
Article:
Zhou, J. and Walker, A.C. (2015) The Need for Community Care Among Older People in China. Ageing and Society. ISSN 1469-1779

https://doi.org/10.1017/S0144686X15000343

The Need for Community Care Among Older People in China*

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*** We gratefully acknowledge the support of the British Academy / Royal Society Newton Fellowship (NF090389)**

Abstract: Because of the rapid ageing of China's population its social care system has come under close scrutiny from policy makers. Unfortunately there is very little Chinese research evidence that might be used to plan future service developments.

This article is a contribution to filling that gap and it provides essential new information on the expressed demand among older people in China for various community care services. The data are from the 2008 wave of the Chinese Longitudinal Healthy Longevity Survey. According to the characteristics of the dependent variables, we used Binary Logistic Regression Analysis to analyse the need for community care among older people in China. The results show considerable need for such care, but China is still a developing country and there are insufficient resources to fund a Western style social care system (even if that was desirable). Thus it is argued that the development of social care in China should emphasise community-based care, in partnership with families, with institutional care as a last resort. In addition it is argued that China (and other countries) should introduce measures to prevent the demand for social care.

Key Words: Community care; Older people; Need; China

INTRODUCTION

Population ageing is a challenge to all health and social care systems and, especially so when the main driver of the formal sector is cost-containment: where resources are limited it is extremely difficult to meet growing demand (Sixsmith & Sixsmith, 2008). In ideal terms health and social care systems aspire to be needs-driven but they usually rely on less than perfect information on user needs (Seal et al., 2002). The planning and purchasing of services should be based on accurate assessments of individual needs and on informed expectations of individual outcomes, and then

services can be provided on needs-based criteria (Larsson & Thorslund, 2002; Nelson, et al, 2004; Abarshi et al, 2010). Older people themselves are the best qualified to give a holistic perspective on their perceived care needs, and listening to the needs of older people is vital (Themessl-Huber et al., 2007). In the west the dominant theme of both older people's perspectives on growing older and their need for care is the desire to remain for as long as possible in their own homes, or 'ageing in place' (Walker, 1982; Qureshi & Walker, 1998). In policy terms this translates into 'community care'.

In China, family planning policy has quickened population ageing when, in socio-economic terms, the country is still underdeveloped. This is a huge challenge to which society is not ready to respond to (Wang & Mason, 2005). Older people in China are keen to uphold traditional filial piety and prefer to 'age in place'. Therefore, as in many other societies, policy makers are increasingly turning to community care to narrow the growing gap between care needs and provision (The State Council, 2006). In different societies and cultures, community care services are also likely to differ in various ways with, for example, country specific infrastructures and utilisation patterns. Thus policy and practice have to be geared to the particular national and cultural contexts in which they are being implemented. This puts a premium upon research to inform future service development. Up to this point there has been no systematic analysis available about what China's older population itself would like by way of social support. (Although, as we argue later, expressed need should not be the only factor behind the development of community-based services.)

The Need for Community Care

Older people dominate the case loads of community health professionals now and will do so increasingly (Oberski, Carter, Gray & Ross, 1999). Factors previously reported to be predictive for the overall utilisation of community care services were also seen to determine the amount of services allocated to recipients (Meinow, Kåreholt & Lagergren, 2005). Three types of factors are important determinants of older people's need for community care services: (1) predisposing factors: differences in the demographic structure, such as age and gender; (2) needs factors: socioeconomic inequalities in health, health status or the likelihood of being in poor health and therefore in need of help, and (3) enabling factors: the availability of social and material resources, such as income, personal, family and community resources (Kosloski & Montgomery, 1993, Gill et al., 1998).

At the macro-level it is changing demographic structure that drives the need for community services (Lai, 2008). It is population ageing and, especially, increasing numbers of the oldest-old that have led to the universal need for care and support in the community (Sixsmith & Sixsmith, 2008). Some studies have indicated the overall predictors of older people's need for community care services. Gender is a significant factor, with men more commonly receiving care from a co-resident person while women more often rely on relatives outside of the family and on formal home help (Barrett & Lynch; 1999, Wister & Dykstra, 2000).

As for needs factors, the aggregate local pattern of chronic diseases is an important predictor of service needs and ultimately the capacity to age in place (James et al, 2008). Thus functional disability, physical and cognitive impairments are by far the strongest predictors of older people's need for community care services. In particular physical function has consistently been found to be strongly predictive of the need for community care in a number of countries (Banerjee & Macdonald, 1996; Jorm, et al., 2010). For example, activities of daily living (ADL) or instrumental activities of daily living (IADL) were the strongest predictors of community care resource utilisation in a Western Australian study (Calver, Holman & Lewin, 2004). However, research regarding the impact of mental disorders has been ambiguous.

Enabling factors also have important effects on the need for community care of older people. For example, older people's economic status affects the level of their need for help (Nihtilä, & Martikainen, 2007). Household composition and living arrangements have been crucial for predicting the need for formal services (Lagergren & Johansson, 1998; Calsyn & Winter, 2000). For example, the growth in older people living alone has increased demand for care and support within the community (Sixsmith & Sixsmith, 2008). Children not only provide direct support but are also important intermediaries between parents and care services, so enabling better access to formal care for older people (Choi, 1994). Shrinking family size and social networks are major contributors to unmet needs (Cvitkovich & Wister, 2001) and increasing the

need for community services (Penning, 1999). Insurance coverage and eligibility criteria also affect the relationship between socioeconomic status and service usage among older people. Older people with close personal relationships with neighbours are likely to get basic support when their health and functionality deteriorate (Meinow, Karehold & Lagergen, 2005). However, social care systems for older people are rarely coordinated effectively with family care (Qureshi & Walker, 1989). Geography can be considered as an enabling factor too, for example rural dwellers often have to travel further and wait longer for services (McDonald and Conde, 2010).As well as assessing the predictive strength of particular variables, studies have focused on which one predictor domain explains most of the variance in the utilization of services: enabling variables are at least as important as need variables in predicting service utilization among disabled older people (Toseland et al., 2002).

Because of different historical paths of development, population structure, welfare regimes and culture, the development and patterns of community care services for older people are necessarily diverse across different countries. 'Familistic' welfare regimes use formal help sparingly, and are more inclined to support family carers than to invest in services; whereas 'mixed conservative' regimes use formal help and the relatively high provision of means-tested, public-sector services; and 'liberal' welfare regimes tend to limit the use of formal help and purchase care in the private market (Daatland, 2001; Broese van Groenou et al., 2006). China has a long familistic history, the traditional practice of family care being based on the ideological foundation of

filial piety and mutual support. But the growth of individualism, urbanization and mass migration, along with the rapid social and economic transformation, has undermined the Confucian tradition (Yan, 2006; Cheung & Kwan, 2009). With the rapidly rising need for care deriving from both population ageing and the increasing shortfalls in existing familial, neighbourhood and state-sponsored care, Chinese policy makers are emphasising ageing in place and community care to fill the growing gap between care needs and provision. However community care is still in its infancy in China. So, in light of the filial reduction following the one-child policy, how to provide care for older Chinese people and how to find a service that responds to both their needs and their culture are burning challenges for both policy and practice.

Conceptual Framework

Our starting point is the tripartite framework outlined above which identifies three types of factors as important determinants of an individual's need for services: predisposing, needs and enabling factors (Andersen & Newman, 1973). Wolinsky (1994) argued for the inclusion of variables reflecting health insurance and community resources and Andersen (1995) expanded the original model to include measures of health behaviour as enabling factors. Broese van Groenou et al (2006) further developed the model to make it more sensitive to national or societal differences through two types of variations: (a) cultural factors, particularly beliefs and norms about family behaviour; and (b) welfare policies regarding the availability,

cost and quality of service provision for older people. McDonald and Conde (2010) argue that geography is an enabling factor too.

China's Community Care System

A brief introduction to China's community care system provides a context for our analysis of the expressed need for community care among older Chinese people. But, first, we must acknowledge that 'community care' covers a wide range of health and social care services and is ambiguous in that it can refer to both 'care in the community' and 'care by the community' (Walker, 1982). The notion of 'care in the community' denotes the provision of care within the locality of older people, in order to avoid their segregation and exclusion from the wider community to which they originally belonged. Whereas 'care by the community' emphasizes the willing commitment on the part of members of the community to support older people living among them (Bayley, 1977). Indeed, the spirit of community care is that older people should remain in their familiar neighbourhood. Community care is an alternative to institutional care and, ideally emphasizes users' perspectives, respects their rights to be autonomous, and distributes welfare resources according to need. It also assumes the integration of formal and informal care and the provision of support services to the most vulnerable (Bornat, et al., 1997; Morris, 1997). In the West it includes services such as home care, recreational activities, day care, respite care, and supported housing and employment (DH, 1990). In China, since the market oriented economic

reforms were introduced in 1978, the traditional social welfare system could not meet the care needs of the rapidly growing older population and this led to reforms which were mainly aimed at fostering the development of community services. After 30 years of discussion, community care for older people has just begun to be realised. In January 2008, the China National Committee on Ageing, the National Development and Reform Commission, the Minister of Civil Affair (MCA), and seven other Ministries jointly issued the policy paper 'Views of Promoting Home Care Services' and called for the promotion of a comprehensive home care service, for the first time home care had been recognized officially as an important way to deal with China's ageing. 'Home care service' was defined as 'government and social forces based in the community, and providing life-care, housekeeping services, rehabilitation care, spiritual comfort and so on for older people ageing in place.' In practice, home care services also include day care, dining rooms, canteens or centralized meal delivery and so on, and is the same as 'community care' in its content, form and purpose (Tian, 2010). Since the publication of this guidance, community care has also developed in rural China.

Governments at all levels in China increasingly emphasise community services and people's sense of identity with and reliance on these services are growing. At present, there are 6923 sub-districts and 87000 urban communities in China, and the number of community service centers totalled 12,720 in 2010, while the number of community care facilities was 153,000 (MCA, 2011). In one of China's series of

remarkable recent policy hyper-developments, at the end of 2010, a total of 43.44 million retirees were subsumed into this community care system from state-owned enterprise care, accounting for 76.2% of the total. In December, 2011, the State Council released a new regulation 'Social Care Service System Program for Older People' regulation which stipulates that, by 2015, the community care net will be 'basically sound', which means that day care centres, nursing homes, activity centres, mutual support service centres and day care services will cover all of the urban communities and more than half of rural ones.

DATA AND METHOD

Data Sources

The data are from the 2008 wave of the Chinese Longitudinal Healthy Longevity Survey (CLHLS). The CLHLS began in 1998, is the first national longitudinal survey of the oldest-old (aged 80 or over) in China, and has subsequently interviewed every 2 or 3 years. Older people aged 65–79 were included as a comparative group from 2002. The data were first collected in 631 randomly selected counties and cities of the 22 provinces in China, and the survey areas represent 85% of china's population. The CLHLS sampling frame started with lists of all centenarians in the randomly selected counties / cities (the age of each centenarian was validated from various sources such as birth certificate, genealogical documents, household booklet and, when available, children's and sibling's ages). Almost all centenarians were interviewed in a randomly selected half of the counties/cities. For each centenarian interviewed the CLHLS

randomly chose one nearly octogenarian and one monogenarian, with pre-designated age and gender, to be interviewed. This sampling strategy ensured the inclusion of comparable numbers of males and females at each age from 80 to 99 (Zeng, et al, 2008). The 2008 dataset includes 4,149 respondents aged 65-79 and 11998 aged 80+. Of these 3,283 were re-interviewed in the 2005 wave, and a total of 5,455 were first interviewed in 2008. The refusals were low, so the CLHLS sample had a high representation (Gu, 2008), the data quality is reasonably good and the psychometric measures are judged to be reliable (Gu, 2008; Gu & Dupre, 2008). A detailed description of the design, sample distribution, and content of data collected can be found in Zeng, Poston, Vlosky & Gu (2008). Table 1 provides the unweighted sample distribution for the full sample.

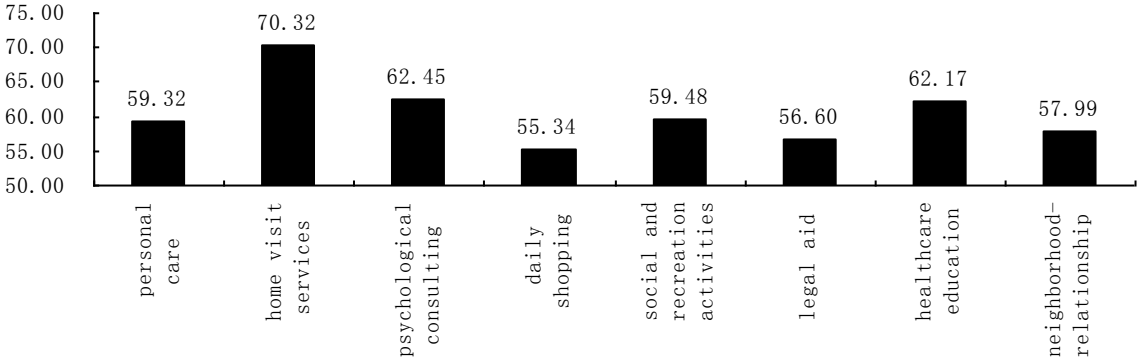
TABLE 1 HERE

Measures

As noted, community care in China encompasses a wide range of programmes providing support to various groups. In our study, community care is defined more narrowly to focus on support to older people, and includes broad community health, allied health, pharmacists and preventative programmes as well as those services funded by local governments. The expressed need for community care services was measured by responses to the question 'What kinds of community care services do you need?' The options included personal care (such as washing), home visiting (such as cleaning, cooking), psychological consulting, daily shopping, social and recreation

(such as singing and dancing), legal aid, health education (such as teaching older people how to care for themselves) and neighborhood-relationships (such as mediating in conflicts among neighbors) (Diagram 1). The number of older people expressing a need for other services is very small (1-4 cases), so we excluded them.

Diagram 1 The Expressed Need for Community Care Services by Older People



Older people were stratified by age into three sub-groups: oldest-old (80+), 70-79 and 65-69. Gender (male vs. female) was considered too.

Education was ascertained by 'years of schooling'. Social networks and intergenerational relationships were measured by current marital status (married vs. single/widowed/divorced), the number of sons, daughters and persons were living with the respondent; biological siblings alive and social support, which was measured by the four following items (Wang, Chen & Han, 2014): (1) 'Who usually takes care of you when you are sick?' (2) 'To whom you usually talk frequently in daily life?' (3) 'The first person you talk to when you need to share some of your thoughts?' (4) 'The first person you ask for help when you have problems/ difficulties?' For each item, it

is significant that very few respondents (0.1%–2.1%) answered ‘nobody’. In case of the categories with low-frequency counts in the regression analysis, we introduced a new variable as ‘social support’. If the answer for any of the four items was ‘nobody’, the variable was coded as ‘lack of social support’. Such enabling factors as income, personal, family and community resources, income were assessed by asking ‘how much was your household income per capita last year’. Employment status was allocated on the basis of whether or not the respondent was in receipt of an old age pension. Other relevant questions are ‘Do your own your own home’, ‘How many years that you have lived in this community?’ ‘Your category of residence in 2008 (town, rural vs. city)’.

Need factors focused mainly on health status, and health status included: by asking whether the respondents had difficulty or needed assistance in performing any of the following ADLs: feeding, bathing, dressing, indoor mobility, continence, going to toilet and gatism. The respondents were classified as ‘ADL disabled’ if they needed assistance with at least one activity. The cognitive functioning of respondents was determined on the mini-mental state examination (MMSE). Older persons with no scores of less than 18 are categorized as having normal cognitive functioning, otherwise are considered cognitively impaired. Health practices were measured by ‘regularly does exercise at present (yes vs. no)’, ‘smoke or not at present? (yes vs. no)’, drink or not at present (yes vs. no).

The self-reported need for community care might be highly related to the psychological well-being (PWB) of older people, so we needed to control for such factors in our models. The PWB was measured in previous research by the following five items (Wang, Chen & Han, 2014): (1) ‘Do you always look on the bright side of things?’ (2) ‘Do you usually feel anxious or fearful?’ (3) ‘Do you usually feel lonely and isolated?’ (4) ‘Do you feel the older you get the more useless you are?’ and (5) ‘Are you as happy now as when you were younger?’ Five levels of responses were possible, i.e., always, often, sometimes, seldom, and never. The scores of negative questions (i.e., questions 2, 3, and 4) were reversed to positive scores, so higher scores represent better PWB.

Methods

According to the characteristics of the dependent variables we used Binary Logistic Regression Analysis. Two important issues were taken into account: weighting and the missing values for certain variables in CLHLS:

The CLHLS has oversampled the oldest-old group. Previous research using CLHLS had not used weighting ‘Given that the sampling weight variable in the publicly released CLHLS dataset was calculated based on the age–sex–urban–rural residence-specific distribution of the population and did not capture other important compositional variables (e.g., marital status, economic status), the weight was not applied in the current study’ (Gu, Zhang & Zeng, 2009). Others have shown that including variables related to sample selection produces unbiased coefficients without

weights (Winship & Radbill, 1994) and weighted regression results might enlarge the standard errors (see http://www.sociology.ohio-state.edu/people/ptv/faq/weights.htm, Accessed on July 18, 2007). So we used unweighted results.

Unlike other questions in the CLHLS that could be answered by a proxy (e.g., a spouse or family member), both MMSE and PWB questions must be answered by the respondent. Because of low cognitive functioning, some respondents cannot answer some of the questions, so there are three possible answers for each item: correct, wrong, and unable to answer. Consistent with previous studies, we found that the level of 'unable to answer' was much higher for the relatively difficult tasks compared to the relatively easy ones (Herzog & Wallace, 1997). Between 14.6% and 36.6% of respondents could not answer at least one of the PWB or MMSE questions in the CLHLS data, and most of the missing data (95.6%–99.5%) were associated with lower than 18 MMSE scores. We evaluated three alternative approaches to assess how best to handle the responses of 'unable to answer': (1) coding them as missing values and using multiple imputation; (2) excluding them from the analysis; and (3) coding them as incorrect answers (eg. Zhang, Gu, Hayward, 2010). The three sets of results were very similar, and the results shown below are based on the third approach.

RESULTS

We checked the multi-collinearity of all independent variables and the variance inflation factors are all less than 3, which suggests that multi-collinearity was not a

problem.

TABLE 2 (a and b) HERE

Older people aged 65–69 had the highest need for social and recreation activities, and older people aged 65–69 and 70-79 years wanted more legal aid service, healthcare education service and neighbourhood-relationship services.

A higher education level was associated with a decrease in the need for home visiting services, and older people who were currently married needed more personal care services, daily shopping services, social and recreation activities and neighbourhood-relation services. Surprisingly the number of sons did not have a significant effect on the need for community care, while older people who had more daughters needed less personal care services, daily shopping services, social and recreation activities and healthcare education service. The larger the household size, the greater the need among older people for all services except personal care services and daily shopping services. The more living siblings, the less the older person's need for all the services except psychological consulting services and legal aid service. Social support did not play a very important role, and lack of social support only increased the need for social and recreation activities services but decreased the need for personal services care.

Per capita household income also increased the need for all of the services. Older people who had a pension needed less of all services. These who owned their own homes expressed the need for more home visiting services, daily shopping services, social and recreation activities, legal aid service, health care education service and neighborhood services than other housing tenure. The more years that older people have lived in the community decreased their expressed need for home visiting services and social and recreation activities. Urban older people said that they needed less of all the services than older people living in towns and villages.

People who often exercised said they needed less personal care services, daily shopping services but more social and recreation activities and health care education service. People who often drank said they needed less of all the services. Older people having normal cognitive functioning was associated with a decreased the need for personal care services, and home visiting services, daily shopping services.

DISCUSSION

The findings from this study provide the first reliable and timely national information about the need for community care among older people in China. Older people are a heterogeneous group and vary greatly in terms of the kind of services required according to demographic characteristics, health status, socioeconomic factors, family and so on.

Older people aged 65–69 had the highest expressed need for social and recreation activities, and those aged 65–69 and 70-79 years said they needed more legal aid services, health care education service and neighbourhood-relationship services. In future the number of older people in the 65-79 age group will increase in China (UN, 2011) and, other things being equal therefore, so will demand for more services.

Better off older people said that they had a higher need for community care services than poorer ones. This paradox is likely to be attributable to the subjectively expressed nature of the need, given that the more affluent are often more demanding consumers than the less well-off. The number of surviving siblings decreased the need for all the services except psychological consulting services and legal aid services. But with socioeconomic development and the family planning policy, the majority of Chinese families now have only one child, and the ‘only child’ generation total 90 million (China's National Population and Family Planning Commission, 2007). As they age, they will need more community care services. Furthermore family supports and intergenerational relationships are becoming weaker as the nuclear family has recently become the major form in China (Palmer & Deng, 2008; Cheung & Kwan, 2009). Thus, in contrast to Western countries and other East Asian ones, the number of sons has no significant effect on the need for care. With modernization, urbanization and the weakening of filial piety, large numbers of young adults (typically men) are migrating for work and more and more women are participating in the labour market (Joseph & Phillips, 1999; Seeborg, Jin, & Zhu, 2000).

Consequently, a growing number of older people are unable to get care from their children in modern China (Zhan et al., 2006). Moreover the traditional gender division of labour means that sons provide mainly economic support for their parents, while the daughters provide mainly physical and emotional care (Spitze and Logan, 1990), so the role of daughters is more important in providing care and, therefore, the number of daughters plays a significant role in relation to the expressed need for community care.

Despite being a familistic country, it is striking that family care did not decrease greatly the need for community care and even appears to increase it. Clearly the shrunken Chinese family cannot meet the care needs of older people. Moreover the family's support capacity will be inevitably further weakened in the forseeable future (Delgado and Tennstedt, 1997; Wu and Du, 2012). Also China's rapid urban development and the younger generation's mass migration are leading to the break-up of many lifelong neighbourhoods. As a result older people often say they prefer community to family care.

In sum, socio-economic development in China including changes in family structure, living environment, housing, employment, and economy, declining total fertility rates and decreasing family size (Palmer & Deng, 2008), the younger generation's mass migration for work resulting in dwindling co-residence with their older parents (Asis et al, 1995; Quach & Anderson, 2008), and the increasing child-centered resource flows because of the erosion of traditional filial piety (Croll, 2006), have made it

increasingly difficult for parents to receive family support (Croll, 2006; Quach & Anderson, 2008; Zavoretti, 2006). This huge socio-demographic transformation suggests that family-centered services should be encouraged when community care is developing, with the extended family as its main target in order to stimulate family care resources. It is likely also that more institutional care will also be needed, especially for the oldest-old. This age group did not express a need for more community care services, but it is well known that many of the oldest-old are less able to take care of themselves, and so some of them will need institutional care when family care is weakening or non-existent. Despite the fact that Confucian ideas stigmatize non-familial institutional care in China, regardless of their health status, many older adults have began to express positive opinions about this form of care (Chen, 2011). With improved living conditions, medical and health care, more and more Chinese people are living into advanced old age, and so there is likely to be rising demand for institutional care services unless the government can develop alternative community services that older people find attractive.

Homeowners expressed a need for more home visiting services, daily shopping services, social and recreation activities, legal aid services, health care education and neighborhood services. The main factors here are likely to be the relative affluence of this group and their strong desire to age in place. Having a pension decreased the need for all services. Having a pension in China means that an older person can still access State-owned enterprise (SOE) care. Each SOE functioned as a self-sufficient welfare

society within which an individual received employment and income protection, and enjoyed heavily subsidized benefits and services such as housing, food, education, recreation, child care and social security benefits for sickness, maternity, work injury, invalidity, old age and death (Leung, 2000), which clearly reduces their need for community care. Rural older people needed more of all the services. Rural older residents experience more social exclusion than other groups (Milne, Hatzidimitriadou & Wiseman, 2007). So a priority for old-age support in the future should be the provision of community care services to older people in rural areas. But, as the 'only child' generation age and older people's economic resources improve gradually in urban areas, the need for community care will increase in cities too.

CONCLUSION

In light of these results, with the continuing demographic and social transformations, especially with increases in the older population, much of which is marked by unhealthy longevity, China's nascent community care services are facing a serious challenge. As many older people are not covered by the pension system and the family is less and less able to contribute more economic resources and to provide care, there is a steady increase in the need for services. At present, community care has only a basic level of organization and management in China. There are a variety of currently available services that, in various combinations, could potentially help to address the needs of older people in the urban areas, but the targets of community care are varied: some services are for the 'three Nos' older people (no offspring, no money,

no ability to take care of oneself), the poor older people, some are for empty nesters or the sick, while others are for all older people (China National Committee on Ageing, 2008). In short there are no effective integrated social systems of community care for older people with different levels of need.

Moreover, the growing number of older people will inevitably increase requirements for assistance of various kinds, which creates pressures for major structural reform in China's health and social care systems. Taking account of probable changes in the size, structure and partnership status distribution of the older population together with projections of their disability, household composition and financial resources, policy makers face a challenging task when making decisions about care systems for older people. Policies that promote better co-ordination of services are crucial to meet these challenges (Oberski et al, 1999; Rechel, Doyle, Grundy & McKee, 2009). Thus, in our view, the development of elder care in China should be 'home-based, community-service-relied, and institutional-care-supplemented' as argued by national policy makers. 'Home care' could be minimally defined - older people living at home rather than in LTC institutions. However there is a wider societal challenge too, especially since the one-child policy is more strictly implemented in urban than rural areas. The married single sons and daughters will face two pairs of parents to support and, most likely, will not be able to provide effective services to them. This is a growing problem for elder care in China: meeting the needs of those older adults who lack sufficient family care resources. So there is a need for independent as well as

family-integrated services.

Institutional care will be necessary for a minority of older people because community care is not an option for everyone. In this study the most disabled had lower levels of need for community care services. The ageing in place prescription could become harmful if it is not accompanied by comprehensive supports for all levels of need and if it is used as an excuse not to develop institutional care (Heumann & Boldy, 1993). This form of care has a relatively long history in the West but, in the past absence of sufficient financial resources and heavy emphasis on the family, it is only now being invented in China. Thus this particular cost pressure behind 'ageing in place' in the West has yet to materialize in China. What is lacking is sufficient investment and a strategy to share care effectively between the state and the family (Walker, 1991; Qureshi & Walker, 1989). None the less policy makers have recognized its importance. Shared care should be the aim, which would mean community care services encouraging and supporting family and neighbourhood care.

Evidence from this research, combined with Western experience, indicates that community care policies should not be purely about service development. In collaboration with older people, the Government should also act to prevent dependence on services. Before the ageing Chinese express a need for services it is important for them to maintain their own well-being: for example, encouraging older people to exercise and abstain from smoking and alcohol, increase their health

knowledge and maintain healthy lifestyles (Department of Health, 2005). In this research those who often exercised and had higher education levels needed fewer services (although there is no research that we are aware of into the attitudes of Chinese people towards health promotion). It is also important to enlarge participation and communication among older people and others, so that networks are no longer limited to family members but can also include various social institutions, friends, neighbours, elderly peers and particularly siblings. Policy should also aim to reduce migration in order to maintain the local networks of older people, especially in rural areas. Our analyses show that the longer older people have lived in a community, the less they needed home visits, daily shopping and social and recreation activities. This emphasises the point that older people have a strong emotional attachment to their homes and communities (Phillipson et al., 2001; Cheng & Chan, 2006) and, once they leave their life long community or the younger members of the community leave them, they lose many social supports and, consequently, will need more community or other services.

The main aim of this paper is to generate, from a reliable data source, fresh information about the expressed need for community care among older people in China. As an initial analysis the intention is to stimulate further research and feed into policy thinking about the development of community care services in China. The timeliness of this analysis is emphasised by the fact that the Government in now focused on this topic, as part of its strategy to ‘re-socialise the social services’ (Lei and Walker, 2013) and is currently working with the World Bank to develop a policy

for elder care. There are also likely to be policy lessons for other less developed societies with ageing populations but which lack the data sources available to China. As we have noted, although this analysis is concerned with expressed need, Chinese policy makers should be aware that it is equally important to try to prevent demand, by for example early intervention and health promotion, as it is to respond to it by service development and, in terms of the health and well-being of older people, arguably more so.

Table 1 Sample distribution, community care type by covariate

Variables		Sample a #, mean, %	Variables		Sample a #, mean, %
Age	65-69	9.83	Years of has lived in the area		3.95
	70-74	17.19	Homeowner	yes	93.42
	80+	72.98		no	6.58
Gender	male	42.71	Category of residence	city	60.36
	female	57.29		town	19.4
Years of schooling		2.29		rural	20.24
Married	yes	30.7	Smoke at present	yes	17.47
	not	69.3		no	82.53
The number of sons		4.62	Drink at present	yes	17.40
The number of daughters		2.16		no	82.60
The number of persons were living with the respondent		2.7	Exercise at present	yes	26.99
Number of biological siblings alive		2.08		no	73.01
Lack of social support	yes	10.65	ADL disabled	yes	11
	no	89.35		no	89
Household income per capita		12.93	MMSE	normal cognitive	52.45

Have a pension	yes	17.76		functioning cognitively impaired	47.55
	no	82.24	PWB		14.11

Table 2a Factors associated with the need for community care

		Personal care services	Home visit services	Psychological consulting services	Daily shopping services
Age (80+)	65-69	1.105	0.993	0.876	1.067
	70-74	1.097	1.072	0.951	1.058
Gender (Female)	male	1.033	1.043	0.982	1
Years of schooling		0.993	0.991*	0.993	0.994
Married (No)	yes	1.119*	1.059	1.042	1.162**
The number of sons		1	1.009	1.015	0.994
The number of daughters		0.960***	0.982	0.982	0.969**
The number of persons were living with the respondent		1.014	1.060***	1.024*	1.018
Number of biological siblings alive		0.996*	0.996*	0.997	0.995*
Lack of social supports (No)	yes	1.233**	1.117	0.884	1
Household income per capita		1.008***	1.005***	1.007***	1.007***
Have a pension(No)	yes	0.772***	0.727***	0.814***	0.769***
Homeowner (No)	yes	1.071	1.411***	1.07	1.558***
Years of has lived in the area		0.969	0.869*	0.935	0.922
Category of residence (City)	rural	1.132*	1.346***	1.164**	1.272***
	town	1.681***	1.781***	1.736***	1.865***
Smoke at present (No)	yes	1.029	1.076	1.033	1.034
Drink at present(No)	yes	0.816***	0.847**	0.883*	0.818***
Exercise at present(No)	yes	0.839***	1.065	1.026	0.914*
ADL disabled (no)	yes	1.070	0.988	0.992	1.029
MMSE (normal cognitive functioning)	cognitively impaired	0.791***	0.869**	0.955	0.891**
PWB		1.010**	1.007	1.010**	1.013***
χ^2		302.973	281.26	203.279	327.101
N		13314	13315	13314	13314

Table 2b Factors associated with the need for community care

		Social and recreation activities	Legal aid service	Healthcare education service	Neighborhood-relation services
Age (80+)	65-69	1.149*	1.261***	1.197**	1.244**

	70-74	1.101	1.223***	1.146*	1.265***
Gender (Female)	male	1.007	1.04	1.002	1.001
Years of schooling		0.997	0.997	0.995	0.996
Married (No)	yes	1.137**	1.038	1.02	1.109*
The number of sons		1.005	1.013	1.007	1.019
The number of daughters		0.964**	0.984	0.970**	0.983
The number of persons were living with the respondent		1.043***	1.038***	1.045***	1.054***
Number of biological siblings alive		0.994**	0.995	0.993***	0.993***
Lack of social supports (No)	yes	0.842**	0.924	0.907	1.038
Household income per capita		1.007***	1.007***	1.006***	1.005***
Have a pension(No)	yes	0.883*	0.809***	0.830***	0.698***
Homeowner (No)	yes	1.474***	1.621***	1.428***	1.685***
Years of has lived in the area		0.871*	0.923	0.954	0.936
Category of residence (City)	city	1.258***	1.184**	1.173**	1.231***
	town	1.777***	1.669***	1.687***	1.855***
Smoke at present (No)	yes	1.056	1.023	0.993	1.036
Drink at present(No)	yes	0.844**	0.841***	0.811***	0.838***
Exercise at present(No)	yes	1.129**	0.996	1.147**	1.087
ADL disabled (No)	yes	0.991	1.068	1.006	0.983
MMSE (normal cognitive functioning)	cognitively impaired	1.042	1.014	1.014	0.974
PWB		1.010**	1.009*	1.007*	1.005
χ^2		298.875	256.753	239.123	359.128
N		13314	13314	13315	13314

Note: (1) Category in the parentheses of each variable is the reference group. (2)*p<0.05, **p<0.01, ***p<0.001.

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Accepted 10th March 2015