therapist, visits the older person to develop a care plan based on case management. The SHC Programme provides (i) health counselling, including medication review, medication counselling, and health education for disease prevention, (ii) rehabilitation services, including pain management, physical exercise support, and fall prevention education, (iii) nutrition management through dietary assessment and supplemental food support, (iv) referrals for home health care, mental health care and social welfare services.

The public–private partnership in this care model is an innovative model that assigns different roles to the public and private sectors according to their strengths. Due to low copayments for older persons and a large number of service providers in the community, the utilization rate of clinics for older

persons is very high in Korea. Physicians at these clinics may be the most knowledgeable about the health needs of older persons in the community. On the other hand, public health centres have access to multidisciplinary staff and can make referrals to social services. Community-based teams are also able to intervene in the daily lives of older persons to increase medication adherence and the practice of healthy behaviours that clinics cannot control. The SHC model builds a partnership between the public and private sectors, which can reduce tensions that arise from competing for the same pool of patients. As of March 2023, 158 primary care clinics in Seoul are participating in the Programme.

Human resources

Although the heath workforce has expanded significantly since the introduction of NHI, the Republic of Korea still faces shortages in key health professions *(31)*. As of 2020, there were 130 000 practising physicians, or 2.51 physicians per 1000 population (Table 3.2). The physician density is higher in the city of Seoul, with 4.5 physicians per 1000 population.

Table 3.2. Number of physicians and registered nurses in the Republic of Korea and Seoul (2010, 2020)

	National		Seoul	
	2010	2020	2010	2020
Practising physician (per 1000 population)	2.4	3.4	3.0	4.5
Registered nurse (per 1000 population)	2.3	4.4	2.9	5.6

Source: HIRA *(46)*

The number of registered nurses per 1000 population has nearly doubled from 2010 (2.3) to 2020 (4.4). However, only half the nurses work in clinical settings, with the remaining 27% inactive and 13% in non-clinical settings *(47)*. Within the clinical setting, a high proportion of nurses provide care in general or tertiary hospitals, and less than 10% are stationed in primary care clinics *(48)*.

Regulation

To effectively provide quality public health and medical services to citizens and contribute to the improvement of national health, there are various regulations governing the health-care sector in the Republic of Korea. Medical institutions can be established only by medical personnel (includes a physician, dentist, doctor of Korean medicine or midwife), the State or a local government, medical corporations and other cooperatives with a public interest, which are listed in a restricted manner in Article 33 of the Medical Service Act in Korea. The National Health Insurance Act provides detailed regulations for the contracting, fee-setting and quality assurance of providers by the public insurance system. According to Article 63, the Health Insurance Review and Assessment Service performs regulatory activities such as reviewing and assessing the appropriateness of costs, developing quality assessment criteria and controlling the quality of medical care.

Social-care services for older persons: public long-term care insurance

Social care for older persons through public LTCI is centrally planned and financed.

Financing

Public LTCI has a compulsory social insurance scheme. The LTCI is financed by (i) insurance contributions, (ii) government subsidies, and (iii) user copayments. The LTCI contribution rate is determined each year by multiplying the NHI premium by a rate (12.27% * NHI premium in 2023; 0.91% of income). The contribution rate was fixed until 2017 and increases steadily in response to the increasing fiscal expenditures of LTCI. Each year, the government is responsible for supplementing the LTCI with approximately 20% of the expected annual revenue from LTCI premiums. The user copayment is 15% for home care and 20% for institutional care. The copayment is reduced by up to 60% for those receiving medical assistance and is waived for those receiving basic subsistence benefits.

LTCI spending has increased steadily since its introduction. In 2020, LTCI expenditure from NHI was won (₩)8882.7 billion (approximately US$ 6.8 billion)[4], an increase of 14.8% from 2019 *(49)*. The sustainability of LTCI

[4] US$ 1 = KR₩ 1300

financing has been a key issue. In 2017, the LTCI faced a deficit due to the expansion of population and service coverage. Since 2020, the financing of the LTCI through the NHI has turned into a surplus balance, mainly due to the consistent increase in the premium rate and the decrease in LTC utilization during COVID-19. However, with a decreasing contribution pool due to population ageing, the LTCI will require innovative revenue sources and cost-effective spending to maintain funding.

Provisioning

LTCIs can be divided into home-based care facilities and institutional care facilities. Home-based care facilities include a wide range of services, including home-visit care, home-visit nursing, home-visit bathing, day and night care, short-term (respite) care and welfare equipment rental, and institutional care facilities include LTC facilities and shared living homes.

The number of LTC facilities has increased annually at both the national and city levels to meet the growing demand for services. The increase has been particularly concentrated in home-based care facilities, with a 21.5% increase from 2018 to 2019 (Table 3.3). As for ownership of facilities, less than 1% of all facilities were publicly owned *(49).* The remaining facilities were privately owned, with 84% owned as individual businesses. With the introduction of LTCI in 2008, the government encouraged the rapid expansion of private providers to meet the growing demand for care. According to a national survey in 2019, more than half of all facilities were small, with fewer than 30 service users *(50).*

Table 3.3. Number of long-term care institutions by benefit type in Republic of Korea and Seoul (2017–2020)

	2017		2018		2019		2020	
	HC	IC	HC	IC	HC	IC	HC	IC
National	15 073	5 304	15 970	5 320	19 410	5 543	19 621	5 762
Seoul	2 516	524	2 606	515	2 990	514	3 005	512

*HC: home-care; IC: institution care

Source: LTCI statistical yearbook (51)

Human resources

The LTC workforce includes various health- and social-care professionals, including social workers, doctors, nurses, nurse aides, physical therapists, direct care workers and others (Table 3.4). As of 2021, there were 33 736 social workers working in LTC facilities, with the majority working in home-care agencies (Table 3.4). There are a small number of medical personnel in LTC, with 2349 physicians (contracted and part-time) and 3645 nurses. On the other hand, direct care workers, who provide routine care such as cleaning, bathing and feeding, account for the highest proportion of LTC workers (about 90%). All LTC personnel in the LTC institutions reimbursed by public LTCI are required to be licensed (Box 2).

Table 3.4. Personnel providing long-term care in Republic of Korea and Seoul (2021)

	National			Seoul		
	Total	HC	IC	Total	HC	IC
Social welfare workers	33 736	25 509	8 294	4 320	3 739	583
Doctors (including part time)	2 349	88	2 322	224	17	215
Nurse	3 645	2 100	1 594	562	309	261
Nurse's aid	14 196	5 589	9 495	1 524	858	739
Physical therapist	2 723	441	2 416	252	63	192
Direct care workers	507 473	434 041	79 799	87 312	81 320	6 431

*HC: home-care; IC: institution care

Source: LTCI statistical yearbook (52)

Box 2. Licensing and training of LTCI direct care workers in Republic of Korea

Direct care workers comprise the majority of the LTC workforce in Korea. Direct care workers provide personal care for older persons under the direction of nurses, physician, and social workers. Caregiving tasks include assistance with activities of daily living (cleaning, eating, mobility, etc.) and instrumental activities of daily living (cooking, cleaning, accompanying during outdoor visits, etc.).

The national certification system for direct care workers based on hours of training was introduced alongside with the LTCI in 2008, leading to a dramatic increase in the supply of care workers. In 2010, to strengthen the professionalism of the direct care workforce, the government introduced a licensing examination in addition to the 240-hour training requirement. The license examination, administered by the Korea Health Personnel Licensing Examination Institute, covers the basics of welfare for older persons, caregiving and basic nursing.

The LTCI Act made the municipal governments responsible for assigning training sites and issuing licenses to those who have passed the examinations.

Regulation

Social care for older persons in the Republic of Korea is also mainly regulated by the LTCI Act, the Enforcement Decree of the LTCI Act, and the Welfare of Senior Citizens Act. There are detailed regulations on eligibility, benefits, responsibilities of the State and local governments, and quality inspections. The legislation describes specific guidelines on the range of services provided by the LTCI, staffing regulations and facility requirements. The LTCI Act also provides criteria for which LTC providers are suspended, including illegal installation of facilities, illegal waiving or discounting of copayments, inducing users to use services, and/or elder abuse.

Social-care services for older persons: community-based care

Community-based social services for older persons are described here with a focus on the Customized Care Service for Older Adults. While

Customized Care is a central policy, the delivery system involves supervision and reporting at the central, city, and municipal levels. Currently, Customized Care is provided in all 25 municipalities in Seoul.

Financing

The Customized Care Service for Older Adults is a means-tested welfare programme for low-income older persons living in the community. Funding for the service is based on taxes, and the annual budget is prepared by the MoHW. The MoHW allocates its annual budget for social welfare and public health to various subsectors within each category. For 2023, KR₩ 502 billion was allocated to the main community-based care service for older persons, the Customized Care Service for Older Adults Program *(53).* A 15% increase in the budget from the previous year reflects the expansion of recipients and staff size in recent years *(53).*

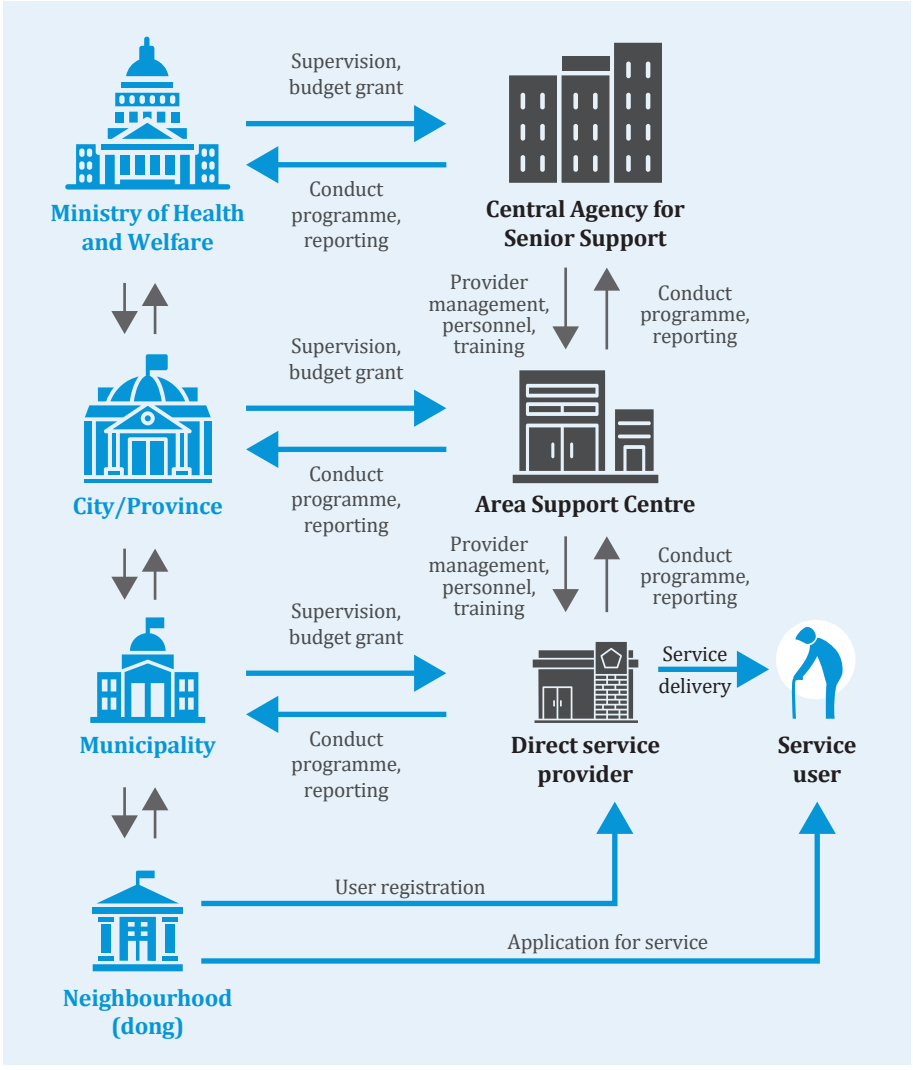
For community-based care for older persons, the MoHW allocates the budget to local municipalities and contracted private management agencies. Contracted private service providers receive 50% financial support from the central and local governments and are bound by strict guidelines for budget execution *(39).* Providers are required to submit a business operation plan, including an annual budget, which is approved by the local government. The MoHW provides detailed guidelines for the allocation of personnel expenses, operating costs and programme costs. All funds must be used for service-related purposes, and unused funds are returned to the government. Providers and administrative agencies may also receive funding from donations. Donations must be received without charge or compensation, and the details of the payments and administration must be clearly disclosed. Donations may be received from corporations, organizations and individuals.

Provisioning

Community-based social care for older persons is provided through a system based on public–private partnerships (Fig. 3.5). The service user applies for services through the community administration welfare centres located in the neighbourhood, which transmits the registration information to direct service providers within the community. The user receives a

needs assessment and direct services from private providers contracted by the government. As shown on the left side of Fig. 3.5, public institutions provide oversight and funding to providers at each level (central, city/province, municipality and neighbourhood ["dong"]). The Central Agency for Senior Support and the area support centres in each region provide staff training for direct service providers in their region. Customized Care also serves as a complementary service to the LTCI, for those with lower levels of dependency who have fallen below the needs requirements to receive LTC benefits. The contents of the direct services provided by Customized Care include safety supports (i.e. check-up phone calls, ICT-based monitoring through sensors and artificial intelligence [AI] calls), social participation programmes and support groups, health education, household assistance and referrals to community services provided by public and private actors. Specialized services will be provided to those with high psychosocial needs (i.e. isolation, depression, suicidal ideation) based on the needs assessment.

Fig. 3.5. Delivery system of the community-based social-care system (Customized Care Service for Older Adults) in Republic of Korea



Source: MoHW *(39)*

Human resources

Table 3.4 summarizes the facilities providing Customized Care Service for Older Adults in the community as of 2022. Service providers are contracted by local governments for a period of 2–5 years. A total of 660 facilities provide Customized Care in the Republic of Korea. Of these, only 14 facilities are publicly owned by municipal governments and public agencies; all others are privately owned. The contracted facilities must (i) have public interest, (ii) be part of a community network, and (iii) have the necessary infrastructure to effectively provide care services. All participating facilities must be non-profit in nature, operating through foundations or corporations. As of 2022, Customized Care services are provided by approximately 60 social workers at the city level, 2300 social workers and 29 000 care support workers across approximately 650 service providers nationwide *(54).* Staff training is provided by the Central Agency for Senior Supports and the area support centres in each city. Although they are not licensed professionals, care support workers are at the forefront of the Customized Care services as they provide direct services to older persons. They receive mandatory training from the Central Agency and participants are required to attend 36 sessions on the content of the programme and the basics of social welfare and care for the older people *(54).* On average, one care support worker takes care of about 16 older persons *(54).* As the burden of care is high, especially during the hot and cold seasons when special monitoring is needed, alternative solutions using ICT and AI have been implemented to reduce the workload.

Case study 3: Thiruvananthapuram, Kerala, India

Context

The number and proportion of older persons have increased in India over the past decades. This is attributed to increasing longevity and decreasing fertility rates. The life expectancy at birth for India is 67 years *(20)*. As per the Census of India, in 2011, there were about 104 million older persons above 60 years making up 8.6% of the population. This population group is also more vulnerable to disabilities and diseases, specifically noncommunicable diseases (NCDs). According to Census 2011, people above 60 years of age constituted 21% of the disabled population *(55)*, and 75% of them suffer from at least one chronic condition *(56)*. All this demands improved health and social care for older persons. The public expenditure on health is 2.96% and disaggregated figures for social care of older persons are not available.

Given the federal nature of governance of health and social policies in India, the Central Government initiates programmes and finances these partially at the state level. The proportion of financing varies across programmes and, depending on their fiscal health, states add their share to implement the programmes. The two major ministries involved in the care of older persons are the Ministry of Social Justice and Empowerment (MOSJE) and the Ministry of Health and Family Welfare (MOHFW). The former is primarily responsible for the social care of older persons while the latter includes the health needs of older persons in vertical national health programmes. Between the two, the MOHFW enjoys a larger financial outlay while the MOSJE receives comparatively little financial outlay.

India's social-care services for older persons have evolved over the years across the five-year plans, programmes and policies. It is the Eighth Five-Year Plan (1992–1997) that introduced the Integrated Programme for Older Persons (IPOP)1992, and the National Social Assistance Programme in 1995. The National Policy of Older Persons (1999), which was introduced during the implementation phase of the Ninth Five-Year Plan (1997–2002), was the first step by the government to address the needs of older persons in India. This was followed by other programmes and schemes like the Indira Gandhi National Old Age Pension Scheme, which was introduced

during the implementation phase of the Tenth Five-Year Plan (2002–2007). The Eleventh Five-Year Plan (2007–2012) introduced the National Programme for Health Care of the Elderly (NPHCE) in 2010, which focused on establishing eight regional geriatric centres (RGCs), geriatric OPDs and wards. The expansion of the NPHCE was prioritized by the 12th Five-Year Plan (2012–2017), which paid attention to the training of health providers in geriatric care by setting up 12 new RGCs and two national centres for ageing.

In India, a mix of public and private (for-profit and non-profit) groups offer health and social care services for older persons. The role of the public sector in providing social care services for older persons is primarily through government-funded institutions, such as old age homes (OAH), day-care centres and hospitals. The government also provides financial support through grants-in-aid to NGOs that deliver social care services for older persons. The public sector plays a dominant role in the provisioning of health insurance and pensions, but these are mainly targeted for those below the poverty line.

The private sector, which includes both for-profit and not-for-profit organizations, has also played an increasingly important role in providing social care services for older persons in India. Private organizations have been involved in developing and managing OAH, day-care centres and hospitals, as well as in providing home-based care, palliative care and other services. Thus, social-care services for older persons in India involve a complex mix of public, private and highly commercial organizations. Still, these arrangements fall short of providing adequate health and social care for older persons in India. This mandates the review of a mix of the public and private sectors for addressing the health and social care needs of older persons in India (Table 3.5).

Table 3.5. Architecture of the public–private mix in health and social care in India

Type	Nature	Health services	Social-care services
Public	State or public institutions take responsibility for provisioning of social and health services to older persons. Government tries to make such services accessible, irrespective of affordability	Hospitals, specialized geriatric units, assisted devices, free diagnostics and medicine	OAH, day-care centres, insurance, old-age pensions
Private (for-profit)	Services provided by private (for-profit) entities for revenue generation and access to these services is determined by affordability	Specialized geriatric health-care units, secondary and tertiary health services, long-term care services	OAH, recreation centres, day-care centres, assisted living, home-based care
Private (not-for-profit)	Providing services to older persons and particularly from marginalized sections of society who cannot afford these services	Free diagnostics and medicines, mobile health-care units, physiotherapy, dementia care centres	Non-profit care units like OAH, day-care centres
Public–private partnership	Collaboration between public and private sectors for ensuring that the social and health care needs of older persons are met. Though revenue generation is not the main motive, for sustaining such initiatives nominal charges are levied	Primary health care, mobile, medical care units, counselling sessions	OAH, insurance, recreational centres, community-based palliative care
Profit and non-profit	Eyeing the senior care market, projects focusing on senior living facilities, assisted living facilities, community living, geriatric care products for older persons who can afford such services and are willing to invest in them	On-site health-care services, in-house doctors and nurses at the living facilities, home diagnostics, medical equipment	"Care homes and care at home" services, living facilities specifically designed to address the needs of older persons

Source: Authors' analysis

Kerala, a southern state in India, has seen rapid demographic changes with one of the highest proportions of older persons accounting for close to 16.5% *(57).* The major causes of mortality and morbidity among older persons are NCDs. Kerala reports the highest share of NCDs among older persons across all Indian states *(58).* There are 1280 hospitals and 38 004 beds in the public sector. Private sector institutions are more numerous than public sector ones, with 2062 hospitals and 61 223 beds. In Thiruvananthapuram, the capital of Kerala, there are 117 public sector institutions and 101 private hospitals.

The state has 589 OAHs that are managed by public and non-profit agencies. Of these, only 16 are fully financed and managed by the state and some of the remaining receive partial grant-in-aid from the Social Justice Department (SJD) *(59).* Thiruvananthapuram has 47 grant-in-aid homes.

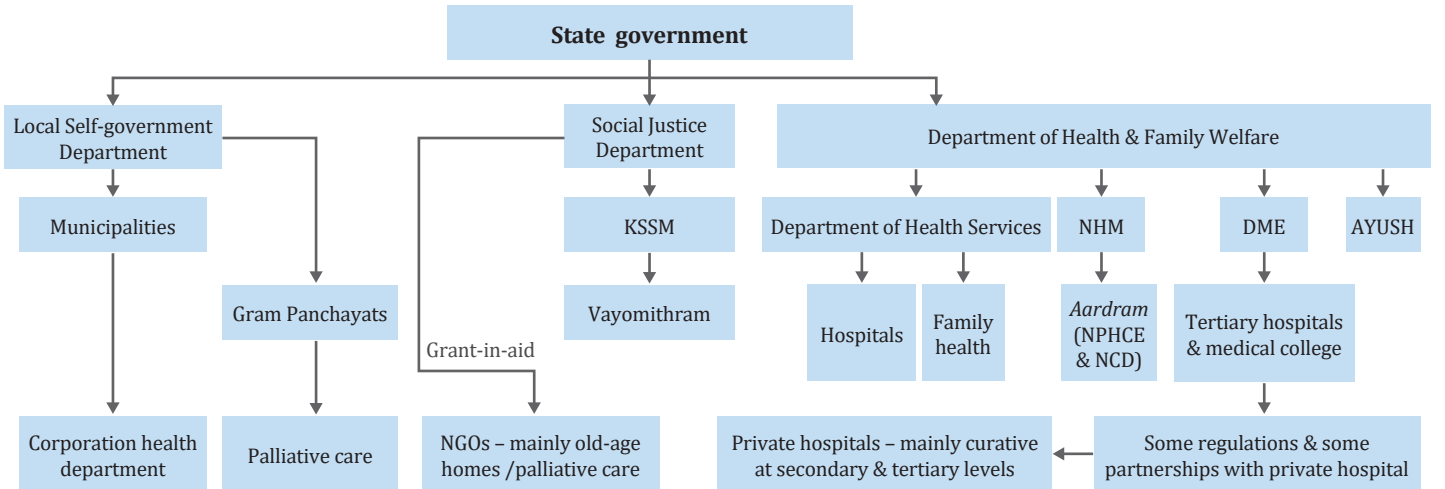
The Kerala state policies are a combination of central- and state-level initiatives. Further, the state policy reiterates older persons' rights, including freedom, protection and dignity in accordance with the human rights principles of the United Nations. Given the higher life expectancy for women, the state policy pays special attention to older women's access to employment, landed property and economic resources. Kerala is among the earliest to have a state policy for older persons. The first one was brought out in 2006 and a revised one in 2013. The state policy covers a range of social assistance schemes such as social pensions and has a broader scope compared to many other states.

The crisis of care for older persons is aggravated in Kerala due to the working adult population migrating for work both within and outside India. This has resulted in a large proportion of older persons living on their own without family support, thereby creating a high demand for supportive and social care. This demand for medical and social care is increasingly being met by informal, domestic workers and the private sector. For those who are able to pay, the for-profit retirement communities, assisted living institutions and home-based care agencies cater to the diverse needs of older persons belonging to the middle- and upper-middle classes.

Mapping and governance

The study of Thiruvananthapuram showed the presence of multiple actors and agencies that provide health services and social care *(10).* These included the public sector, private for-profit and non-profit sectors, which resulted in a fragmented landscape of financing and provisioning. There is little cooperation and collaboration, let alone partnerships across the public and private sectors. The link between social care organizations and the health services is weak. The fragmentation in financing and provisioning burdens older persons in terms of access, utilization and continuity of care across health and social care. In addition, there are community-based organizations with an extensive network of community-level workers. Within the public sector, there are multiple actors: health department, local self-government department (LSGD) and SJD, for the provision of health services for older persons (Fig. 3.6). The Health Department, comprising the Directorate of Health Services (DHS) for primary and secondary care, State Health Mission (SHM) under the National Health Mission (NHM) and Directorate of Medical Education (DME) for tertiary care, provides general and specialist health services and also administers national health programmes. Apart from these, there are autonomous specialist centres for cancer, neurology and cardiology.

Fig. 3.6. Departments/agencies providing health services for older persons, Thiruvananthapuram Municipal Corporation



AYUSH – Ayurveda, Yoga, Unani, Siddha, Homeopathy;

DME – Directorate of Medical Education

KSSM – Kerala Social Security Mission. This is organized under the SJD and runs programmes largely for the weaker sections. For older people it has the *vayomithram* programme. But all other programmes written under the KSSM are directly under the SJD.

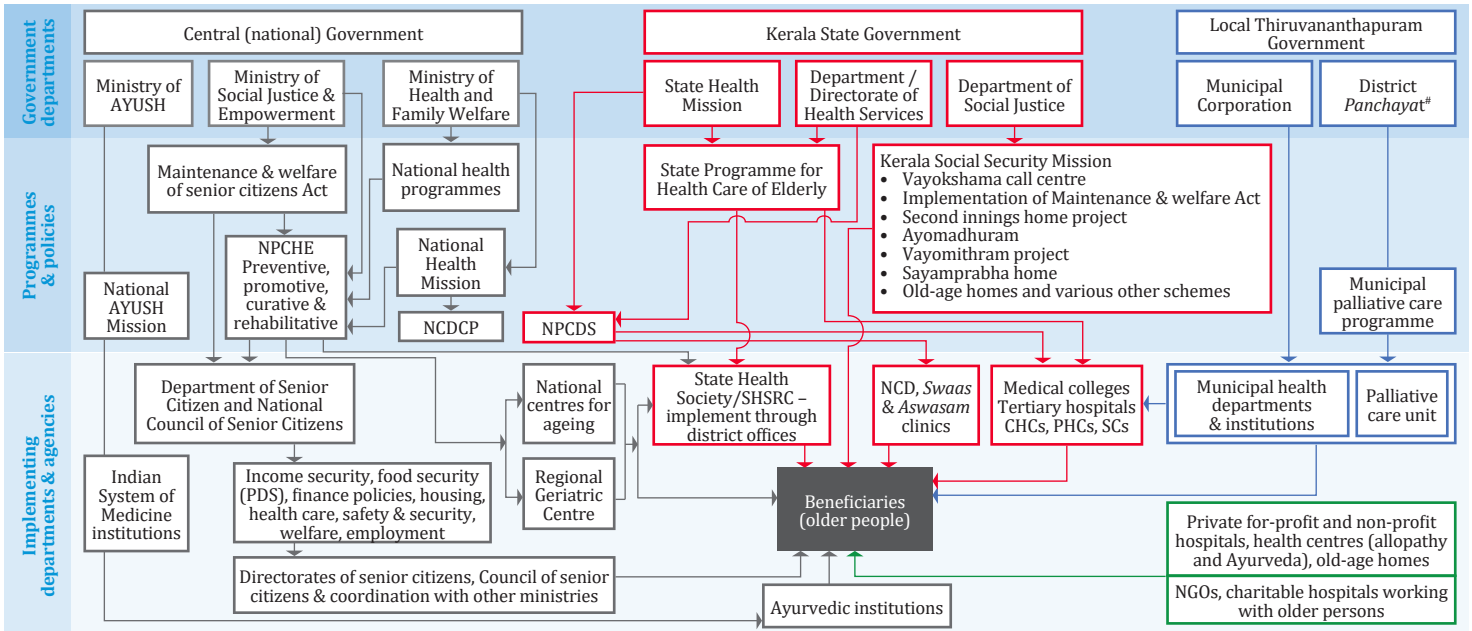
NHM – National Health Mission

NPHCE – National Programme for Health Care of the Elderly

Vayomithram (friend of an old person). This is a scheme that provides free medicines, counselling services and limited palliative care through mobile clinics.

Source: Author's representation

Fig. 3.7. Structure and organization of agencies providing health and social care for older persons in urban Thiruvananthapuram



#*Panchayat* – an elective council of about five members organized in India as an organ of village self-government.; NCDCP= Non-communicable disease control programme; NPHCE= National programme for healthcare of elderly; CHC= Community health centre; PHC= Primary health centre; SC= Sub-centre; SHSRC= State Health Systems Resource Centre; NPCDCS= National Programme for Prevention of Cancer, Diabetes, CVDs, Stroke; ISM= Indian system of medicines; *Swaas* = local word for 'the act of breathing' - a public health program in Kerala, India that aims to prevent and control chronic obstructive pulmonary disease (COPD) and asthma; *Aswasam* = Local word for 'consolation' - a health project in Kerala, India that aims to address depression at the primary care level.

Colour Codes:

Black – agencies, programmes and services by central government; Red – agencies, programmes and services by state government; Blue – agencies, programmes and services by local government; Green – private providers

Source: Author's representation

As far as services for older persons is concerned, the district *taluk*[5] hospital at the secondary level provides separate outpatient services while district hospitals have distinct inpatient facilities designated as geriatric wards.

At the tertiary level, TMC has an RGC, associated with the Trivandrum Medical College Hospital (MCH), which is one among the eight RGCs in India. This centre was established under the aegis of the NPHCE under the National Health Mission of the Central Government. This programme, which is under the NCD programme, is the major initiative specifically focused on care for older persons in Kerala and in TMC. Under the provisions of the NPHCE, the RGC provides outpatient and 30-bedded inpatient facilities, including specialized care depending on requirements, free of cost. The RGC functions as part of the Medical College Hospital, which facilitates specialized care through interdepartmental reference. Apart from the RGC, services for older persons are provided at the primary and secondary levels as well.

The other major national and state health programmes that focus on the needs of older persons include the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease, and Stroke (NPCDCS); National Blindness Control Programme (NBCP); National Mental Health Programme (NMHP).

Besides the health department, the SJD has a few programmes for older persons who are below the poverty line (BPL). Under the SJD, the KSSM among its various programmes has a specific programme for older persons called *Vayomithram*[6]. This programme offers free medicines through mobile clinics, palliative care and counselling services for older persons (rural and urban). It also includes the "Grand Care Programme" that provides care and support through phone calls (help desk service), particularly for older persons who are living alone. This is a joint initiative with the LSGD. Apart from the *Vayomithram* programme, the SJD runs programmes for the provision of ayurvedic care in old-age homes, *Mandhahasa*[7], *Vayomadhuram*[8]

5 *Taluk* is an administrative subdivision within a district, which is a division of the state.

6 A friend of older persons

7 Supply of artificial dentures

8 Supply of glucometer

for older persons from the BPL category, free of cost. There are also several other services for caregivers and chronically ill persons, which are not specifically for older persons but these categories would also include assistance for caregivers of older persons and chronically ill older persons, especially for those BPL.

Under the LSGD, TMC has a health unit that largely addresses sanitation, birth and death registration, and food safety issues through the 25 health circles and 11 zonal offices in which some of them overlap, as the area has both a health circle and zonal office. It does not include clinical management but offers palliative care. While the health circles are solely for health and related issues, the zonal offices also assume the responsibility of health issues, apart from other administrative issues. The district *panchayat* does not play much of a role in the provision of health care in the TMC area except for limited funding for palliative care.

The private/for-profit sector largely delivers curative services through a wide range of institutions from small clinics to multispecialty and superspecialty hospitals. Despite a greater representation of private (for-profit) institutions, in TMC, the private not-for-profit sector provides palliative care services.

The public sector consists of a three-tier health service system providing preventive, promotive, curative and rehabilitative services to the general population. Private health-care institutions largely provide curative services. Social and supportive care is mostly provided by the family, the public sector and institutions in the non-profit and for-profit sectors. In social care, the private sector consists of home-based domestic workers, agencies that provide care workers and various categories of allied health professionals that look after a range of rehabilitative measures for older persons. The long-term care sector is not well developed and hence the role of the public and private sectors is limited.

Financing, provisioning, human resources and regulation

Financing

There are multiple levels of and actors in the financing of health services and social care. These include the Central, state and local governments. The major health financing partnership between the public and private sectors is through several state-led public sector insurance schemes and the *Ayushman Bharat Pradhan Mantri Jan Arogya Yojana* (AB-PMJAY)[9], which is sponsored by the Central Government. PMJAY is a targeted programme for those BPL with no special provisions for older persons. In PMJAY, partnerships are with secondary and tertiary hospitals. This is effected through public financing and a public–private mix in provisioning. Private hospitals are empanelled by the government and services are provided to PMJAY beneficiaries. The empanelled hospitals are reimbursed for the services provided. Kerala has formulated the Karunya Arogya Suraksha Padhathi[10] (KASP) converging all state and central programmes for financing health care[11]. This provides INR 500 000 per family per year for secondary- and tertiary-care hospitalization across public and private empanelled hospitals in India. The PMJAY is fully funded by the Central Government and the cost of implementation is shared between the Centre and state government on a 60:40 ratio, respectively.

The financial requirements of the private not-for-profit sector is largely met by the organization as well as the SJD through limited grant-in-aid, which is applicable only to organizations registered under the Board of Control for Orphanages and other Charitable Homes (BCOCH). Yet another category functions as charity as well as paid homes. The grant-in-aid of the SJD is availed largely by institutions of the non-profit sector than the for-profit sector, though it is a meagre amount, which is often inadequate

[9] A national health insurance scheme, which was launched in 2018 by the Central Government for BPL people. Given the federal structure, the states were given flexibility to modify coverage according to their capacities and needs.

[10] This is an insurance scheme that covers critical illness for those who need financial support.

[11] Currently, programmes such as Rashtriya Swasthya Bhima Yojna (RSBY), Comprehensive Health Insurance Scheme (CHIS), Senior Citizen's Comprehensive Health Insurance Scheme (SCHIS), and Karunya Benevolent Fund (KBF) state scheme implemented through the lottery department are converged in the PM-JAY programme.

even for meeting the expenditure on food and health-care requirements of the residents. Apart from the grant-in-aid from the government, non-profit institutions receive donations from different sources, including the general public, relatives of the patients, and business groups to meet their financial requirements.

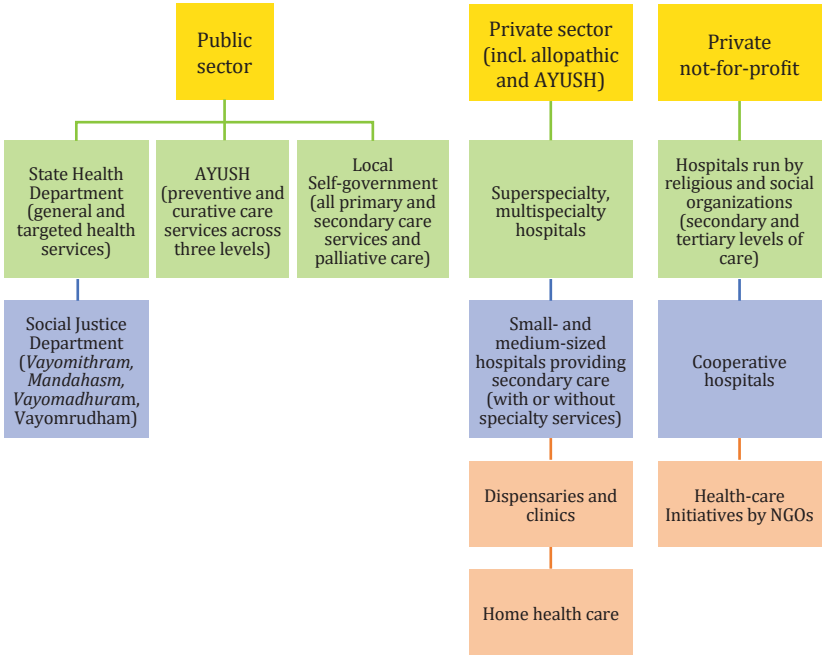
Provisioning

In the health sector, the public sector has a variety of institutions ranging from dispensaries and subcentres to other primary, secondary and tertiary care institutions, including teaching institutions, medical colleges and superspecialty hospitals in the allopathic medical system. This is financed and managed by the Central and state governments. Similarly, public sector institutions practising Indian systems of medicine, particularly ayurvedic institutions, are financed by the Central and state ministries. They have a range of institutions from dispensaries at the primary level and hospitals at the secondary and tertiary levels. The health department is the primary provider of public health-care services. Kerala's innovative decentralization policies of the mid-1990s devolved financial and administrative power to the Local Self-government for primary and secondary health services. The tertiary level of care is under the aegis of the health department.

The SJD also provides a few health inputs that are largely limited to those BPL. The KSSM of the SJD provides mobile clinical services for older persons through the *Vayomithram* programme largely in urban areas.

The private for-profit sector includes individual private practitioners; nursing homes, hospitals and large/corporate multispeciality hospitals; and the private non-profit sector has medium and large hospitals (largely run by religious/organizations) and dispensaries. Nongovernment organizations focus mainly on social care with minimal inputs in health services (Fig. 3.8).

Fig. 3.8. Typology of institutions in the public–private mix for health services, Thiruvananthapuram



Source: Authors' representation

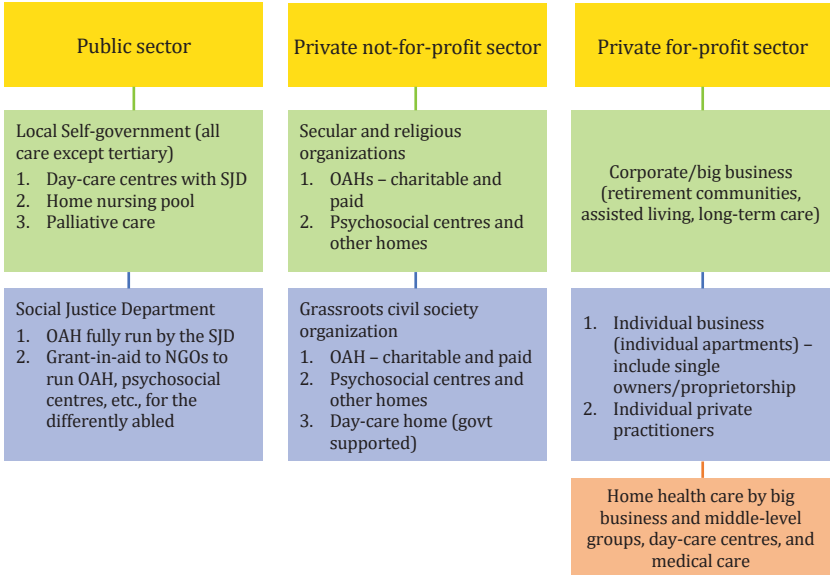
Under the public sector – green represents those health services under the Department of Health Services, which is more dominant, and the blue represents services under the Department of Social Justice. Under the private sector – the colours represent tertiary- (green), secondary- (blue) and primary-level (orange) services.

The social care sector provides a range of supportive services such as day care and institutional stay. Compared to the public sector, the private sector, both for-profit and non-profit, which cover a range of needs of older persons, has a higher proportion of institutional stay provisions. The palliative care initiative renders a mix of health and supportive care for older bedridden patients provided by the public, non-profit sector and community-based organizations. These provide services at the primary level and there is a close interface between the patient, institution and the community. Pallium India (palliative care organization) is a model wherein

health and supportive care is at the community level with the involvement of and cooperation between the public, non-profit and for-profit sectors.

Several public and private hospitals provide specialized services such as physiotherapy, occupational therapy, speech therapy, dialysis support for inpatient and outpatient services. In recent times, there has been a growing market for home-based care services for older persons. These services are to assist in activities of daily living (ADL), nursing care and a range of specialized care. There are some non-profit and for-profit initiatives for day-care centres. There are several publicly funded and numerous privately (for-profit and non-profit) funded organizations providing social care for older persons in Thiruvananthapuram. The private for-profit sector has several institutional stay facilities such as retirement community homes and assisted living facilities. In both these institutions there is provision for primary-level outpatient care with nursing and/or doctors. The referral services are worked out with tertiary hospitals (non-profit and for-profit). These arrangements are dependent on individual initiatives (Fig. 3.9).

Fig. 3.9. Typology of public–private mix in social care for older persons in Thiruvananthapuram



Source: Authors' representation

The green colour code represents institutions for social care across the public and private sectors; the blue represents smaller homes and centres available in the community by the public and private sectors and the orange colour represents home-care services.

Human resources

There is a lack of reliable data on the number of nurses and doctors in the public and private health services but the public sector lacks human resources. Lack of trained and qualified human resources for older persons' care is a major problem. Given the financial crunch and poor availability of trained or certified care workers it is difficult for most of the organizations to deliver quality care. The policy dialogue and interviews clearly brought out the lack of trained human resources, including certified care workers. There is a high level of dependence on family members and domestic helpers to provide care for older persons who may not have the required skills for caregiving. Similarly, even care workers provided by private home care organizations are semi-skilled or unskilled. One of the arenas where some kind of training exists is palliative care. Pallium India's (NGO) Trivandrum Institute of Palliative Sciences is a WHO Collaborating Centre and imparts professional palliative care training to doctors, nurses, social workers and volunteers (Box 3).

Box 3. Pallium India: an institution for palliative care

Pallium India (PI) is a private non-profit (NGO) organization located at Thiruvananthapuram, which provides palliative care services. Their service provision includes outpatient services, inpatient services and home visits, as well as palliative care training. Inpatient (IP) services (only 15 beds: 5 rooms and 10 beds in a ward) are offered only if they cannot manage the case at the patient's home and only for the short term. The Trivandrum Institute of Palliative Sciences is the training and service provision arm of PI, which is a "WHO Collaborating Centre for Policy and Training on Access to Pain Relief". PI covers almost three fourth of the wards in the Thiruvananthapuram Municipal Corporation area. Their home-based service provision includes clinical examination, drug supply and care of bedridden patients, including catheterization, bed sore dressing, Ryle's tube feeding, counselling, support for personal hygiene, etc.

Regulation

One of the major issues in the older persons' care sector, both health and social, is the lack of regulations, standard operating procedures (SOP) and guidelines for health and social care of older persons. A large and diverse private sector is present in the health and social care sectors that is largely unregulated. The growth of private institutions lacks governance and regulatory structures for quality of services and cost. Though the health sector has some SOPs, strict implementation and a monitoring mechanism is non-existent, particularly in the private sector. There is no clear guideline from the government for even registering and licensing social-care institutions.

Public–private partnerships: an emerging phenomenon

In the health services, PPPs are relegated to a few governmental health-care programmes such as the Reproductive and Child Health Programme, Universal Immunization and Tuberculosis Programme and the NBCP. All these programmes have contracted private participation in service provisioning, diagnostics, supply of medicines/vaccines and community mobilization. The major health-care financing partnership between the public and private sectors is through several state-led public sector insurance schemes and the AB-PMJAY that is sponsored by the Central Government. PMJAY is a targeted programme for those BPL with no special provisions for older persons. In PMJAY, partnerships are with secondary and tertiary hospitals. This is effected through public financing and a public–private mix in provisioning. Additionally, retired state government employees get insurance through Medisep and the central Employee State Insurance scheme provides insurance for those retired workers included in the scheme, depending on the type of sectors/institutions in which they were enrolled.

Several of the retirement communities and assisted living facilities have links with the private for-profit health sector. Many of the former have sought referral facilities in corporate and multispecialty hospitals for inpatient and emergency services. The cost of treatment is borne through direct OOP payments as well as public and private insurance coverage. There are instances wherein some doctors or promoters of private tertiary

hospitals serve as board members with the retirement communities. The representatives of private hospitals pointed to the increasing vertical integration between small- and medium-sized private nursing homes and the corporate sector. This results in referrals by the former to the latter. Private assisted living initiatives have built networks with corporate or multi/superspecialty private hospitals for health services and with home care agencies for residents. In several of these institutions, there is some form of agreement drawn up between private hospitals and agencies with terms and conditions of services to be rendered.

Case study 4: Shanghai (China)

Context

In 2000, China officially became an ageing society with just over 7% of the population being more than 65 years. By 2022, the percentage of those over 65 years reached 13.7% *(60).* It is predicted that by 2025, China will move from an ageing society to an aged one. The rate of urbanization in China has been increasing at a steady pace. This phenomenon has created the issue of left-behind older people in the rural areas.

China has six social insurance systems – pension, medical care, work-related injury, unemployment, maternity and long-term care. Out of these, older persons receive coverage through pension, medical care and long-term care insurance (LTCI) *(61).* China provides universal health insurance to its population through two types of insurance schemes – employee-based insurance scheme and the rural and urban resident insurance schemes for the self-employed and unemployed population. Universal coverage was achieved by 2015. In the same year, China issued guidelines on implementing an LTCI policy and officially piloted LTCI in 15 cities, Shanghai being one of them. The Communist Party of China (CPC) introduced the LTCI by summarizing the experiences of Germany, Japan and the Republic of Korea's practices on LTCI. There are also newer models and innovations of community-based interventions available for home-based care *(62).* China intends to follow the 90-7-3 model, which means that the policies aim at 90% of older population receiving care at home, 7% at community-based residential institutions and 3% in nursing homes.

Shanghai is the first among the ageing cities in China, and is also the most populous city with 29 million persons. As early as 1979, Shanghai's 60-year-old and above household registration population accounted for more than 10% of the total registered population. At present, the registered population above 60 years accounts for 35% of the total population and those above 80 years constitute 18% of the population.

Health and social care in Shanghai: governance, financing, provisioning and human resources

The Chinese population is covered under the universal health insurance either through employee-based insurance for formal sector employees or urban and rural residents' health insurance scheme (unemployed and self-employed, including children and older persons) (Table 3.6).

Table 3.6. Overview of health care in Shanghai, China

Organization (admin and planning) • National Health Commission (Ministry of Health; China National Committee on Ageing) • National Healthcare Security Administration (health insurance schemes – Ministry of Health and Social Security; Ministry of Civil Affairs and National Development Reform Commission) At the provincial level: • Provincial health department • Local government (municipalities)	**Finance** • Significant proportion covered by single payer national health insurance (urban employees and urban resident insurance) • Government input budget • Out-of-pocket expenditure is less in Shanghai than the average in China • Mix of fee for service • Private voluntary insurance, which supplements public insurance – proportion covered is still low
Resources (physical and human) • Tertiary hospitals, general hospitals, community health centres • Higher density of public institutions and human resources in Shanghai – inequalities exist across regions. Shortage mostly at the primary level	**Service delivery** • 80% delivery is by public institutions. • Private provisioning is increasing. • Shanghai makes attempts at gatekeeping health care but faces challenges. • Partnerships are mostly at the tertiary level.

In social-care services for older persons, Shanghai has taken the lead in exploring and practising the community-embedded old-age service mode in China, mainly including care homes for older persons and community-

based services such as day-care centres. In addition, it has strengthened the construction of community feeding places, old-age-friendly home environments, digital health services, carried out informal care services for family members and volunteers, piloted LTCI care, explored barrier-recognition care, established a community pension consultant system and deepened the combination of medical care and nursing.

In 2022, there were a total of 217 nursing homes in both the public and private sectors in the city, with a total of 6535 beds. There was a total of 825 day-care centres for older persons in the city, providing services for an average of 15 400 persons per day. There were 288 community-care service organizations for older persons in the city, with 74 000 older citizens receiving government subsidies for these care services. A total of 428 community comprehensive older persons' care service centres were established in the city by 2022, with an additional 57 added that year. Community-embedded older persons' care service institutions are established within communities, utilizing idle housing, land or renovated residential buildings to provide flexible distribution points, making full use of community-idle resources. This not only reduces operating costs and effectively saves significant government investment but also creates more favourable conditions for the establishment and promotion of these institutions. Since they are located within the districts and communities where older persons live, they facilitate daily visits by family members and enhance communication between parents and children, resulting in high social acceptance. In terms of service functions, this model provides a variety of services such as rehabilitation medical care, day care, short-term foster care, social worker intervention, home-based services and LTC within institutions for older persons to choose from. It combines the functions of home-based, community-based and institutional care for the older people. This fully utilizes the role of scattered land resources in the community and the collective effect of various community services. This model overcomes both the drawbacks of insufficient interactions with family as well as the problem of institutionalization (Table 3.7).

Table 3.7. Overview of social care – LTCI and community-based services in Shanghai, China

Organization **Planners** • Commission on Ageing under the National Health Commission • Civil Affairs Bureau • National Development and Reform Commission • Finance Bureau • Planning and Land Administration **Administration** • Safety Supervision Bureau • Committee on Ageing • Development and Reform Commission Emergency Management Bureau	**Finance** • Long-term care insurance • Input budgets by Health Commission • Out-of-pocket expenditure • Fragmentation in financing due to multiple departments involved – nursing care is under the Civil Affairs department; health services under the Health Commission and LTCI is managed by Health Security Administration
Resource • Community-based long-term care institutions • Caregivers – public and private • Nursing staff available across government, private (for-profit and non-profit) sectors – fragmentation and lack of integration of nursing care with other health services as nursing comes under the Civil Affairs department	**Service delivery** • Nursing homes • Community-based old age institutions by municipalities • Welfare institutions for older persons – PPP model • Home-based outreach services linked to LTCI • Day-care centres • Home-based services • Meal services

Public–private partnerships

There are different models of partnership across care services in Shanghai for community-based institutions as well as for meal services in the districts of Shanghai. The private sector is being encouraged by the government to promote services for older persons. Participation of the private sector has been seen as important in the provision of integrated care for the older people by promoting public–private partnerships *(63)*. The following are some of the models.

- Operations and maintenance, which is outsourcing that does not last for more than eight years;

- Build–Operate–Transfer (BOT) model where the government grants funds to selected private companies, the right to undertake design, financing, construction, operation, maintenance of PPP projects under franchise agreements (Fig. 3.10).

Box 4. PPPs in the community senior meal programme in Shanghai

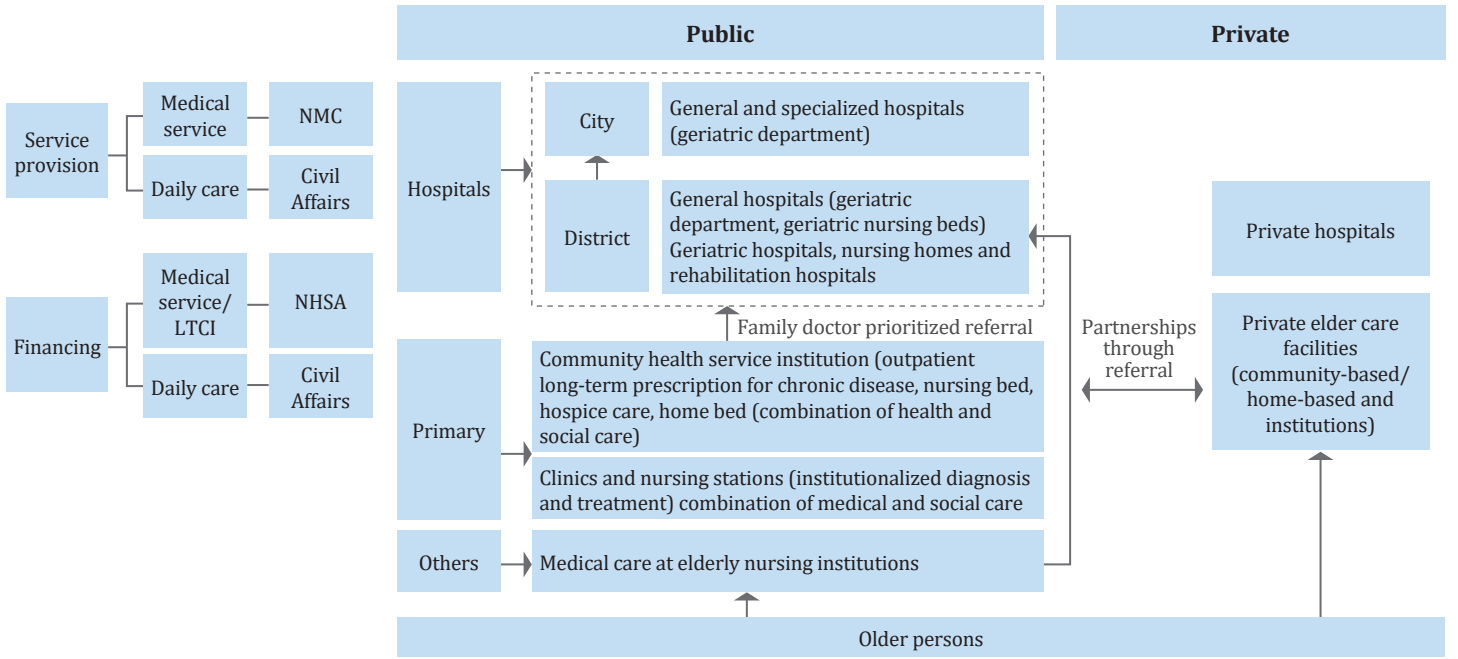
Community-based self-management mode (PPP): meal assistance services are viewed as a public service led by the government. In this mode, relevant government departments are primarily responsible for funding the infrastructure (tables, cutler, and other facilities and equipment), while communities provide venues, and community workers are responsible for hiring staff at meal assistance points, as well as managing and supervising the daily operations.

Government-entrusted social enterprise operation mode (PPP): the government directly entrusts existing catering establishments to carry out modifications to some of their dining areas, providing relatively low-cost meals for older persons in the community. Alternatively, the government mainly takes charge of locating and providing meal assistance sites, supervising the operation and food safety of catering companies, and providing financial subsidies to cooperative enterprises. The government commissions professional catering enterprises to manage and operate meal assistance sites, relying on their own professional experience. These enterprises adjust the environment, facilities and menu items of meal assistance points in a timely manner based on the practical needs of the older people. This ensures that not only do they meet the diverse dietary needs of senior citizens, but also that the prices of their meals are relatively low.

Central kitchen + professional distribution mode (PPP): the central kitchen refers to an organization established by catering chain enterprises that have an independent place and equipment to centrally complete the processing and production of finished or semi-finished food products, and directly deliver them to catering service units located in the community. Older persons can choose to dine at the meal assistance points or have community workers provide door-to-door meal delivery services for those with special needs. This centralized meal supply mode can effectively utilize resources, reduce unnecessary waste of resources, and effectively provide meals for older persons in need through systematic operations from procurement to preparation to final centralized delivery.

Government purchasing social enterprise and institution service (PPP): the local government integrates the resources available in its jurisdiction to provide meal assistance services. It purchases meal assistance services from social enterprises and institutions, transfers the meal assistance services to embedded community old-age institutions and also sets up meal assistance points in the cafeterias of enterprises and institutions. The venues, required equipment and infrastructure for meal assistance services are all provided by social enterprises and institutions (private non-profit). In this mode, the dishes commonly provided in the cafeterias of enterprises and institutions are relatively diverse, easily meeting the requirements of older persons. There is standardized and systematic management by the local government. Food safety can be effectively guaranteed.

Fig. 3.10. Health and social care system in Shanghai



NMC – National Medical Commission
NHSA – National Healthcare Security Agency
Source: Adapted from Zhu 2019 *(64)*

Efforts towards integration

There have been governance reforms that have forged integration across the health and social sectors. The Department of Elderly Health was established under the National Health Commission in 2018. The Department's work is focused on policy coordination and resource integration. The National Healthcare Security Agency was established as an independent body to manage the national health insurance of China. Now it also manages the LTCI, which would help in policy and financial integration *(63).*

The Chinese government has taken initiatives towards integration of health and social care – at the institutional and community levels. At the institutional level, hospitals sign referral agreements with nursing homes and elderly care institutions for rehabilitative services after the patient gets discharged. Also, hospitals provide medical services to elderly care institutions at intervals.

At the community level, strengthening of primary-level health services has facilitated integration. Residents have contracts with a family physician in their district. The family physician can recommend home medical beds, which is a home-based care service for any resident who is disabled or suffering from a chronic illness. Shanghai has the largest number of home medical beds, approximately 72 000 in 2019 *(63).*

The role of the private sector has been encouraged in the field of care for older persons. There are many community care services, rehabilitation hospitals, nursing facilities and care homes for the older people that have a significant private sector presence. Many insurance companies and real estate companies operate these facilities. Public–private partnerships are encouraged for better integration of services.

Chapter 4: Conclusion and policy implications

This study has noted considerable variations in demographic profiles across nine Asia Pacific economies and four case study sites. East Asia is ahead of the silver curve as compared to South and South-East Asia. The history of policy intervention for older persons is further ahead in those economies that are ahead in the silver curve. The location along the silver curve corresponds broadly to the variations in the levels of socioeconomic development; public financing of health services; extent of UHC (ranging from near-full to partial and targeted); variation in the proportion of State:market provisioning for health and social care. Public financing seems to be the key to facilitating the road to integration within health services, social care and between the two. The private sector (for-profit and non-profit organizations) has also occupied a prominent place in both financing and provisioning of such services. More mature partnerships are seen in economies that have near-universal public insurance coverage. Contracting of for-profit and non-profit sectors in health and social care also exist to varying degrees. Monitoring of the quality of private services is a challenge and there are instances of failure.

Table 4.1 summarizes the findings from the case studies. Cities like Hong Kong, Shanghai and Seoul are already ageing and hence there is a greater effort towards integration of services. PPPs are being encouraged to facilitate integration with the private sector. Insurance programmes (both health and LTCI) have promoted partnerships between the public sector and private providers and have facilitated efforts at integration. In these cities, strengthening social care and health services at the community level has been important for facilitating integration as well.

Table 4.1. Summary of findings for health services and social care of older persons across the four cities

Case study sites	Health services			Social care			Efforts at integration
	Public	Private	Partnerships	Public	Private	Partnerships	
Honk Kong SAR	90% inpatient services. Public hospital system operates on rigid referral mechanisms through seven public health-care clusters. Long waiting time and deficit in human resources	70% outpatient services Weak gatekeeping in private	Elderly Healthcare Voucher Scheme eligible citizens aged 65 years or above earmarked vouchers to purchase private health services, including preventive care Partnerships in outpatient visits, cancer-related & other diagnostics, cataract surgeries, haemodialysis with the private sector	Financial support for the older people who are in need Government subsidizes services provided by the private sector A rigorous needs assessment system called Standardized Care Need Assessment Mechanism for Elderly Services determines the allocation of subsidized LTC services	Presence of residential care services Limited presence of LTCI OOP for these services is very high. These range from economical to high end. Informal caregivers who come from Indonesia and Philippines	The large NGO sector receives government grants and operates with high autonomy in providing the bulk of residential care services and community care services. The latter includes day-care centres, integrated home-care services, and enhanced home- and community-care services. Large waiting time for government-subsidized services Residential Care Service Voucher Scheme for the Elderly – the government also purchases a large quantity of residential care beds from the private sector that in turn provides services to eligible older persons at heavily subsidized rates. Pilot Scheme on Community Care Service Voucher for the Elderly –vouchers to choose community-care services that suit their individual needs. Applicants need to pass the needs assessment and are currently waitlisted for government-subsidized services.	Some efforts have been made between the health and social care domains at the organizational and operational levels. Integrated home-care services for support, care and rehabilitative services for the older people Enhanced home- and community-care services to provide integrated services to frail older people In integrated discharge and care support, the older people are provided support after discharge from hospital. Community Geriatric Assessment acts as a gatekeeper for hospital admission or whether support can be provided at home. Strengthening primary care services at district level and identifying and treating chronic conditions at the primary level has been one of the initiatives. Information and communication technologies are being used for integration.

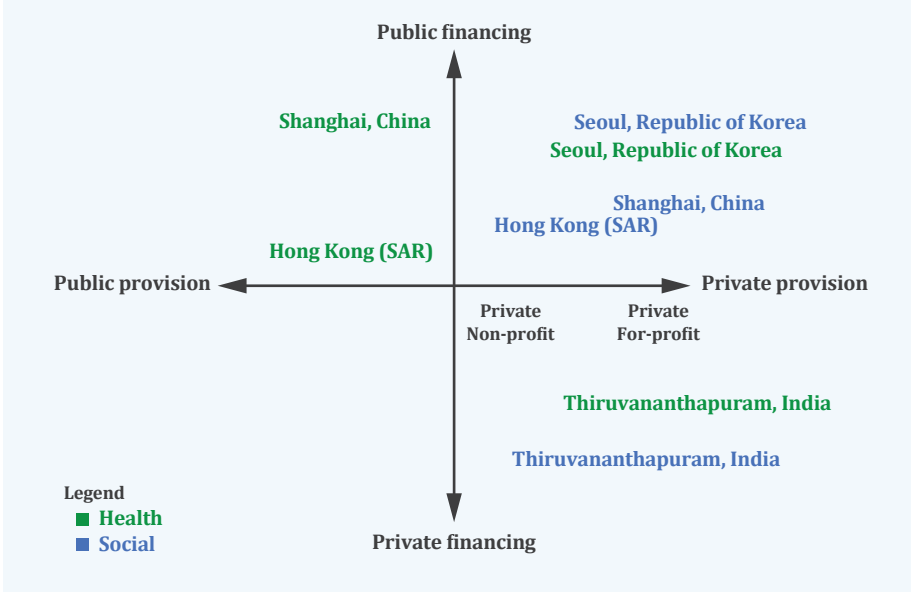
Case study sites	Health services			Social care			Efforts at integration
	Public	Private	Partnerships	Public	Private	Partnerships	
Seoul	Universal health coverage through national health insurance (NHI) At the Seoul metropolitan level, the Citizen's Health Bureau oversees policies for promoting and improving health. Funds are distributed across 25 municipalities. Public providers are present and regional medical centres and 25 public health centres are present in each municipality.	Provisioning of health care is dominated by the private sector.	Financing and governance of services is by the public sector while the private sector provides the services. LTC hospitals provide inpatient medical services for older persons with geriatric conditions under the NHI and is separate from the LTCI. The board of physicians and health networks play important roles in representing private providers for participating in publicly administrated services for older persons.	Pensions are given to older persons whose income is low. A public long-term care insurance (LTCI) is present for the older people. The eligibility of what services an older person would get is based on needs assessment. Public providers account for only 1%.	Private sector dominates provision of social care. These include long-term care facilities, home-care facilities, adult day-care centres and so on.	LTCI is through public financing and governance and private provisioning. Customized Care Service for Older Adults is a programme that provides preventive community-based services for the older people who are not covered by LTCI. This is tax based and services are provided by private providers. Local government contracts the facilities for a period of time. Training for these personnel is provided through the Central Agency for Senior Supports and the Area Support Centres located at each city. LTC providers are mostly private and financed through the LTCI. Licensing and training of all care workers are done by the government.	Efforts towards integration of health and social services have been taking place through financing through insurance – NHI and LTCI. The needs assessment of older persons determines what category of health or social services the person would require. At the city level, much of the decentralization of services is done at the municipal level. The challenges remain due to weak integration between the health and social services.

Case study sites	Health services			Social care			Efforts at integration
	Public	Private	Partnerships	Public	Private	Partnerships	
Thiruvananthapuram, Kerala	The public sector has its own facilities from primary to tertiary institutions – primary health centres, hospitals, specialized geriatric units, assisted devices, diagnostics and medicine. The municipality has a regional geriatric centre that is one of the eight in the country.	The for-profit sector has specialized geriatric health-care units, secondary and tertiary health services, long-term care services. There is a non-profit sector that provides low-cost or free diagnostics and medicines, mobile health-care units, physiotherapy, dementia care centres, palliative care.	Partnerships through the insurance model where government funds are used for people covered under the state health insurance scheme and people in need of inpatient services can access private services. Palliative care services are by an NGO, Pallium Institute. It works with the municipal government to extend home-based palliative services in the city wards. Palliative care training of staff is provided by a government agency. There are partnerships between the private sector as seen in tie-ups between older people residential units and private hospitals.	Social care is under the Ministry of Social Justice. Old-age homes, day-care centres, insurance, old-age pensions There are few programmes for older persons below the poverty line like free medicines, free dentures and free glucometers.	Informal caregivers include the family and domestic helps. The for-profit sector also has old-age homes, recreation centres, day-care centres, high-end residential homes designed for older persons, home-based care services. The non-profit sector has care units like old age homes, day-care centres.	Grants-in-aid by the government are received by old age homes in the non-profit sector.	Least integrated among all the cities. Has very little to no integration between health and social care within and across sectors. There is also disconnect between different levels of governance from the centre, state and municipality.

Case study sites	Health services			Social care			Efforts at integration
	Public	Private	Partnerships	Public	Private	Partnerships	
Shanghai	80% of service delivery is by public facilities. Primary-level institutions provide essential treatment, vaccinations, nursing care, end-of-life care and rehabilitation for the aged population. Nursing homes, rehabilitation institutions and medical institutions with beds for the older people mainly provide hospital care and specialized rehabilitation services for the older people. These are in the private sector as well.	Shanghai has a larger private sector presence in health services than any other city. There are secondary- and tertiary-level private hospitals.	Partnerships are through the insurance model where the government funds services that could be privately delivered.	Every person above 65 years in Shanghai is given a monthly allowance by the local government. Other in-kind support includes "grain and oil help card". The LTCI was introduced as a pilot in Shanghai. Older people are eligible for receiving services through LTCI based on a needs assessment that determines which category of services the older people would receive. Community-based service centres are present in districts to assist the older people with services from pensions to home-based care.	Care homes for the older people, community-based services, home-based services, skilled nursing staff are available in the private sector. These institutions and services are available at the district level.	Long-term care and community-based services through day-care centres, meals, home-based services can be accessed through referral and needs assessment and is paid for through insurance.	There have been efforts to integrate health and social care. At the governance level there have been reforms for better policy coordination and financial coordination. Institutional services are available at the district level, near homes. Primary-level strengthening has facilitated integration. At the institutional level, there have been efforts to make referrals between facilities in the public and private sectors for health and social care.

Based on an analysis of patterns of the public–private mix across the four sites, there is variation in the role of the State and the market in financing and provisioning of health and social care for older persons. Fig. 4.1. represents the public–private mix in financing and provisioning for health and social care at the four sites – Hong Kong SAR, Seoul, Shanghai and Thiruvananthapuram. In health services, Hong Kong occupies an intermediate position where public and private actors play a largely equal role. In social care, public financing in Hong Kong plays a stronger role while much of the provision is undertaken by a mix of for-profit and non-profit actors. Seoul has stronger public financing with mainly not-for-profit private provisioning for both health and social care. In the case of Shanghai, public financing in health and social care is strong while the provisioning for health services is largely public. For social care, it is a mix of public and private provisioning. Thiruvananthapuram represents poor public financing in health and social care while the for-profit sector dominates provisioning.

Fig. 4.1. Public–private mix in financing and provisioning of health and social care



Source: Authors' representation

Across the four sites, governance structures comprise the involvement of multiple ministries such as health, social welfare, civil affairs and local self-governments, resulting in silos in operation within and across ministries. Across all the sites, inconsistencies in the roles and responsibilities between the central, provincial (state) and local governments complicate policy planning, coordination and implementation. This fragmentation is further reflected in the siloed service network, making continuity of care even harder. Against such a complex background, designing a comprehensive regulatory framework is vital but largely absent.

Imbalance between supply and demand for services varies across the four sites. For instance, in Hong Kong, there is lack of doctors in the health system and long waiting times. In social care, government subsidies for provisioning are lacking. In Seoul, there is a large supply of hospital beds mainly due to private provisioning in urban areas resulting in regional inequalities in health services. For social care, there are a large number of relatively small-sized nursing homes and home-care agencies, mainly located in urban areas, creating inequities in access. Human resources are unequally distributed across regions as well. In Shanghai, given the high demographic pressure, the available provisioning for health and social care is inadequate. Therefore, plural institutional forms that include public, for-profit and PPPs have emerged. In Thiruvananthapuram, there is an imbalance between the supply of human resources and institutions in the public sector. This is exacerbated by the presence of a large, heterogeneous and unregulated for-profit private sector. In social care, there is a dearth of publicly financed institutions and community-based services. There is an emerging market of institutions for the care of older persons.

All sites experience challenges in the availability of human resources for health and social care. To fill this supply constraint, Hong Kong relies on migrant workers. There are both formal and informal providers of care across sites. For the latter, which include the family and domestic care workers who act as caregivers, there is a need for training and support. For formal care workers, there is a need for skill-building, certification and licensing for ensuring good-quality care. Both Hong Kong and Seoul offer good examples of licensing formal workers, certification and third-party accreditation. Across sites, there were also concerns of regulating the working conditions and remuneration for care workers.

There have been innovative efforts towards a public–private mix for continuity of care in some of the sites. For example, in Hong Kong, active purchasing by the government of various health and social care services in the private market represents the most salient characteristic of care integration. In Seoul, the Seoul Health Companion programme provides an innovative public–private mix model for chronic care of multimorbid older persons in the community. The identification of patients in need is done through private clinics and subsequent health management through the public health centre by coordinating and providing health and social services, thereby promoting continuity of care for effective chronic care management. In Thiruvananthapuram, the palliative care initiative provides an innovative approach in public–private mix providing health and social care. Thus, often community- and home-based care inviting participation from multiple public and private agencies gives a kind of continuum of LTC for older populations.

The learnings from Hong Kong, Seoul and Shanghai suggest that needs assessment tools for older persons are the cornerstone for financing, service planning and implementation for continuity of health and social care. The learnings from these sites will be useful for other societies as they plan for continuity of care for older persons. Without comprehensive needs assessment, only incremental improvements can be expected.

Digitalization provides a powerful instrument to integrate health and social services, and our case studies have shown some commendable progress in Hong Kong. These innovations improve portability of medical records, enable effective monitoring of chronic conditions and facilitate health management of older persons. There are legitimate concerns on privacy, data safety and digital divide, which need to be addressed properly.

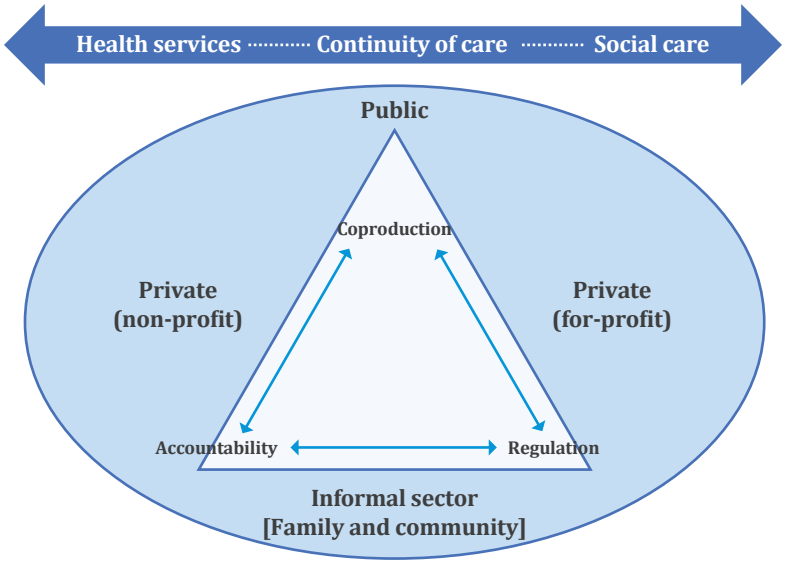
This study as a whole has once again indicated that there is no one-size-fits-all model, as context matters. The use of policy instruments is ultimately shaped by the respective demographic, socioeconomic and political contexts. In some economies where fiscal strength and policy capacity are present, functioning public–private partnerships for continuity of care have taken shape. In low-middle-income contexts, there are many lessons to be learned from the advanced ageing economies in identifying and using policy instruments for continuity of care. International experience has

suggested the value of multidirectional policy learning. Given the diversity of this region and the proliferation of various innovative practices, there is abundant potential for cross-jurisdictional learning in the complex path towards continuity of care.

Fig. 4.2 depicts a suggested framework that emerged from our study. This illustrates the overarching strategies for building good continuity of care for older persons in this region. Multiple actors are involved in the broader ecology of health services and social care, including public, private (non-profit and for-profit), and family and community. Despite the varied mix of these four categories of actors in different societies, constructive interactions among them are critical for coproduction of such services for continuity of care. Our case studies have reinforced the importance of regulation in these sectors. While a state-level regulatory framework is essential, self-regulation of various service providers is equally important. All actors should be held accountable in the spirit of person-centred care for all.

There is a plurality of actors consisting of the informal and formal sectors. The informal sector includes the family and community. The formal sector consists of the public and private (for-profit and non-profit) sectors. The mix of the informal and formal sectors varies across the four cities.

Fig. 4.2. Suggested framework for public–private mix in continuity of care for older persons in the Asia Pacific region



Source: Authors' representation

Our study also suggests that the binary thinking of the market and State may not be conducive to the development of the health and social care sector in light of rapidly ageing populations. Despite the great potential of the for-profit sector, it must be stressed that essential government regulation and some form of code of conduct should be put in place to promote accountability. NGOs can and should be empowered to engage in coproduction of such services. The commitment of the government in planning, financing and delivering services is of critical importance.

The policy recommendations below are learnings from the four sites. Though these are contextual, they will be useful for policy-makers and practitioners to plan towards greater integration of services for continuity of care among older persons.

Needs assessment tools are the cornerstone for financing, service planning and implementation for health and social care. Learnings from Hong Kong

SAR, Seoul and Shanghai would be useful for low-middle-income countries in the Asia Pacific region in this regard.

1. The identification of patients in need through private clinics and subsequent health management through the public health centre by coordinating and providing health and social services, promoting continuity of care for chronic care management, has been an innovative learning case from Seoul.
2. Training and support for both formal and informal caregivers for social care; licensing, certification and third-party accreditation of formal workers are important for good-quality care.
3. Digitalization can assist in integrating services across the public and private sectors, as well as health and social care for continuum of care.
4. Piloting different models in health and social care for continuity of care for older persons will be useful before scaling up.
5. Despite the varied mix of actors (public, private [for-profit and non-profit], family and community) in different societies, constructive interactions among them are critical for coproduction of integrated services for continuity of care.
6. Our case studies have reinforced the importance of regulation in these sectors. While a State-level regulatory framework is essential, self-regulation of various service providers is equally important.

References

1. Boyd CM, Fortin M. Future of multimorbidity research: how should understanding of multimorbidity inform health system design? Public Health Rev. 2010;32:451–74.

2. Maruthappu M, Hasan A, Zeltner T. Enablers and barriers in implementing integrated care. Health Syst Reform. 2015;1(4):250–6.

3. Picco L, Achilla E, Abdin E, Chong SA, Vaingankar JA, McCrone P et al. Economic burden of multimorbidity among older adults: impact on healthcare and societal costs. BMC Health Serv Res. 2016;16:173. doi:10.1186/s12913-016-1421-7.

4. Chiu C-J, Hu J-C, Lo Y-H, Chang E-Y. Health promotion and disease prevention interventions for the elderly: a scoping review from 2015-2019. Int J Environ Res Public Health. 2020;17(15):5335. doi:10.3390/ijerph17155335.

5. Lourenço A, de Brito MF, Gomes B. The future of integrated care in aged individuals. In: Oliveira PJ, Malva JO, edtors. Aging: from fundamental biology to societal impact. London: Academic Press; 2023:649–61.

6. World Bank. World development report 1993: investing in health. New York: Oxford University Press; 1993.

7. Goodman R, Kwon H, White G, editors. The East Asian Welfare Model: welfare orientalism and the state. London: Routledge; 1998.

8. Mackintosh M, Koivusalo M, editors. Commercialization of health care: global and local dynamics and policy responses. Basingstoke, UK: Palgrave Macmillan; 2005.

9. Baru R, Nundy M. Commercialisation of medical care in China: changing landscapes. Oxon & New York: Routledge; 2020.

10. Baru RV, Nundy M, Bisht R, Thresia CU, Sarma J. Integration of health services for older persons in urban India – a scoping review. Econ Political Wkly, 2021;56 (37):36–43.

11. Gilton K, Vellani S, Yeung L, Chishtie J, Commisso E, Ploeg J et al. Identifying and understanding the health and social care needs of older adults with multiple chronic conditions and their caregivers: a scoping review. BMC Geriatrics. 2018;18(231):1–33. doi:10.1186/s12877-018-0925-x.

12. World Health Organization. WHO clinical consortium on healthy ageing 2019. Report of Consortium meeting held 21–22 November 2019. Geneva, Switzerland, 2019 (https://iris.who.int/bitstream/handle/10665/333913/9789240009752-eng.pdf?sequence=1, accessed 4 August 2024).

13. Healy J, Jaafar S, Noh KM, Muttalib KA, Othman NH, Maskon K et al. Malaysia health system review. Health Systems in Transition.2012;2(1). Manila: World Health Organization Regional Office for the Western Pacific; 2012 (https://iris.who.int/bitstream/handle/10665/206911/9789290615842_eng.pdf?sequence=1&isAllowed=y, accessed 4 August 2024).

14. Kwon S, Lee T, Kim C. Republic of Korea health system review. Health Systems in Transition. 2015;5(4). Manila: World Health Organization Regional Office for the Western Pacific; 2015 (https://iris.who.int/bitstream/handle/10665/208215/9789290617105_eng.pdf?sequence=1&isAllowed=y, accessed 4 August 2024).

15. Mills A, Tangcharoensathien V, Meng Q, Yang H, Chen W, Sun Q et al. People's Republic of China health system review. Health Systems in Transition.2015;5(7).Manila: World Health Organization Regional Office for the Western Pacific; 2015 (https://iris.who.int/bitstream/handle/10665/208229/9789290617280_eng.pdf?sequence=1&isAllowed=y, accessed 4 August 2024).

16. Hort K, Patcharanarumol W, Mahendradhata Y, Trisantoro L, Listyadewi S, Soewondo P et al. The Republic of Indonesia health system review. Health Systems in Transition. 2017; 7(1). New Delhi: World Health Organization Regional Office for South-East Asia; 2017 (https://iris.who.int/bitstream/handle/10665/254716/9789290225164-eng.pdf?sequence=1, accessed 4 August 2024).

17. Rajapaksa L, De Silva P, Abeykoon A, Somatunga L, Sathasivam S, Perera S et al. Sri Lanka health system review. Health Systems in Transition. 2021;10(1). New Delhi: World Health Organization Regional Office for South-East Asia; 2021 (https://iris.who.int/bitstream/handle/10665/342323/9789290228530-eng.pdf?sequence=1&isAllowed=y, accessed 4 August 2024).

18. United Nations Population Fund (UNFPA). 8 billion lives, infinite possibilities: the case for rights and choices. State of World Population Report 2023. 2023 (https://www.unfpa.org/sites/default/files/swop23/SWOP2023-ENGLISH-230329-web.pdf., accessed 4 August 2024).

19. Health indicators. 2020. In: World Bank Group [online database] (https://data.worldbank.org/topic/health?end=2023&start=2020, accessed 4 August 2024).

20. World Bank Open Data. 2021, 2022. In: World Bank Group [online database] (https://data.worldbank.org/, accessed 4 August 2024).

21. Population trends 2020. In: United Nations Population Fund (UNFPA) Population Data Portal [online database] (https://pdp.unfpa.org/?data_id=dataSource_2-0%3A4&page=Visualization-Overview, accessed 4 August 2024).

22. Census and Statistical Department, Government of HK SAR. Hong Kong Census 2021 Population Census: summary results. 2021 (https://www.censtatd.gov.hk/en/EIndexbySubject.html?pcode=B1120106&scode=600, accessed 4 August 2024).

23. WHO global strategy on integrated person-centred health services 2016–2026. Executive summary. Draft for Consultation. Geneva: WHO; 2015 (https://interprofessional.global/wp-content/uploads/2019/11/WHO-2015-Global-strategy-on-integrated-people-centred-health-services-2016-2026.pdf, accessed 4 August 2024).

24. Population statistics, Hong Kong SAR Government. In: Health Bureau [website]. 2023. (https://www.healthbureau.gov.hk/statistics/en/health_statistics.htm, accessed 4 August 2024).

25. Standardised care need assessment mechanism for elderly services and central waiting list. In: Social Welfare Department, Hong Kong SAR [website]. 2023 (https://www.swd.gov.hk/en/pubsvc/elderly/elderly_info/assess/scnam_cwl/, accessed 5 August 2024).

26. Primary health care blueprint supplement. Hong Kong SAR: Health Bureau (https://www.primaryhealthcare.gov.hk/bp/cms-assets/Primary_Healthcare_Blueprint_Supplement_Perfect_Binding_Eng_2106cc00c6.pdf, accessed 5 August 2024) .

27. KOSIS 1960–2072. Projected population by age group (Korea). 2023 (https://kosis.kr/statHtml/statHtml.do?orgId=101&tblId=DT_1BPA003&conn_path=I2&language=en, accessed 5 August 2024).

28. Statistics on the aged. In: Statistics Korea [website]. 2022 (https://kostat.go.kr/board.es?mid=a20111030000&bid=11759&act=view&list_no=421350, accessed 5 August 2024).

29. OECD Health statistics 2023. In: OECD [website] (https://www.oecd.org/els/health-systems/health-data.htm, accessed 5 August 2024).

30. Global Health Expenditure database. World Health Organization; 2014 (apps.who.int/nha/database, accessed 5 August 2024)).

31. Health at a glance. OECD indicators. 2021. Paris: OECD Publishing; 2021.

32. [Health personnel: big data open portal] (인력 현황, 빅데이터개방포털). In: HIRA [online database]. 2023 (https://opendata.hira.or.kr/op/opc/olapHumanResourceStatInfoTab2.do, accessed 5 August 2024). (In Korean)

33. Jeong H, Kim H, Lee E, Min H, Cho B, Lee S, Nam C. A study on the improvement of welfare affairs distribution system between central government and local governments. Korea Institute for Health and Social Affairs; 2020.

34. Shin J, Seo JS. Welfare state, decentralization, and local politics interpreting welfare decentralization in South Korea from historical-comparative perspectives. Korea Social Policy Review, 2016;23(4):61–89.

35. Kim J. Welfare decentralization in Korea: in between two models of unitarism and federalism. Working Paper. Korea Institute of Public Finance; 2011.

36. Shon C. The response of the Seoul municipal hospitals against COVID-19 and Its Implications for public hospitals. Korean Journal of Hospital Management. 2020;25(3):38–52.

37. Kim H, Kwon S. A decade of public long-term care insurance in South Korea: policy lessons for aging countries. Health Policy. 2021;125(1):22–6.

38. Chon Y. The meaning and challenges of the introduction of the customized care services for older adults. Journal of the Korea Gerontological Society. 2020;40(4):599–616.

39. [Customized care services for older adults program manual] (노인맞춤돌봄사업 설명서). Ministry of Health and Welfare (MoHW); 2023 (https://www.mohw.go.kr/board.es?mid=a10411010100&bid=0019&tag=&act=view&list_no=374747, accessed 5 August 2024). (In Korean)

40. [SOS care center operation mannual] (2023 돌봄SOS센터 운영매뉴얼). Seoul Metropolitan Government (SMG); 2023 (https://wish.welfare.seoul.kr/swflmsfront/board/boardr.do?bmno=10015&opno=10007&bno=98116, accessed 5 August 2024). (In Korean)

41. Enrollment in private insurance (by household). In: KOSIS [website]. 2021 (https://kosis.kr/statHtml/statHtml.do?tblId=DT_33109_D011&orgId=331&language=kor&conn, accessed 5 August 2024)._

42. Health and welfare statistical yearbook (2018~2020). MOHW; 2020.

43. Kim AM, Cho S, Kim HJ, Jung H, Jo MW, Lee JY, Eun SJ. Primary care patients' preference for hospitals over clinics. Int J Environ Res Public Health. 2018;15(6):1119.

44. Kang HJ. Policy direction for decreasing the concentration of patients to extra-large hospitals. Health Welfare Policy Forum. 2014;210:65–76. doi:10.23062/2014.04.7.

45. [Seoul health companion program manual] (서울시 건강동행사업 매뉴얼). SMG; 2023. (Accessed in print). (In Korean)

46. [Big data open portal. 2010 & 2020. In: HIRA [online database] (https://opendata.hira.or.kr/op/opc/olapHumanResourceStatInfoTab1.do, accessed 5 August 2024). (In Korean)

47. [Survey on the health and medical personnel] (보건의료 인력 실태조사). In: MoHW [website]. 2022 (https://www.mohw.go.kr/board.es?mid=a10411010100&bid=0019&act=view&list_no=373498&tag=&nPage=1, accessed 5 August 2024). (In Korean)

48. [2021 Health insurance statistical yearbook]. National Health Insurance Service (NHIS); 2022 (https://www.hira.or.kr/bbsDummy.do?pgmid=HIRAA020045020000/&brdScnBltNo=4&brdBltNo=2314&pageIndex=1&pageIndex2=1, accessed 5 August 2024). (In Korean)

49. [2020 Health insurance statistical yearbook]. National Health Insurance Service (NHIS); 2021 (https://www.hira.or.kr/bbsDummy.do?pgmid=HIRAA020045020000&brdScnBltNo=4&brdBltNo=2313&pageIndex=1, accessed 5 August 2024). (In Korean)

50. [Survey on the state of long-term care 2019] (2019 장기요양 실태조사 결과 발표). MOHW;]2020 (https://www.mohw.go.kr/react/al/sal0301vw.jsp?PAR_MENU_ID=04&MENU_ID=0403&CONT_SEQ=353801, accessed 5 August 2024). (In Korean)

51. [LTCI statistical yearbook 2017~2020]. NHIS; 2021 (https://www.nhis.or.kr/nhis/together/wbhaec07200m01.do, accessed 5 August 2024) (In Korean).

52. [LTCI statistical yearbook 2021]. NHIS; 2022 (https://www.nhis.or.kr/nhis/together/wbhaec07200m01.do?mode=view&articleNo=10820535. Accessed 5 August 2024). (In Korean).

53. Choi H. [Health and welfare budget for 2023] (2023 년 보건복지분야 예산안 분석: 노인복지분야). 2022 (https://www.peoplepower21.org/welfarenow/1919016, accessed 5 August 2024). (In Korean).

54. Central Agency for Older Adult Care. Korean Foundation for support of the senior citizen in need (informational pamphlet). 2023.

55. Department of Empowerment for Person with Disabilities [website]. Ministry of Social Justice and Empowerment, Government of India. 2021 (http://www.ccdisabilities.nic.in/resources/disability-india, accessed 5 August 2024).

56. International Institute for Population Sciences (IIPS), NPHCE, MoHFW, Harvard TH Chan School of Public Health, University of Southern California. Longitudinal ageing study in India (LASI) Wave 1, 2017–18, India Factsheet, 2019. Mumbai: International Institute for Population Sciences; 2020 (https://lasi-india.org/public/documentation/LASI-FACTSHEET_INDIA_3-1-2021.pdf, accessed 5 August 2024).

57. Economic review 2021. Thiruvananthapuram: Kerala State Planning Board, Government of Kerala; 2021 (https://spb.kerala.gov.in/sites/default/files/2022-03/ECNO_%20ENG_21_%20Vol_1.pdf, accessed 5 August 2024).

58. UNFPA. Building a knowledge base on population ageing in India: report on the status of elderly in select states of India, 2011. Working Papers id:5209, eSocialSciences. 2013 (https://ideas.repec.org/p/ess/wpaper/id5209.html, accessed 5 August 2024).

59. SJD. List of old age homes in Thiruvananthapuram district. In: NGO Base [website]. 2022 (http://sjd.kerala.gov.in/DOCUMENTS/Downloadables/OTHERS/35921.pdf, accessed 5 August 2024).

60. Population ages 65 and above (% of total population) – China. In: World Bank Group [online database]. 2023 (https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS?end=2022&locations=CN&start=2022&view=bar, accessed 5 August 2024).

61. Chen S, Li L, Yang J, Jiao L, Golden T, Wang Z, et al. The impact of long-term care insurance in China on beneficiaries and caregivers: a systematic review. Journal of Global Health Economics and Policy. 2021;1:e2021014 (Published online on 16 November 2021). doi: 10.52872/001c.29559.

62. Nundy M, Baru R. Arrangements for the care of elderly in Shanghai. China Report. 2020; 56(3):317–33. doi:10.1177/0009445520930388.

63. Hu L, Glavin Y-FW, Yan R, Pei C, Yan M, Zhang Y, Liu Y. Integrating health and care in China: lessons learned and future outlook. Int J Integr Care. 2021;21(4):18. doi:10.5334/ ijic.5681.

64. Zhu B. Patterns of expenditure for elderly care in Shanghai, International Conference on Arrangements of Care for Elderly in Delhi and Shanghai, 12–13 March 2019, India International Centre, New Delhi, Organised by the Institute of Chinese Studies, Delhi.

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