The Road to Better Long-Term Care in Asia and the Pacific

Building Systems of Care and Support for Older Persons

May 2022
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MAY 2022
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In Asia and the Pacific, increased longevity and declining fertility are hallmarks of development success. Taken together, they have also brought about a demographic shift: a rapidly aging population. The impact of this is being felt by almost every country in the region, and governments are grappling with how best to develop effective policies and programs to address the needs of older populations, including the accelerating demand for long-term care (LTC).

The coronavirus disease (COVID-19) pandemic has underlined the importance of strengthening existing systems and developing new capacities. As with many other aspects of development, COVID-19 has exposed systemic and societal weaknesses, and has had a disproportionate impact on older persons and on existing care systems.

As the region’s development bank, the Asian Development Bank (ADB) is acutely aware of the increasing need to establish and finance LTC services in response to these demographic, economic, and social trends. There is also a need to develop enabling environments to support older people to age well, and to ensure families and communities can care for their older citizens. ADB not only has a growing portfolio on LTC to help mitigate the social and fiscal risks of population aging; it is also at the forefront of providing the technical assistance (TA) that countries need as they go about developing models of care that are affordable, sustainable, accessible, efficacious, and adapted to local contexts.

In May 2016, ADB approved the regional capacity development TA project, Strengthening Developing Member Countries’ Capacity in Elderly Care (TA 9111-REG). The project aimed to bolster the capacity of developing member countries to design policies and plans for the improvement of their LTC services. The six countries included in this regional TA are diverse and at different stages of aging: Indonesia, Mongolia, Sri Lanka, Thailand, Tonga, and Viet Nam.

The project had three main aims:

- build a knowledge base in the region for the development of LTC systems and services;
- improve the capacity of officials and other stakeholders in these countries to design and implement strategic LTC plans; and
- create a network for disseminating knowledge, good practices, and expertise.

This report provides a summary of the six country diagnostic studies that were conducted under the TA. It explores LTC in these countries, and their unique circumstances as they grapple with an aging population. It also examines what they have in common and showcases good practices that may be helpful to other countries facing similar issues. The challenges created by population aging are not going away any time soon. Neither is ADB. We will continue to stand with our developing member countries as they adapt to new realities and continue down the road of development success, prosperity, and sustainability.
Acknowledgments

The following Asian Development Bank staff and consultants provided invaluable inputs into the preparation of this report: Rachanichol Arunoprayote, Peter Chan, Lydia Domingo, Wendy Holmes, Caitlin Littleton, Imelda Marquez, Peter Morrison, Arlene Tadle, Wendy Walker, Camilla Williamson, and Meredith Wyse. This report summarizes the findings from the regional technical assistance (TA) for Strengthening Developing Member Countries’ Capacity in Elderly Care (TA 9111) which was funded by the Japan Fund for Poverty Reduction and the Republic of Korea e-Asia and Knowledge Partnership Fund and completed in December 2021. The findings and lessons from implementing the TA are informing the development of innovative community-based long-term care systems and services under the succeeding TA (TA 9928).

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## Abbreviations

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<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>ADL</td>
<td>activities of daily life</td>
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<td>DMC</td>
<td>developing member country</td>
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<tr>
<td>IADL</td>
<td>instrumental activities of daily living</td>
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<td>ISHC</td>
<td>Intergenerational Self-Help Club</td>
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<tr>
<td>LTC</td>
<td>long-term care</td>
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<tr>
<td>NGO</td>
<td>nongovernment organization</td>
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<tr>
<td>NSE</td>
<td>National Secretariat for Elders</td>
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<td>TA</td>
<td>technical assistance</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Family support. Boonmee Supharatha (left) spends time with her family in Ban Mai, Chiang Mai, Thailand. The bulk of the responsibility for long-term care lands on women (photo by Jittrapon Kaicome/Asian Development Bank).
Key Points

- Population aging is one of the most important trends facing the world today and, in Asia and the Pacific, the pace of this demographic transition is fast. The share of the region's population aged 65 years and over is estimated to increase almost 2.5-fold from 2020 to 2050 to surpass 14% for women and reach 11% for men.

- The widening gap between supply and demand for aged care, amid changing family and labor market patterns and shifts in cultural norms around care for parents, is hugely challenging for developing member countries (DMCs) of the Asian Development Bank (ADB).

- ADB recognizes that long-term care (LTC) is a key population development issue for its DMCs. From 2016 to 2021, an ADB regional capacity development technical assistance project, Strengthening Developing Member Countries' Capacity in Elderly Care, worked with the governments of Indonesia, Mongolia, Sri Lanka, Thailand, Tonga, and Viet Nam to understand their current situation in LTC, identify good practices and gaps, and help map out the road ahead to meeting the challenge of growing demand for LTC.

- ADB conducted diagnostic studies of country policies and programs, leadership, financing, service delivery, workforce, and information systems for LTC. These studies revealed both challenges and inspiring responses to them.

- While each study country has its own unique LTC ecosystem, there are common threads, including a commitment to aging in place, the central role of the family emphasized in legislation and policies, the wide variety of nonfamily caregivers, the role older people themselves play in providing care to others, and the challenges of financing care and of developing an adequate care workforce.

- Across Asia and the Pacific, ADB’s DMCs have recognized the accelerating need for LTC policy, services, and personnel. They are actively working to bridge gaps and meet the demographic challenges ahead. As they do, they are running five key races: (i) to bridge the gap between policy and practice, (ii) to integrate care, (iii) to design a sustainable financing model, (iv) to meet human resource needs, and (v) to capitalize on technology.

- DMCs can take strategic action to increase the LTC workforce; establish clear roles and lines of responsibility for government, the private sector, civil society, and the public; and improve the availability of data. By taking action now they can build solid foundations for an integrated home- and community-based LTC system.
Building capacity. A clinic staff member measures an older person’s blood pressure in Yogyakarta, Indonesia. The Asian Development Bank’s regional technical assistance project, Strengthening Developing Member Countries’ Capacity in Elderly Care (TA 9111-REG), helps to increase the capacity of developing member countries to develop policies and plans for the establishment and support of long-term care services in Asia and the Pacific, and creates a knowledge network to disseminate good practices and expertise (photo by Anita Reza Zein/Asian Development Bank).
Introduction

POPULATION AGING IN ASIA AND THE PACIFIC

Population aging—a shift in the distribution of a country’s population toward older ages—is one of the most important trends facing the world today. The pace of this demographic transition is fast in Asia and the Pacific. According to the Organisation for Economic Co-operation and Development and the World Health Organization (WHO), from 2020 to 2050, the share of the region’s population aged 65 years and over is estimated to increase almost 2.5-fold in lower-middle income and low-income countries to surpass 14% for women and reach 11% for men.¹

Globally, the number of care-dependent older people is forecast to quadruple by 2050.² This growth is due to both the aging of populations (more older people and longer life expectancies) and the shifting patterns of disability and disease, with increasing rates of noncommunicable diseases associated with dependency and need for care.

The implications are far-reaching, including an emerging and widening gap between supply and demand for aged care. There is also tension between the need for care, changing family and labor market patterns, and traditional cultural beliefs and practices around care for parents. This is hugely challenging for developing member countries (DMCs) of the Asian Development Bank (ADB). Recognizing that long-term care (LTC) is a key population development issue for its DMCs, ADB is working with countries across the region to help develop strategic approaches to the development of LTC systems and services.

From 2016 to 2021, an ADB regional capacity development technical assistance (TA) project, Strengthening Developing Member Countries’ Capacity in Elderly Care (TA 9111-REG), worked with the governments of Indonesia, Mongolia, Sri Lanka, Thailand, Tonga, and Viet Nam to understand the current situation in LTC; identify good practices and gaps; and help map out the road ahead to meet the challenge of growing demand for LTC.³ In the process, the TA identified the pace of the demographic transition (Figure 1), as well as key commonalities between the countries. It also revealed important lessons for other countries grappling with the same issues, be they DMCs or more highly developed countries, in the region or beyond.

³ ADB. *Regional: Strengthening Developing Member Countries’ Capacity in Elderly Care*. 
The Road to Better Long-Term Care in Asia and the Pacific—Building Systems of Care and Support for Older Persons

There is no universally accepted definition of aged care or LTC (this report uses the two terms interchangeably). The six focus countries in this report do not have a shared understanding of what it means. However, a useful definition of LTC is the support provided, and the activities undertaken by, informal caregivers (including family, friends, or neighbors) or by public, private, or voluntary sector providers to ensure that an older person can optimize their functional ability and maintain the highest possible quality of life.

Functional ability is a key part of healthy aging. The WHO defines functional ability as having the capabilities that enable all people to be and do what they have reason to value. This includes “a person’s ability to
- meet their basic needs;
- learn, grow, and make decisions;
- be mobile;
- build and maintain relationships; and
- contribute to society.”

Assessing the need for LTC at the individual level can be done by gauging a person’s ability to perform the basic activities necessary for daily life. These activities include bathing or showering, dressing, eating, getting in or out of bed or chairs, using the toilet, and getting around inside the home.

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In addition to these activities of daily life (ADLs), another useful metric is instrumental activities of daily living (IADLs)—these are activities that support independence, although they are not fundamental to survival. IADLs include housework, meal preparation, shopping, accounting, medication management, and transportation.

THE BUILDING BLOCKS OF LONG-TERM CARE SYSTEMS

LTC systems are complex and are influenced by many factors, including where the LTC policy is situated in the country’s governance structures, labor market dynamics, how LTC is paid for, the role of technology, and the cultural context and social norms around gender, filial piety, and individual versus state responsibility.

To help tease out these and other factors, investigate LTC across diverse country settings, and make meaningful comparisons between them, the WHO building blocks of health systems provide a useful framework (Figure 2). ADB conducted country diagnostic studies based on desk reviews of available data and literature, and key stakeholder consultations, and used a modified version of the WHO framework to synthesize the findings. Indonesia and Sri Lanka also did some analysis of existing survey data and implementation of a survey on private sector providers.

**Figure 2: Building Blocks of Long-Term Care**

- Effective governance, coordination, and quality management
- Strategic policy frameworks, effective oversight, and coalition building
- Provision of appropriate incentives, and attention to system design and accountability

- Adequate funds for care
- Protection from financial catastrophe
- Resource allocation that improves quality, equity, and efficiency

- Quality, access, safety, and coverage

- Adequate human resources, both formal and informal
- Sound human resources management, skills, and policies

- Timely and reliable information
- Sound analysis, dissemination, and use

BUILDING A PICTURE OF LONG-TERM CARE IN ASIA AND THE PACIFIC

Each country diagnostic study presents a unique portrait based on the demographic stage the country is at and the role of government, civil society, and private sector stakeholders in LTC. There are clearly huge challenges to face, and each country is tackling these in its own unique way. However, it can be said that adversity fuels creativity and, although this report does not shy away from discussing the challenges facing countries, it also showcases the ways in which DMCs are creating robust and workable solutions to the challenges of developing LTC systems and services. These good examples can be an inspiration, starting point, or even a template for other countries to use as they grapple with similar challenges. Moreover, while each study country has its own unique LTC ecosystem, there are common threads (Figure 3).

Figure 3: Long-Term Care in Asia and the Pacific

- **Commitment to aging in place**: Supporting older people to stay in their homes and communities.
- **Central role of the family**: The family as the bedrock of long-term care.
- **Wide variety of nonfamily caregivers**: Government agencies, nongovernment organizations, community groups, and the private sector.
- **Community involvement by older adults**: Clubs and volunteer services.

A Commitment to Aging in Place
All study countries favored supporting older people to stay in their homes and communities—what is known as aging in place—rather than to go into residential care. Home-based and community-based care programs that address people’s needs for assistance with everyday activities, such as dressing or bathing to enable them to age in place, are far more prevalent than residential care. In all of the study countries, nongovernment organizations (NGOs), civil society, and faith-based organizations are providing care for older people in their homes and in the community, but demand outstrips supply. Residential care is not widely available, and is often expensive and beyond the means of much of the population. Where available, publicly funded residential care is often focused on the most basic needs for shelter and food rather than specialist geriatric care services.

Emphasis on the Central Role of the Family
The family remains the bedrock of LTC, with the bulk of the responsibility landing on women. However, these traditional patterns of caregiving are straining under a range of forces, including increasing dependence ratios, labor migration, increasing female participation in the workforce, and changing social norms. While governments clearly want the central role of the family in the provision of care to continue, and some have made efforts to support families to do this, examples of this are exceptions rather than the norm.

A Diverse Range of Care Service Providers
Outside the family, LTC provision comes from government agencies, the private sector, and NGO community groups. In some countries, the already established cadre of public health volunteers, who conduct basic health promotion or health care, also plays a significant role in LTC. Moreover, governments are making strenuous efforts to encourage shared responsibility for LTC across a plurality of service providers from the public, private, and voluntary sectors. In all contexts, home- and community-based care was identified as the priority approach to aging in place and sustainable LTC.

Community Involvement by Older Adults
Older people themselves are a huge resource to draw upon, often providing volunteer services to other older people in need of assistance in their community. Community initiatives such as older people’s associations or elders’ clubs exist in five of the six study countries (excluding Tonga), and some include services that support older people—e.g., peer support to help with personal care (as is the case in Viet Nam), other ADLs, or to simply provide company.
Vital work. A caregiver sweeps an older person’s yard in Nong Hoi, Chiang Mai. In Thailand, a home-based long-term care program is managed by the National Health Security Office and local authorities (photo by Jittrapon Kaicome/Asian Development Bank).
Country Summaries

INDONESIA

Table 1: Indonesia – Key Facts

Indonesia’s population is relatively young but, with a slowing birth rate and increasing life expectancy, it is aging. It is predicted that, by 2050, Indonesia will be home to more than 70 million persons aged 60 years and above (21% of the population).

Demography

Indonesia’s population is relatively young but, with a slowing birth rate and increasing life expectancy, it is aging. By 2019, nearly 10% of the country’s population (25.7 million people) were aged 60 and above. The figure is predicted to increase to 70 million by 2050 and to account for 21% of the country’s population by 2050 (Table 1). There are significant regional variations. In the Special Regions of Yogyakarta and Bali, for example, older adults already account for 14.5% (Yogyakarta) and 11.3% (Bali) of the population; whereas, in the Special Capital Region of Jakarta, the demographic transition is at an earlier stage, with only 7.8% of the population aged 60 and above.

Governance and Leadership

In September 2021, Indonesia adopted a new multisector National Strategy on Aging, with a clear policy direction on expanding the scope of long-term care (LTC) for older persons, related indicators and activities, and responsibilities defined. This bodes well for the country’s future direction in LTC toward an integrated system. Although there is no single body responsible for the overall management of quality in LTC, there are binding protocols stipulating basic standards for social and health services for older people at the district or municipal level.

Financing
Apart from the health services and basic social care services provided by the government, most complex care and paid home care services are unaffordable and out of reach of the majority of older persons. However, the country’s universal health insurance scheme does insure several services related to LTC (e.g., post-stroke rehabilitation and limited finance for eyeglasses, hearing aids, and assistive devices), even though the scheme does not explicitly identify LTC as a benefit category. Health service benefit packages for older people offered through primary care and covered by social health insurance are also being expanded.

Service Delivery
Home- and Community-Based Care
Indonesia has an interwoven network of care, including primary care providers, nurse-based elderly centers, health stations, social centers, elderly and family education centers, and women’s groups.

In addition to a small number of civil society and private sector providers, there are programs run by different line ministries. In 2017, these programs included

- 31,266 Elderly Family Development Program cadre, providing skills training and support for family carers (625,320 older people);
- 1,450-strong social welfare institutions cadre, providing mostly befriending and material support (14,000 older people);
- 4,492 cash transfer cadre, providing befriending support and delivering cash benefits (52,500 older people); and
- 417,000 Posyandu Lansia volunteer health workers (2.5 million older people).

Residential
There are 277 registered homes, with varying numbers and qualifications of staff for 3,260 older residents. Some are operated by the central and local governments, but the majority are privately owned.

Workforce
As is the case across all six study countries, in Indonesia, most long-term caregiving is undertaken by family members, and most often by daughters, daughters-in-law, and wives. Indonesia has recognized the importance of training caregivers. The ministries of health, education, and manpower, together with professional organizations, are currently collaborating to develop five levels of certified caregiver training focused on care workers. Support groups and training are also a feature of Indonesia’s Elderly Family Development program, designed to increase the quality of family care through improved knowledge and skills.
Indonesia has a history of health and social welfare volunteerism, and there is potential for this to be tapped to overcome workforce shortages. Staff and volunteers of the Ministry of Health, Ministry of Social Welfare, and Department of Family Planning are all potential pools of care for the LTC workforce. Indonesia’s LTC workforce may also be influenced by the flow of workers overseas: approximately 540,000 Indonesians working abroad classify their job as caregiving for older people and may bring back their skills and experience acquired overseas to Indonesia.

Information Systems
Data on older people is held by both the Ministry of Health and the Ministry of Social Affairs, but their information systems are not integrated and the information collected is fragmented. Often, the same information on specific indicators is collected many times by different agencies. To overcome these challenges and promote integration, data information systems connecting national, provincial, district, and community levels are now being developed. The National Development Planning Agency (BAPPENAS) is currently developing SILANI, or the Elderly Information System. SILANI is an online database and digital application containing information on the socioeconomic and well-being status of older persons. Introduced in 2021, it aims to facilitate integrated planning and monitoring of social protection and LTC programs and will be used in regional care planning and for individual case management, such as screening.

Find out more: Country Diagnostic Study on Long-Term Care in Indonesia.
Aging in place. Mbah Djarayah sews patchwork in Yogyakarta, Indonesia. Home-based and community-based care programs address people’s needs for assistance with everyday activities, such as dressing or bathing, enabling them to age in place (photo by Anita Reza Zein/Asian Development Bank).
Demography

Mongolia is one of the least densely populated places in the world. It had an estimated population of 3.2 million in 2018 and a land area of over 1.5 million square kilometers. Mongolia’s demographic trend—shifting from high to low birth rates—is typical of the region. Rapid migration has led to 70% of Mongolia’s population now living in urban areas, and there is still a large rural and nomadic population that requires access to services. This contributes to a unique pattern of population change and, as a result, Mongolia is not easy to compare with other countries. From 1990 to 2010, only 6% of the population were aged over 60, and population aging was very slow. However, this has since accelerated. By 2040, 16.7% of its population will be aged 60 and above (Table 2).

Governance and Leadership

In 2009, the government adopted the National Strategy for Population Ageing (2009–2030), setting out the responsibilities of the various ministries involved in implementation, with funding from annual government budgets. In support of this, the government approved the National Program on Healthy Ageing and Health of Older Persons (2014–2020) in 2013. The goal of the program was to enhance the quality of life of older people through active, healthy aging and by working to improve older people’s health, wellness, social protection, and social participation. A national strategic plan on elderly care is pending approval. If approved and implemented, this will help build a common understanding of LTC and facilitate coordination between the social and health sectors.

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A more recent development was in 2017, when the Law on the Elderly was approved by Parliament, and a national council was established to ensure broad intersector coordination on the rights of older people (Box 1). This, in turn, led to the development of the National Program on the Development and Protection of Elderly People, approved in 2019. The program will offer a comprehensive framework for the coordination of all partner inputs in older people’s care and development in Mongolia. A draft strategic plan on LTC is pending approval.

Box 1: Spotlight on Good Practice: Mongolia’s Law on the Elderly

Mongolia has a well-developed policy and legal framework to protect and care for older people. The 2017 Law on the Elderly is wide-ranging, covering various aspects of support. These include social protection and welfare, health, and employment services. The law’s purpose is to regulate the factors that help determine the type and extent of social security services each senior citizen receives, as well as to define the rights and duties of state and business entities and of organizations regarding these services.

According to the Law on the Elderly, older people have the right to a range of key services covering

- information and communication;
- counseling;
- medical care;
- voluntary support;
- day care, nursing, and residential care;
- food and nutritional support; and
- protection from domestic violence and other risks.

If the provisions of the law are implemented, it will provide a good basis for the biopsychosocial elements of long-term care service provision. The law specifies the state’s responsibilities in several areas:

- support to organizations providing social, psychological, economic, and legal counseling;
- organization of outreach services, such as cleaning and providing fuel, cooking, and laundry services;
- organization of day care services, such as temporary shelters for feeding, training, and development;
- support to citizens and organizations who want to volunteer to care for older people;
- organization of nursing homes based on local needs, and covering those who need permanent care;
- support with specialized services for older people who are incapable of living independently; and
- protection against domestic violence or the risk of violence.

Financing

There is no clear picture of how much Mongolia spends on LTC. Public funding for LTC comes from both the Ministry of Labor and Social Protection and the Ministry of Health. Mongolia is currently expanding health service benefit packages for older people through primary care covered by social health insurance. This may provide a foundation for the development of LTC financing models, but sustainability will rely on mixed funding sources. Table 3 presents public spending of institutions and providers of care for older persons in 2015.

Table 3: Public Expenditure of Main Institutions and Care Providers in Mongolia, 2015

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Expenditure ($ million)</th>
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<tr>
<td>Nursing residential care</td>
<td>0.51</td>
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<tr>
<td>Hospices</td>
<td>1.60</td>
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<tr>
<td>Sanatoriums(^a)</td>
<td>41.60</td>
</tr>
<tr>
<td>Informal caregivers</td>
<td>0.29</td>
</tr>
<tr>
<td>Rehabilitation care</td>
<td>10.10</td>
</tr>
<tr>
<td>Conditional cash transfers and vouchers</td>
<td>7.50</td>
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<tr>
<td>Residential and temporary nursing care services</td>
<td>1.60</td>
</tr>
<tr>
<td>Community-based social welfare services</td>
<td>0.80</td>
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\(^a\) Sanatoriums offer medical and rehabilitative services through both traditional and modern medical approaches. Users typically stay there for about 10 days at a time.


Service Delivery

In Mongolia, the most common form of LTC support is home-based family care. This is in line with cultural values. Some older people receive services through Mongolia’s community-based social welfare services. Coverage of residential care accounts for only 1.6% of the population estimated to be in need of it. There are only 11 nursing care homes caring for under 400 residents. Mongolian LTC is mostly medically driven. Current services emphasize rehabilitative care and sanatorium care, with gaps in social and psychological services for persons with care and support needs.

There is a large urban–rural divide: in sparsely populated areas, there are even more challenges in terms of coverage, quality, and comprehensiveness.

Workforce

Most of the LTC workforce comprises informal caregivers (typically family members). However, they have not generally received any caregiving training. Although the 2012 revision to the Social Welfare Law indicates that informal caregivers should receive a minimum of 20 hours of training, this has not yet been widely implemented. Professional human resources for LTC are highly medicalized, so only health-care services are available to older people, and even then, there are significant gaps in health human resources for geriatric care (Table 4).
Table 4: Geographic Distribution of Geriatrician and Geriatric Nurses and Projected Needs in Mongolia, 2015

<table>
<thead>
<tr>
<th>Geographic Region</th>
<th>Number of Older Persons</th>
<th>Geriatricians Needed</th>
<th>Geriatricians Available</th>
<th>Gap in Geriatricians (%)</th>
<th>Geriatric Nurses Needed</th>
<th>Geriatric Nurses Available</th>
<th>Gap in Geriatric Nurses (%)</th>
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<td>Central region</td>
<td>40,786</td>
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<td>3</td>
<td>63</td>
<td>16.2</td>
<td>5</td>
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<tr>
<td>Western region</td>
<td>28,931</td>
<td>5.9</td>
<td>3</td>
<td>49</td>
<td>11.7</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Khangai region</td>
<td>47,459</td>
<td>9.5</td>
<td>4</td>
<td>58</td>
<td>19.0</td>
<td>4</td>
<td>79</td>
</tr>
<tr>
<td>Eastern region</td>
<td>16,296</td>
<td>3.2</td>
<td>2</td>
<td>38</td>
<td>6.4</td>
<td>3</td>
<td>53</td>
</tr>
<tr>
<td>Ulaanbaatar</td>
<td>110,690</td>
<td>22.0</td>
<td>12</td>
<td>45</td>
<td>44.0</td>
<td>8</td>
<td>82</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>244,162</strong></td>
<td><strong>48.7</strong></td>
<td><strong>24</strong></td>
<td><strong>51</strong></td>
<td><strong>97.3</strong></td>
<td><strong>28</strong></td>
<td><strong>71</strong></td>
</tr>
</tbody>
</table>


Find out more: Country Diagnostic Study on Long-Term Care in Mongolia.
SRI LANKA

Table 5: Sri Lanka - Key Facts

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban Population (% of Total) 2017a</td>
<td>18.4%</td>
</tr>
<tr>
<td>Gross Domestic Product Per Capita (Current $) 2017b</td>
<td>$4,105</td>
</tr>
<tr>
<td>Poverty Headcount at National Poverty Line (% of Total Population) 2016c</td>
<td>4.1%</td>
</tr>
<tr>
<td>Social Pension Age of Eligibility</td>
<td>70 YEARS</td>
</tr>
<tr>
<td>Estimated Monthly Benefit</td>
<td>$13</td>
</tr>
</tbody>
</table>

Sri Lanka has been experiencing an accelerating decline in fertility and an increase in life expectancy, and is thus facing a rapidly aging population. By 2050, more than 25% of the population or 6 million persons will be aged 60 and above.

Demography
Sri Lanka is a lower-middle-income country, which, since the 1950s, has been experiencing an accelerating decline in fertility and an increase in life expectancy. As a result, the country is facing a rapidly aging population. In 2000, 8% of the population was over 60 years of age, growing to 12% in 2012. More than 25% of the population will be over 60 years of age by 2050 (Table 5). The need for LTC among older people is rising. At the same time, households are shrinking and migration is increasing. More and more women are participating in the labor market. These factors are weakening traditional family support systems.

Governance and Leadership
The rights of elders are protected in the Constitution of Sri Lanka. The National Elderly Health Policy of Sri Lanka was launched in 2017 to reflect the government’s commitment to provide comprehensive health-care services to older people, and the delivery plan mandated the redevelopment of underutilized inpatient health-care facilities into LTC facilities. The action plan suggested requiring special human resources development to staff those facilities. The level of implementation and effectiveness of these laws are rather limited, likely due to financial and human resource constraints. The Ministry of Health, together with the newly established State Ministry of Primary Health Care, Epidemics and COVID Disease Control, are responsible for policy and formulating LTC services. The National Secretariat for Elders (NSE) under the state ministry is responsible for coordinating the services, with the Youth Elderly Disabled and Displaced unit of the Ministry of Health.

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**Financing**

At present, family members who need LTC for their elders pay for these services themselves, and data on this is unavailable. Sri Lanka has no systematic data on financial flows to LTC. Health care in Sri Lanka is provided by the government, the private sector, and, to some extent, the nonprofit sector. Public sector health care aims to be universally accessible and is free at the point of delivery. But the reality is many older people face barriers in accessing health care, including the need to pay for medicines and supplies, and the inequitable coverage of national health and social services.

**Service Delivery**

As is the case across the region, in Sri Lanka, care for older persons is provided primarily by family members, as well as by domestic helpers in the home. State-funded and private centers and clubs provide a variety of daytime and residential services that allow elders to socialize and remain active. Both the NSE and NGOs operate day care centers that are largely social centers for older people who do not require assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). The NSE supports 662 day care centers around the country.

A few NGOs focus on providing aged care, but services and coverage are inconsistent due to limited and unreliable funding sources. There are an estimated 25 private home nursing care service providers, but because of gaps in the implementation and monitoring of the formal registration system for this industry, the exact number is not known. Care provided by nursing care services and in-home care assistant services ranges from simple meal preparation to 24-hour nursing care. The cost of these services is usually out of reach for lower-income families. There are two main types of residential facilities in Sri Lanka: those primarily designed to provide housing for older people who lack shelter, and those that aim to provide LTC support and nursing care. In the Sri Lankan context, most facilities fall into the first category. Table 6 shows the type and number of eldercare facilities in Sri Lanka in 2017.

<table>
<thead>
<tr>
<th>Type</th>
<th>Homes (no.)</th>
<th>Residents (no.)</th>
<th>Residents per Home (no.)</th>
<th>Residents Needing Assistance with ADL (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>5</td>
<td>500</td>
<td>100</td>
<td>26</td>
</tr>
<tr>
<td>Private (for profit)</td>
<td>30</td>
<td>500</td>
<td>15</td>
<td>24</td>
</tr>
<tr>
<td>Private (not-for-profit)</td>
<td>220</td>
<td>6,100</td>
<td>30</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>255</strong></td>
<td><strong>7,100</strong></td>
<td><strong>30</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

ADL = activities of daily living.

Workforce

Family caregivers and domestic workers provide most care of older people, as well as, to some extent, trained in-home care assistants. Health care and social workers also provide some LTC services to older people. However, it is not possible to provide the number, age, and gender profiles of LTC workers since none of the cadres are dedicated to LTC alone.

Currently, Sri Lanka does not have a national standard for evaluating care performance, career structure, and incentives that focus on LTC. Rather, different professions and institutions use their own systems and methods to evaluate performance. The elders’ committees and NGOs usually operate volunteer networks, which provide support with IADL, but this does not usually include personal care. HelpAge Sri Lanka’s home care volunteer program is an effective model for implementing a network of voluntary caregivers, whereby able elders can be mobilized to provide community-based care by trained volunteers at the village level (Box 2). It has proved invaluable in rural areas with strong community ties.

Box 2: Spotlight on Good Practice: The “Young-Old” Volunteers of Sri Lanka

HelpAge Sri Lanka’s home care volunteer program is an effective model for implementing community-based care by trained volunteers at the village level. It has proved particularly valuable in rural areas with strong community ties.

The program, managed and funded by HelpAge Sri Lanka, harnesses the wisdom and energy of “young-old” people—older people aged between 60 and 70 years—identified by local elders’ committees. Their role is to visit and monitor other elders who live in their area. The volunteers participate in a 5-day residential training program on basic first aid, hygiene, and health care. They learn to identify vulnerable elders and advocate for their rights as elders. They conduct home visits and gather information on the living arrangements of those in their care. They have linkages to the Office of the Medical Officer of Health, so they can provide information about elders in need of care. They also liaise with HelpAge Sri Lanka if an older person requires an assistive device. HelpAge Sri Lanka began operating in the 1990s and now trains about 200 volunteers every year. Currently, approximately 2,000 volunteers provide these services in the community.


Find out more: Country Diagnostic Study on Long-Term Care in Sri Lanka.
Care in the community. Caregiver Phongphan Buddhaphadung visits a family in Nong Hoi, Chiang Mai, Thailand. Caregivers are supervised by a care manager, who is typically a nurse from a community health promotion hospital (photo by Jittrapon Kaicome/Asian Development Bank).
THAILAND

Demography
Thailand’s population is rapidly aging: 16.7% of its population was over the age of 60 in 2017. Projections for 2040 put the figure at 32% (Table 7). This is due to a drop in fertility rates and increased life expectancy. In recent years, economic growth has slowed, and because of structural challenges, low productivity, and the aging society, this trend is expected to continue. Poverty and inequality are continuing problems for Thailand, with 9.9% of its population (6.7 million people) living below the poverty line in 2018.

Governance and Leadership
Thailand is a frontrunner in the region for having a clear plan for LTC and has numerous innovations to share with other countries. It has made significant progress toward developing an LTC system, which it is working to strengthen, expand, and improve. Although Thailand does not have an overarching governing body responsible for LTC, the division of labor across ministries and departments is clear and well-organized (Box 3). In 2009, Thailand developed a national definition of LTC. This definition encompasses all the dimensions of care: social, health-related, economic, and environmental. It states that LTC is needed by older people who have difficulties due to chronic disease or disability, and who are partially or totally dependent on others for ADLs. Thailand’s conceptual framework for LTC is contained in the concept of “active aging.” Aging in place remains the priority for those older people who have a degree of dependency. Care services and other measures either already exist or are being developed to enable that.
The government has adopted a stepwise approach to the development of care services, the first step being increasing the availability of home-based support for older people with high care needs. This is being done through a home-based LTC program managed by the National Health Security Office and local authorities (Box 4).

Residential care services for dependent older people are available at private nursing homes, private hospitals, government residential homes, and homes for poor older people supported by charitable organizations. These facilities provide services ranging from basic to complex care and are intended only for those who cannot be cared for at home.

Outlined in the 12th National Socioeconomic Plan 2016–2021, Thailand’s plan for LTC includes the aim of improving the LTC system and creating adequate environments for an aging society.

**Service Delivery**

The government has recognized the population’s growing needs for care. It has adopted a stepwise approach to the development of care services, the first step being increasing the availability of home-based support for older people with high care needs. This is being done through a home-based LTC program managed by the National Health Security Office and local authorities (Box 4).

Residential care services for dependent older people are available at private nursing homes, private hospitals, government residential homes, and homes for poor older people supported by charitable organizations. These facilities provide services ranging from basic to complex care and are intended only for those who cannot be cared for at home.
Lessons from Thailand’s National Community-Based Long-Term Care Program for Older Persons

Financing
Financing for the National Community-Based Long-Term Care Program for Older Persons is covered under the main tax-financed health program, Universal Coverage Scheme, managed by the National Health Security Office. In the first year of the LTC program, the central government allocated B600 million ($19 million), of which B500 million ($16 million) went to the local health funds to support care provision at home, and the remainder went to district hospitals and health centers for human capacity building, including care management and volunteer caregiver training. Case coordination is covered by the program’s budget, but services provided by health professionals and social workers are not. Therefore, the scope of services received relies on the functioning of the health and social welfare systems.

Workforce
In Thailand, over 90% of older people requiring care receive it from their family members, especially daughters, who account for 41% of caregivers, and spouses (32% of the total). The potential rural LTC workforce is adversely affected by internal migration of working-age adults from rural to urban areas. Thailand’s established history of health volunteers gives it a strong base on which to build. Some of the volunteers have received caregiving training and they play a significant role in the LTC workforce. In 2018, approximately 75% of the institutions participating in the national pilot home-based LTC program used volunteers.

Box 4: Spotlight on Good Practice: Thailand’s National Community-Based Long-Term Care Program for Older Persons

In 2016, the government launched a pilot project to establish a care management system for community-based long-term care. The initial target was 100,000 beneficiaries in 1,000 out of 7,255 subdistricts. Since then, it has scaled up every year. The program assigns a care manager to each eligible older person. The care manager is typically a nurse from the community health promotion hospital or primary health center, and assesses the care needs of the older person. Based on this, an individual care plan is drawn up, mobilizing a multidisciplinary team. The care manager assigns and supervises the trained community caregivers who provide social care services according the individual’s care plan, complemented by health services covered by health professionals. Under the program, the community caregivers provide 2-8 hours of home-based care support per week. Medical services—including preventive services, rehabilitation, and assistive devices—are also provided.

In 2018, the program budget was increased to B1.159 billion ($35.4 million), to enable the project to reach 193,200 people. As of that year, 72,000 trained caregivers were participating in this project.

The program provides an invaluable case study for other low- and middle-income countries looking for feasible, integrated home- and community-based care models.


Find out more: Lessons from Thailand’s National Community-Based Long-Term Care Program for Older Persons.

In Thailand, over 90% of older people requiring care receive it from their family members.
Caregivers under the program receive 70 hours of training regardless of whether they are volunteers or paid caregivers. Some of the home care volunteers for the elderly are also part of the million-strong cadre of village health volunteers.

However, voluntary care has its limitations, and volunteers cannot entirely substitute for paid caregivers. Evaluations of the national community-based LTC scheme revealed that paid caregivers outperformed volunteer caregivers. Volunteers provided inconsistent levels of care and faced difficulties providing regular or routine care. This was particularly so for those caring for severely dependent older people. Volunteers were expected to provide basic health care and personal care for dependent older people, but the help they can offer is usually limited to home visits, psychosocial support, and case referral to responsible agencies. Table 8 presents the number of volunteers and professionals providing care for older persons in Thailand.

**Table 8: Number of Volunteers and Professionals Caring for Older People in Thailand, 2018**

<table>
<thead>
<tr>
<th>Formal Care/Caregiver</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Volunteers</strong></td>
<td></td>
</tr>
<tr>
<td>Village health volunteers</td>
<td>1,067,746</td>
</tr>
<tr>
<td>Home Care Volunteers for the Elderly Program</td>
<td>80,000</td>
</tr>
<tr>
<td>Friends Help Friends project</td>
<td>8,074a</td>
</tr>
<tr>
<td>Volunteer caregivers</td>
<td>72,000</td>
</tr>
<tr>
<td><strong>Professionals</strong></td>
<td></td>
</tr>
<tr>
<td>Medical doctors</td>
<td>36,938</td>
</tr>
<tr>
<td>Geriatricians</td>
<td>40</td>
</tr>
<tr>
<td>Geriatric nurses</td>
<td>...</td>
</tr>
<tr>
<td>Registered nurses</td>
<td>165,541</td>
</tr>
<tr>
<td>Technical nurses</td>
<td>7,257</td>
</tr>
<tr>
<td>Practical nurses</td>
<td>7,257</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>4,836</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>1,200</td>
</tr>
<tr>
<td>Social workers</td>
<td>...</td>
</tr>
</tbody>
</table>

... = data not available.

Notes:
1. There are also several categories of paid nonprofessionals who care for older people, including trained caregivers, care assistants, care teams, untrained paid caregivers, and domestic workers. However, no data are available regarding their numbers.
2. Some of the volunteers counted in the table may be double counted, as there were 1 million village health volunteers in 2018 and most long-term care volunteer caregivers, as well as those working with Home Care Volunteers for the Elderly, are also village health volunteers.
3. This figure is from 2008.

**Assistive Devices, Technology, and Home Modifications**

In accordance with the Persons with Disabilities Empowerment Act, the Universal Coverage Scheme also provides assistive devices to people with disabilities, based on a doctor’s assessment. There is also a home modification scheme for people with disabilities, administered by the Ministry of Social Development and Human Security. This provides a one-off allowance for home modifications.

The nongovernment sector and/or civil society are important advocates for the provision of LTC services to older adults (Box 5).

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**Box 5: Advocacy for Thailand’s Older Adults**

In providing long-term care, coordination with the nongovernment sector is key, and they are important advocates for older adults. In Thailand, civil society is involved in policy design and formulation, and plays an active role in the implementation of policies on aging. Older people themselves are encouraged to form and manage clubs for older adults. The Senior Citizens Council of Thailand, a nongovernment organization established in 1989, is responsible for coordinating and helping to establish these clubs. By 2018, there were 28,422 such clubs nationwide. The National Elderly Assembly, formed by the Ministry of Social Development and Human Security, is an active advocate for older persons’ rights, and has older adult club representatives from all the provinces.

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Find out more: [Country Diagnostic Study on Long-Term Care in Thailand](#).
Rich harvest. Income-generating activity borrowers, Nguyen Thi Thai (right) and Tran Van Trung (left), work in their field in Lai Dong No. 2 Village, Bac Ninh Province, Viet Nam (photo by Xuan-Phong Le/Asian Development Bank).
TONGA

Demography
The island state has a population of approximately 104,000, with a median age of 21 years. In 2017, life expectancy in Tonga for people aged 60 and above was 70.2 years for men and 76.2 years for women. In 2019, those over the age of 60 made up 5.6% of the total population (9,000 people), and this is expected to increase to 11,926 persons or 8.9% by 2050 (Table 9).

Governance and Leadership
The government’s main policy document is the Tonga Strategic Development Framework, 2015–2025, which identifies older people as a priority group, alongside the disabled, young, and those considered vulnerable. This policy guidance framework requires government departments to include older people in their planning as a priority group. While Tonga still lacks the legal framework required for LTC, in August 2020, the prime minister launched the Aged Care National Strategic Plan, 2020–2024. The preparation for this plan was supported under ADB’s regional capacity development TA project, Strengthening Developing Member Countries’ Capacity in Elderly Care (TA 9111-REG).

Table 9: Tonga - Key Facts

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban Population (% of Total) 2017</td>
<td>23.0%</td>
</tr>
<tr>
<td>Gross Domestic Product Per Capita (Current $) 2017</td>
<td>$4,562</td>
</tr>
<tr>
<td>Poverty Headcount at National Poverty Line (% of Total Population) 2016</td>
<td>22.5% (2009)</td>
</tr>
<tr>
<td>Social Pension Age of Eligibility</td>
<td>70 YEARS</td>
</tr>
<tr>
<td>Estimated Monthly Benefit</td>
<td>$30–$35</td>
</tr>
</tbody>
</table>

In 2019, people over the age of 60 made up 5.6% of the total population, and this is expected to increase to 11,926 persons or 8.9% by 2050.

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The Road to Better Long-Term Care in Asia and the Pacific—Building Systems of Care and Support for Older Persons

Service Delivery
Tonga’s first home care pilot program, run by local NGO Ma’a Fafine moe Famili, provides care to 190 older people with the highest need (Box 6). The program manager and team supervisor assess the older person and allocate a care worker. The manager makes monthly on-site visits to observe and report on the status and quality of the services delivered. An evaluation of the pilot program found it to be effective, and the government adopted it as a national home care program and will roll it out gradually to older and disabled persons with high care needs. It is estimated that there are up to 1,000 persons who meet the eligibility criteria for the scheme.

There is only one residential home with five residents run by an NGO. The lack of residential facilities for older people with advanced dementia is a concern because it puts them at particular risk of abuse if they are instead admitted to a general psychiatric residential ward, where there have been cases of assault by other patients.

Financing
The government allocated $208,000 to the national home care program in 2020 (footnote 9). This scheme provides home care services to up to 200 older persons, delivered by an NGO contracted by the government. Due to budgetary limitation, it is estimated that these services reach only one-quarter of eligible persons. Health care for older persons is included in the general pool of funding, at an estimated cost for elder health care on the main island, Tongatapu, but not for those living on the remote islands.

Box 6: Spotlight on Good Practice: Contracting a Nongovernment Organization for Service Provision in Tonga

In 2012, the Tonga Social Service Pilot was launched, a joint project between the Asian Development Bank and the Japan Fund for Poverty Reduction, with a budget of $125,000 per year for the design of home care services for older persons. Under the pilot scheme, home-based care was provided to 150 older people and disabled patients in Tongatapu and Ha’apai by the organization Ma’a Fafine mo e Famili. The pilot has since been rolled out as the national aged care service by Ma’a Fafine mo e Famili, serving up to 200 older persons, with the highest needs based on their assessments. The total annual cost of the home care services was $208,000 in 2020, funded directly by the government through the Ministry of Internal Affairs.

Ma’a Fafine mo e Famili employs 73 women care workers, aged 30–50 years, providing care to about 200 older people and others with disabilities. All receive on-the-job training and some have received professional aged care qualifications. Their salaries are comparable to those of junior public servants with limited qualifications. Staff turnover is low: the workers say that they enjoy their role and are very passionate about it because of the positive impact they have on their older clients.

Workforce
Tonga’s LTC workforce capacity battles two headwinds: high levels of emigration and low pay. Almost 5% of the working-age population migrate each year, and many do care work in Australia, New Zealand, and the United States. Caregivers in Tonga are hard to recruit and retain as the wage rate is lower than that of local farmhands and government cleaners. Training and opportunities for certification are ad hoc and, currently, there is limited in-country capacity to provide professional training.

Assistive Devices, Technology, and Home Modifications
The country diagnostic study identified a lack of assistive devices such as wheelchairs, commodes, walkers, and other support resources throughout Tonga. Eyeglasses and hearing aids are not provided as part of the core health services. Those requiring eyeglasses or hearing aids typically wait until the arrival of international teams of volunteer hearing and eyesight specialists, who visit Tonga once or twice a year. Incontinence supports such as diapers are expensive, with families bearing the cost.

Information Systems
There is no specific information system for LTC, and the Ma’a Fafine mo e Famili home care program uses a paper-based case management system. The personal health records system used in Samoa has been identified as a suitable model for Tonga to follow, whereby records could be shared with health care and social welfare professionals.

Find out more: Country Diagnostic Study on Long-Term Care in Tonga.
A huge resource. Vu Van Dien belongs to an Intergenerational Self-Help Club in Lai Dong No. 2 Village, Bac Ninh Province, Viet Nam. Older people are a huge resource, often providing volunteer services to other older people in their community (photo by Xuan-Phong Le/Asian Development Bank).
VIET NAM

Table 10: Viet Nam - Key Facts

| URBAN POPULATION (PERCENTAGE) 2017 | 35.0% |
| GROSS DOMESTIC PRODUCT PER CAPITA (CURRENT $) 2017 | $2,389 |
| POVERTY HEADCOUNT AT NATIONAL POVERTY LINE (PERCENTAGE) 2016 | 9.8% |
| SOCIAL PENSION AGE OF ELIGIBILITY | 60 YEARS (POOR) 80 YEARS (NO SOCIAL SECURITY) |
| ESTIMATED MONTHLY BENEFIT | $12–$35 |

The country’s older adult population is set to double from 7% of the total population in 2019 to 14% by 2035. By 2050, the population above the age of 65 is forecast to surpass 22 million or 20% of the total.

Demography
Viet Nam is experiencing population growth at a faster pace than any of its regional peers. The country’s older adult population is set to double from 7% of the total population in 2019 to 14% by 2035, a timeframe of just 16 years (Table 10). By comparison, its neighboring countries did not reach this threshold for a country’s aged population for a period of 22 years, in the case of Singapore, and 20 years for Thailand. Viet Nam will see an absolute increase in its population over the age of 65 years from 7.5 million to 22 million persons.11 By 2050, the population above the age of 65 is forecast to surpass 20% of the total.12

Governance and Leadership
The Government of Viet Nam considers older people to be a priority target group, and this is reflected in the numerous policies related to older people and LTC. These include overarching policies on health care and social welfare for the population as a whole, and policies targeted directly at older people. Mindful of the rapid pace of population aging, the government is increasingly proactive on policies to address this. As such, the policy landscape for LTC is quite favorable.

The National Health Care for Older Persons Project, 2017–2025 includes strategies to develop and disseminate LTC models, while Decree No 135/2013 ND-CP allows for voluntary primary caregivers in the community to care for older people who lack family carers.

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The key government stakeholders are the Ministry of Health and the Ministry of Labour, Invalids and Social Affairs. The Viet Nam National Committee on Aging assists the prime minister in directing and coordinating the activities in relation to older people and promoting their role in the country. It has a cross-sector remit over all 23 ministries. However, coordination between ministries is a challenge. The country’s social protection care centers are licensed and subject to requirements on environment and location, area and physical facilities, and standards of care. However, monitoring of regulations is not yet systematically applied.

Mass organizations are important stakeholders in LTC, notably the Viet Nam Association of the Elderly, which was established in 1995 and currently has 10,000 local associations of older people in communities around the country.

**Financing**

Government expenditure is not reported specifically for LTC. There is no available data on out-of-pocket expenditure, the contribution of unpaid labor, and family transfers beyond general information on sources of income for older people. Some older people can pay out-of-pocket for care with their own savings. There is currently no LTC insurance available in Viet Nam.

**Service Delivery**

Most LTC is provided by family carers, largely without training or outside support. The Ministry of Health and the Ministry of Labour, Invalids and Social Affairs both have some programs that provide elements of LTC service. Mass organizations and the private sector are also engaged in LTC service provision, but there is not yet a comprehensive coordinated community-based LTC national model or integration between the various services.

Viet Nam is exploring LTC models, including those that build on and support family care provision with home-based services. It is also exploring models for residential home care. The Intergenerational Self-Help Club (ISHC) model is currently the primary home- and community-based care model (Box 7). It provides home care to over 17,000 people, and this number will grow as the model is replicated. Currently, there are 3,400 ISHCs. The National Program of Action on Ageing, approved in December 2021, targets at least one ISHC in 80% of communes by 2030. There are 134 social welfare centers, with 2,458 older people, and 13 nursing care homes (8 public and 5 nonstate) serving those with means to pay user fees.
Workforce

The ISHCs have 17,000 volunteer caregivers who provide a mix of services to about 17,000 older people. There are no approved qualifications for caregivers; only 956 health workers are trained in geriatrics across the country; and trained allied health professionals—including physiotherapists, occupational therapists, speech therapists, and podiatrists—are lacking. Internal migration also affects the availability of LTC workforce in rural areas. Expanding the remit of existing health cadres (village health workers) to include LTC responsibilities has the potential to overcome workforce shortages. Viet Nam has unique national mass organizations such as Fatherland Front, Viet Nam Association of the Elderly, Viet Nam Women’s Union, and the Viet Nam Red Cross. All of these have a significant presence across the country, including in rural and remote areas, and could be utilized in an LTC system, building on their current programs and engagement with supporting the development of the ISHCs.

The Road to Better Long-Term Care in Asia and the Pacific—Building Systems of Care and Support for Older Persons
Active aging. Members of an inter-generational Self‑Help Club exercise during a monthly meeting in Lai and Long Village, Bac Provinvce, Viet Nam (photo by Xuang Phung).
Challenges for Long-Term Care in Asia and the Pacific

Across Asia and the Pacific, many countries have recognized the accelerating need for long-term care (LTC) policy, services, and workforce. The time to adapt is now. Over the next 15 years, many countries will undergo a profound demographic transition, and there is an urgent need to share knowledge on approaches and speed up action. Countries are actively working to bridge gaps and meet the demographic challenges ahead. As they do, they are running five key races.

1. THE RACE TO BRIDGE THE GAP BETWEEN POLICY AND PRACTICE
All six focus countries have laws and policies related directly to older people’s rights and welfare. Despite this, there are multiple barriers to the implementation of LTC policy. These include too little awareness of the significance of the issue, a lack of clear leadership on LTC, and inadequate resource allocation, which means policies are not realized. Shortages of financial and human resources impede the expansion of LTC across all countries. There is a need to acknowledge the costs of LTC that are currently hidden because they are borne by families. The costs to the health care system are also somewhat hidden and need to be more fully understood.

Public policy is only as good as its implementation. One key challenge in bridging the policy–practice gap is developing the systems and practice of quality management. In Indonesia, for example, with no single body responsible for the overall management of quality in LTC, implementation of standards and protocols for care depends on local fiscal affordability, and there is no evidence of systematic monitoring or oversight of care providers. Likewise, in Mongolia, policy on quality management is not matched by practice. Quality management of LTC is not uniformly regulated, and the existing mechanisms may not meet the needs of older people nor be in line with internationally recognized approaches that are also feasible for local implementation.

2. THE RACE TO DEVELOP INTEGRATED SERVICE AND CARE
Health care and social care are typically under separate ministries. But the reality for older adults is that the two converge, and older people would benefit from greater coordination between different levels and different types of care. Greater integration of services for older adults is the global trend, and the study countries are in the early stages of exploring the same path. Integration with services provided by NGOs, and religious and spiritual organizations, is important. In Indonesia, religious organizations play a major role in eldercare funding support. Similarly, in Mongolia, NGOs (such as elderly associations) advocate and provide leadership in eldercare. Integrated care management, as a mechanism to provide integrated services to individuals, has also been identified as imperative by all six countries studied.
Leadership and coordination for LTC are a particular challenge for governments because of the range of stakeholders involved. While responsibility for LTC often sits most obviously with the ministries of health and social welfare, the division of responsibilities and the coordination mechanisms between these two are often unclear. The involvement of other ministries or agencies is also important, such as ministries for housing, transport, women's affairs, education, industry, and finance. However, in many cases, they are not engaging with policy formulation and developing programs to help adapt to aging societies. New policy development, like the National Strategy on Aging in Indonesia, are actively engaging with and working across sectors to address these challenges. Even within ministries, there can be a range of stakeholders. For example, in the ministry of health, it might be necessary to include and coordinate across departments for family health, noncommunicable diseases, mental health, and disability.

3. THE RACE TO IDENTIFY SUSTAINABLE LONG-TERM CARE FINANCE MODELS

Financing is a fundamental component of any LTC system, including revenue raising, how accumulated funds are then pooled and allocated to pay for services, and deciding who is eligible for what services. All six focus countries understand three things: (i) demand for services already exceeds supply; (ii) demand is only going to grow; and (iii) they do not yet have a sustainable, well-functioning system in place to pay for it. Lack of access to and limited affordability of care services are major issues for many families across the region.

Secure and reliable funding sources are needed, including public LTC funding. Public investments in formal LTC are important as population aging coincides with declines in the availability of family caregivers, many of whom are women. Public LTC funding is a good investment with a strong economic case, for three reasons. First, it is a key component of social protection. Second, it is a good social and health investment because it eases the pressure on demand for acute care, which normally is far more expensive than community care and primary care. Third, it promotes quality of care if funding is linked to safe care. Financial pooling is key to ensuring risks are shared. Investment in LTC will create jobs and improve the well-being of carers.

Shared Responsibility

Another critical question is how the division of financial responsibility will be split between the individual, the family, and the state (including between central and local governments). In terms of the state taking responsibility for financing, health care financing has evolved to more than financing for LTC, with all countries striving in different ways for universal health coverage through various population-wide health insurance mechanisms. In LTC, however, across all countries, most of the care is provided by family and volunteers or financed through out-of-pocket payments, private financing, and charitable financing.
Promising public LTC financing initiatives are emerging in some countries. In Thailand, there are discussions underway about a social insurance model for LTC to provide wider and more comprehensive coverage, especially to those excluded from the current LTC program. An alternative suggestion is using local taxes or tax transfers to finance the social support elements of LTC. In Mongolia and Viet Nam, the importance of social mobilization and mixed funding sources from different sectors has been highlighted in building up sustainable sources of funding.

Information Gaps

However, countries face many gaps in information that stymie efforts to develop meaningful costing plans. Seeing LTC as a good investment with a strong economic case is key. If countries do not invest in LTC, older adults in need may end up in acute care settings, which will be far more expensive both to the state and to the individual. Basic data on financing, including on need, demand, informal and formal care provision, for-profit and not-for-profit care providers, and costs of services, is still too limited. With much of the costs currently hidden in the unpaid labor of (usually female) family members, it will be necessary to reframe the costs of LTC. These costs should account for the unintended economic and family consequences of women assuming the bulk of LTC. Rather than seeing LTC as a cost, it can be framed as an investment in enabling young family members to attain their full educational potential, for women to join the workforce, and for risk pooling to protect families from catastrophic expenditure due to the cost of protracted LTC. Similarly, adequate funding for LTC, especially for care in the community, can protect the health system from the cost of keeping older people in hospital when they could be discharged, but there is no one to care for them at home or in their community.

4. THE RACE TO DEVELOP HUMAN RESOURCES IN LONG-TERM CARE

Scarce human resources for LTC are a global phenomenon, but some of the countries studied face particular difficulties in this regard. At the same time, as adult children are increasingly moving away from home to work in the cities, there is also more migration to work in other economies, such as Japan, Singapore, the Republic of Korea, and Taipei, China. In Viet Nam, the largest portion of internal migration is rural–urban, and younger cohorts (18–39 years of age) are most likely to migrate. While remittances to older rural households are a major benefit of this migration, provision of care is not possible at a distance. Indonesia, Sri Lanka, and Tonga all have significant portions of their workforce going overseas as migrant workers, many of whom become carers in their host economies.

As fertility rates have fallen in recent decades, there are fewer adult children available to provide informal care. The shape and speed of this transition vary by country. Generally, though, those aged over 80 had more children than those aged 60–69, and future generations will have even fewer children. Migration and urbanization also reduce the number of family living near enough to provide regular social or personal care to older people.
Volunteers can go some way to addressing this shortfall, but this cannot address the human resources shortage on its own.

5. THE RACE TO CAPITALIZE ON TECHNOLOGY IN LONG-TERM CARE

Much of LTC revolves around person-to-person care, but there is a key role for technology. Many assistive technologies can enhance the lives of older people and enable them to age in place. However, the current lack of access to assistive technology and lack of widespread coverage are key impediments for older persons and care. Information systems are another important aspect of the role of technology. Thailand and Indonesia are leading the way in this regard. Indonesia’s Elderly Information System, SILANI, is an example of harnessing information and communication technology to support better care. In Thailand, both government and private providers are focusing on this issue, and interesting uses of new technology by private companies are emerging. Breaking away from paper-based record-keeping and switching to digital records are the first steps toward a seamless flow of information about elderly care between different sectors, including health and social welfare.
Support for caregivers. Vu Van Ngan and Tran Thi Ngan pose in front of their house in Lai Dong No. 2 Village, Bac Ninh Province, Viet Nam. Family caregivers can be supported through social transfers, training, and peer assistance (photo by Xuang-Phong Le/Asian Development Bank).
Looking Ahead—10 Steps to Better Long-Term Care in Asia and the Pacific

1. **Develop LTC systems and services that provide a continuum of care**, with a focus on home- and community-based services, supplemented by residential care options.

2. **Integrate LTC with health and social support services**, with a specific focus on integration with primary care, and start to build up the necessary skills and experience for complex care, such as for advanced dementia.

3. **Develop effective LTC systems, with clearly defined governance, roles, and mandates for each of the major stakeholders: government, the private sector, civil society, and the public.**
   For each level of the government’s responsibilities, outline regulation, financing, implementation, and oversight. This multilevel governance requires efficient distribution of resources, effective coordination mechanisms, and enhanced data systems to capture and provide accurate information. Failure to focus and develop sustainable and improved systems will strain stakeholders at all levels. Strategic planning for LTC is imperative to provide the framework for system expansion.

4. **Develop coordination mechanisms to enable collaboration across government stakeholders**, such as the ministries of health, social welfare and social protection, education, and finance; and build systems to incentivize collaboration.

5. **Prioritize the design and expansion of LTC financing systems** to build systems that raise adequate funds to deliver services, pool financial risks, provide clarity of coverage, and offer incentives to drive efficiency. Increase public and political support for LTC through public debates on responsibilities for care and building the evidence case for LTC investment.

6. **Galvanize human resources** by exploiting opportunities for job creation that arise from a growing demand for a wide range of positions, including care assistants and allied health professionals, and training and accrediting medical staff and allied businesses.

7. **Develop support to family caregivers** through social transfers, training, peer assistance, and increased availability of home- and community-based care.

8. **Foster the development and use of technology**, including accessible and assistive devices that support persons to maintain their independence and technology to enhance service delivery, underpinned by support to increase digital literacy amongst older adults.

9. **Recognize the place of LTC within the broader context of age-friendly communities, housing, transport, social protection, and healthy aging programs**; and support the role of these sectors in strengthening overall adaptation to aging societies in the region.

10. **Learn from global and regional practices** in this rapidly emerging area, which will continue to increase in importance in tandem with the demographic transition underway in the region.
The Road to Better Long-Term Care in Asia and the Pacific
Building Systems of Care and Support for Older Persons

The Asian Development Bank is at the forefront of providing countries across Asia and the Pacific with the technical assistance needed to develop long-term care systems and services for older people. This report shares insights from six diverse countries at different stages of demographic change: Indonesia, Mongolia, Sri Lanka, Thailand, Tonga, and Viet Nam. It explores the situation of long-term care development in these countries, identifies common challenges and promising practices, and recommends key priorities for future action in system strengthening and service delivery.

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