

BOOK REVIEW

HEALTH AND LONG-TERM CARE INFORMATION IN AGING ASIA ERIA RESEARCH PROJECT REPORT 2022, NO. 07

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This study provides the most up-to-date evidence and information (2022) regarding the causes of death in ASEAN+3 countries, indicating the overview of this region and each country's situation. Many causes of death are preventable or treatable; therefore, government, public health sectors, including policymakers, and related professions could gain a greater understanding of the causes of death in their population and potentially provide prevention measures. Consequently, it gives the demand and supply of long-term care for older people in Asia, including the demand for long-term care among the elderly who are in need of care and live alone, as well as the supply of workforce and care facilities. By analysing the demand and supply for elderly and long-term care services, policymakers can identify areas where access to care may be restricted. They can then attempt to improve the availability of services in specific locations, ensuring that more elderly have access to the necessary care.

This study is divided into three components, with the first section, Part 1, analysing death statistics in ASEAN+3 countries. Then, Part 2 presents the most recent demand and supply of long-term care for the elderly in Asia. Finally, the analysis of the Vietnamese Population database is introduced in Part 3. The following sections introduce the main points and further information about each section of this book.

Part 1: Cause of Death Statistics in ASEAN+3 Countries

This study points out how important the cause of death is at the national level by proposing that tracking cause-of-death data is essential for monitoring people's health and is also intimately associated with calculating Sustainable Development Goals (SDGs) indicators. The study indicates that although this data is critical, it is often of low quality and limited in Asian countries. This study highlights the cause of death statistics

gathered, classified, and standardised by World Health Organisation (WHO). Furthermore, the study indicates that death registration is incomplete in the middle- and low-income countries. The ASEAN+3 countries are divided into four categories:

- Category 1. Multiple years of data with high completeness and quality
- Category 2. Moderate quality issues
- Category 3. Severe quality issues

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- Category 4. Death registration data are unavailable or unusable due to quality issues

The Philippines, Singapore, Japan, and the Republic of Korea are in Category 1, while Brunei and Malaysia are in Category 2, Thailand is in Category 3, and Cambodia, China, Indonesia, Lao PDR, Myanmar, and Vietnam are in Category 4. An interesting point in this section reveals the influence of population age structure on the crude death rate, which causes Japan to have the highest crude death rate (number of deaths per 100,000 people) with 1,066. However, Japan has the lowest age-standardised death rate. Consequently, this study highlights the significance of the ageing society and its influence on the whole ASEAN+3 countries. This study also shows that, according to epidemiological transition theory, the causes of death should transition from communicable to noncommunicable diseases in relation to the development of the country. Interestingly, ASEAN+3 are already post-transition countries, in contrast to many low-income countries in other regions, where communicable diseases, maternal and perinatal, and nutritional deficiencies cause the majority of deaths.

When considering each country's situation, the Philippines, Singapore, Japan, and the Republic of Korea, placed in Category 1, have a strong and progressive system and regulations in both birth and death registration. The Philippines is an outstanding demonstration of how coverage of births and deaths has improved: from 89.3% in 1995 to 90%-99% in 2010 and from 67.1% in 1995 to 87.6% in 2015. Singapore, Japan, and the Republic of Korea can investigate the causes of death online; Singapore and Japan can search for official information in their own languages and English versions. Brunei and Malaysia are in Category 2. Due to the rapid expansion of the Malaysian government's online annual report publication, Malaysia's death registration coverage

is between 90 and 99 per cent, and WHO has increased the quality of category of cause of death statistics for Malaysia from 4 in 2016 to 2 in 2019. Despite Thailand's birth registration coverage of 100% and death registration coverage of 85% in 2012, Thailand's statistics are of quality category 3; the completeness of death data for ages 15 and older is between 91% and 100%, but only 34% to 65% is useable. Lastly, Cambodia, China, Indonesia, Lao PDR, Myanmar, and Vietnam are in Category 4. These countries' cause-of-death statistics are not covered (Cambodia, Indonesia, Myanmar, and China), and some have just recently established an organisation to address this issue, e.g. Lao PDR. Despite certain limitations about the causes of mortality in the countries mentioned, this research systematically collects existing causes of death from 13 countries, offering various advantages to individuals in the policy and public health areas. Importantly, this study suggests that governments may possibly implement preventative actions if they know the exact causes of death in their populations.

Part 2: Demand and Supply of Long-Term Care for Older Persons in Asia (Updated)

Similar to previous studies and research, this study continues to draw attention to the rapid increase of older people, particularly in Asia and the decrease in the working-age population and young person population. This study reveals a variety of definitions of older people, with high-income nations, such as the OECD, tending to adopt the UN classification of 65 and above. In contrast, most medium and low-income countries identify older people as those above the age of 60. However, the specific age influences how each country's government provides state benefits, such as the United Kingdom's pension eligibility requirements for persons aged 65 and above. Therefore, the purpose of classifying any individual as senior may involve not just population

awareness but also socioeconomic-political considerations. In terms of ageing speed, Japan has been recognised as having a faster rate of ageing than European countries. According to this study, Kuwait is the fastest ageing country in Asia, with the number of people aged 65 and above rising from 7% to 14% in only ten years. It is followed by the UAE (11 years), Saudi Arabia (12 years), and the Maldives and Brunei (13 years). The number of older people is not expected to grow much in areas where ageing has already started, such as Europe or North America; in contrast, the number of older people rises substantially in regions with middle- and low-income nations. Regarding this scenario, it may require the provision of proper care for the elderly to improve their quality of life, especially in Asia.

Considering the demand for long-term care for the number of elderly people in need of care, the primary point of this study is that the number of people in need of care in Asian countries, especially Southeast and West Asia, would expand dramatically from 15 million in 2020 to 113 million in 2100. Interestingly, it was previously believed that Japan had the largest number of elderly people living alone. However, according to this study, there were more elderly people living alone in South Korea than in Japan in 2018.

This need has prompted worry among Asian nations, and this study explores two potential supply challenges for long-term care: workforce and care facilities. Using available census data, the percentage of the labour force working in the health and social work industry is once again the greatest in Japan at 11.9%, followed by the Republic of Korea at 6.5%. In contrast, the lower percentage countries are Cambodia at 0.6, Myanmar and Laos at 0.5%. This study also demonstrates that in some Asian nations, family members were expected to care for the elderly; consequently, long-term care workers may not

promote awareness in these countries. It also contributes to the underdevelopment of long-term care professions in many Asian countries. The gender imbalance in the health and social work labour force in Asian countries, such as the majority of physicians being men and the majority of nurses being women, is also important for this section. Depending on the country's background, this situation generates a variety of issues. For instance, if only male physicians are available, some women might avoid critical medical treatment, such as a gynecological examination. If there are only female nurses, males who desire to become nurses will be excluded from the industry, and workplace diversity will decrease. This study concludes that the health and social work industry is a potential area for women's involvement in the labour market, even though gender equality has been improving. This study also offers limited information about various welfare facilities, but beyond this limitation, it describes how diverse parties in each country, such as the government, religious organisations, and charities, may operate long-term care facilities.

Part 3: Analysis of the Vietnam Population Database

This study then proceeds to analyse a specific nation, Vietnam, without explaining why Vietnam was chosen. Perhaps Vietnam is an example of a country where the birth registration rate is as high as 95%, but there is no official publication on the death registration rate, and there may be sufficient room for improvement. Vietnam developed a system of population and family planning (PFP) database, which covers the total population of Vietnam. It includes statistics on contraceptive usage, births, deaths, and migration, as well as basic demographic information from 11,159 communes to 713 districts in 63 provinces, all of which are integrated at the national level. Despite the fact that Vietnam has collected several

databases from different national organisations, a coordinating mechanism is currently in place to organise them. Consequently, the accuracy of the cause of death in Vietnam has improved, and Vietnam has shown the significant use of the PFP database, a vital component of its information infrastructure.

This study provides valuable information on the causes of death, demand and supply for long-term care in Asian countries, including a case study of Vietnam. However, it may unintentionally reveal why Vietnam was selected to present in Part 3. Significantly, a comparison between Vietnam and other countries that have achieved success in these areas, such as Japan or Singapore, should be provided for the reader who may prefer to learn more about these topics.