EU-CHINA
Social Protection Reform Project
中国欧盟社会保护改革项目

Component 1

NOTES ON A VISIT TO SHANGHAI PILOT SITE – DEMOGRAPHIC AGEING

2 FEBRUARY 2016

1. The objective of the mission was to get acquainted with the situation in Shanghai concerning demographic ageing – for which the City had been selected as a pilot for Component 1 activities – and to brief NDRC local representatives on the modalities for their possible future involvement in project activities under the heading of Demographic ageing and social security – including preparation for the training course on Ageing to be held in Spain in June 2016.
2. Took part on the mission from Beijing for NDRC Ms. Tang Ling and Mr. Chang Hao, Component coordinators, Ms. Wang Yue and Ms. Wang Yingsi, project officers, for SPRP Component 1 Mr. Gruat, EU Resident expert, and Ms. Xu Chenjia, Component assistant. Mr. Tang Huizhong, Division director, and Mr. He Manlin, Programme officer from Shanghai Development and Reform Commission, accompanied the mission throughout its duration.
3. The mission consisted of visits to local facilities dedicated to elderly care followed by discussions with responsible persons, with a briefing/debriefing session on project objectives and possible association of Shanghai authorities to relevant activities.

Visit to and dialogue at the Elderly Care Home of Yangjing Community

4. 

This is one of the 6 pilot sites of community elderly care in Shanghai and has been extremely successful since its opening early in 2015. The care centre is located within the community,

on the ground floor of the residential building, taking up around 500 m^2 of space. It can accommodate up to 30 people, and provide temporary care for people in need up to 2 weeks. Especially, the care centre has managed to build its own kitchen, making it realistic for them to provide timely warm meals to the elders housed here. Other featured facilities include sun rooms, which are quite popular among those, lived here. The details of the décor and specific design are also very thoughtful, and these include themed colour of each room, making it easier for the mentally impaired to find their way 'home'.

5. 

The site visit is then followed by an informational and in-depth multi-lateral conversation. The attendants include Mr. Yang Guangming from the Yangjing Community Office of Pudong New District, Shanghai, Ms. Li Sujin of the Shanghai Bureau of Civil Affairs, Mr. Qi Haidong from the Pudong New District Bureau of Civil Affairs, Ms. Ouyang Xuemei who is the major person in charge of the facility, together with the six member of the Shanghai Mission, who are accompanied by colleagues from SDRC.

6. First, Mr. Qi Haidong presents a brief overview of the progress of public providing elderly care institutions in Pudong New District during the period of XIIth Five-years plan. He mentions that the ageing population within Pudong has reached 770,000 (excluding migrants). To cope with the growth of the elders, the district has developed three models of service provision that are characteristic of their 'embeddedness' within the local communities. In total, there are already 125 nursing houses, 77 daycare centre and 88 'help meal' centre. In terms of fiscal investment, during the Plan period, the district government has devoted more than 106 million directly on the provision of elderly care services, and over

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1 billion if taking into consideration various additional costs and subsidies. The model of combining medical care and elderly care has also been implemented, and there are already 48 nursing houses, which 1/3 of the total, have in-house medical facilities.

7. Mr. Qi also points out one of the major challenges, which is the lack of professional personnel and suggests that currently the subsidies for experts and nurses are rather limited to attract and keep professionals, who, as he believes, will have critical impacts on the performance of institutions.

8. He then goes on to introduce the general directions in which the district will lead the work of elderly care during the XIIIth Five-years plan. First, there is the general transition from subsidising the supply towards subsidising the demand side, which is believed to be useful to enable and empower the elders themselves in deciding what they need. Second, the fundamental principle is to make sure that people at the very bottom (including low-income group and the severely handicapped), who are also the people in the greatest need of public care services, would receive relatively comprehensive protection. As a final remark, he brings to the foreground the importance of coordination among different government departments.

9. Building on these experiences, Ms. Li Sujin elaborates on the planning of public elderly care services in the city of Shanghai for the years to come. In general, the restructuring of public institutions will be carried out, with the institutions providing 2/3 basic public services especially for those low-income and severely impaired subjects, and 1/3 community services or care at home, allowing for more diversification of the means of support and care.

10. More specifically, during the period of the XIIIth Plan, Shanghai will focus on the strengthening the 'software' in the provision of public elderly care services. The model of the community care has been proved through 1-year pilot to be successful and applicable in Shanghai, and hence will be promoted citywide. The goal is to have more institutionalised professional care, which involves day care services, training of nursing skills, and temporary care services. Flexibility and feasibility are emphasised as the basic principle given the high population concentration and resource scarcity in Shanghai.

11. Another task is to further improve the 7-tier evaluation system, which is used to differentiate the elders into different categories based on their needs (health condition) and their capacity (income level) so that the public resources can be fairly and equally allocated. During the upcoming years, at the municipal level, the goal is to establish the unified information system platform. In addition, the combination of medical care and nursing will continue to be explored in terms of what forms it can take. Possible means include first care centres contracting with 'visiting doctors' who regularly go to the centre to provide medical services, second in-house medical facilities and professionals for big institutions, which requires

further policy support, and third the incorporation of nursing into the medical insurance system, which means people can pay the cost of nursing care with their medicare funds.

12. In the discussion session, attendants explore several issues in depth. The most highlighted issue concerns the fiscal sustainability of public elderly care services. Mr Yang, the Deputy Director of Yangjing Community Office, acknowledges it as a serious issue and challenge. As for their own experiences in establishing and operating the Elderly Care Home of Yangjing Community, the community fiscal budget provides three-year subsidies and after that it is expected that the institution itself is capable to maintain the balance on its own.

13. The policy measures taken to achieve this goal include the chaining-up and integration of various facilities to curtail the cost and to open up various services to the public including help meals and bath assistance.

14. In this regard, the comprehensive evaluation system is essential to the financial sustainability in the sense that it guarantees the most efficient and economical allocation of resources, by differentiating people and admitting them into different levels of institutions (home, activity centre, day care centre and nursing house, etc.) according to their physical wellbeing and personal wealth. It is noted that the elderly – people about 60 years of age – are of course not all requiring institutional or even occasional care. In fact they can broadly be classified according to the so-called 90 – 7 – 3 rule, which is 90% enjoying autonomy, 7% requiring temporary or limited support, and 3% requiring continued, heavy care.

15. As a conclusion, Mr. Gruat suggests that there are various issue on which the EU and China can share experiences and perspectives with each other, including the various ways in which the financial sustainability and affordability can be addressed, and the coordination not only among different government departments but also among different agents and stakeholders, an issue that is brought up but not dealt with in detail during the dialogue.

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Visit to and Discussion at the Jian Gong Hospital/Jian Yang Elders Care Centre/Jian Feng Nursing Centre.

16. The attendants include Mr. Lu Yingyi, the Director of Jian Yang Elders Care Centre, Ms. Wu Guojiong of Jian Yang, Mr. Tan Weilin from Jian Gong Hospital as well as Ms. Zhu Yueshu from Jian Feng Nursing Centre. Mr. Liu Zhongfei, the Deputy Director of Social Welfare Department, Shanghai Bureau of Civil Affairs, and Ms. Pu Haihong, Vice-President of Shanghai Academy of Development and Reform also join the discussion.

17. Mr. Lu provides a comprehensive introduction on their practice of combining medical care and elderly care, or what he terms as 'the trinity' of the hospital, the care centre and the nursing centre. The hospital has been established for long, as the affiliated hospital of Shanghai Construction Group. In 2008, Jian Yang Elders Care Centre was established due to the increasing demand for the service, which is of course due to the issue of ageing population. The care centre has in total 150 spaces and currently houses 126 people. The monthly rate is around 4000 per person per month, and has stayed the same ever since its establishment in 2008, since the centre identifies itself as a non-profit organisation. By nature the care centre is established by private capital, with some funding from the government in the form of subsidy. Since it is affiliated to the hospital, the care centre also has in-house resident doctors, a specific feature that promises stability to the elders and their family and as a result makes the care centre extremely popular. As the popularity grows, the issue of availability emerges: the fact is that once the elders are admitted into the care centre, it is very unlikely for them to leave and make spaces for others in need in the

near future. In part to address the difficulty of availability, the Nursing Centre was established in 2013 focusing on medical nursing and recovery. The nursing centre can accommodating up to 230 'patients', who can pay the fees through self-funding as well as medical fund. As is the case with the care centre, the turnover rate is quite low due to the same reasons, which also reflect the general social condition of ageing.

18. 

It is important to note the disparity in terms of function between the elderly care centre and the nursing centre. Whilst the former provides mainly everyday life attendance and assistance, the latter is in essence a medical clinic, offering medical nursing and post-treatment recovery and care to the elders that are severely impaired. The disparity becomes quite evident and concrete through the site visits to both centre. The care centre is designed in resemblance to hotel accommodation, whereas the nursing centre looks just like a regular hospital. Since the functions differ, different departments of the government oversee the two institutions: the care centre is an element of the system of civil affairs, and the nursing centre belongs to the health department since it involves medical practices.

19. Mr. Lu then goes on to talk about the reflections based on the practice of the hospital-care-nursing 'trinity'. The first thing he makes clear is that their practice is a very specific case and

to a certain extend too unique to be replicated. The profit space is extremely limited for both the care and the nursing centres, and they are still in operation only because they benefit from the existing logistic facilities and arrangements of the hospital which allows the cost to be effectively contained. He candidly states that either of the affiliated centres could not possibility survive on their own if there were not the hospital sharing facilities and human resources with them. Building on this observation, Mr. Lu suggests that institution-based elderly care shall not become the mainstream form of public elderly care service, since the financial burden would be unbearable, but can nevertheless function as the supplementary measure to the mode of in-home elder care. At the same time, it is also necessary to explore the various ways in which the sustainability of funding can be guaranteed to elevate the existing institutions out of deficit. Another thing Mr. Lu highlights concerns the issue of 'standard', which resonates with the discussion in the morning. He suggests a third-party assessment be established to maintain the fairness and the equality in the allocation of care and nursing resources. In addition, he also puts under spotlight the necessity of having in-house medical care within the elderly care centres and institutions. One of the possible solutions, according to him, is to have hospitals setting up external sites of practice in elderly care institutions, which, however, is constrained by various policy restrictions.

20. This final point also brings about the issue of policy making and top design, in relation to the financial sustainability of both public and private elderly care services, which is discussed in depth on the discussion session to follow. Specifically, Mr. Liu from Shanghai Bureau of Civil Affairs offers the insight that the policy design should be based on the premise of the 'non-

profitability' of both public and private institutions that provide basic public services. He further emphasises that as a general principle, policy design should not be based on pure hypotheses and disregard the actual reality, otherwise the implementation will instigate widespread discontent among the public, which is not only in itself passive and negative, but also consumes and dissolves the positive agencies of institutions and individuals, incurring various invisible costs. With reference to the EU experience, Mr. Liu acknowledges the necessity of learning from the lessons and successes in other countries, but at the same time he also points out that the 'localisation' of such lessons and experiences is a critical issue to ponder upon – that is, how to apply the policy designs, and specific measures and instruments, into the Chinese context.

Concluding session

21. The mission is concluded in the evening of 2 February at Shanghai DRC Training centre. The project delegation discusses the possible forms of collaboration with Shanghai DRC and Shanghai Academy of Development and Reform on the case study of the pilot practices in Shanghai regarding Demographic ageing. Ms. Pu Haihong, the Vice-President of Shanghai Academy of D&R and Mr. Tang Huizhong and Mr. He Manlin from the Shanghai DRC are present. The SPRP also hears from Ms. Pu and Mr. Tang in regard of their expectations in terms of the content of the training programme in Spain. Although the specific items are still pending, Mr. Tang suggests that they would be happy to learn more about the EU practice on the following issue including the establishment and operation evaluation system, and at the same time look forward to more systematic introduction on the EU policies on the provision of elderly care in general.

22. To help in the preparation of the Shanghai Case study on Ageing, Ms. Pu received the attached short note prepared by the project Component 1 which presents in an integrated manner the various aspects under which Demographic ageing may affect social protection mechanisms.

Xu Chenjia
JV Gruat,
3 February 2016

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DEMOGRAPHY AND SOCIAL SECURITY
SOME BASIC CONSIDERATIONS
JV GRUAT,
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1. **In a society, demographic ageing may result from a variety of factors: increased life expectancy because of improved living conditions; better access to medical care; early retirement; more financial autonomy of the elderly through decent pension systems; decreased fertility rates not compensated by migratory flows; return of elderly population having spent their active life on different territories, etc.**
2. **Demographic ageing is a factor common to most European countries – China is still below European levels but may be catching up rapidly.**

2010 % of the population	F	Ge	UK	I	Dk	Sp	Nl	PRC
Over 65	16.6	20.7	16.3	20.3	16.1	16.9	15.3	8.2
Over 80	5.2	5.1	4.6	5.8	4.1	4.9	3.9	1.34
Dep.ratio OA	25.81	31.7	24.72	30.99	24.98	24.43	22.82	11.3

3. **Change in age structure of the population has important implications for social protection as a whole – not only for pensions financing.**
4. **There is a strong influence on the Labour market – with a need to adapting the workplace to an ageing population. Require particular scrutiny: working conditions, work place ergonomics, transition from income to retirement.**
5. **Demographic ageing may cause a particular strain on unemployment schemes, since elder workers are more likely to be unemployed – and less likely to re-enter the labour market (pre-pension arrangements, decreasing hours of work with compensation, transition from activity to retirement)**
6. **Older workers have more frequent use of disability pension provisions. In some schemes, there is presumption of disability once reached a certain age. Arduous occupation is an important factor (individual hardship account)**
7. **Occupational accident and diseases can occur more frequently for elder workers, who might be victims of more specific types of accidents linked to ageing – also more likely to incur accidents late in the day hence ad hoc preventative measures. In some professions, there are age limits for safety reasons**
8. **Social services specially dedicated to the elderly may be in more demand. Conversely, services for families with children may be less required, but this cannot be guaranteed (difference between old age and global dependency).**
9. **Health care is in more demand by the elderly than by the active population (expenditure per head above 65 can be over 5 times more than in age group 15-44). Also needs can be different. Ageing can have an influence on health care organization and provision of health services. Financing is not easy since even when elderly have earned relatively good pensions, their resources are still less than those of the active population. Deductibles can**

be less for elderly. Also contribution rates on pensions for HC can be higher than on salaries. Ethical questions if limits on health care for elderly because of cost.

10. Dependency is a critical challenge for old age. It relates to the situation where the elderly person cannot care for him/herself without more or less constant assistance from a third party. Dependency grows in number and severity with age. In some cases it requires specialized assistance, in some cases simple family help is sufficient. Modern trend is to try to avoid institutionalization of old age dependent persons. In some countries cost of support to dependency (financing assistance, compensating family members for loss of income, subsidizing specialized institutions) is ensured through a special insurance part of social security (France, Germany, Spain, the Netherlands, etc.). Other provisions exist within social security: pension supplements for constant care attendance; increase in basic pension passed a certain age.
11. Pension systems may be affected by demographic ageing since pensions are paid longer because of increase in life expectancy. Hence a trend in increasing legal retirement age in line with improvements in life expectancy. Demographic factor may also be included in benefit formula. There is no obvious link however between legal and actual retirement age in Europe – the work efficiency of elder workers may not be very high hence a temptation by employers to make them redundant and taken care of through specific provisions when approaching legal retirement age. There is no equality among workers concerning life expectancy at retirement age – a lot depends on working conditions. Increase in actual retirement age may also affect life expectancy.
12. Financing – The demographic base of contributors maybe shrinking with ageing – hence the need for corrective measures and/or expansion in personal scope of coverage. There is no clear evidence why funding would function better than pay-as-you-go in times of demographic ageing. In fact, funding requires high yields in real terms over a long period to provide good results, and there is no historical evidence of such circumstances.
13. Sources of financing alternative to contributions based on salaries should be explored to address demographic ageing (pre-funding, reserve funds, buffers exist. Also, base contributions on non-labour factors for non-labour intensive industries). The % of GDP spent on pensions and health care is a better indicator for affordability than rough contribution rates. Bear in mind that social security benefits as deferred salaries are part of workers' share in economic output – tendency is towards decrease, not increase (to the detriment of capital remuneration).
14. Supplementary schemes may provide some relief to the burden cause by demographic ageing for social security financing. However these schemes are usually voluntary or not accessible to some vulnerable workers. They cannot therefore be considered as a proper solution for ensuring sustainable decent basic protection. Supplementing pensions by income derived from extended work after retirement is probably also not a sustainable approach.
15. Demographic ageing is not only a cost for social protection. It is also an asset for the society – voluntary work available, investment in future generations by elderly, new customers for service industries not too much exposed to outside competition, etc. These positive factors have to be taken into account when debating the issue of affordability of demographic ageing.

Jean-Victor Gruat,

1 February 2016.