

## “Walk before you can run” The Catholic Church and the Care of China’s Elderly

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### Introduction

That China for the last 30 years has been going through a period of rapid development stage is a truism and not necessary to discuss in depth. The social changes that follow from such a sustained period of economic growth have been commented on many times by western observers. Two elements in particular that impact on the care of the elderly are well known in the West, vis the consequences of the one child policy and rapid urbanisation. Smaller families have created an inverted age pyramid similar to those seen in developed countries but, because it is driven by a draconian population control policy, the impact is being experienced much more quickly. The single child policy means that any couple, being without siblings, will have sole responsibility for the care of four elderly parents. At the same time urbanisation is creating “empty nest” homes where the young are no longer living with or near their elderly parents. Elders in these circumstances may well be financially supported by children working in distant cities, but lack the quality of care associated with the traditional close-knit family structure. According to official statistics, China had about 185 million people over the age of 60, or 13.7 percent of the population, by the end of last year. By 2053, the number of senior citizens in China is expected to hit 487 million, or 35 % of the population. Japan by contrast, at 20% is already considered to be in a very serious situation.

### Poor preparation

What is less well known is the absence of long term preparation for what is now an acute social problem. Traditionally, seniors were cared for according to a family model. Until

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recently, in a still largely agrarian society, it was still possible to think of elderly care taking place without intervention from the State. The Chinese family ideal of “four generations under one roof” was the norm. The rapid changes in society makes the family model of elderly care untenable for urbanised adults living in small apartments whose parents live long distances away. Society urgently needs other models of professional care to compensate for the breakdown of the family model, but there has not been the long term investment in policy, plant, or, most critically, in personnel training to meet that need. The absence both of skilled personnel at all levels and the programmes to train them is a severe bottleneck in the development of care services. Further, the speed of the demographic change means that despite the rapid growth in GDP, China is getting old before it becomes wealthy. The State, its bland promises and pilot schemes notwithstanding, probably cannot afford to rule out nationally the services that the elderly citizenry requires. The for-profit sector will be able to develop services for which the rich are willing to pay, government services, if they follow existing trends, will be concentrated in urban areas and the elderly poor, especially in the depopulating rural areas, will depend on the not-for-profit sector to provide for their needs.

## Challenges

Geriatric care policy in developed economies has identified two complimentary models of care to replace and/or shore up the family model. The first is the medical model of care, i.e. residential facilities for those who suffer chronic conditions and need full time nursing care. Western policies also recognise a second, complimentary, model which relieves the burden on the medical model. The community care approach ensures that seniors of varying degrees of disability can remain in their own homes. China’s elderly care policy is skewed towards a medical model, and the current five-year plan is committed to increasing the number of nursing home beds to 3% of the elderly population.<sup>1</sup> Developed societies with a good mix of elderly services typically have nursing home places for 7% of the elderly population. Existing neighbourhood programmes in China tend to be urban and cater for active, healthy elderly. Services for the partially invalided or those confined by infirmity to their own homes are poor or nonexistent. These non-residential options are seen as essential in developed countries as they ease the strain on expensive residential places. A further complication is that the medical model requires significant numbers of qualified, certified personnel at all levels of the system. The sector has an estimated need for 10 million caregivers but only 300,000 working in the sector, of whom only 100,000 have any kind of certification.<sup>2</sup>

China will struggle to meet the goals it has set for itself for elderly care. Even if it succeeds, given the focus on a medical model of the issue, the majority of seniors who don’t need full time medical care but still need support will have little access to the community based services which would give them a reasonable quality of life. The reality in China is

1 See [http://www.chinadaily.com.cn/china/2011-08/24/content\\_13184532.htm](http://www.chinadaily.com.cn/china/2011-08/24/content_13184532.htm).

2 *Ibid.*

that, “From policy formation, service design, implementation to quality control, there are still too many areas of weakness that need to be addressed.”<sup>3</sup>

## Church Run Elderly Homes

One would imagine that services provided by the Catholic Church would be of some quality, drawing on its wealth of international experience. In fact, local circumstances make the transfer of skills difficult and, in practice, Church based NGOs do not bring a particularly fresh approach to the issue of elderly care. Instead, these groups are proposing medical model solutions (nursing homes) not unlike government or private sector offerings, without the funds, experience, or skills to ensure that a quality service can be provided sustainably. Church run homes are often underfinanced and poorly maintained. Investment is confined to hardware, and little or no attention is being paid to the “soft skills” of geriatric nursing and management. They ostensibly seek to offer quality care to the “poorest of the poor” but have neither access to sufficient government subsidies nor well run fundraising programmes to supplement the fees paid by impoverished residents.

Church initiatives which follow the medical model of geriatric care absorb large amounts of available funds, much of which come from overseas. Few of the resulting facilities would meet even the most rudimentary of government regulations in developed countries. It is not uncommon for nursing homes to be built with poor wheelchair access, no lifts, insufficient washing facilities, and only rudimentary kitchens. Given that there are no templates for best practice and a poor regulatory framework these problems are inevitable. As standards improve and flaws become apparent, these mistakes have to be rectified, often at high cost.

The financial management of the facilities is often weak, with little or no allowance for ongoing investment in training and upgrading of services. Fees can, on a simple analysis, cover costs and even give a small profit, but long term running costs are rarely factored in and even winter fuel bills can put a strain on the organisation’s finances. The underfinancing of these operations means that the quality of care suffers.

Staffing, in a constricting labour market, is becoming increasingly costly. Staff retention is an issue and certified staff can and will increasingly be able to command higher salaries in government or private sector facilities. There is little or no training for existing staff, and this writer is unaware of any Sister (most nursing homes are run or managed by religious communities) studying any aspect of geriatric care at advanced level either in China or overseas.

Church run nursing homes are not models of best practice. They are able to “compete” only in the current, unregulated environment where neither government nor private enterprises provide alternatives of any quality. Nursing Homes are expensive to build and maintain and make the Church effectively a competitor with the State and the private sector. However, unlike its competitors, it has not got the financial resources nor the skill set to be a significant player in the market for nursing care.

<sup>3</sup> See <http://www.asiahealthcareblog.com/2010/04/26/elderly-in-china-in-need-of-an-innovators-prescription/>.

It is unfortunate that the Church based NGOs have chosen to be present to the crisis among China's elderly by diverting scarce resources to the inadequate care of the few. Community care models are urgently needed, involve better synergies with existing organisational structures, require smaller investments, are better able to adapt to changing needs, and have the potential to bring a better quality of life to far more people.

## Community Model of Services

Chinese society as a whole has not yet accepted the need for community models of elderly care as the necessary compliment to medical models. Community based services are provided in neighbourhood centres and focus on the needs of the active elderly. Day care for the semi-invalided or home based services for the housebound are almost non-existent. Catholic lay groups offer spiritual support to elderly parishioners, taking Holy Communion, praying the Rosary in their homes, etc., but there are few, if any, efforts to use the familiar model of locally based volunteer groups to extend the services beyond the spiritual comfort of existing members of the Church.



Spiritual comfort is important for the elderly in their daily life in rural China.  
Photo: Vincentian Fraternal Family.

A rare exception is the Vincentian Fraternal Family founded by Xingtai priest Fr. Paul Xi. Originally Fr. Xi attempted to meet the needs of unmarried rural seniors with no caregivers to support them. He set up a small ten-bed residential facility in Hou Dong Wu. The



Supply of eggs and clothing to the elderly in rural areas.  
Photo: Vincentian Fraternal Family.

assumption was that the residents would grow their own food and the facility would, without expensive staffing levels, offer a quality of life to ten residents “without son or daughter.” Unfortunately, the concept was untenable because the assumption was that residents would be ambulant and in good health. It failed to consider that residents might require ever-increasing levels of nursing care during the course of their time at the facility.



The elderly require increasing levels of nursing care over the years.  
Photo: Vincentian Fraternal Family.

Once the risks became apparent, the service was radically redesigned. The result was the development of a community based programme using a “cell” structure, modelled on the Society of St Vincent de Paul. The Vincentian Fraternal Family uses a decentralised structure, where care of seniors is attended to by local groups of volunteers according to a template similar to all the groups. Specialist services, as well as volunteer training, are man-



New shoes are tried during the home visit. Photo: Vincentian Fraternal Family.



Above and right: Distribution of clothing and trying on of some pieces directly on site.  
Photo: Vincentian Fraternal Family.

aged from a central location. The services managed centrally (nutritional supplements, laundry, and basic rudimentary health services) are beyond the capacity of local volunteers in rural communities operating alone. Equally the services would be too expensive to offer were it not for the experience of the local volunteers and their capacity to take on local responsibility for the seniors in their immediate area. The network is low cost and



Home visit for taking the blood pressure and providing the elderly with eggs as nutritional supplements.  
Photo: Vincentian Fraternal Family.

easily expanded and the entire system can be duplicated. Currently 600 seniors are being cared for by volunteers in 6 cells. Without too much organisational challenge that number can expand significantly (or the quality of the service improve) by the addition of more cells. Other groups who wish to adopt the method can do so easily without training as it is essentially only a variation of the basic model of the Church management, i.e. the parish and the diocese.



The helpers provide the elderly with new shoes, warm underwear, and blankets. Photo: Vincentian Fraternal Family.

Unfortunately, this kind of community model programme is rare. While many parishes have individual groups providing some kind of service, they are splintered and uncoordinated. Their potential as service providers in the wider society is underdeveloped. As a result the opportunity to provide services on a community model which are low cost, volunteer based, and immediately improve seniors' quality of life is set aside.



Group photo after the supply with food in front of the church. Photo: Vincentian Fraternal Family.

## Conclusion

China is facing a convergence of demographic changes which have impacts particularly on the elderly. Government-sponsored medical model responses are increasingly accepted as flawed and unsustainable, as they are hardware driven, expensive to manage, and require expertise at all levels of geriatric care, which currently are in short supply. The absence of a good regulatory framework inhibits the for-profit companies from entering the market, but they are still expected to succeed at providing paid solutions for the very wealthy. The voluntary sector remains disorganised, under-resourced, and without models of best practice to emulate. The Catholic Church is presenting itself as a provider of services to the elderly in this complex environment. However, despite the considerable expertise available in the Universal Catholic Church, the Chinese Church has not been able to draw on that expertise in devising policy or in the design or implementation of projects. As a result, its proposals ape those of the government or the private sector, though without the resources that their competitors can provide. The Catholic agencies claim to offer services to the poor at low cost, but are not able to develop, attract, or retain the professional personnel necessary to design, offer, and maintain over time services of real quality.

Much of the Church-sponsored medical model responses are funded by overseas donors. The scale of these projects would presume that sufficient investment has gone into needs assessment and the design of the chosen response. Few, if any Church based organisations, have the capacity to analyse needs and propose useful solutions in this complex environment. Medical model projects presented to overseas agencies are often naïve in concept and significantly underestimate the costs of implementation long term. Overseas agencies need to apply a nuanced critique to projects presented for consideration and prioritising the funding of community based responses. Funding priorities should be altered away from hardware to software and focus on capacity building, scholarships in geriatric care and management, exchange visits to see best practice in other countries, etc. If building projects are justified, the building specification should conform to building codes that, at least, approximate to those of developed countries. Such measures could help shift the Church towards solutions within its existing competencies and allow it time to develop the competencies to be a significant player in the entire sector.

The Chinese Church has demonstrated that it has a heart to love the elderly poor especially of rural China, and is taking halting steps in that direction. Government policy is taking an approach to the issue of elderly care which is untenable and the risk is that Church agencies will, in their inexperience, rush into a misguided duplication of that same flawed policy. International funding bodies, by focusing on creating a cohort of professional, informed, geriatric care-givers at all levels linked to the Church, can help the Catholic agencies to build on their own strengths before competing in the most complex and expensive areas of need. With a partnership of this kind between international donor agencies and local service deliverers, the Catholic Church can first learn to walk with confidence in a very complex environment before it begins to run.